Imaging Use Drops With Tighter Coding & Reimbursement

Use of medical imaging in the US has decreased significantly after years of widespread growth. This has lead to less hiring, fewer equipment purchases, and reduced access to technology due in part to cuts in federal reimbursement and new coding arrangements. The study describes how funding changes have forced providers to carefully weigh their hiring and patient-care decisions. Providers may not purchase as much imaging equipment or hire additional radiologists because of the reimbursement decline as they prepare for a future of limited or no growth in imaging use, said Dr. Daniel Levin, lead author of the study. The new results are a sharp contrast with the state of imaging in the early 2000s. Imaging was on the rise from 2001-2008. This increase sparked improvements in technology and saved providers time as they attended to patients, the researchers found. Echocardiography grew 42% between this time but fell 61% between 2008-2009. Nuclear and CT imaging also saw sharp drop-offs in utilization during this time. The decreases are most likely due to changes in federal policy, the study’s authors wrote. In 2007, the Deficit Reduction Act of 2005 was brought into effect, and put in place imaging reimbursement cuts. The decline in imaging also stems from changes in healthcare culture, as doctors become more concerned with radiation exposure and providers adhered to practice guidelines more closely. Radiology management companies, which contract with health plans to preauthorize advanced imaging requests, put a barrier between test authorization and the actual test. Additionally, accountable care organizations and bundled payments in recent years have encouraged providers to focus more on cost-cutting. High-deductible healthcare plans have forced many consumers to do the same. “We believe it most likely that, absent further major code bundling, imaging rates will remain at current levels for the foreseeable future without sustained or significant moves in either direction,” researchers wrote.

Next Code Change...Chest & Abdominal X-Rays
Coding and Compliance Tips by Lori Shore, CPC, RCC

I have been coding for far longer than I care to admit and the one constant has been chest x-rays. I never had to look them up, I’ve had them memorized since the late 1970s, but chest and abdominal x-rays are slated for changes in 2018. Why? Why? Why? For once, the logic makes sense. These are the only two code categories in diagnostic imaging that are based on individual views and not the number of views. For example: we commonly refer to 71020 as a two view chest; however, it is listed in the CPT book as a frontal and lateral chest x-ray. Likewise, the single abdomen code is specified as an AP view. The AMA is looking to standardize the diagnostic radiology section of CPT to classify all codes by number of views rather than the views themselves. We have gone through similar changes in the last couple years in diagnostic radiology with the hip and spine codes. These are now based on how many views were done rather than somewhat ambiguous terms such as “with flex and extension.” Were just the flex and extension views done? Was the whole cervical or lumbar spine done in addition to flexion and extension views? Coding is now just based on the number of views performed, or should I say documented. The golden rule of coding is, “If it’s not documented, it didn’t happen.” For diagnostic x-ray this is particularly important when it comes to plain films. Coding guidelines instruct coders that if the number of views is/are not documented the coder MUST code the LOWEST number of views for that code category. It is acceptable to list the number of views themselves; however, be aware of a few pitfalls. For example: PA, lateral and oblique views. Is that 3 or 4 views? Were bilateral obliques done? My suggestion is that if you want to list the actual views that you also list the number of views as a verifying mechanism.
Trump Budget Would Cut $636 Billion From HHS Agencies

As part of his $4 trillion budget for next year, President Donald Trump is proposing a $636 billion cut in federal funding for CMS programs over the next decade. The cuts are intended to make room for more spending on defense and border security. The budget also proposes deep cuts to Medicaid—about $800 billion over the next decade.

The savings would come from transforming Medicaid into a per capita cap program starting in 2020. Medicare is not directly cut in the budget, allowing the President to maintain part of his campaign promise not to touch either entitlement program despite federally subsidized healthcare being one of the biggest contributors to the national debt. Trump’s budget extends funding for the Children’s Health Insurance Program as well, which is up for renewal at the end of this year. States, however, would lose the en-hanced match provided by the Affordable Care Act. The law gave states a 23-percentage-point bump in federal matching rates. The draft budget also ends a provision that has prevented states from narrowing the pool of eligible CHIP beneficiaries below what it was in 2010, the first year the ACA went into effect.

The proposed budget still needs to be passed by Congress, which is unlikely to happen in its current form. Other changes include repealing the Independent Payment Advisory board, a panel that was created in the ACA whose purpose was to rein in Medicare costs if the program reached insolvency. That move would garner $7.6 billion in administrative costs over 10 years, according to the budget proposal.

The President’s plan promises that overhauling the tax code and easing regulations will lift economic growth from the lackluster 2.1% average rate of recent years to sustained annual gains of 3% or higher. Trump’s plan folds in more than $2 trillion in unspecified deficit savings over the coming decade from “economic feedback” to promise balance.

Diana Zuckerman, president of the National Center for Health Research, does not expect Congress, which was generous to the institutes earlier this month, to support Trump’s cuts. “I have never known Congress that enthusiastically cut NIH funding,” she said. The administration is prioritizing opioid abuse prevention efforts, combating childhood obesity, vaccine stockpiling and investing in CDC infrastructure. The budget also proposes a 17% cut to the CDC’s sexually transmitted disease and tuberculosis prevention efforts. Chronic disease prevention and health promotion would be cut by 19%.

How Imaging Leaders Should Respond To Controversial Breast Density Notification Laws

5:35 PM on May 3, 2017 by Lea Halim and Pooja Desai of The Advisory Board Company (ABC). ABC is the owner and publisher of this article.

Since Connecticut passed the nation’s first breast density notification law in 2009, many other states have followed suit. As of today, 32 states have passed breast density notification laws, 12 of which were signed in the past two years alone.

Though notification laws are intended to increase transparency in women’s health and improve access to alternative screening, the diversity of legislative requirements have left many questioning how they can be improved.

Why should women be notified about breast density?

Dense breast tissue can make it harder to evaluate the results of a mammogram and may be associated with an increased risk of breast cancer. According to “Are You Dense,” a breast density notification advocacy group, mammography misses every other cancer in women with dense breast tissue. With approximately 40% of women having breast dense tissue, the probability of an ineffective mammography exam is certainly not slim. According to the National Institute of Health and the American College of Radiology, breast density is one of the strongest risk factors of breast cancer—even stronger than having two direct relatives with the disease. Advocates of notification laws believe that awareness about breast density should be brought to a woman's attention early to allow for informed conversations with physicians, including alternative screening mechanisms, which can increase detection of early stage invasive breast cancer among women with dense breast tissue by 100%. By failing to enact life-saving screening protocols for women with dense breast tissue, cancers are detected at a later stage, creating fewer treatment options and worse survival outcomes.

What does breast density notification legislation entail—and what’s the controversy?

Critics of breast density notification laws cite their lack of uniformity on a national level. Though the majority of states that have passed such laws require a letter to be sent to the patient, the letter itself, and the patients receiving the letter, vary greatly. Some states, such as California and New York, require physicians to send letters to all women who recently received a mammogram, notifying patients if they have dense breast tissue, the specific category their breast tissue falls into, and what next steps they should take. But other states, such as Louisiana and Missouri, take a more controversial approach. They require sending a letter to all patients—regardless of whether they have dense breast tissue. These letters often begin with “If your mammogram demonstrates that you have dense breast tissue, which could hide abnormalities... you might benefit from supplemental screening tests.” Such vague language often leaves women wondering why they received the letter, whether they in fact have dense breast tissue, and what steps they should take next. Furthermore, some states only require letters to be sent to women with ‘extremely dense’ breast tissue, leaving notification of all other forms of breast tissue up to the physician’s discretion. Further controversy around legislation also lies in how messages are delivered to patients. Many worry that sending letters to patients without appropriate discussion incites more anxiety than intended. “The manner in which the information is shared is important,” Richard Frank, MD, PhD, chief medical officer for Siemens Healthcare North America told Diagnostic Imaging in a 2016 article. Read the full article here.