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Radiology Trends

CMS Moves Forward With Out-Of-Pocket Limits Rule

CMS is standing behind it's ruling on maximum out-of-pocket limits for medical care, stating that members within families shouldn't have to pay more than individual consumers. The rule was originally finalized in February.

Currently, the Affordable Care Act limits how much people have to pay out-of-pocket for deductibles, copayments and coinsurance. The maximum yearly amount is $6,850 for individuals and $13,700 for families. For example, under the CMS rule if a four-person family buys a health plan and has a $13,700 out-of-pocket limit for 2016, and one of the family members gets sick and is billed $20,000 from the hospital, the family member would only have to pay the maximum $6,850 and the self-funded employer or insurer would have to cover the rest even though the family limit hasn't been met. Those limitations apply to individual, small-group, large-group and self-insured plans.

"We believe that applying the individual $6,850 maximum...helps remedy the difficulty a consumer could face in paying up to $13,700 out-of-pocket for certain covered medical care under the plan because he or she purchased family coverage instead of self-only coverage," Kevin Counihan, CEO of the Affordable Care Act's health insurance marketplaces, said recently. He believes the policy protects families from racking up burdensome medical debt.

Many large employers are against the rule, including self-funded companies, since it means the company or insurer will be on the hook for the rest of those costs.

Did You Know?

Screening CT colonography (CTC) is almost 1/3rd less expensive than colonoscopy in Medicare patients, according to a new report. The results are promising for what advocates hope is imminent approval of a Medicare payment for the CT-based test.

Healthcare Leaders Say Stage 3 Could Jeopardize Medicare Payment Rules

Healthcare groups support the plans to delay Stage 3 of meaningful use rules, especially since those rules need to harmonize with the recently passed "doc fix" to the Medicare program.

A recent example is Senator Lamar Alexander (R-Tenn). He said he would like to see the rule-making delayed until January 1, 2017 on the more stringent Stage 3 meaningful use testing and certification criteria. That could push back provider start dates for Stage 3 into 2019 or beyond. "I believe then that the Stage 3 requirements should be phased in at a rate that reflects how successfully the program is being implemented," said Alexander, who chairs the Senate Health, Education, Labor and Pension committee, which has jurisdiction over the country's $31.3 billion electronic health record program. The American Medical Association (AMA) said in a statement the delay is necessary because it was developed "prior to and without consideration of the changes enacted by the Medicare Access and CHIP Reauthorization Act (MACRA)." MACRA, passed by Congress this year, replaces the sustainable growth-rate formula with a merit-based incentive payment system. A recent analysis of the program data indicated that physician participation dropped by 12% in 2014 compared with a year earlier.

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Breast Density Law Leads To Higher Ultrasound Costs In NJ

The number and cost of breast ultrasound exams have more than doubled in NJ after the state enacted a breast-density notification law in 2014, according to a new study published in the *Journal of American College of Radiology.*

The study results indicate that density notification laws can carry a heavy financial cost, to say nothing of possible clinical limitations of the technology, such as false-positive rates and low positive predictive value says lead author John Sobotka of St. George's University School of Medicine in St. George's, Grenada.

Sobotka and his colleague Dr. Clay Hinrichs of Hackettstown Regional Medical Center in Hackettstown, NJ, conducted the study to assess the financial effects of the NJ breast density notification bill. The bill was signed into law in January 2014 and enacted in May of that year.

"We saw that we had an opportunity to study this issue because the law had passed and we knew the date it would be enacted, so we could compare ultrasound volume before and after," Hinrichs said. The study included a sample of patients seen for mammography and subsequent breast ultrasound at the Hackettstown Regional Medical Center for three months before and three months after the law was enacted. After the law went into effect, the percentage of women who had follow-up ultrasounds after mammography more than doubled, the researchers found. Ultrasound may find more cancers in women with dense breast tissue, but this benefit must be weighed against the risk of unnecessary studies, false positives and increased healthcare costs, Sobotka and Hinrichs concluded.

Coding and Compliance Tips by Lori Shore, CPC, RCC

The Whole New World of Radiology

The much anticipated transition to ICD-10-CM is here! This will be a learning experience for all of us as we do our best to navigate hospital systems, updated insurance policies and referring physicians. Document as much detail as possible and we will try to fill in as many gaps as we can. Please remember to respond to addendum requests in a timely manner to avoid further delays in claim submission.

Just as we get used to ICD-10-CM, there are many changes to CPT on the horizon for 2016 in radiology. Bundling continues with fourteen new percutaneous biliary procedure codes anticipated. There will also be clarifications made with twelve anticipated new codes in diagnostic x-ray for thoracolumbar spine, hip and pelvis. New codes are expected to be introduced for fetal MRI; ureteral brush biopsies, dilations and embolization, percutaneous sclerotherapy of fluid collections and soft tissue marker placements. Nuclear medicine can expect the addition of codes for small bowel and colon transit.

Physician Quality Reporting System (PQRS) requirements are not expected to change significantly for 2016. It is a good time to begin thinking about how you and/or your group would like to participate next year. Claims-based reporting for PQRS is becoming more difficult as the number of measures dwindle. Consider one of several registry options as an alternative reporting method.