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INDUSTRY UPDATES

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Radiologists Inconsistent With How They Convey Diagnostic Certainty

Diagnostic certainty phrases (DCPs) are common in radiology reports, helping the radiologist convey certainty in an imaging finding or its clinical significance. According to a new study published in *Academic Radiology*, however, radiologists use a wide variety of DCPs, and reducing this variation could improve the overall quality of radiology reports.

The study's authors reviewed the DCPs used at a single academic medical center in 2016, tracking DCPs shown to have good agreement between radiologists and referring physicians. Overall, 43% of all radiology reports were found to include at least a single DCP. A DCP was used in 68% of all CT reports, making it the most common modality to feature such a phrase.

"Only 3% of these DCPs were those that previous studies have shown as having good agreement between radiologists and referring physicians," wrote Ronilda Lacson, MD, PhD, department of radiology at Brigham and Women's Hospital in Boston, Massachusetts. "These DCPs with good agreement are typically used to express extremes of certainty; radiologists utilize these terms when they are 'most certain' (e.g., 'diagnostic of') or believe a phrase as conferring a 100% likelihood of a diagnosis." A high level of variation was noted in the use of DCPs with good agreement between physicians, which the authors described as "not surprising."

"Further studies could assess whether years in practice or physician risk profiles are associated with variation in DCP usage," the authors wrote. "Interventions to harmonize the use of DCPs among individual radiologists, including minimizing use of DCPs without 'good agreement,' may be helpful to reduce ambiguity of reports for referring providers and patients."

CMS Changes Documentation Requirements For E/M Services

Coding & Compliance Tips by Lori Shore, Industry & MBMS Expert, CPC, RCC

The Centers for Medicare and Medicaid Services (CMS) released its 2019 Final Rule last week which included the long-awaited news that many have anticipated, they are reducing the documentation burdens for Evaluation and Management (E/M) services. In an open letter to clinicians, CMS Administrator Seema Verma announced the reduced documentation requirements for 2019 as well as the payment changes effective in 2021.

The changes from Seema Verma's letter to clinicians for 2019:

- Simplify the documentation of history and exam for established patients such that when relevant information is already contained in the medical record, clinicians can focus their documentation on what has changed since the last visit rather than having to re-document information.
- Clarify that for both new and established E/M office visits, a Chief Complaint or other historical information already entered into the record by ancillary staff or by patients themselves may simply be reviewed and verified rather than re-entered.
- Eliminate the requirement for documenting the medical necessity of furnishing visits in the patient's home versus in an office.
- Remove potentially duplicative requirements for certain notations in medical records that may have previously been documented by residents or other members of the medical team.

To see a complete copy of the letter to clinicians, please go to: https://www.cms.gov/About-CMS/Story-Page/Clinician-Letter-Reducing-Burden-Documentation-and-Coding-Reform-.pdf

Beginning in 2021 the payment for E/M services will be condensed into three levels instead of the previously proposed two levels. Level 1 services will receive one level of payment, Levels 2-4 will receive a blended level of payment, and Level 5 services will receive higher reimbursement. Add-on codes will be made available for Levels 2-4 care to adjust payment for extended visits. This is all part of CMS' commitment to "Patients over Paperwork" initiative.