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Radiology Trends

Did You Know?

MR images are providing encouraging evidence that children with multiple sclerosis (MS) who exercise regularly are more likely to have smaller brain lesions.

Billing Squeeze: Hospitals Stuck In Middle Of Charge Battle

As more insurers shift to narrow provider networks to keep premiums down, hospitals increasingly find themselves caught in the middle as patients, insurers and physicians fight over who should pick up bills for services that patients unknowingly receive from out-of-network doctors. A March 2015 study from Consumers Union found that surprise medical bills hit 30% of privately insured Americans, and a quarter of those patients said the bill came from a doctor they did not expect. A growing number of hospitals and insurers are setting up processes to resolve out-of-network bills before the problem escalates into a public relations disaster that could undermine support for narrow-network plans.

But eliminating surprise bills altogether may require broader business changes by healthcare organizations and/or regulatory action by policymakers. Some hospitals and insurers now take steps to address the volatile issue and remove the patient as much as possible from these disputes. Typically, the balance billing issue arises with contracted physicians. Physician groups typically say they refuse to accept insurers' unreasonably low rates, while insurers argue the medical groups are demanding excessive prices. The most stressful part for hospital officials, who often serve as mediators between insurers and out-of-network physicians, is getting physicians to come to the table. Sarah Davis, a law professor at the University of Wisconsin and associate director of the Center for Patient Partnerships, said the underlying problem is that insurers and employers are imposing larger deductibles and coinsurance on consumers. At the same time, providers face pressure not to saddle patients with ruinous out-of-pocket costs. That's putting a big squeeze on providers, said Davis, whose organization counsels patients who face confusing or unexpected medical bills. "I think that's unrealistic," she said. "That's setting providers up for failure."

"The real crux of the problem is that health insurers are refusing to pay fair market rates for the care provided," Dr. Steven Stack, a Lexington, Ky., emergency physician who is president of the American Medical Association, said. "Then they turn and say to the physician who is billing (for out-of-network services), 'You're the bad guy.'" Experts agree that hospitals, physicians and insurers will continue to face heat from the public until more is done to protect patients from unexpected bills.

CMS Says Positive Testing Results Prove They Are ICD-10 Ready

As providers around the country brace for the Oct. 1 conversion to ICD-10 diagnostic and procedural codes, CMS is reporting positive results from the final round of end-to-end testing of the Medicare claims processing system. CMS reported an 87% acceptance rate on 29,286 claims received. They added that 2.6% of the claims were rejected because of invalid ICD-9 code submission and that another 1.8% bounced back because of invalid submission of ICD-10 diagnosis or procedural codes. CMS also postulated that among the 1,200 or so testers—providers, claims clearinghouses and

billing agencies—some of the errors were intentional to make sure the claim would be rejected as part of a regime called "negative testing." The testing was conducted between July 20 through July 24. "We thought the testing was extremely successful," said Stacey Shagena, a CMS technical adviser who presented the test results. Health IT consultant Stanley Nachimson, principal of Nachimson Advisors and an ICD-10 expert, added that more

testing is needed.

"Remember, these are people who believe they are ready," Nachimson said. "And with the errors they (CMS) are still encountering, it sounds like there are issues in setting up the (providers') new systems. We don't know what's happening to those entities who haven't prepared or been involved in the testing yet."

MBMS

111 Continental Drive
Suite 315
Newark, DE 19713

Phone: 1-888-625-4753

Fax: 302-731-2498

E-mail:

mostrum@mbms.net

VISIT US ON
THE WEB!

WWW.MBMS.NET



Private Insurers Still Experience DBT Reimbursement Woes

Since three new billing codes and reimbursement values were created in January for DBT, many imagers are finding that many private insurers continue to find the modality investigational and thus are not reimbursing. "I thought that when reimbursement was approved for digital breast tomosynthesis insurance companies would pay for it and with that, more practices would adopt this technology," says Jaime Geisel, MD, an assistant professor of diagnostic radiology at the Yale University School of Medicine. "Tomosynthesis is the most dramatic change we've had recently in breast imaging and is an incredible thing for women." "We have seen more adoption of DBT by radiologists and practices, even without definitive reimbursement," says Dana H. Smetherman, MD, MPH, FACR, vice chair for clinical affairs and section head for breast imaging in the department of radiology with Ochsner Health System in New Orleans. "With more vendors developing tomosynthesis, we see more usage." According to the ACR, where Smetherman serves as co-chair of the organization's breast imaging economics committee, DBT is not considered an experimental modality for breast cancer screening or diagnosis, she says. Study findings support use of DBT as a supplement to mammography, showing that the 3D modality is useful in increasing the detection of breast cancer, particularly finding small, invasive cancers, as well as in decreasing recalls. Allegheny Health Network in Pittsburgh offers DBT to all patients along with a card stating that while this 3D technology is beneficial in the early detection of breast cancer, the patient may be responsible for the cost. Dr. William Poller, director of the division of breast imaging at the network says that a lack of reimbursement could be one of the reasons why he has seen a decrease in tomosynthesis volume.

As with any new imaging technology, there's an evolution between FDA approval and coverage. Only four years have passed since the first FDA approval of DBT in the United States. Imagers make a comparison between this and the adoption of other new imaging technology, such as breast MRI and computer-aided detection, when considering how much more time it might take before insurers begin to offer more widespread reimbursement for DBT. Like other breast imaging modalities, tomosynthesis use will evolve as users learn more about best practices and the reimbursement process matures.

Coding and Compliance Tips by Lori Shore, CPC, RCC

PQRS Measure 195---Carotid Stenosis Measurements

Of all the PQRS measures, measure 195 is the one for which I receive the most questions. It all comes down to semantics. The measure requires "direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement" **OR** an equivalent validation method that correlates anatomic measures that use the distal internal carotid lumen as the denominator for stenosis measurement. Where it applies, including the verbiage, "**All measurements were calculated based on NASCET criteria**" covers this measure. Statements that will also successfully report the measure are: "**Direct measurement of the distal internal carotid diameter as the denominator for stenosis measurement was made**" Or "**Indirect reference to measurements of the distal internal carotid diameter as the diameter for stenosis measurement was made.**"

Listing one of the statements noted above on all reports for carotid angiography (36222), CTA of the neck (70498), MRA of the neck (70547-70549), carotid duplex (93880-93882) will ensure that the measure is coded successfully for PQRS. Even claims with "no stenosis" or "minimal stenosis" should include the basis for measurement to avoid any confusion.