Providers and insurers are among healthcare leaders lobbying Congress and the Trump administration to continue to push Medicare into value-based payment models. A number of healthcare organizations, including the Healthcare Leadership Council, sent letters recently to Republican lawmakers hailing the benefits of payment models that focus on quality and value. The reasoning behind the push is that adopting value-based payment models, such as accountable care organizations, can cost anywhere from millions to billions depending on the practice or system size, according to estimates by the American Medical Group Association. The models require technology to track quality metrics and encourage collaboration between providers that could also result in added costs. Those investments could be lost if those models end.

The fear of penalties, felony conviction, or exclusion from Medicaid and Medicare has dampened interest in alternative pay models. Congress would have to intervene to add more flexibility to the anti-kickback laws.

“We're looking for a signal from incoming policymakers that they continue to support (these models) and the investments being made in the private sector,” said Jeff Micklos, executive director of the Health Care Transformation Task Force, a consortium of payers, providers and purchasers and others who have committed to putting 75% of their business in alternative pay models in 2020.

Documentation Requirements For Billing Moderate (Conscious) Sedation Coding and Compliance Tips by Lori Shore, CPC, RCC

For so many years we have become accustomed to moderate sedation being bundled into most procedures that we have rarely focused on the documentation requirements. Now that these codes are unbundled and we have six new codes from which to choose it is a good time to review. The most important element of moderate (conscious) sedation is who ordered and/or administered the sedation. Was it ordered and/or administered by the same physician, or other healthcare professional, performing the procedure or a physician, or other healthcare professional, other than the physician performing the procedure?

Procedures with moderate sedation ordered and/or administered by the same physician performing the procedure are reported using codes 99151-99153. Procedures with moderate sedation ordered and/or administered by a physician other than the one performing the procedure are reported using codes 99155-99157. Age is also now a factor. Codes 99151 and 99155 are reported for patients younger than 5 years of age. CPT codes 99152 and 99156 are used to report services for patients age 5 and older. Add-on codes 99153 and 99157 are used for either age group for each additional 15 minute increment of intra-service time.

A chart has been added in the CPT book to clarify the exact codes to report for specific sedation times. No code is to be reported for moderate sedation less than 10 minutes in duration. The intra-service time should be clearly documented in the report. Intra-service time begins when the sedating agent is administered and ends when the procedure is complete and the professional providing the sedation ends his/her personal face-to-face time with the patient. In order to bill the add-on code for “each additional 15 minutes intra-service time”, at least 8 minutes of that requirement must be completed. Documentation for moderate sedation must also include a statement that an independent trained observer was present to monitor the patient’s level of consciousness and physiological status throughout the procedure. The trained observer is to have no other duties during the procedure except to monitor the patient. To recap:

- Physician, or other healthcare professional, performing procedure?
- Patient Age
- Intra-service start and end times
- Trained observer statement
Your New Year’s Resolution: Learn Fresh Ways To Demonstrate Imaging’s Value From 5 Of Your Peers

1:27 PM on January 6, 2017 by Erin Lane of The Advisory Board Company (ABC). ABC is the owner and publisher of this article.

2016 was a year to remember: health systems underwent significant consolidation, took on greater payment risk, and saw details emerge for MACRA. To top it all off, the presidential election has brought an unprecedented level of uncertainty to health care.

Between reimbursement cuts and utilization scrutiny under risk-based payment, imaging risks being viewed as a commodity to health systems and a cost burden to patients. To ensure that imaging is seen as a vital component of the care delivery system, programs must demonstrate radiology’s value to these stakeholders.

But how? Progressive imaging programs innovate their value proposition to stakeholders by tuning in to their needs and designing or elevating relevant services that yield measurable outcomes. To kickstart your thinking, we’ve highlighted our five blogs profiling radiology groups and imaging programs that did just that:

1. **3 years later: Catching up with Lahey’s lung screening program**
Lahey Hospitals and Medical Center’s Rescue Lung, Rescue Life program is a pioneer in lung cancer screening, with nearly 70% of cancers diagnosed at stage 1, and less than 10% at stage 4. Read on to learn about the program, its biggest challenges, and where it’s headed.

2. **How radiologists make great neighbors for Brigham and Women’s medical home**
Radiologists have long served as the “doctor’s doctor,” providing guidance to PCPs on image ordering and follow-up care. As patient-centered medical neighborhoods become more prevalent, so will this role—that’s why Brigham and Women’s created a radiologist consultation program targeted at primary care.

3. **What Children’s Healthcare of Atlanta wants you to know about interventional radiology**
In this week’s interventional radiology (IR) post, we sat down with the director of Atlanta’s only pediatric IR program. Read on to get his take on what sets pediatric IR programs apart from traditional programs, and the role of telemedicine in IR.

4. **Better together: How one radiology group improved care, collaboration for hospital partners**
Improving information exchange can be especially challenging for radiology since most organizations operate with fractured PACS infrastructures. Find out how Radiology Associates P.C. in Oregon was able to overcome this challenge for its entire region through the use of a community PACS.

5. **Columbus Radiology’s road from A to A+ in turnaround time performance**
For some imaging providers, being in the 90th percentile for turnaround time (TAT) would be good enough. For Columbus Radiology, leaders wouldn’t rest until they met their ER goal of 95% of scans read in under 30 minutes, putting the organization at the 95th percentile.

For more ideas on measuring imaging’s value, look out for our 2017 National Meeting. We will be sharing our latest research on quality in diagnostic imaging, strategy for interventional radiology programs, and patient safety. Stay tuned, and let us know if you have any questions or would like to participate in the research.


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.