

# RADIOLOGY TRENDS

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## How Much Exposure Do Medical Students Have to IR Programs?

According to new research published in the [Journal of the American College of Radiology](#), few institutions offer formal IR subinternship rotations to medical students. "Medical students often have relatively little formal radiology education, and when clinical rotations are offered, they are frequently elective," wrote lead author Daryl T. Goldman, MD, of the Icahn School of Medicine at Mount Sinai in New York. "Prior research has demonstrated the importance of early structured exposure to both diagnostic radiology (DR) and IR and has also demonstrated the paucity of required core clerkships in diagnostic radiology."

Goldman and his colleagues added that before the recent creation of IR integrated residency, the opportunities for medical students to explore IR were limited to "brief experience" as part of a DR rotation, or as an elective within a surgical clerkship. These researchers aimed to highlight the availability of medical student education in IR and propose a basic framework for the clinical rotations. They reviewed the Liaison Committee of Medical Education (LCME) website to generate a list of accredited medical schools in the U.S. They then evaluated school websites and course listings to search for the availability of IR and DR rotations, and reviewed the curriculum of "well established" IR rotations to identify and categorize the course content. The researchers found a total of 140 LCME-accredited medical schools which had course information. They found:

- 71 percent of schools offered an IR rotation.
- 85 percent of IR rotations were only available to senior medical students.
- 2 percent of IR rotations were offered to preclinical students.
- 8 percent of courses were listed as subinternships.
- Well-established IR clerkships included a variety of clinical settings, including: preprocedural evaluation, experience performing procedures, post-procedure management and discharge planning.

"The continued expansion and advancement of IR begins with medical student education and recruitment, and it is crucial that medical school officials and IR departments are encouraged to integrate IR into all phases of medical education," the authors concluded. "Medical student instruction is an investment in the future of radiology—this effort must be made a priority in the field."

## The Importance of Pain and Shortness of Breath

Coding and Compliance Tips by Lori Shore, CPC, RCC

More and more claims are being pended each day in search of signs and symptoms. What's the reasoning behind this? "Rule out" has never been a coding option, and it never will be. Neither will "evaluate for" or any of the other ways people have tried to skirt around "rule out." The two biggest culprits: R/O DVT" and "R/O PE." Most people do not have a DVT or PE. Now what?! That's why signs and symptoms are so important. Why did the ordering physician think the patient might have a DVT or PE? It's not crucial to know that the patient had cellulitis, just that he/she had pain and/or swelling in the limb. **A sign or symptom is**

**always preferable to a suspected diagnosis.** There's a level of excitement when any coder sees "shortness of breath" because they know it will cover almost anything (including both venous duplex for DVT and CTAs for PE)!

Another example is "evaluate for fracture" as the reason for exam. Most often the study is normal and now it needs to be pended to obtain signs and symptoms. This could all be avoided by changing the reason for exam to "pain." A radiologist is obviously going to evaluate for a fracture and a coder cannot code pain unless it is documented.

There are endless amounts of examples on what NOT to do but a good place to start is with what information is being provided by your facility. Radiologists don't always get good information regarding cases but this is where techs can help. It needs to be documented that the data was obtained by the tech from the patient in the clinical history paragraph of the report in order for coders to use it. *Example: Tech reported: Patient complained of pain in left hand.* Taking these simple steps may help reduce the number of addenda requests you receive.

# How radiology will fare under 2019 Medicare proposals

**10:15 AM on September 11, 2018 by Erin Lane, Catherine Kosse and Ty Aderhold. *The Advisory Board Company* (ABC) is the owner and publisher of this article.**

This July, CMS released proposed rules governing [hospital outpatient facility](#) and [provider payments](#) for calendar year (CY) 2019. Included in the rules are payment and regulatory updates important for imaging program leaders to understand as they consider their outlook for 2019 and beyond. Our team analyzed the more than 2,200 pages so you don't have to. Keep reading for the five biggest takeaways for imaging leaders and radiology programs:

## 5 key takeaways

### 1. Hospital and clinician payments remain flat, but independent diagnostic testing facility payments decrease, again

*Hospital outpatient payments:* CMS proposed a 1.25% increase in payment for hospital outpatient services, an even smaller increase than last year's 1.35%.

*Clinician payments:* CMS proposed a \$36.05 conversion factor for 2019, only 6 cents greater than the 2018 conversion factor. CMS estimates that in aggregate reimbursement for radiology specialties will not change from 2018. The notable exception is for independent diagnostic testing facilities (IDTFs), which may experience a 4% reimbursement reduction due to a drop in practice expense RVUs. If finalized, this will be the second year in a row IDTFs see significant cuts.

**Our guidance:** While payment rates aren't increasing for imaging providers, many internal costs are—meaning that programs face mounting financial pressures. Imaging programs must focus on controlling costs and securing revenue to prepare for margin pressure that will likely increase in future years.

### 2. An expansion of site-neutral payment policy brings off-campus HOPD payment closer in line with freestanding sites

CMS first implemented site-neutral payments in 2017 to level the payment discrepancy between hospital outpatient departments (HOPDs) and provider-based sites. Currently, newer HOPDs that do not meet site-neutral payment exemption criteria, are paid at 40% of the hospital outpatient (HOPPS) rate. While CMS has proposed to maintain the current site-neutral payment rate, the agency put forth two key changes that would significantly expand the number of services that are paid at this reduced rate.

*New services no longer exempt.* Currently, site-neutral payment exemptions are granted at the facility-level. Off-campus sites built or acquired before November 2, 2015 are exempt from site-neutral payments and may continue to bill at the full HOPPS rate. This exemption covers the entire site, meaning even newly added services and will receive HOPPS reimbursement.

CMS proposed to shift exemptions from facility-wide to procedure-specific. If finalized, facilities that were previously exempt would receive the site-neutral rate for "new" service offerings. Services offered between November 1, 2014 and November 1, 2015 will remain exempt—in other words, receive the full HOPPS rate. But any newly offered services (after the November 1, 2015 date) will be impacted by site-neutral payments and therefore paid at 40% of HOPPS. For more information on how the agency has proposed to organize services into clinical families and implement this change, review our [recent blog on site-neutral payment policies](#).

*Routine clinic visits now site-neutral.* CMS proposed to make the code GO463, hospital outpatient clinic visit for assessment and management of a patient, site-neutral at all sites. In other words, clinic visits will be billed at the site-neutral rate at all off campus HOPDs, even those sites previously exempted.

Based on Advisory Board analysis, 78% of diagnostic radiology claims for this code are provided at currently-exempt off-campus sites. That means if finalized, imaging programs will see a significant payment reduction for these clinic visits.

**Our guidance:** Regardless of what exactly is finalized, these proposals demonstrate that CMS views off-campus HOPDs as a significant source of future Medicare savings. Imaging leaders should prepare for continued payment level at these sites.

Read the rest of the article [here](#).



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