Doctors urge caution over new analysis of Medicare payments

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There's much to learn from the recent release of unprecedented amounts of data from the nation's second largest health insurer, Medicare, but only if interpreted cautiously, write two doctors at Fox Chase Cancer Center in the June 9 online edition of the *Annals of Internal Medicine*.

In April, the Centers for Medicare and Medicaid Services (CMS) released the most detailed data in its history, related to $77 billion worth of physician billings to Medicare. In its analysis of the data, The New York Times showed that only a small percentage of healthcare providers usurp nearly one quarter of all federal payments. For instance, in 2012, more than $600 million went to just 100 doctors.

So what conclusions should be drawn from this analysis? Although high payments to a few individuals raise concerns that some doctors have billed more than they should, there's often much more to the story, say Fox Chase's Eric M. Horwitz, MD, Chair of the Department of Radiation Oncology, and David S. Weinberg, MD, MSc, Chair of the Department of Medicine.

Specifically, more or less payments from Medicare are not indicative of the quality of care a doctor provided, argue Horwitz and Weinberg. In fact, the more doctors perform a particular procedure, the better they should be at it. And the data only discuss the amount of care, not whether it was appropriate – it's possible that many of these large expenses stemmed from therapies or tests that were entirely necessary. "Most important, Medicare annual payment figures provide no insight into whether the patient benefited from the treatment," the doctors say.

In some cases, add Horwitz and Weinberg, it makes total sense that certain physicians bill more to Medicare, since they specialize in conditions that affect the elderly, such as cancer, cataracts, and macular degeneration. "Wide variations invite thoughtful discussion of how best to allocate finite resources," they write. "The amount of money in question and the potential for misuse demands it. However, comparing the annual Medicare payments to a physician or medical specialty without deeper consideration of the data represents misuse as well."

A closer look helps explain why some doctors received more than others. For instance, in Philadelphia, where Horwitz and Weinberg are based, total reimbursement to individual radiation oncologists ranged from $237 to more than $2.7 million; in San Francisco, payments fell between $7437 and $33,177. What is the explanation? Looking at one diagnostic code (77421, using stereoscopic X-ray guidance to guide radiation therapy), they found that one physician at an academic practice in Philadelphia performed this service 616 times on 321 patients, billing an average of $63 per treatment to Medicare, and receiving $15. But at a suburban private practice, for this same service, a physician billed $300 for each treatment performed 1744 times, and was given $69. Here, the difference stems not from geography, but more the type of practice.

Furthermore, Medicare pays for much more than just physician services – it also covers the cost of drugs, tests and facility fees. In an accompanying editorial in the same issue of the journal, Gail R. Wilensky, PhD, senior fellow at project HOPE and a former administrator for CMS, notes that these data do not provide any information about procedures covered by other insurers, such as private companies and Medicaid. Making major changes to health care spending based solely on physician reimbursement data from Medicare would miss the larger picture, note Horwitz and Weinberg.

It helps to have these data to promote transparency in health care spending – but only if we acknowledge what they can and cannot reveal, the authors conclude. "Used carelessly," these data

"may provide great headlines, gossip, and controversy but will offer little insight, thereby hindering—instead of promoting—efforts to improve health care value."

Provided by Fox Chase Cancer Center