

Radiology and the Consolidated Appropriations Act, 2021

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As you undoubtedly know by now, the 2021 Medicare Physician Fee Schedule brought about reimbursement changes particularly significant for radiologists, and not in a good way. The revaluation of families of E/M codes finalized in this fee schedule resulted in significant increase in valuation for those specialties which routinely bill for them. To understand how this negatively affects radiologists, a quick review of CMS reimbursement of physicians is useful.

All physician services are given a value (i.e. relative value unit or RVU) which represents its relative worth compared to other physician services, both within their specialty and across specialties. To arrive at the actual CMS reimbursement for these services and procedures, this relative value is multiplied by the conversion factor (CF), essentially a multiplier which is set by CMS each year in the Physician Fee Schedule: $RVU (\text{procedure}) \times CF = \text{CMS payment}$. The finalized increased valuation of certain families of E/M codes (CPT 99202-99205 and 99211-99215) and addition of new E/M codes (G2211, G2212) naturally result in increases of CMS expenditures. However, CMS has a mandate of budget neutrality which states that increases in expenditure are required to be counterbalanced by decreases somewhere else so that overall expenditures remains the same. The logical method for CMS to maintain budget neutrality in the face of these increased E/M valuations is to proportionally decrease the conversion factor, and this is exactly what they did. The 2021 Physician Fee Schedule finalized a conversion factor of \$32.41, a large decrease from the 2020 value of \$36.09.

Although the conversion factor decreased CMS payment across the board for all medical specialties, recall that specialties which bill for E/M codes saw increase in valuation of these codes with this final rule. As a result, the increased valuation of these E/M codes offsets the decreased value of the conversion factor for specialties that routinely bill for these codes. In fact, primary care specialties that primarily bill E/M codes saw overall increases in reimbursement. For example, the estimated impact on family medicine as a result of the 2021 final rule is a 13% **increased** reimbursement, despite the decreased valuation of the conversion factor. Unfortunately, those specialties that do not routinely bill E/M codes do not benefit from the valuation increase of these codes and as a result feel the full force of the conversion factor decrease. Diagnostic radiology (DR) is one of these specialties, and the 2021 final rule would have resulted in an estimated 10% decrease in reimbursement. Interventional radiology was also estimated to see a 4% decrease in reimbursement, less than DR due to the ability to bill for some E/M codes.

As a result of instrumental work by the ACR, these reimbursement cuts were partially alleviated, at least temporarily. The ACR-led coalition of multiple medical specialties (which also included the ASNR) representing over a million providers directly resulted in a lessening of the planned reimbursement cuts through the Consolidated Appropriations Act, 2021. This act mandated a one-time increase in reimbursement for 2021 resulting in a conversion factor that increased from the final rule amount of \$32.41 to \$34.89. The result of this is a lessened estimated decreased reimbursement of 4% to diagnostic radiologists, significantly less than the 10% decrease that was originally finalized. It cannot be overly stressed that these changes were made possible through the leadership and hard work of staff and volunteers at the ACR and ASNR.

We must not rest on our proverbial laurels, however. The Consolidated Appropriations Act only applies to calendar year 2021. Without further action the mandate of budget neutrality will again be in effect by the end of the year and we will once again be facing extensive decreases in CMS reimbursement. In many ways, physicians are in a similar situation as we were in the 2000s, when the Balanced Budget Act of 1997 mandated the use of the sustainable growth rate formula of calculating the conversion factor. This in turn brought about annual decreases (often in double digits) of physician reimbursement that were averted by annual “doc fixes” legislated by Congress at the eleventh hour.

We should not get into the vicious cycle that we did during those times of hoping for annual temporary fixes to avert disaster. Instead, we should proactively support our medical societies such as the ASNR and ACR who advocate on our behalf to promote better economic healthcare policies to our lawmakers. More importantly, the development of permanent stronger payment policies are critical to ensure that we as radiologists can continue to provide quality and equitable healthcare for our patients.