

April 1, 2007

Workers' Compensation

Managing High-End Radiology Costs

**How much are you spending on imaging costs in your workers' comp program?
Probably more than you think.**

BY BILL COLACURCIO

Today, more than \$70 billion is spent nationally on radiology testing. Of that, \$35 billion is directly related to high-end radiology, magnetic resonance imaging or CT scans, for example.

About \$3 billion of this can be attributed to spending on workers' compensation. That sum means that high-end radiology comprises 9 percent of the total workers' comp medical expenditure.

How did radiology become such a large expense? Consider that over the last five years, the emergence of new MRI facilities has grown 116 percent and the frequency of testing is up 45 percent nationally—dramatic figures.

Additionally, high-end radiology has become a significant overhead expense for providers when factoring in the costs associated with the purchase and maintenance of the highly sophisticated equipment, the salaries and fees to pay technical personnel to operate these machines, and the amount of office space required to manage imaging centers. All of this contributes to providers needing to keep their machines busy and promote utilization.

How can stakeholders, such as risk and claims managers with national and regional workers' comp insurance companies, third-party administrators, state funds and self-insured employers, manage costs in the face of these inflationary trends?

WORKFLOWS HOLD THE KEY

Most are surprised to learn that more than 60 percent of their high-end imaging payments are essentially "unmanaged."

Fees are charged at the Usual Customary and Reasonable State Fee Schedule, also known as State Fee/UCR. This translates into payments made directly to the providers for a specified service. They could be repriced through a PPO network yielding 8 percent to 10 percent in savings. By contrast, a well-managed specialty program can deliver savings of 35 percent to 45 percent, on average nationally.

To manage out-of-control imaging costs, it is critical to clearly understand claims office workflows and potential leakage

points. A unique approach being developed at One Call Medical begins with a comprehensive analysis of high-end radiology payments to better understand referral patterns, trends and areas where cost management is low.

Often the results of this analysis point to specific geographic areas where a large percentage of the unmanaged diagnostic imaging tests have been paid at higher reimbursement rates, most at State Fee/UCR.

This is generally caused by breakdowns in communication between adjusters or nurse case managers, referring physicians and diagnostic-imaging providers. In addition to higher costs, there are also significant delays in the turnaround time for medical reports, and varying imaging-center quality issues—for example, poor film quality, misinterpretation of results and failure to meet standard protocols.

A well-designed diagnostic management program results from integrated collaboration among a specialty radiology network, the claims operation and the bill-review process. The integration of data, bill processing and claims management protocols uncovers leakage points that can be effectively addressed with practical, easy-to-use solutions. There are several critical aspects to consider when launching a successful programmatic approach. While a well-defined process is essential, the tools and resources needed to execute this type of program are vital. The work of highly qualified, proven workflow analysis consultants, combined with the results derived from customizing industry-standard software solutions, becomes the key driver within the implementation process.

The first step in the process is to obtain radiology pay data. Once obtained, the data is sorted by tax identification number and type of service, an MRI/CT, for example, to exclusively filter out just the high-end radiology pay data.

A full drill-down analysis of the pay data is then performed, which ultimately identifies the facility where the procedure was completed, provider charges and any discounts that were applied.

In the next step in the process, the network disruption analysis and geomatching functions are performed. Using a comprehensive suite of network analysis tools, accessibility summary reports are then generated.

These reports provide a full network comparison overview and cost-savings opportunity. They show how many procedures were performed by providers in a PPO network versus how many procedures were performed by the desired provider network contracted by One Call Medical.

Additionally, these reports reflect the number of providers and average distance between the facility to which patients are currently directed and the closest One Call Medical contracted provider.

Upon the completion of these steps in the process, a complete workflow assessment is performed to review claims processes and to identify all areas in which communication touch points are made between a carrier's adjuster or case manager and the health-care provider, such as hospitals, clinics or physicians groups.

DEEPER UNDERSTANDING

These assessments provide a great deal of understanding related to the relevant account protocols and influences

affecting the ability to prospectively manage high-end radiology costs.

Once defined at a local level, straightforward and inexpensive actions to tighten the handoffs between adjusters, nurse case managers, treating physicians and imaging providers can be initiated quickly, resulting in immediate benefits.

In one data sample of \$35 million in radiology spending, \$1.5 million of savings opportunity presented itself by eliminating direct billing from network providers. As much as \$6 million in savings, or 20 percent, was possible simply by redirecting radiology care to in-network providers.

The pay data analysis identified 18 facilities within a 50-mile radius of a major U.S. city where all of their procedures have been performed. The One Call Medical network identified 44 facilities within the same service area.

The benefits of a comprehensive formalized program such as this—including applied technology and targeted outreach programs to change the behavioral patterns in which claims offices make or are involved in high-end radiology referrals—affords more control over imaging cost inflation, reduces diagnostic-imaging payouts, improves the quality of care received by injured employees, enhances the efficiency and effectiveness throughout a claims processing operation, and realizes a higher level of satisfaction from all stakeholders.

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