Relevant Information Creates Smart Dashboards

By Jeff Maze

Radiologists face a gamut of industry and legislative developments that challenge their already tenuous hospital relationships, managed care reimbursement agreements, and the fierce imaging center competition that come with those. Inclusive of rising health care costs and declining reimbursements, radiology administrators are encountering new obstacles as they witness changes and maturation in digital technology.

Obtaining timely information that impacts these changes for the better, presented visually, and with usability that is carried out through the entire organization is becoming increasingly more important. In addition, drilling down into practice data in order to discover more detailed information in an ad hoc manner is critical to empowering radiologists in the decision-making process.

While the importance of monitoring and managing day-to-day operations of a radiology department – such as workflow, throughput, report turnaround times, or exam volume – remain vital to quality improvement, it is still often provided via retrospective static reporting. A key challenge facing radiologists will be transitioning away from the comfort of familiar static (and stale) tabular reporting into the new world of real-time interactive dashboards that perform complex analysis and visualizations 24/7/365.

Ongoing Advancement

There is no doubt that health care technology for business is advancing rapidly. Business intelligence dashboards were born roughly four decades ago in health care, referred to as the Executive Information Systems (EIS). The EIS was comprised of a basic foundation that centered on condensing data, typically revolving around an industry’s key performance indicators (KPIs), into a form that fits into a single screen or report for high-level decision-making. The static interface and non-integrated usability were drawbacks to these prehistoric dashboards and their inability to help with the rapid decision-making needs of executives led to their eventual demise. Interactive dashboards were the next development, created out of EIS shortcomings. These more advanced
dashboards offered the benefits of enhanced visuals and usability, which empowered physicians at different levels with greater decision-making tools.

Dashboard technology has evolved today with the ability to stream and integrate information from various health care systems by consolidating the data into warehouses that can be accessed and manipulated to create valuable information and powerful dashboards. In other words, the history of the EIS and Interactive Dashboard systems has paved the way for today’s dashboard applications that are highly visual, rich in information, and provide rapid access to real-time information.

The functional features in dashboards can package all information needed for short-and long-term decision making ability in the form of graphs, charts, tables, dials, and other formats. Physicians are enabled with a keener understanding of the business of their practice and its trends. With detailed summaries and data analysis, physicians are provided with their electronic information rapidly, throughout the entire organization. Ultimately, dashboards can be described as the “one-stop shop” for a physician’s business information needs.

**Dashboard Customization**

However, not all dashboards are created the same. The radiology practice dashboard should be tailored to meet the unique needs of a radiology business where practices can define goals and form a vision as they create their business model. For customization, radiology practice leaders must consider the daily, weekly and long-term information and comparisons needed in order to make strategic decisions, including:

- Monthly run rate against targets for charges and reimbursements
- Key A/R metrics against targets (e.g., days in A/R, A/R percentage over 120 days, adjusted collection percentage, and bad debt with trending and historical information)
- Modality information (e.g., volumes, charges and reimbursements by modality or CPT; sorting available on a “click-on” basis by top charges, payments, or collection percentage; and links to corresponding procedure analysis reports online)
- Payer mix information (e.g., reimbursements by payer with volumes, charges and reimbursements for each payer as well as numerous selection criteria for specific payers)
- Referral information (e.g., referral patterns such as top 10 referring doctors by total volume or the top 10 referring doctors by lost volume)
- Managed care contracting
- Physician productivity

A critical piece of business intelligence is KPIs, which serve as a benchmark for data aggregation and analysis. However, simply setting KPIs is not enough. Practices should focus on setting realistic and achievable goals while making a point to revisit and review frequently to ensure they are still accurate. Inaccurate or outdated KPIs can do more damage to your practice than simply not having them set in the first place since users will become numb to the constant variances and discrepancies and be less likely to spot an actual issue when one arises.

In addition, advanced functional capabilities are also important including the ability to “drill-down” into the details, save custom views and settings, allow for commenting and collaboration inside the
tool, and access to historical financial reports. Radiologists who can see graphical and numerical trending across their practice with the ability to rapidly filter and sort the information can get a big picture view quickly of decisions that must be made. These capabilities also impact the manner in which they integrate with other facilities and systems, including mission critical systems for RIS, scheduling and the like.

In closing, advanced dashboard applications are one of the biggest weapons radiologists have against rising health care costs and declining reimbursements. These dashboards should reflect a practice’s unique business strategies and meet their varying and individual needs. While visually pleasing graphics and flashy dials may be a draw, at the end of the day practices should make sure they trust the information being presented and ask themselves what empowers them to make timely decisions to ensure long-term financial success for the practice.

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Succession Planning for Radiology Practices
By David Myrice, CPA, MBA

There is a reality that most radiology groups out there have no plan in place for when their leadership retires, and it seems the most common approach to succession planning among radiology practices is no approach at all. Like most professional corporations, the owners are also the workers, and that makes planning more complex and emotional. As a result, too many radiology groups are just operating on the fly.

A widely held misperception regarding succession planning is that it focuses solely on new leadership, when, in fact, incoming leadership represents just half of the equation. Succession planning is both how you train your future leaders and how you treat your departing leaders. Questions many groups should ask themselves:

- Do we have the ability to accommodate older members of the practice as they are winding down?
- When it comes to younger people, how do we address the disparities between our goals?

Deciding on an exit strategy for departing leadership is as important as how you groom new leadership coming up. You want to establish processes and policies while everyone is happy, and stick to them.

Goals that Align Between Generations

The disparities in goals referenced above include both generational differences and differences inherent to radiologists’ professional timelines. Generational differences are well-trod territory: younger radiologists tend to be more invested in maintaining work-life balance, making them more amenable to lifestyle-enhancing decisions like outsourcing night and weekend call or even moving to hospital employment.

For instance, a lot of your younger radiologists coming out of medical school are very lifestyle-structured, and they want to make the same income as their older colleagues, but they never had that experience of having to work all night long. They also never had to deal with everyone sitting in the reading room together, popping films up onto the viewer. Technology has changed a lot of perceptions of where the profession is going.

Lest the blame for disparities be placed solely on the shoulders of the younger generation, it should also be stressed that the older generation can also be tempted to put its priorities ahead of the good of the group. As an example, senior radiologists have traditionally been running the group, and they have the experience and the knowledge, but their goals have changed over time. They are willing to ride things out—and they do not want to rock the boat. The younger generation is looking at the future and feeling nervous.

There is a catch-22 inherent to handing over the leadership reins, caused in no small part by health
care’s current instability. The older people have to be willing to step down and train the younger people to come forward, but the younger people have to keep in mind that their long-term goals will not always match up with the older generation’s goals. There’s no easy answer to address it.

**Planning with Policies and Procedures**

Radiology groups should take a formal, structured approach to succession planning, setting policies and procedures in advance and sticking to them. The first step is for leadership to identify the type of leader they believe the group needs in the future based on their experience and knowledge – and who is the right fit for the future. Secondly, it’s critical to quickly gauge their level of interest before moving on to another candidate.

Most radiologists did not set out on careers in medicine with the intention of becoming business leaders, so practices should invest in supplementary training for their future leaders, which includes mentoring them, testing their capabilities, or sending them to a few leadership courses on the company’s dime. It is important to involve them over time and groom them for their future roles. As opportunities present themselves to involve them on a more formal basis—becoming a member of the board, accompanying current leadership during hospital administration meetings—take advantage of them. The specialty of radiology is recognizing the need to develop leaders in the challenging environment of healthcare management. The ACR recently implemented the Radiology Leadership Institute (RLI) to educate radiologists in critical leadership skills.

Meanwhile, the group should decide on a policy for outgoing members. An example might be for the older radiologist who wants to transition to working part-time. Most groups really cannot afford to maintain a partner on a part-time basis, but on the other hand, the older members of the group are often the ones with the relationships with hospital administration, so there is a value to transitioning them out slowly. Maybe the group will decide that radiologists can work part-time, but lose their voting rights. The ideal scenario is when the group comes together before the question is raised to decide whether they will allow people to slowly taper off, or whether their retirements will be abrupt endings.

In initiating the succession planning process, members of radiology groups would be well advised to remember that every vote they take will be taken personally, as most people are looking at it from the perspective of how it will affect them. If groups want good leaders, they should groom them to be good leaders, but also show them how well people are treated who were leaders when they are on the way out. If practices decide in advance what the rules are and stick to them, they will have an easier time down the line.

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Practice management modeling: wait... business intelligence can enhance that too?

By Jana Landreth, CPA, MBA

By using business intelligence data for descriptive analytics, radiologists are definitely running their practices more efficiently, but also more effectively, because they are using data to affect change. This is so important in an environment where radiologists are consistently being asked to do more with less and given the service pressure being applied by hospitals and centers. A simple increase in volume is no longer a viable remedy to the problem.

The old adage to “work smarter, not harder” certainly applies to radiology practice managers and physician owners in this sense. Business intelligence data can create a practice management model that works for radiology groups, with a significant impact on things like day-to-day operations, physician and staff scheduling processes, relationships with customers, and overall job satisfaction of the physicians.

Think twice before doing what you’ve always done

Many times, an evolution of the practice’s needs over time will illustrate that it’s time for a change. It could be during a sustained period of growth, where a practice might be taking on more physician shareholders after its hospital systems customers consolidated. Or, it could be an opposite situation, whereby a group’s radiologists might be retiring.

If there are thousands of transactional data points at your disposal, that’s when business intelligence can really illustrate what the practice is producing, using descriptive analytics to develop a new model for managing the practice. The use of aggregated data can describe what is happening in a radiology business, but taking the information and using the analysis to advise physicians and help them feel confident can help them better manage their workday, which results in better management of the practice.

Not only that, practices can evolve when the use of business intelligence helps them manage what they’ve always done.

The goal is to create a model that works for the practice, a clear understanding of the business as a whole, as well as a “health check” for present operations and a solid foundation for future planning.

There’s more to it than a volume increase

The task of mining data to inform a decision is a daunting one, mainly because radiologists are typically more passionate about their work as physicians than they are about running a business. With all that’s happening right now in our industry, radiology groups are going to be called upon more and more to use business intelligence to effectively manage resources to keep up with the pressure being put on their businesses. With no increase expected in the number of hours in a day, practice managers and physician owners have to look at the options the data is offering as quality evidence they can use to institute effective changes that will positively impact the business, rather than asking radiologists to increase their workload.
Most of the data used to create a new practice model is readily available and can be found in various areas, including:

- Scheduling software
- Financial statements
- Hospital contract(s)
- The revenue cycle management system

The challenge in this is that the information exists in organizational silos, isolated from the other information and is rarely looked at holistically. That’s why it is important that groups analyze the information to show all the different factors weighted together.

**An example in physician scheduling**

The process of physician scheduling and shift modeling offers a great example of how business intelligence can yield practicality. Many practices schedule physicians and staff based on a legacy model, referring to “the way it has always been done.” Radiologists typically complete a rotation in their practice schedules, so the distribution of work is equitable, or is perceived as such. When the industry transitioned to a PACS environment, and radiologists moved from reading the film that was put in front of them to downloading images and reading from any location, practices had an opportunity to become virtual and were no longer confined or challenged by their geography. This ability to read across locations brought the opportunity to improve productivity immediately without investment but made maintaining equality through scheduling alone more difficult. Furthermore, several years into the PACS revolution, practices desire more productivity improvements than those easily gained at first. Both challenges may be met by mastering practice data.

Using transactional data, practices can make adjustments down to the shift level, and one small change can make a big difference, whether it is altering shift start and end times, or staffing a site based on the individual performance of the physician.

Though the identifying data can be removed when the aggregate physician performance data is presented to the group, a practice can still see how effective each radiologist’s schedule may be for him or her based on the pay-for-performance criteria, and changes can be implemented based on that information.

Because an 8 a.m. to 5 p.m. model may not be the best scheduling option for all physicians, a group might use the model to see when work is ready to be interpreted versus staffing when the hospital is busy. Groups can also tell when a hospital customer slows down between 11 a.m. and 1 p.m. to cycle through a lunch schedule, for example. It may be more effective for a radiologist to assist another facility during that time, or provide specialty reads where there is a need, such as at the breast imaging center.

A new model could be ideal in creating each radiologist’s shift with a similar amount of work intensity, volume and RVUs, and then it doesn’t become as important to move people through a
rotation in order to feed the perception of equivalent workloads for everyone. In other words, shift modeling creates equitable work, and in most cases, a less stressful workday for a group’s physicians.

**Share and share alike**

Each and every radiology practice is different, but there are elements within every model that can be used ubiquitously; and there is certainly a need. In creating a practice model using business intelligence, practices should move beyond simply using resources more efficiently and effectively; instead, they should embrace the challenge to enhance the value of the practice by using business intelligence data to advise shareholders on key decisions.

Because the culture of every practice is also different, each should choose the management model that works best for them.

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Vertebroplasty and Vertebral Augmentation Medicare Coverage Criteria
By Leslie Jones, CPC, CPC-H, RCC, CIRCC, AHIMA Approved ICD-10 Trainer

New for 2015, the CPT codes for vertebroplasty and kyphoplasty were revised to include radiology supervision and interpretation. With the revision the previously existing Local Coverage Determinations (LCDs) for the designated Medicare Administrative Contractors (MACs) were also revised. Since there is no National Coverage Policy (NCP) each MAC can establish diagnosis requirements, indications for medical necessity and procedure contradictions. An LCD is defined as “a decision by a fiscal intermediary (FI) or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (e.g., a determination as to whether the service or item is reasonable and necessary). Medicare contractors develop LCDs when there is no National Coverage Determination (NCD) or when there is a need to further define an NCD.” Currently, there are eight different MACs with a LCD policy for Vertebroplasty and Percutaneous Vertebral Augmentation.

Each MAC contractor has specific and different ICD-9 diagnosis or dual diagnosis requirements. The following information provides a comparison of the requirements for covered medical necessity. It is important to read the entire LCD as it provides detailed information regarding the medical necessity documentation requirements and procedure contraindications.

When comparing the MAC policies, **Cabaha** has the least restrictive medical policy requiring only one diagnosis covering bone neoplasms, myeloma, pathological and traumatic fractures. Included in the list of CPT codes is sacroplasty (0200T and 0201T), a category three code, temporary code for emerging technologies and procedures. All the other policies have sacroplasty listed as a non-covered service regardless of the diagnosis with a separate policy for “Services That Are Not Reasonable and Necessary.”

**Noridian** has the most restrictive policy not only requiring the diagnosis of fracture (pathological or traumatic) but also requiring a secondary diagnosis of specific site of pain (i.e. back pain/lumbago). There are eight specific requirements for pain documentation such as, “Pain must be predominantly related to the demonstrated fracture(s), of moderate to severe intensity (e.g., pain level at least 6 on VAS 1-10), such that the patient cannot perform basic activities of daily living (ADLs), such as ambulation, sitting, bathing, transfers.”

**Novitas and First Coast** have a dual diagnosis requirement for the procedure when performed for a pathological fracture (733.13). The claim is required to have the etiology of the fracture with a secondary code of osteoporosis either unspecified, senile, idiopathic or disuse (733.00-733.09).

**National Government Services and CGS Administrators (Celerian Group Company)** have the same medical policy also requiring a secondary diagnosis with a pathological fracture. However, the etiology of the fracture is expanded into more diagnosis options such as myeloma, neoplasm and osteoporosis. Of particular note, these two contractors do not have traumatic fracture listed as an option for a covered diagnosis. Pathological fracture is defined as, “…‘one due to weakening of the bone structure by pathologic processes, such as neoplasia, osteomalacia, osteomyelitis, and other disease.’ They are also called ‘secondary fractures and spontaneous fractures’ (Dorland's Illustrated Medical Dictionary 2000; 29th edition). Vertebral compression fractures due to osteoporosis are considered pathologic fractures.” The policy states, “relative contraindications to percutaneous
vertebral augmentation include: Painful benign neoplasms; fractures caused by high-velocity injury; or other causes of disabling back pain not due to acute fracture.”

The last two medical coverage policies, Wisconsin Physician Services (WPS) and Palmetto GBA require only one diagnosis on the claim covering neoplasms, osteoporosis, cushing’s syndrome, hypocalcemia, traumatic spondylopathy, pathological and traumatic fracture.

Not all policies require a diagnosis of pain on the claim form; however, all the policies do mention specific criteria of pain to meet the coverage policy. For example, Palmetto states, “The decision for treatment should be multidisciplinary and consider such factors as the extent of disease, the underlying etiology, the severity of the pain, the nature of any neurologic dysfunction, the outcome of any previous non-invasive treatment attempts, and the general state of the patient’s health.” WPS states, “Percutaneous Vertebroplasty or Vertebral Augmentation including cavity creation is not to be considered a prophylactic procedure for osteoporosis of the spine. It also should not be used for chronic back pain of long-standing duration, even if associated with old compression fractures, unless pain is localized to a specific chronic fracture and medical therapy has failed.”

Although the specific policies have diagnoses listed for coverage, all MACs policies state, “Use of these codes does not guarantee reimbursement. The patient’s medical record must document that the coverage criteria in this policy have been met” or something similar. The documentation from the physician and the referring physician should be a detailed medical record meeting all the pre-qualifications for the procedure in case of a post-payment review. The physician should also document the type of fracture, pathological or traumatic, with vertebroplasty, kyphoplasty and/or sacroplasty as there is no “default” fracture for diagnosis coding. As ICD-10 is fast approaching the documentation details are important because of the many more choices in diagnosis codes.

To meet any local policy detailed above a radiology report should include, if applicable: (1) type of fracture (traumatic or pathological) (2) specific location of pain (3) etiology of pathological fracture (4) specific type of osteoporosis. For the purposes of coding, “compression fracture” does not equate to pathological fracture. If stated as compression fracture, the documentation must specify if the fracture was due to trauma or disease process.

In conclusion, vertebroplasty and vertebral augmentation are high dollar reimbursable procedures by Medicare so it is very important for the physician to be familiar with their LCD medical policies to be properly reimbursed. Also be aware these policies are often revised, superseded, and/or deleted on a quarterly basis with an annual review of the coverage policy. It is important to stay abreast of the changes. Please visit http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx to search for any of the new CPT codes to find the list of active policies.

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References:
http://www.cms.gov/medicare-coverage-database/

Local Coverage Determinations:

L30516
L32685
L33625
L24383
L33500
L32032
L33665
L30062
L31797
L29209
L29454
L24492
L26439
L31850