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Radiology Trends

Did You Know?

Diffusion tensor imaging shows females may have lower recovery time after concussions. This type of imaging shows differences in the brain between males and females who sustain concussions.

Did You Know?

Healthcare providers will have one extra year to use 2011 Edition software in their electronic health record systems due to federal incentive program for health IT under a proposed rule the CMS issued in late May. Providers scheduled to jump to the program's Stage 2 criteria will have another year to stay at Stage 1.

Joint Commission Delays Imaging Standards

The Joint Commission has delayed the implementation of new and revised diagnostic imaging standards that were to take effect July 1st, with additional changes to be phased in by 2015. They delay is due to feedback from stakeholders that caused the organization to reconsider several issues, it said.

While there was praise for the overall effort, there were also concerns about several critical standards. The feedback highlighted "issues that may not have been either identified or sufficiently evaluated during the standards development process," the Joint Commission said. "Some of these issues highlighted complexities that require us to engage in further research in order to ensure that the new standards best promote the improvement and quality and safety." The Joint Commission said it now aims to implement the revised standards by July 2015, releasing a full set of requirements at that time instead of partial sets over 2014 and 2015.

The organization is collecting additional information about several critical areas of radiation safety: documentation of radiation dose, annual equipment performance evaluations by a medical physicist or MR scientist, minimum qualifications for radiologic technologists who perform CT, and requirements that align with California's CT law. Additional questions or feedback may be addressed to imagesafety@jointcommission.org.

Flaw in Radiation Reduction Efforts, One Size Doesn't Fit All

"One-size-fits-all" radiation reduction protocols may be misleading, according to a recently published study, because patients receiving the least benefit of the dose reductions may contribute disproportionately toward improved averages.

"Put another way, tailoring dose-reduction efforts to preferentially affect younger healthier patients, thus allowing elderly patients or patients with low life expectancy the benefits in image quality that may be afforded by higher radiation doses, may compromise an institution's performance metrics, even though their efforts may be appropriately patient centered," wrote Jonathan D. Eisenberg, BA, of Massachusetts General Hospital, and colleagues. "Our findings emphasize the need to consider more granular patient-centered benchmarks when evaluating an institution's performance in radiation dose reduction."

For the analysis, they drew from 20,979 CT scans performed at their institution in 2011. Of these scans, 39 percent were performed in patients aged 65 or older. The researchers found that if dose reductions had been applied across all patients, the maximum number of lethal cancers avoided was seven per 100,000 people.

The researchers supported their findings that 39 percent of patients were aged 65 or older by examining previously published data on the age-frequency distribution of abdominopelvic CT. Data from a national level showed that 36.2 percent of abdominopelvic CT cases were performed in patients aged older than 65. - See more at: <http://www.diagnosticimaging.com/low-dose/flaw-radiation-reduction-efforts-one-size-doesnt-fit-all#sthash.KqbJ2kRg.dpuf>

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CT Lung Screening Would Cost Medicare \$10B, Study Finds

A new model-based study of National Lung Screening Trial (NLST) results predicts that implementing CT lung cancer screening in the Medicare population will identify more cancers -- and at earlier, curable stages -- but the costs to Medicare will be substantial.

The new model estimates that implementing screening gradually in the Medicare population would result in approximately 54,900 more lung cancers detected over a five-year period, most of which would be early-stage disease; however, the cost would approach \$10 billion. The model represents the first analysis of NLST data to look specifically at the Medicare population. This group has a high lung cancer incidence and a large segment that qualifies for screening under guidelines approved

by the U.S. Preventive Services Task Force (USPSTF). NLST, published in 2011, showed a 20% drop in lung cancer deaths with low-dose CT (LDCT) screening versus x-ray screening in a population of more than 50,000 individuals. The findings led USPSTF to recommend LDCT screening for people ages 55 to 80 years with a 30-pack-year smoking history who currently smoke or who quit within the past 15 years.

"If we can diagnose lung cancers at an earlier stage, patients can be treated far more effectively and survival prognosis is much better," said lead author Joshua Roth, PhD, from Fred Hutchinson Cancer Research Center, in a statement announcing the results. "However, the key to the success of this screening program is ensuring that those who are at high risk actually undergo screening and subsequently receive appropri-

ate treatment."

Screening eligible Medicare patients is projected to boost the proportion of early-stage diagnoses from 15% to 33%, the study team reported. On the cost side, however, five-year Medicare outlays for CT imaging, diagnostic workup, and cancer care would total \$9.3 billion. This represents a \$3 monthly premium increase for each Medicare member if the program sees "expected" use in 50% of screen-eligible members. In a low-use scenario (25% of eligible members), the Medicare cost would amount to \$5.9 billion; in a high-use scenario (75% of eligible members), the total would reach \$12.7 billion.



Coding and Compliance Tips by Lori Shore, CPC,RCC

Rule Out Doesn't Fly!

As a coder, we are unable to code anything that states: "rule out", "consistent with", "probable", or the like. Although this has been the rule for many years now, I still continue to see these documented in reports. The only equivocal comment we are permitted to code is "evidence of".

There are some studies; in particular, where the clinical history we get is often problematic. "PE protocol" does not work for the CTA of the Chest, nor does "R/O DVT" for a venous duplex of the lower extremity. The issue comes when the study is normal, which is the majority of the time with these studies. In these cases, it is preferable to have signs and symptoms. Among other diagnoses, CTA of the Chest is generally covered for shortness of breath. Venous duplex studies are generally covered for pain and/or swelling of the limb(s).

It is always preferable to a coder to have signs and symptoms in the clinical history rather than a disease process. It gives us a better chance of proving medical necessity if the disease process is not covered.