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House Passes Measure To Repeal and Replace the Affordable Care Act

The House narrowly approved legislation with a vote of 217 to 213 to repeal and replace major parts of the Affordable Care Act, as Republicans recovered from their earlier failures and moved a step closer to delivering on their promise to reshape American health care without supporting mandated insurance coverage.

The House measure faces a great deal of uncertainty in the Senate, where a handful of Republican senators immediately rejected it, signaling that they would start work on a new version of the bill virtually from scratch.

Just before the vote, the Senate gave final approval on Thursday to a \$1.1 trillion spending bill that will finance the government through September, and unlike the healthcare legislation, the spending bill had broad bipartisan support. The House bill would eliminate tax penalties for people who do not car-

ry health insurance. States could also seek waivers that would let insurers charge higher premiums for some people with pre-existing medical conditions. It would roll back state-by-state expansions of Medicaid, which covered millions of low-income Americans. In place of the government-subsidized insurance policies offered on the Affordable Care Act's marketplaces, the bill would offer tax credits of \$2,000 to \$4,000 a year, depending on age. As an example, a family could receive up to \$14,000 a year in credits. The credits would be reduced for individuals making over \$75,000 a year and families making over \$150,000.

The bill would make profound changes to Medicaid, the health program for low-income people, ending its status as an open-ended entitlement. States would receive an allotment of federal money for each beneficiary, or, as an alternative, states could take the money in

a lump sum as a block grant, with fewer federal requirements. The bill would repeal taxes imposed by the Affordable Care Act on high-income people, insurers and drug companies, among others. It would also cut off federal funds from Planned Parenthood for one year. Republicans argued with so many problems afflicting the Affordable Care Act, the status quo is unsustainable, regardless of what Congress does. Many defenders of the bill focused less on its details and more on what they saw as shortcomings in the Affordable Care Act. Democrats, who voted unanimously against the bill, vowed to make the Republicans pay a political price for pushing such unpopular legislation. "I have never seen political suicide in my life like I'm seeing today," Representative Louise M. Slaughter, Democrat of New York, said on the House floor before the vote.

False Claims Case Settles for \$1.6 Million for Incorrectly Billing Radiology Physician Assistants

By Lori Shore, CPC, CPMC

Norman Regional Hospital in Oklahoma has agreed to a \$1.6 million settlement with the United States government to settle a false claims case involving the incorrect billing of radiology physician assistants, (RPAs). The suit alleged that the proper level of supervision was not provided for cases billed by a physician when actually performed by a radiology physician assistant. Laws vary from state to state regarding what is and is not billable for RPAs. One common theme is that RPAs can currently not be credentialed by Medicare and therefore may not bill

for services they perform.

In the Norman, Oklahoma case, not only were the radiologists named in the suit but also the former hospital administrator. This was a qui tam or whistleblower case brought by a former radiologist at the hospital.

The hospital cooperated with the government and settled without admitting liability.

Thomas W. Greeson and Paul Pitts, attorneys with Reed Smith, LLP noted that in a hospital setting Medicare will not reimburse for non-diagnostic procedures (surgical or invasive) performed by an RPA,

even if the radiologist supervised. Any services performed by an RPA and billed under a physician's provider number would be considered fraud.

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Clinical Decision Support: The First Step To Quality In Imaging

8:58 AM on April 11, 2017 by Sruti Nataraja and Ty Aderhold of *The Advisory Board Company* (ABC). ABC is the owner and publisher of this article.

In imaging, quality truly begins at the ordering stage. Ensuring that only the most appropriate imaging exams take place is the first step to high quality imaging.

Inappropriate imaging wastes the time of patients and the health system. Additional imaging also comes with additional patient safety risks such as radiation dose, and when the imaging is unnecessary these risks are no longer balanced by the upside that normal imaging brings. Furthermore, inappropriate imaging can delay a proper diagnosis, as care providers spend time waiting on and then reviewing an exam that will not provide answers.

Even the clearest image, captured with the safest protocols, is low-quality if it was not needed in the first place.

The importance of appropriateness is summarized in a conceptual equation that a leading thinker in radiology at a large academic medical center introduced to our team during our research:

$$\text{Quality} = \text{appropriateness} \times \frac{(\text{outcomes} + \text{service})}{\text{waste}}$$

In this equation, all other aspects of quality imaging are multiplied by appropriateness. If an exam is inappropriate, appropriateness becomes zero, making quality zero overall.

A key role for imaging to play

It may seem that ensuring appropriateness is the responsibility of referring physicians. However, it has become increasingly clear that this expectation is unrealistic. Clinical guidelines are constantly being developed and refined, which means that staying up-to-date can be challenging—especially for referring providers who see many different types of patients with a variety of symptoms. Radiologists and imaging leaders, as the clinical experts, should take the lead on ensuring appropriateness.

Medicare, too, shares this view of radiology's responsibility. As of January 1, 2018, the federal government requires referring providers to consult a clinical decision support (CDS) tool for all advanced outpatient imaging exams—a policy designed to elevate imaging appropriateness. But it is imaging providers, not referrers, who risk losing Medicare reimbursement if this consultation does not take place.

Tackling the appropriateness challenge with CDS

While the looming deadline may be the major catalyst for CDS implementation, imaging programs should recognize the opportunity that the tool provides to reduce inappropriate imaging and therefore improve quality. Through our research we have found that successful CDS implementation leads to a significant reduction in inappropriate exams.

For example, Virginia Mason began their CDS implementation with a small-scale rollout with three of the most overused imaging exams: lumbar spine MRI for low back pain, brain MRI for headache, and sinus CT for sinusitis. Each of these low-utility, high-volume, and high-cost exams was classified as unnecessary by clear appropriate use guidelines. Virginia Mason rolled out CDS for these three exams and prevented providers from ordering against the clinical guidelines without consulting a member of a multidisciplinary team of experts. After implementing this system, they found a 24.4% average percentage decrease in utilization rate for the targeted procedures.

One issue that can reduce the effectiveness of CDS is the fact that many clinicians use a non-physician proxy to order imaging exams. This means that they do not see and learn from the CDS feedback. To help combat this issue, Massachusetts General Hospital implemented a "Hard-Stop on Red" (HSOR), which required a clinician to log in and sign for any "low-value" exam that scored 3 or below on a 1-9 appropriateness scale. **Read the full article here:** <https://www.advisory.com/research/imaging-performance-partnership/the-reading-room/2017/04/appropriateness-in-quality>



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