

# RADIOLOGY TRENDS

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## Appeals Court Rules States Can Fight To Preserve ACA Subsidies

**A** federal appeals court recently said state attorney generals can defend the Affordable Care Act's cost-sharing subsidies in a legal case over whether the federal government must keep making the payments.

A three-judge panel for the U.S. Court of Appeals for the District of Columbia Circuit held that 16 state attorney generals may intervene in *House v. Price* because they showed a "substantial risk" that terminating the cost-sharing reduction payments, or CSRs, would "directly and imminently" cause an insurance premium hike and lead to more people becoming uninsured. The appellate court's order is a major development in the case, which started during the Obama administration. President Donald Trump has repeatedly threatened to end the CSRs, labeling them insurer "bailouts." "If the administration does stop

making the payments, the states—or insurers, or possibly consumers—would be able to sue to require the payments to be made and the injunction entered by the lower court would not be as much of a roadblock to their prevailing."

The Trump administration has been paying the subsidies on a month-by-month basis. But Trump has threatened to quit funding them as a way to encourage Congress to pass a healthcare bill. Experts say the individual insurance market would likely collapse without funding for the cost-sharing reductions.

"The court's decision is good news for the hundreds of thousands of New York families that rely on these subsidies for their healthcare," New York Attorney General Eric Schneiderman said in a statement. "It's disturbingly clear that President Trump and his administration are willing to treat

them as political pawns; but this coalition of attorney generals stands ready to defend these vital subsidies and the quality, affordable healthcare they ensure for millions of families across the country."

## Clinical Decision Support Delayed Until 2019 Coding and Compliance Tips by Lori Shore, CPC, RCC

CMS officially delayed the implementation of Clinical Decision Support until January 1, 2019. The Federal Register reported the proposed rules on July 21, 2017, including using year one as an educational and testing year. Barring any statutory exclusions, a consultation must occur for every advanced imaging study. The consulting provider would consult Appropriate Use Criteria (AUC) and provide the radiologist/provider with the AUC consultation data to include on the claim. CMS will

continue to pay for claims during the first year of the program even if the AUC consultation data is missing.

The proposed mechanism for reporting that a Clinical Decision Support Mechanism (CDSM) has been consulted is similar to those for claims-based MIPS Quality measures. A series of category III G codes will be developed with modifiers to identify compliance. The proposal also suggests a direct link between MIPS and Appropriate Use Criteria (AUC) by adding a high-weighted Clini-

cal Practice Improvement Activity for AUC participation in 2018.

# Imaging CDS: What You Need To Know From Medicare's Most Recent Proposals

9:39 AM AM on July 24, 2017 by Lea Halim, Erin Lane and Pooja Desai of *The Advisory Board Company (ABC)*.

ABC is the owner and publisher of this article.

CMS recently released its **proposed rule** on the Medicare Physician Fee Schedule (MPFS), which dictates clinician payments each year. Some of the biggest news for radiology providers concerns the imaging clinical decision support (CDS) mandate, or Medicare Appropriate Use Criteria (AUC) program. Most notably, implementation of the program is delayed until 2019. We've analyzed the latest proposals and provided guidance for how programs can set themselves up for CDS success.

## A brief recap on CDS

In the Protecting Access to Medicare Act (PAMA) of 2014, Congress included a mandate that ordering providers consult appropriate use criteria via electronic CDS when ordering outpatient advanced imaging exams for Medicare patients. Furnishing providers—most commonly radiologists and imaging programs—must document that consultation for reimbursement.

The legislation required CMS to provide implementation details around four key components of the program:

### **Appropriate Use Criteria (AUC): The clinical guidelines that providers consult to comply with the mandate. Current Status:**

Complete; focus of 2016 rulemaking: CMS finalized the requirements and approval process for organizations—called Provider-Led Entities (PLEs)—that can create and modify AUC. As of today, CMS has approved 17 organizations as PLEs.

### **CDS mechanisms (CDSMs): The electronic tools that allow providers to consult AUC during ordering. Current Status:**

Complete; focus of 2017 rulemaking: CMS finalized the requirements and approval process for CDSMs. As of today, CMS has approved seven CDSMs and provided preliminary qualifications to nine others.

### **Provider requirements: How ordering providers will demonstrate that they consulted AUC and how furnishing providers will submit that information to CMS. Current Status:**

Proposed; focus of 2018 rulemaking: Providers must consult AUC via CDS for all outpatient advanced imaging orders. CMS plans to finalize furnishing provider requirements in this current rulemaking cycle, including provider deadlines and claims-based reporting.

### **Outlier providers: CMS will identify up to 5% of ordering providers as outliers and require them to obtain preauthorization when ordering imaging for Medicare patients. Current Status:**

Focus of future rulemaking: CMS will review adherence to defined priority clinical areas—eight of which have been finalized—to identify outliers. For more information on the previously finalized components and priority clinical areas, [read our analysis of the 2017 final rule](#).

## Four key takeaways from recent CMS proposals

### 1. CMS wants to delay the CDS implementation deadline until Jan. 1, 2019

The agency proposed to move the provider deadline for CDS from Jan. 1, 2018 to Jan. 1, 2019, with the possibility of a voluntary reporting period beginning in July 2018. CMS has also proposed using 2019 as an "educational and operations testing period." During this time, ordering providers would be expected to consult AUC and furnishing providers would be expected to confirm consultation on claims submitted to Medicare. To encourage providers to engage with CDS without fear of immediate reimbursement cuts, CMS proposes to continue paying all claims in 2019. Claims denials and reimbursement penalties would begin Jan. 1, 2020.

**Guidance for providers:** Rather than halting CDS work, organizations should use the educational period to ensure they are set to collect full Medicare reimbursement come 2020. Organizations should use the additional year to improve the system through comprehensive testing and should continue training ordering providers on the importance of CDS adherence. Use our tools and resources to prime ordering providers, assemble a CDS team, and educate all stakeholders.

### 2. Clinical Decision Support Mechanisms (CDSMs) have been approved

Much of last year's MPFS rule focused on requirements and approval processes for CDSMs. This summer, the agency released its first list of approved mechanisms. Until the provider deadline, CMS is allowing two different qualification options for CDSMs...

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