MEDICARE PART B IMAGING SERVICES

Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices

What GAO Found

From 2000 through 2006, Medicare spending for imaging services paid for under the physician fee schedule more than doubled—increasing to about $14 billion. Spending on advanced imaging, such as CT scans, MRIs, and nuclear medicine, rose substantially faster than other imaging services such as ultrasound, X-ray, and other standard imaging.

GAO’s analysis of the 6-year period showed certain trends linking spending growth to the provision of imaging services in physician offices. The proportion of Medicare spending on imaging services performed in-office rose from 58 percent to 64 percent. Physicians also obtained an increasing share of their Medicare revenue from imaging services. In addition, in-office imaging spending per beneficiary varied substantially across geographic regions of the country, suggesting that not all utilization was necessary or appropriate. By 2006, in-office imaging spending per beneficiary varied almost eight-fold across the states—from $62 in Vermont to $472 in Florida.

What GAO Recommends

To address the rapid growth in Medicare Part B spending on imaging services, GAO recommends that CMS examine the feasibility of expanding its payment safeguard mechanisms by adding more front-end approaches, such as prior authorization. HHS stated that it would need to examine the applicability of prior authorization for Medicare.

Private health care plans that GAO interviewed used certain practices to manage spending growth that may have lessons for CMS. They relied chiefly on prior authorization, which requires physicians to obtain some form of plan approval to assure coverage before ordering a service. Several plans attributed substantial drops in annual spending increases on imaging services to the use of prior authorization. In contrast, CMS employs an array of retrospective payment safeguard activities that occur in the post-delivery phase of monitoring services and are focused on identifying medical claims that do not meet certain billing criteria. The private plans’ experience suggests that front-end management of these services could add to CMS’s prudent purchaser efforts.