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# Radiology Trends

## ***Did You Know?***

Patients with nonsolid lung nodules can be safely managed non-invasively using low-dose CT, according to a study of more than 57,000 lung cancer screening patients.

## High-Deductible Plans Change How Hospitals Interact With Patients

High-deductible plans are changing the way health systems interact with their patients, from where they get care to how they're presented with their bills. The changing healthcare environment was a significant focus of the Healthcare Financial Management Association's annual National Institute in Orlando, FL. Healthcare providers are collecting \$0.18 to \$0.34 on the dollar from patients with high-deductible plans, said Christopher Kerns, managing director at the Advisory Board Co. Once a bill exceeds 5% of household income, a patient's propensity to pay drops to nearly zero, he added.

Yet the impact of high-deductible plans on bad debt varies from system to system. While some have reported a significant effect, others say they've experienced little difference. The research on patient collections isn't encouraging thus far. Less than half of patients are paying their share of the bill before it goes to collection, said Diane Watkins, vice president of revenue cycle at St. Luke's Health System in Kansas City, MO. The average deductible for employer-sponsored coverage is now at \$1,200, and it's even higher for exchange plans. "Very few people are fully prepared to meet that obligation," Watkins said. "They just don't have the money, in some cases."

The growth of high-deductible plans also is transforming healthcare into a retail market, especially for services viewed as commodities, like imaging and laboratory tests, said Mark Grube, managing director at consulting firm Kaufman Hall. Some systems are partnering with pharmacies or publicizing their prices as a way to get a foothold in the retail space. But others are tackling the increased competition in a different way...by moving to a bundled payment model. "It's our view that they will not always be able to compete on price," said Dan Clarin, VP of Kaufman Hall. "But it's going to require a more nuanced response than they had before."

## CMS Finalizes Medicare ACO Rule With New Risk Options

More flexibility is coming for Medicare accountable care organizations under a new CMS rule. The revisions are intended to strike a balance between maintaining the program's rigor and making sure providers continue to participate. The Medicare Shared Savings Program will offer a new track to take on more financial risk of patient care, and it will allow Medicare ACOs to avoid penalties beyond the initial three-year term. CMS will also issue future guidance on benchmarking and rebasing issues that have been sources of

contention for many providers. CMS expects 90% of Medicare Shared Savings ACOs will stay with the program because of the rule changes. The agency also made it clear in the rule that the ACO program is a separate, distinct option from traditional fee-for-service Medicare and the capitated Medicare Advantage program even though ACOs incorporate elements of both. Unlike Medicare Advantage, people enrolled in a Medicare ACO still have their full traditional Medicare benefits and can

see any Medicare provider, not just those within the ACO.

"While we frequently relied on our experience in other Medicare programs, including Medicare Advantage, to help develop program requirements and design elements for the Shared Savings Program ... the intent of this program is not to recreate or replace Medicare Advantage," CMS said. Later this year in a separate rule, the agency also will readjust its methodology for what it calls benchmarking and rebasing.

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## Cigna Declines Anthem Takeover Bid

Health insurer Cigna Corp. has rejected a \$47 billion offer to be acquired by Anthem, saying the terms of the bid are inadequate and "woefully skewed in favor of Anthem shareholders." Cigna's sharply worded rejection came after Anthem went public with its cash-and-stock offer.

The proposed deal would make Anthem an even bigger giant in an industry that many see as ripe for consolidation, as insurers struggle to cut costs in the face of new regulations and technological advances. Anthem has said the combined companies would have annual revenue of more than \$115 billion and provide insurance for about 53 million people.

In a letter signed by two top Cigna officials, the Connecticut based company added that it was deeply disappointed with Anthem's offer and cited a number of obstacles to an agreement. Among them are Anthem's failure to address questions about possible regulatory hurdles and the massive breach of Anthem customer data that was revealed earlier this year, according to the letter signed by David Cordani, Cigna's CEO, and Isaiah Harris Jr., the chairman of Cigna's board.

Cigna also objected that Anthem wants its CEO, Joseph Swedish, to assume out-sized responsibilities as president, CEO, chairman and "head of integration" for the combined companies—which Cigna's letter called "disconcerting and risky."

Anthem has been in talks with Cigna since last summer. It went public with its latest proposal after four previous bids were rejected. "Nothing of this size and scale has been attempted in our sector," the Cigna officials said of the merger. Anthem said the total value of its proposal is nearly \$54 billion, including debt. Maneuvering between the two companies comes at a time when several other insurance companies are also reportedly engaged in acquisition talks, although they have not publicly confirmed those efforts.

## Coding and Compliance Tips by Lori Shore, CPC, RCC

### Initial, Subsequent or Sequela?

I recently read an article that put the ICD-10-CM concept of encounter specification in a much clearer light. The extension digit is meant to be coded from the *patient's* perspective, not the *provider's* perspective. Encounter extensions must be coded for all initial trauma cases.

Initial encounters, the default for emergency department visits, are to be coded when the patient is actively seeking treatment for the first time. For example: if a patient is seen for palliative care in the ED for a fracture and referred to an orthopedic physician for fracture care *both* visits would be considered initial encounters.

Subsequent encounters are coded for follow-up care. For example: if a patient is seen and treated in the ED for a fracture and referred to an orthopedic physician for follow-up care, the ED visit would be coded as the initial encounter and the orthopedic visit would be considered a subsequent encounter.

Sequela is the long term result or manifestation of a trauma. For example: if a patient has long term pain following an injury it would be considered a sequela.

To put the examples above in a radiology context, a patient x-rayed but not treated in the ED who had additional imaging studies the next day at the orthopedic office for treatment would be coded as initial encounters for both imaging sessions. A patient imaged and treated in the ED with follow-up studies done in 4-6 weeks would be coded as initial encounter for the ED study and a subsequent encounter for the follow-up imaging. Subsequent encounters for fracture must include documentation of routine or delayed healing, malunion or non-union. A patient seen for an MRI for lumbago following an auto accident 10 years ago would be coded as a sequela.