Deregulation Agenda Expected To Continue Despite Resignation

With Dr. Tom Price’s resignation from the HHS secretary position after a brewing controversy over his use of private planes, many believe that agency heads will put the brakes on any bold new policies. “It clearly puts everything in slow motion,” said Gail Wilensky, who oversaw Medicare during George H.W. Bush’s presidency and is now a senior fellow at the not-for-profit Project HOPE. “The heads of agencies tend to not make major decisions without the head of the organization in place. It makes agency leaders a little more conservative.”

When HHS was under Price, they took a number of steps to scale back several Obama-era regulations. For example, CMS carved small physician practices out of complying with new quality and reporting rules under the Medicare Access and CHIP Reauthorization Act. CMS also took steps to make bundled-payment models voluntary. Additionally, the agency issued a request for information on how it can taper back mandatory participation in new payment programs further.

Price’s resignation comes on the heels of the GOP’s inability to repeal and replace the Affordable Care Act. Congress’ failure to act, said Lindsay Bealor Greenleaf, director at consultancy ADVI Health, put even more of a spotlight on HHS. Aside from easing up on mandatory payment programs, the department is also reviewing a number of Medicaid waivers that would allow states to institute work requirements, lifetime limits or drug testing on employees. Early in his role as secretary, Price encouraged state officials to apply for such flexibility. Regardless of what happens in government, industry leaders can’t afford to take their eyes off the bigger issues involving quality and reducing costs, said Rulon Stacy, managing director of Navigant. “The course that I’ve been talking about for the last 12 months has not changed,” said Stacy, a former hospital executive. “My recommendation to the industry is to get your costs under control. There’s nothing that’s going to happen in D.C. that will justify us providing services at higher costs.”

Clearing the PACs:
Coding and Compliance Tips by Lori Shore, CPC, RCC

During a recent audit for one of our larger clients we discovered that approximately 14% of studies were “unbillable.” Most of these studies were clearing the PACs for other specialists using fluoroscopy in the operating room. These services are bundled and therefore not billable by the radiologist. There are several issues with this scenario. Lost productivity for the radiologists is the first issue to come to mind. Is there a way for a hospital administrator to clear these items from the PACs? Another issue, which could end up being even more costly, is the fact that the radiologists’ name is associated with that procedure. If there is an adverse outcome to one of the surgeries or procedures, all doctors associated with the case are likely to be named in the malpractice suit. While the radiologist would likely be cleared, it is still time, money and an unnecessary distraction. Work with the radiology administrator at your facility to see if you can develop a system to avoid having to deal with work not done, and not billable, by your radiologists.
Anthem, the second largest insurance company in the United States, recently announced that it will no longer pay for certain advanced imaging services at hospital-based facilities. Anthem's leadership cited the substantial price variation between imaging services performed at hospitals versus freestanding sites as justification for the change. This marks the latest instance of hospital-based imaging facilities being targeted as a source of unnecessarily high costs. Medicare has been rolling out a site-neutral payment policy and payers have been steering patients to lower cost sites for nearly a decade—although Anthem's latest move takes steerage to a new level. Since Anthem announced this policy, our researchers have received many questions from members. Read on for answers to your top questions, as well as our take on how programs can respond.

Top questions about Anthem's policy

Q: What is the new policy, and how will Anthem implement it?
A: Anthem’s specialty benefits management company will consider care setting in CT and MR preauthorization. Anthem—specifically AIM (a specialty benefits management company)—will consider clinical guidelines around "level-of-care" in its approval process for CT and MR services. In a clinical guideline document, Anthem defines hospital-based advanced imaging as medically necessary when at least one of the following criteria are met:

• The services being provided are only offered at hospital outpatient departments (and therefore are unavailable at freestanding sites);
• The patient is receiving perinatology services;
• The patient needs an obstetrical observation; or
• "There are no other geographically accessible appropriate alternative sites for the individual to undergo the procedure," including because freestanding facilities do not have needed equipment or sedation services.

Anthem does not define what distance is considered "geographically accessible."

If the order is approved for appropriateness but denied for site of care, AIM will issue a denial and the ordering provider will be given a list of alternative freestanding imaging facilities in the service area.

Q: Who will be impacted?
A: Hospital outpatient imaging programs providing care to Anthem patients in nine states.

As far as we can tell, this policy applies to both on- and off-campus hospital outpatient departments (HOPDs). In other words, freestanding facilities billing at the higher hospital rate will be viewed as hospital-based, and services may be denied at those locations. This includes newly built or acquired HOPDs that are impacted by the Medicare site-neutral payment policy.

Q: If my hospital is in a state included in this policy, how will this impact my hospital imaging volumes?
A: This depends on your location, outpatient imaging footprint, and Anthem's market presence. Follow the five steps below to estimate the impact on your imaging program.

1. Identify the percentage of your patient base that is insured by Anthem. Use our Demographics Profiler tool.
2. Estimate your HOPD CT and MRI volumes. Use our Outpatient Imaging Market Estimator tool, customizing your market, and viewing data by site-of-service (HOPD only). Multiply those estimates by your overall market share.
3. Calculate CT and MRI volumes. Multiply Anthem patient base (step 1) by HOPD imaging volumes (step 2).
4. Remove emergency department (ED) volumes for CT (MRI ED volumes are too low to make a meaningful difference). Multiply CT volumes (step 3) by 70% (since we assume that 30% of CT volumes are in the ED).

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