

RADIOLOGY TRENDS

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Six Months Into MACRA Rollout, Many Docs Still Unprepared

More than halfway through the first year of the rollout of the Medicare Access and CHIP Reauthorization Act, the majority of medical practice leaders still are not ready to comply with the law, according to a survey by American Medical Association and consulting firm KPMG.

The revelation recently released is based on the responses from 1,000 physicians who have been involved in practice decision-making related to MACRA. The survey found that fewer than 1 in 4 physicians interviewed were prepared to meet statutory requirements this year. This could mean that many will face a financial penalty in 2019, which is when 2017 compliance will be measured. The survey found that 51% of the doctors responding were only somewhat knowledgeable about MACRA and its new

quality reporting system, the Merit-based Incentive Payment System, or MIPS. In addition, 90% felt the reporting requirements were somewhat or very burdensome, given the time it would take to comply with MIPS requirements. The physicians also raised concerns about understanding requirements, how MIPS performance is scored, and the cost required to accurately capture and report performance. A week before the AMA/KPMG report was released, the agency announced that more small providers would be exempt from MACRA.

Unsurprisingly, the report found that those without experience with value-based reporting systems were most likely to find MIPS requirements burdensome and feel less prepared for long-term finan-

cial success. It also found that respondents in a large practice with 50 or more physicians were more likely to feel prepared. Physician practices with less than \$90,000 in Medicare revenue or fewer than 200 unique Medicare patients per year would be exempt under the new draft rule released June 20. The move will exclude about 834,000 more clinicians from complying with the quality reporting program under MACRA. The original threshold was \$30,000 or fewer than 100 Medicare patients.



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MIPS Reporting Options

Coding and Compliance Tips by Lori Shore, CPC, RCC

The Merit-based Incentive Payment System (MIPS) can be reported in a number of ways. We are going to discuss the pros and cons of three reporting methods in this article. We will discuss claims-based reporting, qualified registry and qualified clinical data registry.

Let's begin with claims-based reporting. As the name implies, a category II code is appended to each claim when the claim is submitted. This is a free submission method; however, sometimes you get what you pay for. The drawbacks to this reporting method are the lack of reviewable evidence if you wish to dispute your score. Only the initial claim is considered for MIPS Quality so if the category II code is forgotten or incorrect the claim is considered as the

measure not being met.

A Quality Registry reports data once per year through a third-party vendor. This method basically reports the same category II codes that are submitted via claims-based reporting; however, the quality registry allows for claim corrections or addendums. This submission method usually costs around \$200 per physician. Group discounts are available for groups larger than 10 providers. The Qualified Clinical Data Registry option, while the most expensive option, requires the least amount of work on the providers part. Costs vary depending on the size of the group/facility and which third-party registry you choose to report on your behalf. The National Radiology Data Registry (NRDR) offered through the

ACR uses software options to submit de-identified clinical data that do not require the provider to remember to include required verbiage in his/her documentation. The NRDR produces feedback reports quarterly comparing providers to other providers within their geographic area and size. This allows the provider to make adjustments along the way to submit the best scores. This reporting method is also submitted once per year through a third-party vendor. Another advantage to the NRDR is that you can also attest to your Clinical Practice Improvement Activities here, as well.

It is imperative that you choose your reporting method as soon as possible.

Long Wait Times And More: 3 Initial Findings From Our Interventional Radiology Benchmarking Survey

10:12 AM on June 16, 2017 by Lea Halim and Pooja Desai of *The Advisory Board Company (ABC)*. ABC is the owner and publisher of this article.

From new procedures, to new equipment, and ultimately new patient volumes—imaging leaders across the country are working to develop a strategic growth plan for their interventional radiology (IR) programs.

To accompany our 2017 national meeting research on interventional radiology's growth potential, the Imaging Performance Partnership has launched an IR Benchmarking Survey to provide our members with the metrics they need to understand the IR market and design strategy and tactics for IR growth.

Keep reading for our research team's top three insights from our surveys initial results.

1. Interventional radiology aligns with imaging's shift outpatient

Thus far, 47% of respondents belonged to a community (non-teaching hospital) and 32.5% belonged to academic medical centers. With the imaging market shifting outpatient, we found it unsurprising that on average, respondents attributed 47% of their IR procedures to the outpatient setting. Furthermore, 60% of survey respondents stated they either currently offer IR in the ambulatory setting or are planning to do so in the next two years. Many hospitals and radiology groups utilize the outpatient space to conduct low-tier interventional radiology procedures such as biopsies and drainages that do not require the resources of the higher-acuity hospital setting. Imaging leaders looking to build their IR portfolio should consider the impact shifting outpatient would have on freeing up hospital equipment and staff, and if outpatient IR aligns with greater health systems goals.

2. Room for improvement in IR efficiency

Productivity continues to be an area of improvement in interventional radiology, as many programs are just beginning to grapple with optimizing their processes to be meaningfully distinct from diagnostic radiology. Despite a median room turnover time of 17.5 minutes, it was clear that patients often still have to wait for the IR procedure—even in the outpatient setting. Though an impressive 32% of survey respondents boasted wait times of less than an hour, 43% of programs still kept patients waiting for over 90 minutes.

In our 2015 Imaging Consumer Survey, we asked over 2,000 consumers what types of attributes would attract them to an outpatient imaging facility—and learned that short wait times ranked sixth amongst the list of appealing imaging facility attributes. If interventional radiology programs hope to distinguish themselves from the growing list of competitors, optimizing program efficiency would certainly be a promising place to start.

3. Programs often utilize additional staff to optimize IR program functionality

Ninety-six percent of survey respondents use advanced practitioners to support their interventional radiology program. We found the majority of programs utilize physician assistants, followed by nurse practitioners and radiology assistants—with many programs using a combination of the three. Advanced practitioners are often able to conduct basic interventional radiology procedures such as biopsies and drainages, or assist with more complex treatments such as uterine fibroid embolizations. Programs also frequently use advanced practitioners in more administrative and clinical roles such as assisting with patient workups and creating longitudinal care plans. For a more strategic approach, some programs even calculate the estimated ROI on employing advanced practitioners in either procedure-focused or supportive roles.

Read the full article [here](#).



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