

RADIOLOGY TRENDS



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Senate Panel Considers Creating Out-Of-Network Billing Limits

Recently, Alaska's senior GOP senator, Lisa Murkowski, led a charge to determine how Congress could curb exorbitant out-of-network billing, since her state's attempted fix only drove overall healthcare costs higher. Currently, Alaska has the status of having the highest healthcare costs in a country that leads the world in healthcare costs. A rule was issued in the state in 2004 meant to check excessive bills dropped on people with commercial insurance who required treatment from an out-of-network doctor. The state's rule requires that insurers pay 80% of the reasonable, market rate of the treatment. This led to specialty physicians running up the rules, unchecked, and \$85 million in additional healthcare spending.

The issue demands a policy fix, said Murkowski, noting that other rural states could face similar problems. In Alaska's case, tying the benchmark prices to a national average rather than the local specialists' costs could drive incentives the other way, according to Dr. Ashish Jha, who directs the Harvard Global Health Institute. Jha encourages lawmakers to look at ramping back the administrative burden—particularly when it comes to quality reporting—as a way to tamper down on the temptation for small independent providers to fold into larger systems who have the staff to manage billing and reporting. "The trends are feeding into each other, and we have to look at the administrative challenge," Jha said.

Welcome Back To School

Coding and Compliance Tips by Lori Shore, CPC, RCC

This is the time of year when many new doctors join their first radiology practice after years of college, medical school, residency and sometimes fellowship. Just when they think school is behind them they need to learn all of the things they never learned in school, the ins and outs of documentation. Here are a few tips to help the new radiologists in your group:

- Diagnostic X-ray reports must always list the number of views or the lowest number of views will be coded. Multiple views = 2 views.
- CTA requires that 3-D or MIPS reconstruction images are documented or it will be down-coded to a CT. "Multiplanar reconstructions" does NOT qualify as 3-D.
- MRA requires that reconstruction images are documented; however, they don't need to specify 3-D like CTA.
- Duplex must include documentation of gray scale imaging, color flow and one of the following: spectral analysis; mono/bi/tri phasic waveforms, waveform analysis, pulsed doppler.

- Complete abdominal ultrasound must include all 8 of the following elements: Liver, gallbladder, common bile duct, pancreas, spleen, both kidneys, upper abdominal aorta and IVC.
- Complete breast ultrasounds must mention that scanning was done in all 4 quadrants, the nipple and retroareolar area.
- Breast tomosynthesis should be included in the body of the report, not just the header.

Another important documentation issue to consider is compliance with the reporting requirements for the MIPS Quality program. Find out which measures are being reported for your group and make sure your templates are set up to accommodate those measures. Some common measures for radiology include:

- Measure 76 – "Maximum sterile barrier technique" must be documented for all central venous catheter procedures.
- Measure 145 – Fluoro dosage OR fluoro time AND number of images must be reported any

time fluoro is used, including guidance. Cine loop = 1 image

- Measure 146 – Try to avoid the use of BI-RAD category 3 as much as possible when reading screening mammography.
- Measure 147 – Be sure to list what relevant images you used as comparisons for all whole-body bone scans. If no relevant images were available be sure to document that as well.
- Measure 195 – Add a statement to all carotid studies in any modality that stenosis measurements were based on NASCET criteria.
- Measure 225 – Add a statement to all screening mammographies that the patient was entered into a reminder system for her next mammo (Make sure your hospital really does this first!).
- Measure 436 – Add a statement that dose lowering techniques were used for all CT and CTA studies.

Following these simple guidelines will help to ease your re-work as you enter your new practice.

What UVA's experience reveals about the value of CDS

10:15 AM on June 19, 2018 by Erin Lane and Catherine Kosse. *The Advisory Board Company (ABC)* is the owner and publisher of this article.

Clinical decision support (CDS) is a tool that aims to increase appropriateness and decrease unnecessary utilization. Although the Medicare Appropriate Use Criteria Program, which mandates consultation of appropriate use criteria (AUC) via electronic CDS for advanced imaging orders, doesn't begin until 2020, many organizations have moved forward with implementation in order to experience the benefits of CDS.

Members frequently ask our research team if imaging CDS "works." In other words, does this tool positively affect ordering behavior? A research study from University of Virginia Health System (UVA) sheds new light on the tool's effectiveness.

Results from University of Virginia

UVA implemented CDS in 2014 in the inpatient setting and ED. After six months of a silent roll-out, where ordering providers did not see feedback, the organization turned on alerts. Clinicians could then assess the appropriateness of their orders—and change or cancel them, if needed—at point of entry. While UVA did implement CDS for outpatient orders in June 2017, the health system for this study restricted data analysis to the two earlier care settings: inpatient services and ED.

After using the tool, imaging appropriateness improved in both care settings. In particular, CDS consultation decreased the relative frequency of low-utility imaging orders—or those scoring one to three on the appropriateness scale—from 11% to 5.4%. This trend was even more pronounced among trainees (residents or fellows); in this cohort, the frequency of low-utility orders dropped from 10.8% to 4.8%.

Creating a culture of appropriateness

The strong results advance UVA's overarching goal of using CDS to improve quality. Dr. Cree Gaskin, vice chair of informatics, explained why the health system chose to be early adopters of the tool: "We look at CDS as a way to improve patient care and experience. This tool educates providers at the point of order entry, and, as a result, patients should receive better quality care because they are more likely to get appropriate imaging tests and avoid unnecessary ones."

Plus, UVA's results demonstrate that trainees are especially receptive to the tool's feedback, suggesting that the health system is laying a foundation of imaging appropriateness early in physicians' careers that could have a long-term, positive influence on their ordering patterns.

Lessons from Advisory Board: Strategies to improve CDS effectiveness

While UVA's experience supports the hypothesis that CDS increases imaging appropriateness, it also presents opportunities to improve the tool. For example, the organization saw the biggest improvement in appropriateness scores for MRI, CT, and ultrasound—but no impact for PET and nuclear medicine. There are two potential explanations for this discrepancy: the lack of robust vendor content for PET and nuclear medicine exams, or training gaps for providers ordering those modalities.

To address the first problem, CDS vendors are releasing software updates on an ongoing basis to improve CDS clinical content. At time of publication, UVA's software had already released seven newer versions than what was used during the study time period, including updates from the Society of Nuclear Medicine and Molecular Imaging. To resolve the second issue, Advisory Board research has found that organizations must proactively engage referring providers. Read more: https://www.advisory.com/research/imaging-performance-partnership/the-reading-room/2018/06/uva_cds