

Cardiovascular Imaging

Advocating for Sound Imaging Policy

States and payers have responded to growing imaging volume by implementing laws or administrative protocols that make performing in-office imaging difficult or impossible. The cardiovascular community recognizes that there is a high volume of imaging, and believes research is needed to make the distinction between inappropriate and appropriate imaging rates. Below you'll find information about recent trends; what the ACC is doing to address imaging growth; and what chapters can do to address attempts to limit access to imaging.

Federal Actions

On Jan. 1, 2007, a provision of the Deficit Reduction Act of 2005 (DRA) that cut payments for many office-based imaging services took effect. The law requires that payment for the technical component of an imaging service be at either the hospital outpatient prospective payment system (OPPS) rate or the physician fee schedule amount, whichever is lower. A September 2008 Government Accountability Office report found that the provision was successful in reducing payments for imaging, especially among advanced imaging modalities¹; however, the ACC firmly believes that the report provides an illogical precedent of pegging payments to physicians under the Medicare fee schedule to hospital outpatient department payment rates.

The imaging payment cuts contained in the DRA are one piece of the picture when it comes to policy changes that are negatively affecting medical imaging reimbursement. Other causes of cuts to imaging payment include revisions to the practice expense methodology and changes resulting from the five-year review of the Resource-Based Relative Value Scale. With reductions in imaging reimbursements always

a potential way to offset other Medicare payments, it is crucial that lawmakers and their staff understand the impact of payment reductions.

On a positive note, thanks to successful lobbying efforts by ACC members and staff, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) will require accreditation of providers of the technical component for advanced diagnostic imaging services (MRI, CT, and nuclear medicine/PET) by an entity identified by the Secretary of the Department of Health and Human Services prior to Jan. 1, 2012, to be eligible for the technical component payment. It also establishes a two-year, voluntary demonstration program to test the use of [appropriate use criteria](#) for advanced diagnostic imaging services by Jan. 1, 2010.

State Actions

Over the last few years, states have become a battleground on imaging issues. In some states, radiological societies and lawmakers have pushed legislation to completely ban in-office imaging. In others, lawmakers have introduced legislation that would place arbitrary limits on reimbursement for non-radiologists. In all states, the threat of legislation limiting access to in-office imaging is very real. The ACC, working with its local Chapters, continues to battle these threats, while also educating lawmakers on the benefits of in-office medical imaging.

The growth in imaging is slowing.

The rate of imaging on a per-beneficiary basis, which the GAO uses to account for the change in size of the Medicare fee-for-service population, dropped to 3.2 percent from 2006 to 2007, down from a 5.9 percent annual increase from 2000 to 2006.¹

Two recent examples of state-based efforts are in Arizona and Maryland. The Arizona Chapter played an instrumental role in defeating a bill (S.B. 1224) that would have frozen in-office medical imaging for nuclear medicine and certain advanced imaging modalities at Sept. 1, 2008, levels on Jan. 1, 2012. Excellent grassroots outreach by Chapter members; member participation in a House committee hearing and Senate stakeholder negotiations; and the use of a lobbyist with excellent connections to leadership all contributed to the Chapter's success. In Maryland, the ACC Chapter has hired a lobbyist and its members, working in coalition with other specialty societies, are waging a major campaign for patient access legislation that will remove restrictions in a current law permitting only radiologists to perform MRI, CT or radiation therapy. While legislation has yet to be passed, the Chapter has made major headway with state lawmakers.

Payers Actions

Insurers are increasingly using radiology benefit management (RBM) companies as a means of controlling in-office imaging. RBMs use both prior notification and prior authorization as methods of controlling in-office imaging – both of which cause unnecessary delays in time between referral and procedure, and are a large administrative burden for practices, particularly small offices.³ There are steps, however, that chapters can take to attempt to limit the scope. If an insurer's policy will create a significant administrative burden or interfere with the ability to practice medicine, chapters should contact ACC national. The ACC has staff available to meet, along with the chapter, with the insurer to discuss concerns.

For example, the ACC, the New York Chapter and the American Society for Echocardiography met with Aetna in July 2008 to discuss the insurer's decision to require prior approval for echocardiography. After meeting with the ACC, Aetna postponed the policy for six months so that the ACC can conduct research to determine the rates of imaging for echo tests.

ACC Efforts

Attempts to limit medical imaging constitute a failure of policymakers and payers to adequately and rationally address the growth in imaging utilization. The ACC believes that imaging services could best be improved by the use of both accreditation and appropriate use criteria. Accreditation provides an independent evaluation and validation of imaging facilities that allows laboratories to be held to a high level of accountability for the patient care they provide. It also can help reduce inappropriate imaging by serving as a barrier to entry for new imaging labs that otherwise would not meet standards set by accrediting bodies.

Meanwhile, the use of appropriate use criteria engages physicians in shared responsibility for judicious use of imaging services. Appropriate use criteria define “when to do” and “how often to do” a given procedure in the context of scientific evidence, the health care environment and the patient's profile. Appropriate use criteria should be used to understand and improve the rate of clinically appropriate imaging tests, and understand and reduce the rate of clinically inappropriate tests, potentially resulting in cost savings and a higher quality of care.

In addition to the Medicare law pilot (above), the ACC has partnered with United Healthcare on a SPECT-MPI Appropriate Use Criteria pilot designed to help physicians evaluate their test ordering practices in the context of the SPECT-MPI criteria. Both of these efforts should help address questions about imaging growth.

What Chapters Can Do



Quality Efforts. The ACC recognizes that legislative success for accreditation and appropriate use criteria will impact cardiology practices. While such efforts are aimed at avoiding more onerous prior authorization requirements, payment cuts and specialty-specific restrictions, there are real costs associated with effectively participating in these quality endeavors.

- **Accreditation.** If you are not currently accredited, start preparing now for the 2012 deadline. Begin to research your accreditation needs, including what your practice will be required to do to meet the MIPPA requirements. Although the ACC does not provide accreditation, feel free to contact the Intersocietal Accreditation Commission (www.intersocietal.org) for more information. The ACC is available to assist practices in becoming ready to meet the new requirements.
- **Appropriate Use Criteria.** Chapters should help their practices become familiar with the currently published appropriate use criteria. The ACC has developed several tools that can be distributed to members that discuss when an imaging test is appropriate. A number of potential projects using the criteria are currently under discussion, and the ACC is in the process of building an active list of practices willing to participate in collecting data and engaging in quality improvement as a part of these projects. Lastly, the best defense against RBMs is for chapters to encourage practices to use the criteria in ways that demonstrate stewardship and help control growth.

Legislative Efforts. The defeat of S.B. 1224 in Arizona and the ongoing work of the Maryland Chapter are great examples of the power of state advocacy. Keep these things in mind when tackling legislative issues:

- **Find your leaders and identify issues.** Use the state medical society and/or your chapter's Advocacy Committee to identify key issues and politically active cardiovascular specialists. Don't be afraid to form alliances with other stakeholders to help build a stronger case to lawmakers and the public.
- **Don't underestimate grassroots!** Invite lawmakers to be a "Cardiologist for the Day;" testify at hearings; hold lobby days; or throw a fundraiser. It's crucial to form relationships with lawmakers *before* major issues surface.
- **Money talks.** Consider hiring a lobbyist or contributing financially to candidates who support pro-cardiology legislation. A lobbyist can open doors and help draft a successful strategy.

The ACC can provide tools and resources to chapters to assist them in advocating for reform in their state. For additional information and access to these resources, e-mail advocacydiv@acc.org or go to www.acc.org and click on "Advocacy."

¹ Steinwald, A. Bruce. Medicare: Trends in Fees, Utilization and Expenditures for Imaging Services before and after Implementation of the Deficit Reduction Act of 2005. US. Government Accountability Office. 2008.

² Taft, Chloce. "Radiology Benefits Managers Offer Medicare Cost-Saving Option For Imaging." *The Gray Sheet* 2 July 2007.

³ *Impact of Radiology Benefit Management Companies*, American College of Cardiology, Medical Group Management Association and Cardiology Advocacy Alliance 2008.

