



RADIOLOGY TRENDS

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Medicare Shared-Savings ACOs To Cut \$1 Billion In Costs

Accountable care organizations participating in the CMS' Medicare shared-savings program reduced spending by about \$1 billion in three years, HHS' Office of Inspector General reported recently. Over three years, most of the 428 ACOs participating reduced Medicare spending compared to their benchmarks, and a small group produced "substantial" savings. 82% also improved the quality of care they provided and outperformed fee-for-service providers in 81% of the quality measures. "While policy changes may be warranted, ACOs show promise in reducing spending and improving quality," the OIG report concluded. The findings come just weeks after

the Trump administration canceled other alternative payment model experiments, including two mandatory bundled-payment programs, while rolling back another. "It's not just about getting paid differently," said David Muhlestein, chief research officer at Leavitt Partners. "It's about providing care differently, and it takes time." The report adds to the ongoing body of evidence showing that while ACO performance varies widely, ACOs are improving the quality of care overall, he said. Cost savings—the bulk of which are concentrated among just a few ACOs—have trailed improvements in quality, but there's promise for both he added. Clif Gaus, president and CEO of the National Association of ACOs, said that beyond the positive cost

and quality performance results, the report also shows "a huge acceptance" of the program by physicians and hospitals. The positive findings are also evidence that ACOs should be allowed to remain in one-sided risk contracts instead of being required to enter two-sided risk arrangements, he said. "This year's report is further proof that one-sided ACOs are doing well," he said. The vast majority of ACOs in the program participate in one-sided risk contracts. But CMS limits one-sided risk ACOs to two contract terms, or six years. Gaus noted that the majority of ACOs participate in the one-sided risk track of the shared-savings program.

Never Enough History Coding and Compliance Tips by Lori Shore, CPC, RCC

Particularly since the inception of ICD-10-CM, coders can never have enough clinical history. A major challenge for hospital-based radiology groups is that often times, especially from the ED, a detailed patient history is not supplied. We have had success working with some of our large hospital-based radiology groups reducing their "unspecified" diagnosis codes by working with their emergency departments. Clinical staff often do not understand what coders need, but once educated can quickly affect change. One of the more difficult stud-

ies to get paid for is a modified barium swallow, 74230. This study is done in conjunction with a speech therapist. Based on CMS policy, this study is covered for dysphagia following a cerebral infarction or event. Rarely do we get information on previous cerebral events. If we don't get that information, two diagnoses are required in order to get the claim paid.

Venous duplex studies are studies that rarely give history other than "R/O DVT." Rule out is never codable. Signs and symptoms are the best option for these studies as

thrombus and/or embolisms are found in a minimum amount of cases. Edema, pain or other symptoms are more likely to comply with payer policies. Signs and symptoms are always preferable to a diagnosis. If the diagnosis given is not covered under the insurance policy, signs and symptoms give coders additional options to get the claim paid.

What Medicare's 2018 Payment Proposals Would Mean For Radiology

8:40 AM on August 4, 2017 by Lea Halim, Erin Lane and Ty Aderhold of *The Advisory Board Company (ABC)*. ABC is the owner and publisher of this article.

Last month, CMS released proposed rules governing hospital outpatient facility and provider payments for calendar year 2018. The rules cover payment updates, coding changes, and details for Medicare policies regarding clinical decision support and site-neutral payments—all of which directly impact imaging programs.

Our team read through the more than 1,400 pages of proposed rules and identified six key takeaways for imaging leaders and radiologists.

1. Hospital payments would rise, clinician payments would be flat, and Independent Diagnostic Testing Facilities would fall

Hospital Outpatient Payments: CMS is proposing a 1.75% increase in payment for hospital outpatient services, which is up slightly from the 1.65% increase hospitals saw in 2017.

The agency is also calling for a new imaging APC: Level 5 Imaging without Contrast. If finalized, services included in the current Level 4 Imaging without Contrast APC would be split into two different codes: the current Level 4 (which would include high-frequency, low-cost services) and a newly created Level 5 (which would include low-frequency, high-cost services).

Clinician Payments: CMS is setting the proposed 2018 conversion factor at \$35.99, only about 11 cents greater than the 2017 conversion factor.

CMS estimates that in aggregate, diagnostic and intervention radiology would see a 1% reduction and independent diagnostic testing facilities a 6% reduction in payment in 2018. This steep decline would be due to practice expense (PE) RVU changes for IDTF services.

2. CMS proposes to cut reimbursement in half for services impacted by site-neutral payments

As a brief reminder, CMS is attempting to reduce the payment discrepancy between services performed at hospital outpatient departments (HOPDs) and provider-based sites. The number of hospital-owned practices has significantly increased over the past decade, and many sites transitioned billing to the higher hospital rate. This led to a significant jump in Medicare payment for certain services. To control these growing costs, CMS has eliminated the ability of off-campus HOPDs opened or acquired after Nov. 1, 2015, to bill on the higher rate via so-called "site-neutral payments."

CMS currently pays impacted HOPDs based on a non-facility Medicare Physician Fee Schedule (MPFS) rate, which is set at 50% of the hospital rate. Last year, CMS said that the 50% rate may be too high, as the agency found that provider-based rates were about 45% of hospital rates. Though CMS has not conducted additional analysis, it is proposing a further reduction of reimbursement down to 25% of the hospital outpatient rate.

While the 25% would represent a significant payment reduction for impacted HOPDs, it appears the agency may ultimately seek a less dramatic cut in the final rule, depending on stakeholder feedback.

3. CMS proposes delaying the imaging clinical decision support (CDS) deadline but continues to implement key program components

CMS is proposing to move the provider deadline for the Appropriate Use Criteria (AUC) Program—also known as CDS—from Jan. 1, 2018 to Jan. 1, 2019, with the possibility of a voluntary reporting period beginning in July 2018. The program requires ordering providers consult CDS when ordering advanced imaging exams; furnishing providers must document that consultation for Medicare reimbursement.

To read the full article, click here: <https://www.advisory.com/research/imaging-performance-partnership/the-reading-room/2017/08/hopps-mpfs>



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