

Office of External Affairs

FACT SHEET

PROPOSED CHANGES FOR PAYMENT FOR IMAGING SERVICES UNDER THE PHYSICIAN FEE SCHEDULE REQUIRED BY THE DEFICIT REDUCTION ACT (DRA)

Overview

The Medicare Physician Fee Schedule (MPFS) proposed rule for 2007 includes proposals to implement two provisions of the Deficit Reduction Act of 2005 (DRA) affecting payment for imaging services under the fee schedule. The first provision addresses payment for certain multiple imaging procedures, with full payment for the first procedure, but a 25 percent reduction in payment for additional imaging procedures furnished on contiguous body parts during the same session. This is a smaller reduction than had previously been proposed. The second limits the payment amount under MPFS to the outpatient department (OPD) payment amount for the technical component (TC) of certain imaging services. Under this provision, the physician fee schedule payment amount for furnishing certain imaging procedures would not exceed the amount paid to a hospital outpatient department.

Background

Imaging procedures generally have two parts: the actual taking of the image (which is called the technical component), and the interpretation of the image (the professional component). Medicare pays for each of these components separately when the technical component is furnished by one provider and the professional component by another. When both components are furnished by one provider, Medicare makes a single global payment that is equal to the sum of the payment for each of the components. The multiple imaging payment policy applies only to the payment for the technical component.

When multiple images of contiguous body parts are taken in a single session, some portion of the technical component, including clinical labor, supplies, and equipment, is furnished once for the entire series of images. In order to avoid duplication of payment, the March 2005 MedPAC report recommended reducing the technical component of fee schedule payments for multiple imaging services performed on contiguous body areas. The final rule for the 2006 physician fee schedule, provided for a 25 percent adjustment in 2006 payment amounts for the second and subsequent images of contiguous body parts. The final rule also indicated that the adjustment would be increased to 50 percent beginning in 2007, but also sought additional data and comments on the appropriateness of 50 percent as the final level of the adjustment. reduction. Since the adjustment was a change in relative values for practice

expenses, the final rule increased the practice expense relative values by 0.3 of one percent in order to make the multiple imaging adjustment budget-neutral.

Deficit Reduction Act of 2005

After the 2006 fee schedule final rule became effective, the DRA was enacted. The DRA contained two provisions affecting imaging services. The first provision eliminated the requirement to apply the multiple imaging payment adjustment in a budget-neutral manner. This DRA provision is effective beginning with 2007; the 0.3 percent increase in practice expense relative values for 2006 was not changed. This means that the increase in relative values under the fee schedule resulting from the savings realized from the multiple imaging payment policy are to be eliminated beginning with 2007.

Second, the DRA caps the physician fee schedule payment for the technical component of certain imaging services at the hospital outpatient payment amount for the same service. This DRA provision does not affect the professional interpretation of the test, nor does it apply to mammography services. The June 2006 MedPAC report to Congress raised questions about the equipment utilization and capital cost assumptions used to determine payment for imaging services in physicians' offices. Their analysis suggests that Medicare payments for certain imaging services, including MRI and CT services for which payment would be reduced under the DRA provision, are too high and could be reduced significantly while still providing adequate payment.

Physician Fee Schedule Proposed Rule for 2007

As required by the DRA, the proposed rule would, for 2007, remove from the practice expense relative values the 0.3 percent increase previously made to these relative values in 2006 to ensure the budget neutrality of the impact of the multiple imaging policies. The proposed rule would also cap payment for the technical component of certain imaging services at the amount that is paid under the hospital outpatient payment system as required by the DRA.

In response to comments on the multiple imaging adjustment policy in the 2006 final rule, and in light of the cap imposed by the DRA, CMS is not now proposing to increase the multiple imaging payment adjustment to 50 percent, but to maintain the adjustment at the 25 percent level. For imaging services subject to both the multiple imaging reduction policy and the outpatient hospital cap, we propose to first apply the multiple imaging adjustment and then apply the outpatient cap. This approach results in higher payments than if the cap were applied first.

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