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Long-dreaded DRA enters phase one

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For the better part of a year, imaging industry analysts have been studying and hypothesizing about the impact of the Deficit Reduction Act. I considered myself an optimist throughout most of last year, believing that an idea this bad would not make it into practice, at least not in 2007.

That optimism got me through the buying decisions and expansion of two new outpatient centers. It waned in December, however, when the U.S. Congress failed to pass the Access to Medical Imaging Act (HR 5704, S 3795) that would have put the brakes on the 2007 DRA reductions.

Many industry executives, including myself, believed the proposed legislation, a moratorium delaying implementation of the DRA-mandated cuts, would make it into law. As the imaging community now knows, the 110th Congress will not look at this issue again until later this year. The earliest we could see a reversal, therefore, is January 2008. Even that might be too optimistic, based on the 2008 Medicare Budget released last month.

The budget squeezes another $100-plus billion of savings from Medicare over the next five years. A large portion of that is aimed at imaging and physician-related services. Does the saying "you can't squeeze blood from a turnip" come to mind?

The president's budget proposes permanent cutbacks to healthcare providers, so we would never receive full updates or increases for inflation. The industry is going to have to buckle down, brace itself, and see what horrors await us in the coming months. More important, what is reimbursement really looking like now that we are receiving our first Medicare checks? How is this affecting decisions?

At Liberty Pacific Medical Imaging, we have begun to see the first payments from Medicare, and it is pretty much as bad as we thought it could be. In our Southern California centers, we saw the following changes:

- CPT 72148 MRI lumbar spine (w/o) contrast dropped from $652.27 to $496.85, a 23.8% decline
- CPT 73221 upper extremity (shoulder) went from $580.79 to $491.33, a 15.4% reduction
- CPT 72156 (C-spine w/ and w/o contrast) decreased from $1283.01 to $732.98, a 43% drop

Since Medicare represents about 30% of most outpatient imaging centers' revenue, it is not hard to imagine the pain. It is tolerable, however, provided there are no further cutbacks in Medicare reimbursement.

If, and only if, commercial payers stay at their current rates, I see hope for the outpatient industry, as demand will grow. The scariest scenario is the idea of commercial payers jumping on board and adopting this same fee schedule.

I have received correspondence from payers indicating they will not be adopting Medicare's reductions, but I have also received a few indications that they have not yet decided, putting off their decisions until the end of their fiscal year.

Just as vendors continue to fight to maintain reasonable Medicare reimbursements for imaging, so must they assist us in educating local and commercial payers not to follow Medicare. Providing statistics that show how imaging applications benefit not only patients but payers could prove crucial in the months to come.

Last week, a client asked me if this was still a good business. Still an optimist, I replied yes, provided the commercial payers don't follow in Medicare's footsteps. If they do, the outpatient industry cannot sustain itself regardless of productivity, efficiencies, or new applications.

It is possible to push enough patients through at today's cost structure to pay for new technology every five years. But any shift can throw an industry off balance, which could result in stagnation.

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