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How Will The PPACA Affect Diagnostic Imaging Equipment Moving Forward?

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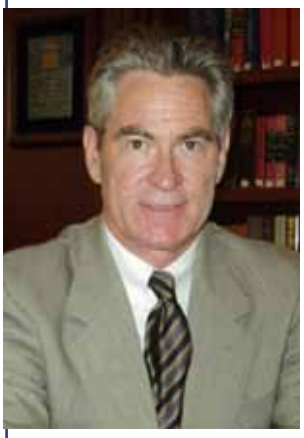

Some of you may have been busy this year providing valuation services for the evolving healthcare industry perpetuated by the Patient Protection and Affordable Care Act (PPACA). Since diagnostic imaging is one of the largest sectors of the healthcare industry, the reality is that the owner, the radiologist/user, and/or the health care provider are dealing with a moving target in deciding what best to do with this equipment.

So what are the major assets out there to be valued? We should label them diagnostic imaging devices which include magnetic resonance imaging (MRI), computed tomography (CT), nuclear medicine, positron emission tomography/computed tomography (PET/CT), ultrasound, X-ray (mammography, radiography, fluoroscopy, surgical c-arm, cardiovascular labs), radiology information systems (RIS), and picture archiving and communications system (PACS).

We are taught to consider all three methodologies of value: the Sales Comparison Approach, the Cost Approach and the Income Approach. But with new bundled procedure codes (CPT), each approach is being impacted by what is being reimbursed for the diagnostic procedure.

So what is going on? Brian Ball, National Vice President of Health Cost Solutions in Chicago for New York based USI Insurance Services, says, "MRI and CT imaging once was the domain of hospitals, which needed them for trauma and emergency cases. But in recent years, physicians realized they could send revenue to themselves if they operated their own equipment. So the idea spread and some of it is logical."

When doctors have imaging done in their offices, it is called self-referring. The volume of self-referred imaging has been rising dramatically with the steady rise of an aging baby boomer generation. This increase to U.S. health care is absorbed proportionately to our GDP.

The results of this imaging boom has made it more convenient for patients to have their RIS imaging results read and relayed back to the patient more quickly by the physician in the clinic. But costs for the same services illogically vary. The same $700 imaging service at a clinic might be $1,700 from a hospital. One problem is the difference between Medicare and private insurance companies. Private insurers can control utilization of imaging services through prior-authorization requirements. Medicare, on the other hand, does not manage costs at the front end but is more efficient paying claims than private insurers, according to Mr. Ball. With cross-currents of processes and differences between who pays how much for what and when, costs leak are out of control.

"Unsustainable" is the word used by the U.S. Government Accountability Office (GAO). So their remedy will be further cost reduction for similar procedures using the same imaging equipment. Whether congress will get our fiscal responsibility in order by the end of the year, one thing is certain; the model first established with the Deficit Reduction Act (DRA) in 2005 when imaging procedure reimbursement to the end user was reduced significantly will be utilized again to offset higher healthcare costs. The impact then was consolidations of OEM's and a reduction in RCN of diagnostic equipment in certain areas.

With this cloud hanging over your client's head, the appraiser should be knowledgeable of the phrase Remaining Useful Life (RUL) or what is the reasonable expectation of the equipment life that you are asked to appraise. To be more succinct, how long should the technology of an asset being appraised be used before it is retired or how would you reconcile the usable life of imaging equipment versus a life table recommended by the Original Equipment Manufacturer (OEM)? For me, it

would be best to go to the market place and see what is considered old. The technician or procurement manager may be your best source as to the assets usability, safety, clinical value, and applicability to the patient population. Other factors would be recalls and safety alerts that are sent by the OEM or the FDA and are the responsibility of the user to implement. Every clinic or hospital is charged with establishing a comprehensive life cycle model. So ask them because the clock is always ticking.

When the OEM has moved on from one series to a newer series of imaging equipment with newer innovations, the after market for your asset begins. You may find that values on the secondary market may have significant variance for the same make and model. How you measure effectively the physical, functional, and economical factors could be features, revision levels, and refurbish replacement of components that could shorten or lengthen the Remaining Useful Life. As an example, do not be fooled if you see the original costs of a Hologic Discovery full body densitometer has secondary values ranging from 54% to 77% of the replacement cost new (RCN). Reasons could be just a basic package versus new full software package capabilities being added to the older refurbished equipment. An OEC 9900 surgical C-arm may now be offered to the radiologist new for $242,000 but they can also purchase a refurbished OEC 9800 from $99,000 to $110,000 with similar features like Computed Radiography Innovation (CR) installed. In this case, the remaining life of the C-arm has been extended and the end user is still receiving the same reimbursement as with the newer equipment.

To the end user, they are attempting to decide whether to keep their existing technology, trade in the old, update the current asset, buy the new series, or replace it with a refurbished series. The end result is that you may be assisting them in making a strategic decision.

If parts are still available for the asset or if maintaining the same asset is still affordable, the end user may keep it longer or even consider purchasing the equipment pre-owned during these challenging times when decreasing reimbursements and government cost reduction programs continue to be implemented.

Mr. Beckwith's career began in 1976 distributing internationally new and refurbished machinery and equipment in the healthcare industry. Though based in Texas, Mr. Beckwith has performed and supervised valuations throughout the United States, Canada, Mexico, and Europe. He has published articles for various valuation topics in The M&TS Journal and the ASA Professional. In addition, Mr. Beckwith has been a staff instructor for the American Society of Appraisers teaching Principle of Valuation courses. Honorariums include: ASA International Appraisal Conferences Presenter and ELFA 49th and 50th Annual Conventions Presenter.