

# RADIOLOGY

## TRENDS

July 2019

## Will We Run Out of Modifiers?

By Lori Shore, RCC, RCCIR, CPC, FRBMA

The standard CMS-1500 form and its electronic equivalent allow for 4 modifiers to further explain the circumstances of a claim submitted to insurances. In hospital-based radiology practices, the most commonly reported modifier is 26, signifying professional component billing only. A couple of years ago, in an effort to ensure that imagers were using the most up-to-date equipment, we were directed to add modifier CT for computed tomography services that do not meet the XR-29-2013 standard and modifier FY to trigger a payment reduction for x-rays taken using computed radiology rather than digital.

Beginning in August, 2019 is the voluntary reporting period for the use of patient relationship modifiers X1 through X5. These will help CMS in determining how to allocate the cost of care to physicians under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

- X1 – Continuous/Broad Services
- X2 – Continuous/Focused Services
- X3 – Episodic/Broad Services
- X4 – Episodic/Focused Services
- X5 – Only as Ordered by Another Clinician

In radiology, most interactions will fall into X-5 but some interventional or face-to-face services will qualify as X-4 services.

This summer we are anticipating the release of the final reporting requirements for Appropriate Use Criteria/Clinical Decision Support. It is anticipated that adherence modifiers will be issued to indicate if the Clinical Decision Support consultation advice was followed. These would only apply to CT, MRI, Nuclear Medicine and PET. Speaking of PET, we must also add a modifier PI or PS to indicate if it is the patient's initial or subsequent study.

While modifiers are an easy way to add information to line item data, with all of the new government programs we won't be left with any room to report modifiers for their intended purpose.

Lori Shore, **RCC, CPC, RCCIR, FRBMA**  
*Vice President of Coding Education & Compliance*

Lori speaks at conferences both regionally and nationally on behalf of numerous organizations, including RBMA.

[lshore@mbms.net](mailto:lshore@mbms.net)





Kim Fell



Jodi Youndt



Rob Carfagno



Larry Buller, Jr.

## Does CDS curb imaging orders? Aurora Health Care says yes

10:15 AM on April 23, 2019 by Catherine Kosse and Erin Lane. The Advisory Board Company is the owner and publisher of this article. Read full article [here](#).

In just eight months, Medicare will require ordering providers to consult appropriate use criteria (AUC) via an electronic clinical decision support (CDS) tool when ordering outpatient advanced imaging exams. When executed properly, CDS can facilitate more appropriate use of imaging, hardwire case standards, and reduce total cost of care. But, with a few studies assessing the tool's impact, many health care leaders are left wondering what to expect after implementation. A recent **study** from Aurora Health Care sheds light on potential outcomes.

### CDS reduces inappropriate imaging orders

From December 2016 to December 2017, Aurora Health Care studied the impact of CDS on imaging orders through a randomized trial of 3,511 providers, about half of who received best practice CDS alerts and half of which did not.

All imaging orders targeted by CDS saw a 6% reduction, the majority of which were CT exams. Specifically, CT exams reduced 9% and MRI exams 2% when providers used CDS compared with those who did not. The results align with earlier studies indicating the CDS leads to a **shift away from higher radiation modalities** in an effort to reduce radiation exposure.

Beyond an increase in imaging appropriateness, Aurora providers showed no evidence of "alert fatigue" (i.e. ignoring alerts) during the study period. This is an important finding, as CDS tools are effective only when used correctly. Unfortunately, many organizations struggle with provider adherence to the tool, a step that is necessary for the tool to improve appropriateness and patient care.

### Encourage provider adherence to maximize CDS potential

After CDS implementation, more often than not, organizations experience some level of provider resistance to the tool. This reaction includes "gaming" the system by using free text rather than structured indications, or selecting the first indication in the list to speed up workflow. Alternatively, providers may input correct information but ignore alerts. Two common CDS adherence challenges are users incorrectly inputting information ("game" system by using free text rather than structured indications, and select first available indication even if not associated with patient condition) and users ignoring guidance (overlooking appropriateness, best practice alerts, and trusting only historical ordering preferences). Despite these challenges, there are strategies organizations can implement to ensure correct use of the tool.

1. **Deliver timely, actionable feedback:** Create reports that display provider-level data and integrate these reports into ongoing CDS education. This approach holds users accountable and shares knowledge about how to best use the tool. This strategy alone **increased** Brigham and Women's Hospital's CDS provider adherence rate to 96%.
2. **Selectively deploy hard stops:** Hard stops are alerts that temporarily or permanently prevent exam orders. In the context of CDS, organizations can implement alerts that require providers to select a structured indication instead of relying on the "free text" field. This prevents "gaming" of the system, and creates more reliable data and patient records. However, leaders should closely weigh the pros and cons of implementing hard stops as to not overly frustrate CDS users. Ultimately, it's important to design an adherence strategy that works for your provider base so the organization realizes the greatest CDS benefits. CDS consultation can result in many benefits, but if used incorrectly, it can result in provider frustration and noncompliance with the Medicare mandate.



*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.*

Interested in learning more about MBMS?  
Please contact Matt at [mostrum@mbms.net](mailto:mostrum@mbms.net)



Matt Ostrum  
Executive Vice President of Sales & Marketing