CDS Is Here, Where Is Your Practice?

By Lori Shore, RCC, RCCIR, CPC, FRBMA

Clinical Decision Support officially introduced its voluntary reporting period in June of this year. While the penalty phase does not start until January 1, 2021, the time to begin this initiative was yesterday. Providers will need to begin to report CDS on January 6, 2020, as an educational year, much like the transition year we had with the implementation of ICD-10-CM. As with any number of the CMS initiatives of late, this is not a simple implementation and requires radiologists to be involved to protect their income. An Appropriate Use Criteria (AUC) vendor must be selected, along with your health system, and plans implemented for both employed and independent referring physicians. Policies and procedures must be developed. Will your group deny service to those who do not consult clinical decision support? The biggest challenge is educating your referring physicians on the use of the CDS/AUC and focusing them on quality rather than their perception that they need to jump through another hoop so you can get paid. CDS/AUC can improve overall processes for everyone. If used properly, the need to change orders should decrease as well as medical necessity denials. Referring physicians are the ones responsible to consult an appropriate use criteria (AUC) product for all “advanced” imaging studies. This includes CT, MR, NM, and PET. Currently, it is the responsibility of the radiologist to report a G code to indicate what type of AUC was consulted and modifiers to indicate whether or not the referring physician followed the suggestion made by the AUC. Ultimately, it is the radiologists’ income that will be at risk beginning in 2021. CMS just released the list of G codes to be reported based on the qualified Clinical Decision Support mechanism that is consulted. Line-item modifiers must also be reported for each eligible procedure.

- **MA** – Ordering professional is not required to consult a CDSM due to service being rendered to a patient with a suspected or confirmed emergency medical condition.
- **MB** – Ordering professional is not required to consult a CDSM due to the significant hardship exception of insufficient internet access.
- **MC** – Ordering professional is not required to consult a CDSM due to the significant hardship exception of electronic health record or clinical decision support mechanism vendor issues.
- **MD** – Ordering professional is not required to consult a CDSM due to the significant hardship exception of extreme and uncontrollable circumstances.
- **ME** – The order for this service adheres to the appropriate use criteria in the CDSM consulted by the ordering professional.
- **MF** – The order for this service does not adhere to the appropriate use criteria in the qualified CDSM consulted by the ordering professional.
- **MG** – The order for this service does not have appropriate use criteria in the CDSM consulted by the ordering professional.
- **MH** – Unknown if ordering professional consulted a CDSM for this service, related information was not provided to the furnishing professional or provider.
The Key Challenges Undercutting Your Lung Screening Growth---And How To Overcome Them

10:15 AM on April 9, 2019 by Lea Halim and Ty Aderhold. The Advisory Board Company is the owner and publisher of this article. Read full article here.

Nationwide rates for lung screening remain in the single digits—as low as 2% according to 2018 research from the American Society of Clinical Oncology. For imaging programs and health systems, these rates should signal that low-dose lung screening is a growth opportunity. Not only can programs benefit from the immediate revenue of additional low-dose CT screening exams, but lung screening programs can generate significant downstream revenue for the system and save overall health care spending by catching cancers early. However, there are a few key barriers to growth for lung screening programs:

1. A lack of physician and patient education; and
2. Inadequate investment in key program resources.

Physician, patient education still necessary
Ensuring physicians and patients are aware of the importance of lung screening and having discussions on the subject can be key to overall program success, particularly with the current requirement that a shared-decision making conversation occurs before screening. However, a recent study in the Journal of Cancer Education found that physicians had conversations about lung screening with less than 20% of current and former smokers.

For programs looking to increase the likelihood that physicians will sit down and discuss lung screening with patients, one option is to turn to the EHR for help. For instance, at Gundersen Health System, when a qualifying patient comes in for a PCP visit, an alert pops up notifying the provider that the patient meets the criteria for lung cancer screening. The provider then reviews the screening criteria and discusses the exam with the patient.

If the patient wants to have the screening, the PCP simply clicks a button within the EHR to make the referral. That action sends a message to the lung screening program coordinator, who then reaches out to the patient to schedule the exam.

For more ideas on how to market your lung screening program to referring providers and patients, check out our Lung Cancer Screening Program Toolkit.

Additional investment in staff can spur program growth
Navigators and coordinators are an increasingly essential component of a comprehensive, patient-centered cancer program. However, given their expansive—and often poorly defined—role, it can be difficult to track their direct impact on quality and financial outcomes. But that’s exactly what Cone Health Cancer Center-Alamance Regional in North Carolina did to justify the addition of a second navigator.

Last year, the lung cancer navigator at Cone Health was working over capacity trying to manage screening patients, diagnosed patients, and smoking cessation counseling. To help make the financial case for a new navigator, Cone analyzed historical data from its existing lung screening program to estimate the additional downstream revenue it would receive by hiring a second lung navigator, which would allow Cone to screen an additional 300 patients a year.

Within four months of hiring the navigator, the organization went from screening an average of 7.5 patients per month to 37—nearly a five-fold increase. During that time, the organization also diagnosed four patients, two of whom were in the early stage. Those four diagnoses have led to $245,000 in downstream revenue—already a significant return on investment for the organization.