MODALITIES & PRACTICE MANAGEMENT

A Working Model?

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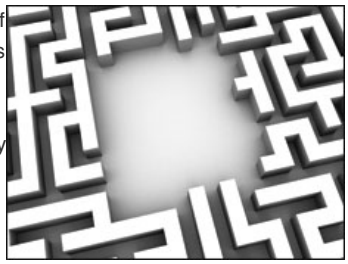
To better control imaging utilization costs, Obama's budget calls for the use of radiology benefit managers in the Medicare environment. But does the RBM model work?



With health care costs spiraling out of control, President Barack Obama has vowed to implement reforms in an effort to rein in costs. One of the areas his administration is particularly focused on is medical imaging, especially within the Medicare environment.

"Imaging is one of the fastest-growing components of the Medicare fee schedule, and imaging costs are growing faster than any other physician service and faster than the rate of prescription drug costs," said Jonathan W. Berlin, MD, MBA, associate professor of radiology at Northwestern University Feinberg School of Medicine.

To address the problem, President Obama has asked radiology benefit managers (RBMs) to play a bigger role in cutting imaging utilization costs, which now reach upward of $100 billion a year. This parallels a recommendation by the Government Accountability Office (GAO) last year, based on a 2005 Medicare Payment Advisory Commission study, that pinpointed MRI, CT, and other diagnostic imaging procedures as the fastest-growing segment covered by Medicare. The Obama budget hopes for a savings of $70 million over 5 years and $260 million over 10.

"RBMs have stemmed the rise of imaging," said Berlin. "Largely through precertification and retrospective denials, they have decreased the slope of the line. So if we define 'working' as decreasing the amount of imaging, then RBMs work. If we define whether RBMs have worked in terms of patient outcomes, that's controversial."

According to industry sources, Nancy-Ann DeParle, director of the White House Office of Health Reform, understands imaging issues. Her perspective on the effectiveness of the RBM model will no doubt be invaluable to the administration going forward. (DeParle declined *Imaging Economics'* request to be interviewed for this article.)

A Myriad of Concerns

The use of RBMs stirs up a host of worries for those in the radiology industry who see the process as cumbersome, costly, and

inefficient. “From the perspective of providers, the radiology business management model has not been very satisfactory,” said James Thrall, MD, chairman of the Board of Chancellors for the American College of Radiology and chairman of the Department of Radiology for Massachusetts General Hospital. “We just did a review at the Partners Healthcare System, of which the Massachusetts General Hospital is a part, and we learned that we have an administrative exposure of just under $6 million because of the RBM process,” he said. The system also has a $4.3 million exposure on claims denied and has had to spend $1.5 million adding additional personnel to support new RBM administration.

The American College of Radiology, and people like Ilyse Schuman, vice president of the National Electrical Manufacturers Association (NEMA) and managing director of the Medical Imaging and Technology Alliance, say the RBM process lacks transparency and consistency. “You are essentially paying an outside administrator to design care, and you really don’t know what they are basing their decisions on,” she said.

Bibb Allen, MD, FACR, chair of the American College of Radiology, Commission on Economics, agrees. “They use a proprietary system, which is never transparent and never provides education to the ordering physician about what would have been a better test and what should have been done first,” he said.

The fear that RBMs will interfere with the doctor-patient relationship is also creating push-back. “This is a decision between the doctor and the patient, and you are taking this decision out of the hands of the doctor and putting it in an unregulated, outside administrator whose basic motivation is to reduce costs and deny care,” Schuman said.

Additionally, Thrall sees the RBM process as devaluing both patient and provider. “It undermines the relationship of the doctor and the patient because the doctor is not trusted to do the right thing,” he said. “All of the medical intuition that they have about a patient has to be reduced into a short transactional conversation with someone who has no knowledge of the patient. Medicine is not practiced as a series of binary transactions. It is practiced across the continuum, with a lot of nuances that are not taken into account [with the RBM process].”

Administrative burdens and garnering prior authorizations are also seen as obstacles. “This is too much of an intrusion on the physician’s work process,” said Thrall. “If a doctor spends an hour a day trying to get prior approval for imaging studies, then someone else is going to have to take care of the patients that they would have seen during that hour.”

The Role of RBMs

Radiology benefit managers see their roles as one of enhancing care, while cutting costs. Cherrill Farnsworth, chairman and CEO of HealthHelp, one of a handful of radiology benefit management companies, stresses that RBMs are not in the business of denying care, but are there to support the diagnostic imaging process. “We have to be very careful that we don’t withhold care,” she said. “Everyone, including RBMs, is very concerned about the clinical correctness of the

various RBMs."

Farnsworth also acknowledges the concerns that physicians have surrounding administrative burdens, but underscores that, in most cases, physicians do not order exams themselves, relying instead on staff and nursing support. "But it still has to happen, and it is a cost," she admitted, recognizing that solutions need to be found. "We cannot have health care continually burdened with paperwork," she said. "This has to be done in a way that makes sense for everybody."

To cut down on administration, Web-based tools are being scrutinized as a partial solution. "The Centers for Medicare and Medicaid Services (CMS) and the GAO are actively talking to the RBMs to try to understand what tools are available and how much of it can be Web-based," Farnsworth said. But she admits that adopting widespread Internet tools can be problematic because not everyone is Web enabled.

Self-referral, the practice of physicians conducting imaging in their offices using their own equipment, has become a problem that the RBM process also is designed to address. According to Thrall, there is a direct correspondence between self-referral and rising imaging utilization. However, he believes that the RBM approach will not impact self-referral "for the simple reason that financially motivated physicians will find ways around the system," he said. "They can easily fit the circumstances of any case to meet the criteria needed for approval. Consequently, the American College of Radiology strongly believes that independent regulation and legislation are needed to curb the abuses of self-referral."

Some argue that the increase in imaging is in direct response to rising lawsuits, but Farnsworth sees the RBM model as a way to help curb such litigation. "I think there's an opportunity to use this as a way to assist with reforms around plaintiffs' lawsuits," she said. "If you have used a radiology benefit manager, and the test has been approved, why wouldn't that protect you from plaintiff lawsuits? If those things could be part of the thinking, I think doctors would see a reason to do this."

A Medicare Mystery

Much of the RBM process will be focused on Medicare, which currently has no preauthorization system in place, and Farnsworth acknowledges the uncertainty this poses. "There is no network, and just how the government will actually impose preauthorization is unknown," she said. "There could be a situation where health care is separated into certain regions under Medicare, and it could be that the RBMs would bid to take over each of those regions," but she is quick to acknowledge the challenges. "It would have to be administered by Medicare, which would be very problematic to everybody involved."

Schuman couldn't agree more. "We don't know the specifics of how the RBM model would be applied to the Medicare context," she said. "CMS and HHS cited problems with applying this in the Medicare context, not the least of which was the cost of doing it. So we're talking about building something from scratch."

Just how all of this will unfold has yet to be determined.

Savings at a Price

Ultimately, the RBM process is designed to cut utilization costs, something that many acknowledge does happen. "Without exception, anyone who

has an RBM in place is saving money," said Farnsworth. "Radiology is a multibillion-dollar industry, and bringing your costs down by 15% or more, while improving the quality of care, becomes real compelling. I think that's why we're seeing the administration so focused on doing something about radiology."

Berlin agrees, but with caveats. "You go onto any of the RBM Web sites and see the number of scans that are done before and after you have RBMs, and there are less scans done, no question about it," he said. "But you have to ask are those cost savings achieved at the expense of access and patient care? Are there better ways of achieving the same outcome and protecting patient safety? I think to some extent there are."

Schuman would like to see the American College of Radiology's Appropriateness Criteria utilized as a basis for determining appropriate use of imaging services. "That's a much better approach than having an unregulated, outside administrator, who's paid to deny care, determine whether a patient is going to get the scan that they need," she said.

Most agree that curbing self-referral, creating better appropriateness criteria, streamlining preauthorizations and paperwork, and better educating ordering physicians are a good start in lessening imaging costs.

"If you address self-referral, have better education of ordering physicians, and address defensive medicine, you would be able to decrease medically unnecessary imaging in a way that is more effective than some of the things that the RBMs do," said Berlin.

Achieving this, while cutting costs and providing access, will require a collaborative approach, said Farnsworth. "We've got to think about it being a give-and-take, and the jury is still out on how this is all going to work."

For now, the American College of Radiology is working with Congress to find solutions with which everyone can live. "We are going to do our best to provide credible alternatives to the members of Congress for an RBM process that is centered around educating the ordering physicians," said Allen. "We always consider the president's budget a series of proposals to the Congress, and assigned to the appropriate committees in the House and Senate, up for debate, comment, and the opportunity to educate members of Congress. I think we are talking about months; I just hope we're not talking about weeks."

In fact, educating physicians may be the ultimate solution. "I think this is a challenge and an opportunity for radiologists," said Berlin. "If we can become guardians of medically appropriate imaging, we can decrease the amount of radiation that people are exposed to, which helps to cut costs. That would help make health care more efficient, and that is a huge opportunity to redefine our specialty and give us value."

Cynthia Kincaid is a contributing writer for Imaging Economics.