APRIL 2017

MBMS
Specializing In What Matters Most To You!

RADIOLOGY TRENDS

"We specialize in what matters most to you!"

MBMS
Specializing In What Matters Most To You!

mostrum@mbms.net
610.564.5314

MedPAC Report On Imaging Volume Sees Glass Half Empty

Despite growth in medical imaging volume per Medicare beneficiary of only 0.5% in 2015, and a decline of 8% in volume since 2009, the latest report by the Medicare Payment Advisory Commission (MedPAC) warns that imaging could still be overused and concludes that Medicare should prioritize reimbursement for primary care over specialties like radiology. "The relatively high use of imaging and tests has led to concerns about appropriate use of these services," MedPAC wrote. "Physicians have warned that diagnostic tests are often ordered without an understanding of how the results could change patient treatment."

The new report documents the shift in imaging utilization from freestanding centers -- many of them cardiology offices -- into the hospital environment.

"In recent years, there has been a trend toward billing for some services in hospitals instead of freestanding offices," the commission wrote in the report. "This change in setting increases overall Medicare program spending and beneficiary cost sharing because Medicare generally pays more for the same or similar services in [hospital outpatient departments] than in freestanding offices." As it did in its 2016 report, MedPAC noted that imaging and cancer screening measures make up 60% of the volume of low-value care per 100 beneficiaries. "In addition to increasing healthcare spending, low-value care has the potential to harm patients by exposing them to risks of injury from inappropriate tests or procedures and may lead to a cascade of additional services that contain risks but provide little or no benefit," MedPAC wrote. "The commission has concerns that the resource-based relative value scale, which forms the basis for the fee schedule, includes mispriced services and that these mispriced services cause an income disparity between primary care and specialty physicians," MedPAC wrote. Fee-for-service "payment allows some specialties to more easily increase the volume of services they provide (and therefore their revenue from Medicare), while such increases are less likely for other specialties, particularly those that spend most of their time providing [evaluation and management] services."

Meet MBMS At An Upcoming Conference!

April 7-8 :TX Radiological Society Meeting, Galveston

April 23-26: RBMA, Chicago

May 1-4: ARRS Conference, New Orleans

Working Together

Coding and Compliance Tips by Lori Shore, CPC, RCC

For complex procedures, insurance sometimes allows for two physicians to work together and bill for the same case as co-surgeons. The likely scenario is when an interventional radiologist is working with a vascular surgeon, for example, AAA endovascular repair. It is imperative that BOTH doctors bill for the same CPT codes for the work they shared with modifier 62. Clear documentation and communication between the billing offices are the keys to making this work. The coders need to know exactly who did what portion of the procedure. In the AAA example, the coders would need to know exactly who did the cut-downs, who inserted the catheters, did both work on the graft positioning, was there an extension, and every detail through the closure. It is imperative that these cases get coordinated so that both physicians get paid correctly.

Another case of working together involves teaching hospitals where supervising physicians are overseeing residents. Any work performed by residents must contain an attestation that the supervising physician reviewed the images and report and agrees with or has amended the findings. This attestation should be signed by the teaching physician. These cases are billed with modifier GC to signify that the service was performed by a resident under the supervision of a teaching physician. The resident may sign the report but it is important that the supervising or teaching physician sign the attestation as he/she is responsible for the case as we are unable to bill for a resident.

Why Improving Access Is A Win-Win For Imaging Patients And Providers

8:19 AM on March 28, 2017 by Sruti Nataraja and Erin Lane of *The Advisory Board Company* (ABC). ABC is the owner and publisher of this article.

In an era of taxi-apps, instant grocery delivery, and even on-demand dry-cleaning, convenience is king for winning consumers. In many ways, health care is no different.

While consumers are not ordering mobile MRIs to their apartments, it is undeniable that patients have become activated players in their health care decisions. Although the majority of imaging patients follow the recommendations of referring providers, consumers are having new conversations with their doctors about their expectations for health care. We hear time and again that providers are making referral decisions based on patient preferences.

Many of the same consumer preferences for easy convenience carry over into imaging.

Imaging consumers demand convenient access

One thing we learned from our Imaging Consumer Preferences Survey is that, when it comes to outpatient imaging, patients want it all. We asked over 2,000 potential patients questions that allowed us to rank 67 different attributes of an outpatient imaging setting according to how valuable they were to patients. The top 10 most preferred factors spanned the full gamut: quality, cost, access, service. But the lowest ranking factors tell a different story: five of the 10 least-preferred factors were related to access.

Notably, two of those bottom 10 factors have to do with appointment wait time. For example, a two-to-seven-day wait for an appointment ranked as the 59th most valuable to patients of 67 total attributes.

Access is crucial to maintaining referrals

Many imaging programs report strong performance on traditional access metrics such as third next available appointment. Interestingly, through our research we found that all programs, regardless of their current performance on access, cited access issues as a top challenge. As evidence, a recent member survey reveals that access-related factors such as appointment availability and scheduling ease were ranked as the most important competitive factors in any given market.

These survey results, taken together demonstrate that access must be approached from the perspective of both patients and referring providers. Offering immediate access for all outpatient imaging exams may be unattainable and even unnecessary. Instead, programs should focus on improving access where patient and referring provider demands align.

Case study: Using a coordinated schedule to provide same-day appointments

Bluefield University Imaging—a pseudonym—noticed that many of their patients travelled significant distances to see Bluefield physicians and had to wait several days between appointments. This created unnecessary strain on both patients and caregivers.

Bluefield collaborated with referring specialists to pilot a coordinated scheduling process. Referrers identify patients who are traveling, and schedulers from both offices collaborate to offer same-day imaging and specialist appointments. On the day of the coordinated clinic visits, the technologist flags the completed study so that it is prioritized in the radiologist's queue. The referring provider receives a preliminary report with a few hours of the exam and prior to the patient's scheduled visit.

Today, half of all Bluefield patients have coordinated clinic visits.

Bluefield University Imaging's coordinated scheduling impacts both of their primary consumers: patients and providers. As patients become more involved in making care decisions with referring providers, imaging programs must meet the demands of each group to safeguard current volumes and attract new business.

Full Article: https://www.advisory.com/research/imaging-performance-partnership/the-reading-room/2017/03/same-day-access

Advisory Board Consulting and Management now has more than 380 management executives and clinicians with an average of more than 15 years of operational experience running critical hospital and medical group departments. We also distinguish ourselves from other consulting firms by providing both management and consulting while also engaging hospitals' and health systems' staff to rapidly implement the system's strategic initiatives.