Radiology Takes a Hit
By Lori Shore, RCC, RCCIR, CPC, FRBMA

It seems as though Radiology is taking a hit from every side. Proposed cuts to specialties to supplement Primary Care is projected to negatively impact Radiology’s E/M revenue by as much as 8%. Appropriate Use Criteria/Clinical Decision Support may help decrease unnecessary studies; however, it may decrease overall income. The bundling trend continues in CPT with guidance being bundled into some cardiology procedures, pain management, and other specialties. And then there is the Merit-based Incentive Payment System (MIPS) that will increase the threshold for success while eliminating some of the radiology measures that have yielded positive adjustments in the past. What can you do to combat these trends?

The “Educational and Operational Year” for Appropriate Use Criteria/Clinical Decision Support begins in January. Although we must report the data, no financial penalties will be imposed in 2020. Beginning in 2021; however, if an ordering physician does not supply CDS data for an “advanced” imaging study, it is the RADIOLOGIST who will not be paid. Advanced imaging studies are defined as CT, MR, and nuclear medicine including PET. You may want to think about your contracts and require that CDS data is supplied.

With all of the continued bundling, it is wise to make billing arrangements with other specialties for guidance that can no longer be billed separately. If you are participating in the care and taking on the liability, you should be compensated, if not by the insurance then by the other specialists.

MIPS is making it increasingly more difficult to succeed since more than 98% of those participating in 2018 received an incentive. It is a budget-neutral program so the incentives are far less than the penalties. For reporting year 2020 the penalty is 9% of Medicare income in 2022. Other program requirements are also becoming more burdensome. For example, in the past only one member of a group needed to attest to a Clinical Improvement Activity. This is changing and will now require that at least half the members of a group participate and attest. Is an Advanced APM with a 5% participation bonus and no need to participate in MIPS sounding more enticing?

There is much to think about and prepare for to protect your income in the New Year.

Wishing you and yours a Happy and Healthy Holiday Season!

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Think you have a best-in-class dashboard? Compare yours to 3 examples.

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With a myriad of metrics available, it's easy to create an overwhelming dashboard that provides more data than insight. But some organizations have mastered the art of effective dashboard design, thoughtfully leveraging data to improve imaging service line performance. Here are three imaging dashboards that, in our view, represent best-in-class work. Review the key components of these dashboards and understand how you stack up.

Track metrics that enable smarter strategic decisions

Before building a dashboard, it’s critical to define a set of strategic priorities, such as growing patient volumes or improving outpatient access. With these goals as the foundation, decide on the metrics you want to represent performance on each. A top-notch dashboard includes metrics that are:

1. Concise yet diverse, and aligned with the goals of your department;
2. Outcomes linked to process metrics;
3. Meaningful to the intended audience; and
4. Feasible to track

Once you’ve decided on a set of metrics, work with your IT team to collect and organize data to track metrics regularly. Then, analyze performance over time to uncover improvement opportunities.

Take data-driven action

UCLA Health provides a prime example as to how an imaging program can realize results from an effective dashboard. Among the dashboards UCLA has, its referral leakage dashboard helps the organization and root cause imaging leakage by tracking key referral data such as ordering provider name and specialty, type of exam ordered, and patient residence. UCLA then created a process to feed this data from Salesforce into Tableau, a data visualization software, to generate market-wide heat maps of physician leakage. Users can view heat maps for volume and patient leakage and drill down by provider origin, patient origin, and provider affiliation. Users can double-click into a region for additional details including:

1. Most commonly referred exams, by office and physician;
2. Leakage by each office, each physician in area, by modality;
3. UCLA sites most often referred to by office and/or physician; and
4. Competitor facilities most often referred to by office and/or physician.

Analysis of these maps uncovered a key opportunity: 75% of patients from one PCP office received mammograms outside the system. To capture these patients, UCLA moved an underutilized machine and provided imaging staff to the PCP office, reducing referral leakage from 75% to 0%. The leadership at UCLA estimates that, by using the heat maps to expand capacity and target outreach, they have generated about $30 million in incremental revenue.

Make sense of system performance

Dashboard creation can be particularly daunting for large health systems, who have a deluge of data to manage. University of Kentucky Healthcare (UKY Healthcare) created a dashboard that balances between depth and breadth of metrics. Its dashboard is broken into two pages:

1. The first page contains a variety of high-level data that provides a holistic gauge of system performance. This includes metrics such as total number of examinations by month and patient class, and median inpatient and ED turnaround time. When leaders look at this first slide, they can easily ascertain UKY’s performance from a system perspective. Read full article here.

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