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Radiology Trends

CMS Launches Online Tool To Assist In MACRA Compliance

CMS recently released an online tool for clinicians to identify which new Medicare payment models best suit them and their practices. This new tool is an application program interface, or API, that will allow physicians and their practices to build software that enables sharing of quality measure data for the Medicare Access and CHIP Reauthorization Act. The application has been used by "tens of thousands" of users so far, according to CMS. In October, the agency released the quality payment program website that helps providers understand how to adhere to MACRA and find the best ways for them to participate. Under the Merit-based Incentive Payment System, which was mandated under MACRA, physician payments will be based on a compilation of quality measures and the use of electronic health records. Physicians could also meet MACRA requirements by participating in an alternative payment model like an accountable care organization.
"An important part of the quality payment program is to make it easier and less expensive to participate, so clinicians may focus on seeing patients," said Andy Slavitt, acting administrator of CMS. "This first release is a step in that process, both for physicians and the technologists who support them."

Getting Ready For 2017

Coding and Compliance Tips by Lori Shore, CPC, RCC

It's difficult to believe that we are nearing the end of 2016 and it is already time to begin preparing for 2017. Over the past several years billing is barely recognizable to those of us who have been doing it for as long as I have. We are still honing our specificity for ICD-10-CM and the end of the "grace period" and soon we will be faced with updated CPT codes for 2017 and the Merit-based Incentive Payment System (MIPS).
Let's start with the 2017 CPT changes effective January 1, 2017. The good news is there are very few changes for diagnostic radiology. There were only 4 new codes added. One new code was added for Ultrasound AAA screening and 3 new mammography codes that include CAD. Ironically, Medicare is not yet ready to accept the new mammography codes! For interventional radiology the bundling continues. This year the victims are the AV "dialysis circuit" codes, CPT's new wording as well as the balloon angioplasty codes and diagnostic and therapeutic injections. Of note is the un-bundling of moderate conscious sedation from all procedures. It is now billable, when documented with the sedation time and the fact that a trained observer monitored the patient. It is now billable based on over or under age 5 and in 15 minute increments. As with any time-based code, you must perform at least half of the time requirement in order to bill for the code.
MIPS also begins January 1, 2017 and replaces the PQRS, Value-based modifier and Meaningful Use programs. The good news is that the number of Quality measures (formerly PQRS) we need to report has been reduced from 9 to 6 with no domain requirements. There is a requirement to report 1 outcome measure, if available, or at least 1 "high priority" measure. The good news here is that if our groups continue to measure what they are currently reporting all will comply with the MIPS Quality reporting requirement. Of course, it doesn't end there, as there are also requirements for Clinical Practice Improvement Activities (CPIA), a new category, or as I like to say, another hoop to jump through! If your practice is considered patient-facing you will also need to report Advancing Care Information (ACI) (formerly Meaningful Use). The Cost category (formerly Value-based Modifier) is not being weighted in the composite score for this transition year. Stay tuned for much more on MIPS in the coming weeks.

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CMS Releases Possible Medicare Quality, Efficiency Reporting Measures

CMS recently published a list of nearly 100 reporting measures under consideration for Medicare's quality and value-based purchasing programs. The list includes new quality and efficiency measures for nursing homes, hospitals, clinician practices and dialysis facilities, and the measures focus on patient outcomes, appropriate use of diagnostics and services, cost and patient safety, Kate Goodrich, director of the Center for Clinical Standards and Quality at the CMS, said in a blog post. CMS publishes a list each year of quality and cost measures that are under consideration for Medicare quality and value-based purchasing programs and works with the National Quality Forum to get input from patients, clinicians, commercial payers and purchasers, on the most suitable measures. For this year, 39% of the measures being considered will focus on outcomes, and specialty societies also submitted more measures than in the previous years, said Goodrich. The measures, if adopted, will ultimately help patients choose the provider that is the best for them, while helping providers deliver quality care.

Did You Know?

Although digital breast tomosynthesis (DBT) has become increasingly accepted as a clinical tool, only 1/3 of U.S. radiology practices use it, with 11% performing all mammograms with DBT.

Physicians Say Patient Survey Under MIPS Not Likely To Give Insight

CMS next year will ask Medicare beneficiaries how their providers are doing under new payment models aimed at improving the quality of care while lowering cost. But because the survey is voluntary and because the agency has allowed providers to ease into the new models, critics say the survey may not offer much insight. The agency is asking to survey only the patients of providers participating in the Merit-based Incentive Payment System, the less risky of two options available under the Medicare Access and CHIP Reauthorization Act. Advanced alternative payment models such as accountable care organizations which share in savings or losses depending on whether they meet clinical quality targets and lower healthcare spending below a certain threshold.
Most providers are expected to participate in MIPS over APMs. CMS anticipates beneficiaries from 461 practices will respond to the survey, which would equal approximately 187,990 providers. An average response of 287 beneficiaries per practice is expected, which adds up to approximately 132,307 beneficiaries potentially weighing about the first year of implementation.
An issue of concern is the posting of survey results. Survey results will appear on the Physician Compare consumer website, something that confused critics of the survey. “It's unclear how posting this information will help consumers make an informed choice on a doctor to pick with so few groups responding,” said Anders Gilberg, senior vice president of government affairs for the Medical Group Management Association, which represents 13,000 practices. The survey will include questions currently being used to evaluate doctors under the Physician Quality Reporting System such as if patients were advised about ways to prevent illness or consulted with on specific health goals.
Another issue of concern is the fact that CMS is proposing to use the PQRS survey. Physicians say the survey is flawed. “All that survey does is assess the patient’s satisfaction, or experience of care,” said Dr. Gregory Fuller, a family medicine practitioner and chair of the Texas Medical Association’s Council on Health Care Quality. “It doesn’t have anything to do with quality of care.”