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RADIOLOGY TRENDS

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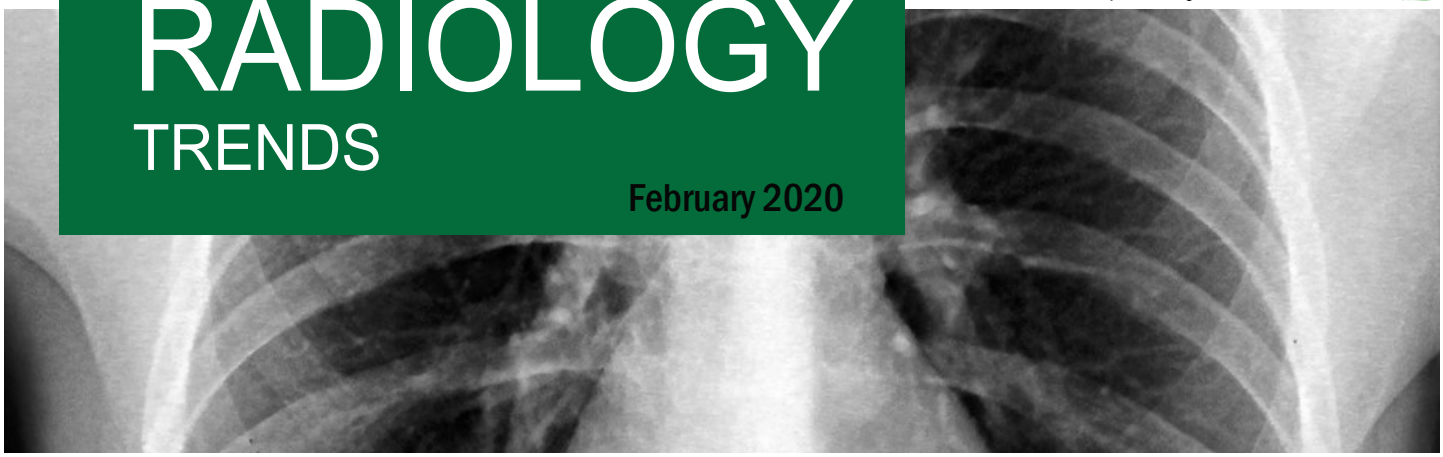

ACR Asks CMS For Supervision During Non-Radiologist Testing

The American College of Radiology is expressing "concerns" about the possibility of letting nonphysicians interpret imaging tests without supervision as a means to boost access in the Medicare program. The concerns come in response to a presidential executive order released in October, which called for the need to expand scope of practice to improve senior care. The October **presidential order** tasked the secretary of Health and Human Services with identifying and removing any unnecessary barriers that might be preventing the care of a patient's choice. "The proposed Medicare for All Act of 2019, as introduced in the Senate would destroy our current Medicare program, which enables our nation's seniors and other vulnerable Americans to receive affordable, high-quality care from providers of their choice. Rather than upend Medicare as we know it, my administration will protect and improve it," President Trump wrote last year.
In a Jan. 15th **letter** to the Centers for Medicare and Medicaid Services, the ACR acknowledged the important role of APRNs and PAs, but asked for caution in making any federal changes to how patient care is delivered. "The ACR recognizes that APRNs, PAs and other nonphysician providers play a vital role in providing care to patients" wrote CEO William Thorwarth, MD. "However, these NPPs are not interchangeable with radiologists or other physicians," he added, nothing that physicians must log upwards of 16,000 hours of clinical education, versus 720 for APRNs. He added that to keep all patients safe, the ACR and the federal government should maintain the requirement that nonphysician providers practice under direct supervision of the physicians. ACR also previously submitted comments expressing concerns about expanding scope of practice, according to a Jan. 16th **news post**.

Novitas to Require Narrative for Use of Modifier 77

Beginning with claims received on February 29, 2020, all claims that contain modifier 77, for repeat procedure by a different physician, will require a narrative on the claim in order to be paid. Novitas is the Medicare Area Contractor (MAC) for Arkansas, Colorado, Delaware, Indian Health, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania, Texas, Washington, DC, parts of Northern Virginia, and Veteran Affairs. Even if you are not located in one of these states, if you have telerads reading in one of these states they need to be aware.

We often see chest x-rays repeated when a patient is admitted from the emergency department and for inpatients. An example of the type of narrative necessary to get the second study paid would be: If the patient was seen for pneumonia in the ED but the radiologist finds a suspicious area in the lung suggesting a tumor. The narrative for the second study would be "indicated suspicious area of lung suggesting tumor requiring further testing." Repeat studies without a narrative will be denied. Please include a reason for any repeat study performed on the same date of service.

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How Medicare's final rules affect imaging in 2020

*10:15 AM on January 7, 2020 by **Ty Aderhold** and Liam Frieswick, edited by **Erin Lane**. The Advisory Board Company is the owner and publisher of this article.*

Recently, CMS released final rules governing **hospital outpatient facility** and **provider payments** for calendar year (CY) 2020. To help you understand new payment changes and regulatory updates, we read through more than 2,500 pages and identified four key takeaways for imaging leaders and radiologists.

Summary of 2020 final regulatory updates for radiology

Changes relevant to both hospitals and clinicians:

- Maintains site-neutral payment rate at 40% of HOPPS, including all clinic office visits
- CDS program begins on Jan. 1, 2020, exact G-codes and modifiers for documentation released

Hospital Outpatient Prospective Payment System (HOPPS): Governs payment for hospital outpatient departments

- Finalized overall payment increase of 2.6%
- Amends price transparency rulings for hospitals
- Established 2 year phase-in period for CT and MRI cost center policy
- Two new C-APCs for vascular, neurostimulator procedures proposed; overall imaging APC reimbursement reductions

Medicare Physician Fee Schedule (MPFS): Governs payment for provider-owned facilities and professional payments

- Finalized $36.09 conversion factor, five cents greater than in 2019.
- Updated Stark Law requirements to reduce unnecessary barrier and improve clarity
- Reduced Physician Supervision (PA) requirements to better align state law and state scope of practice
- Finalized increase to E/M work values beginning in 2021, which could result in a significant decrease in radiology payments

Hospital outpatient payments: CMS finalized a 2.6% increase in payment for hospital outpatient services, an increase from last year's finalized 1.35%
Clinician payments: CMS finalized a $36.09 conversion factor for 2019, 5 cents greater than the 2019 conversion factor.

The estimated impact of all clinician payment changes finalized for 2020 means slight declines across radiology subspecialties. In summary, the Calendar year 2020 proposed clinician payment updates are: Interventional radiology, negative one percent total estimated payment change, Independent diagnostic testing facilities, negative three percent total estimated payment change, Radiology, zero percent, and Nuclear medicine, one percent.

What this means for radiology: Similar to recent years, payment rates will remain around zero or decrease for imaging providers, adding pressure to present financial strains. Imaging programs must continue to control costs and secure revenue to maintain slim margins.

2. Additional price transparency requirements coming in 2021

Likely the most buzz-worthy update centers around the push for price transparency, which comes in response to **President Trump's executive order**, released earlier in 2019. Despite pushback from both hospitals and payers, CMS is forging ahead with proposals to require public disclosure of payer-specific rates for outpatient services.

In a **separate rule** released on November 15th, CMS significantly expanded upon the January 2019 requirements to post chargemaster services online. Beginning in 2021, hospitals will be required to post both payer-specific negotiated charges and discounted cash prices in a machine-readable file. Hospitals will also have to publically post these charges in an easily accessible manner for 300 "shoppable" services. CMS identified 70 of these "shoppable" services, while hospitals are able to individually select the other 230. Read full article **here**.

Advisory Board Consulting and Management now has more than 380 management executives and clinicians with an average of more than 15 years of operational experience running critical hospital and medical group departments.

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