Revenue Cycle Management

- Zotec Partners Launches Distinctive New Technology to Help Physicians With Workflow Management, Staffing and Productivity

Practice Management

- Practice Management Modeling: Wait...Business Intelligence Can Enhance That Too? by Jana Landreth, CPA, MBA, Director of Practice Management with Zotec Partners

Industry

- CMS Clarifies Guidance on ICD-10 "Grace Period" Flexibility
- Top 10 Diagnosis Codes for Radiology
- 2016 Hospital Outpatient Prospective Payment System Proposed Rule
- 2016 MPFS Proposed Rule

Events

ACR-VA Chapter Annual Meeting
August 8, 2015 - Charlottesville, VA
www.acr.org

RBMA Fall Educational Conference
September 27-29, 2015 - Austin, TX
www.rbma.org

RBMA Speaking Sessions:

- Do More with Less: Data Technology Strategies for Radiology - Jeff Maze and Eric K. Jones, September 28, 29
- Thought Leader Deep Dive: What Metrics Should a Radiology Practice Measure to Determine the Effectiveness of its RCM Solution? - T. Scott Law, September 28
- Managing the Self-After Patient Population Can Improve Collections in Your Practice - David Johnston, September 29
Zotec Partners Launches Distinctive New Technology to Help Physicians with Workflow Management, Staffing and Productivity

New ZiPP Tool Designed to Give Zotec Clients a Competitive Edge

We are pleased to announce the launch of the Zotec Interface for Physician Productivity (ZiPP) for radiologists and radiology practices. ZiPP is an unprecedented new technology designed to give you strategic information about your business so you can gain a competitive edge when facing today’s toughest health care complexities.

The module essentially enables robust workflow management across multiple radiology practice locations. By using it, you will have the ability to make evidence-based decisions by analyzing business metrics such as: time, source, modality, urgency, and rendering physician shift of encounters performed. To assist you with elements of your revenue cycle management, ZiPP monitors turnaround time trends with the ability to identify and investigate exceptions. You can also compare demand against physician resources for improved staffing, scheduling and workflow, or conduct peer benchmarks and glean insights into opportunities for operational efficiencies.

“Zotec creates revolutionary tools and technologies that not only give our clients the ability to view their business metrics, but to also apply them in a meaningful and transparent way,” states David J. Law, executive vice president of sales and marketing. “ZiPP is a new tool that can measure operational productivity, gauge work RVUs and enhance communication between the practice, its radiologists and the hospital. By giving radiologists these metrics in an easy-to-understand format, they gain insights into other areas of their business for impactful decision-making.”

To learn more about ZiPP and how it could benefit your group’s productivity, contact us today at radiology@zotecpartners.com.
Zotec Interface for Physician Productivity
For physician groups looking to better manage their workflow, staff their physicians, and provide superior service to their hospital partners, look no further.

**What ZiPP does:**

- Analyzes the time, source, modality, urgency and rendering physician shift of encounters performed
- Compares demand against physician resources for improved staffing, scheduling and workflow
- Enables robust workflow management across multiple practice locations
- Provides access to peer benchmarks and industry insights for greater operational efficiencies
- Monitors turn-around-time trends with the ability to identify and investigate exceptions
- Allows physicians and group leaders to make evidence-based business decisions

With ZiPP, Zotec clients gain strategic business information with a competitive edge.
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 am and 1 pm 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.

*Jana Landreth is a director of practice management with Zotec Partners.*
On July 6, 2015, the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) released a joint statement about their efforts to help the provider community get ready for ICD-10. This statement included guidance from CMS that allows for flexibility in the claims auditing and quality reporting processes.

- On July 27, CMS issued Clarifying Questions and Answers regarding these ICD-10 flexibility policies. CMS clarified that “family of codes” refers to an ICD-10 three (3)-character category.
- During post-payment review, claims will not be denied based solely on the code specificity, as long as the provider used a code from the three-digit character “family of codes.” For example, if an unspecified code is used, as long as it is in the same family as the more specified code, the provider would not be penalized.

The bottom-line is that after October 1, it will still be crucial to assign codes that are not only valid but also specific. Use of nonspecific codes may result in claim denials and loss of payment.

Important Limitations to Know

- Claims must include valid ICD-10 codes. In other words, if the full code requires 6 characters, all 6 characters must be provided in order for the claim to be processed. Upon rejection, Medicare will provide a specific reason to inform the provider that a claim is denied because a valid code was not provided and will allow the claim to be resubmitted with a valid code.
- On Post-Payment Review, Medicare will not deny claims based solely on the specificity of the ICD-10 code. This will be applicable to automated medical reviews or complex medical reviews performed by Medicare Administrative Contractors (MAC), the Recovery Audit Contractors (RAC), the Zone Program Integrity Contractors (ZPIC), and the Supplemental Medical Review Contractor. This does NOT apply to initial claims adjudication, prepayment reviews, or prior authorization requests.
- Claims will continue to be denied when the ICD-10 code submitted is not consistent with an applicable coverage policy. When a Local Coverage Determination (LCD) or a National Coverage Decision (NCD) exists that includes limited coverage based on the diagnosis codes submitted, if a claim does not include one of the listed diagnosis codes, it will be denied for medical necessity just as it is with ICD-9. In other words, if an unspecified code is not on the LCD, it will be denied even though it is in the same family of codes as a code that is included in the LCD.
- Laterality will be required, when applicable.
- This flexibility policy only applies to Medicare. State Medicaid agencies and commercial payers will have to determine whether they will offer similar audit flexibilities.
ICD-10 QUICK FACTS

- The number of diagnosis codes is expanding from **13,000 ICD-9 codes** to **68,000 ICD-10 codes**.
- 78% of ICD-9 diagnosis codes map 1-to-1 with an ICD-10 code, either exactly or approximately.
- Most ICD-10 diagnosis codes still provide for unspecified options.
- About half of the ICD-10 codes that do not have an ICD-9 counterpart are related to laterality.
- External cause reporting and encounter type make up another large part of the new ICD-10 codes.
- In the Radiology specialty:
  - Eight (8) ICD-9 diagnosis codes make up 25% of the average practice charge volume.
  - Thirty-eight (38) ICD-9 diagnosis codes make up 50% of the average practice charge volume.

Preparing for the Transition

Below is a list of the Top 10 diagnosis codes typically used in Radiology. Learning the key documentation concepts for the most commonly used diagnosis codes is one of the best ways for physicians to prepare for and ensure a smooth transition to ICD-10. This article focuses on the specific elements that are available for these common conditions. Providing these elements within the dictated report will be necessary in order to minimize unspecified codes, which will be essential in limiting the impact of the transition to ICD-10 as much as possible on October 1, 2015.

#1 – Screening Mammography

The top diagnosis code for radiology is **Screening Mammography**, which makes up almost 11% of total radiology charge volume. There is a 2-to-1 crosswalk for mammography codes, meaning both “high risk” and the “regular” ICD-9 screening codes cross to a single new ICD-10 screening code. The additional supporting “family history” or “personal history” are now reported with a separate “Z” ICD-10 code. No additional documentation is necessary from the physician and/or referring physician side as long as good documentation practices are currently in place.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>V76.11</td>
<td>Z12.31</td>
</tr>
<tr>
<td>V76.12</td>
<td></td>
</tr>
</tbody>
</table>

Screening mammogram for high-risk patient
Other screening mammogram
Encounter for screening mammogram for malignant neoplasm of breast
#2 – Chest Pain, Unspecified

The second most commonly used diagnosis code is **Chest Pain - Unspecified**, which makes up approximately 4% of total volume. Chest pain has a 1-to-1 crosswalk from ICD-9 to ICD-10, although it is for an unspecified location/cause. If more specific information can be provided, then it should be included. However, it is recognized and reasonable that in many cases it will be difficult to get more information from a patient to make this a “more specified” code before the diagnostic examination is performed.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>786.50</td>
<td>R07.9</td>
</tr>
<tr>
<td></td>
<td>Chest Pain, Unspecified</td>
</tr>
<tr>
<td></td>
<td>Other Related Codes with More Specificity</td>
</tr>
<tr>
<td></td>
<td>R07.1</td>
</tr>
<tr>
<td></td>
<td>R07.2</td>
</tr>
<tr>
<td></td>
<td>R07.81</td>
</tr>
<tr>
<td></td>
<td>R07.82</td>
</tr>
</tbody>
</table>

#3 – Abdominal Pain, Unspecified Site

The third highest volume diagnosis in radiology is **Abdominal Pain – Unspecified Site**. Although there is a 1-to-1 crosswalk with a similar unspecified ICD-10 code, ICD-10 provides for specific coding with the documentation of Location, Laterality and Type of Pain. If available, these three important elements should be documented to allow for more specificity in coding services.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>789.00</td>
<td>R10.9</td>
</tr>
<tr>
<td></td>
<td>Unspecified Abdominal Pain</td>
</tr>
<tr>
<td></td>
<td>Other Related Codes with More Specificity</td>
</tr>
<tr>
<td></td>
<td>R10.0</td>
</tr>
<tr>
<td></td>
<td>R10.10</td>
</tr>
<tr>
<td></td>
<td>R10.11</td>
</tr>
<tr>
<td></td>
<td>R10.12</td>
</tr>
<tr>
<td></td>
<td>R10.13</td>
</tr>
<tr>
<td></td>
<td>R10.2</td>
</tr>
<tr>
<td></td>
<td>R10.30</td>
</tr>
<tr>
<td></td>
<td>R10.31</td>
</tr>
<tr>
<td></td>
<td>R10.32</td>
</tr>
<tr>
<td></td>
<td>R10.33</td>
</tr>
<tr>
<td></td>
<td>R10.84</td>
</tr>
</tbody>
</table>
The fourth most common code (almost 2% of the diagnosis codes reported) is **Pain in Limb**. In ICD-9, unless the joint was involved, there was not a more specified code available for limb pain. In ICD-10, there are new code choices for the limb affected as well as the specific location (i.e. forearm, thigh, etc.) and laterality. This more specific information is available in many currently dictated reports, if not from the clinical indication, then from the location of the specific examination performed.

**It is important to note:** CMS has stated that if a Local Coverage Determination (LCD) includes a code that specifies laterality, they will **NOT** include the unspecified laterality option in the coverage policy.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>729.5 Pain in Limb</td>
<td>M79.609 Pain in Unspecified Limb</td>
</tr>
</tbody>
</table>

**Other Related Codes with More Specificity**
- M79.601 Pain in right arm
- M79.602 Pain in left arm
- M79.603 Pain in arm, unspecified
- M79.604 Pain in right leg
- M79.605 Pain in left leg
- M79.606 Pain in leg, unspecified
- M79.609 Pain in unspecified limb
- M79.621 Pain in right upper arm
- M79.622 Pain in left upper arm
- M79.629 Pain in unspecified upper arm
- M79.631 Pain in right forearm
- M79.632 Pain in left forearm
- M79.639 Pain in unspecified forearm
- M79.641 Pain in right hand
- M79.642 Pain in left hand
- M79.643 Pain in unspecified hand
- M79.644 Pain in right finger(s)
- M79.645 Pain in left finger(s)
- M79.651 Pain in right thigh
- M79.652 Pain in left thigh
- M79.659 Pain in unspecified thigh
- M79.661 Pain in right lower leg
- M79.662 Pain in left lower leg
- M79.669 Pain in unspecified lower leg
- M79.671 Pain in right foot
- M79.672 Pain in left foot
- M79.673 Pain in unspecified foot
- M79.674 Pain in right toe(s)
- M79.675 Pain in left toe(s)
- M79.676 Pain in unspecified toe(s)
#5 – Shortness of Breath

The fifth and sixth on the Top 10 list is **Shortness of Breath** and **Cough**. Both of these have a 1-to-1 crosswalk. Using these diagnoses are straightforward in both ICD-9 and ICD-10, and there are no concerns with “specificity” when dealing with these symptoms.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>786.05</td>
<td>R06.02 Shortness of Breath</td>
</tr>
</tbody>
</table>

#6 – Cough

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>786.5</td>
<td>R05 Cough</td>
</tr>
</tbody>
</table>

#7 – Fitting and Adjustment of a Vascular Catheter

The seventh on the Top 10 is **Fitting and Adjustment of a Vascular Catheter**. This code is often used on chest X-rays to check CVC catheter placements. There is a 1-to-1 crosswalk from ICD-9 to ICD-10 with just a change in the ICD-10 description.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>V58.81</td>
<td>Z45.2</td>
</tr>
</tbody>
</table>

Other Related Codes with More Specificity

- J91.0 Malignant pleural effusion
- J91.8 Pleural effusion in other conditions

#8 – Pleural Effusion

**Pleural Effusion** is the only code on the Top 10 list that is usually coded from a finding of a diagnostic report. However, the further specificity available for pleural effusion would typically come from the clinical indication. When the underlying condition causing the pleural effusion is known, it should be documented for the most specific code selection.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>511.9</td>
<td>J90</td>
</tr>
<tr>
<td></td>
<td>Other Related Codes with More Specificity</td>
</tr>
<tr>
<td></td>
<td>J91.0 Malignant pleural effusion</td>
</tr>
<tr>
<td></td>
<td>J91.8 Pleural effusion in other conditions</td>
</tr>
</tbody>
</table>
#9 – Headache

The diagnosis of **Headache** is ninth on the Top 10 list and also has a 1-to-1 crosswalk and is a symptom that does not require further specificity. However, **vascular headache** has been added as an additional headache code option that was not previously available in ICD-9.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>784.0</td>
<td>R51 Headache</td>
</tr>
<tr>
<td></td>
<td>Other headache diagnosis</td>
</tr>
<tr>
<td></td>
<td>G44.1 Vascular headache, not elsewhere classified</td>
</tr>
</tbody>
</table>

#10 – Abnormal Findings of Lung Field

The last code on the Top 10 list is **Abnormal Findings of Lung Field**. This diagnosis is coded when *lung mass, pulmonary infiltrate, lung shadow* or any other nonspecific abnormal finding in the lungs is documented. This code is often reported on chest x-rays when there is a finding where further investigation is necessary. This code is also reported for clinical indications where an abnormality was found on previous studies as the reason for the current exam such as for PET scans with the indication of lung mass.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>793.19</td>
<td>R91.8 Other nonspecific abnormal finding of lung field</td>
</tr>
</tbody>
</table>

While obtaining the level of detail needed to avoid unspecified codes is not always possible, providing the elements mentioned above when available could reduce potential reimbursement issues as well as provide valuable data on how patients are being treated and cured.
On July 1, 2015 CMS released the CY 2016 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule, which was published in the Federal Register on July 8, 2015. Although this rule does not directly affect Part B providers and physician groups, many of the provisions provide insight into general industry initiatives. Outlined below are key provisions related to Radiology.

**Overall HOPPS Payments**

For CY 2016, CMS proposed a first for the HOPPS sector, a 2.0 percent decrease in the conversion factor (CF); typically, there is a slight increase.

- The decrease in CF was offset by other factors resulting in an estimated net CY2016 HOPPS payment decrease of -0.2 percent, or $43 million compared to CY 2015 payments. CMS goes on to estimate the impact to certain type facilities; urban hospitals would experience a 0.2 percent decrease and rural hospitals would see a 0.3 percent decrease.
- Major teaching hospitals would see payments decline by 0.3 percent, compared with 0.2 percent decline for nonteaching facilities and 0.1 percent decline for minor teaching hospitals.

**Significant Provisions**

**APC Consolidation:**

CMS has been consolidating and restructuring its ambulatory payment classifications (APC) in HOPPS and the end result will be fewer APCs overall for nine clinical APC families.

- Specifically the proposed rule would combine the excision/biopsy and incision and drainage APCs and those for diagnostic radiology (X-ray, CT, MR and ultrasound) with nuclear imaging. CMS uses the same logic for both combinations, stating that the current APC’s are too “granular” and that the proposed consolidation better reflects the goals of a prospective payment system based on clinical similarity and resource homogeneity. Additionally the APC classifications would allow acceptance of future services more readily. The proposal illustrates evolving payment methodologies, notably assigning a flat payment rate to a variety of similar services.
- CMS’ long-term goal is to create single encounter payments for comprehensive APCs (C-APC), which is the HOPPS version of an episode-of-care, by packaging all planning and preparation services that occur prior to the primary procedure. To better implement that goal, CMS proposes to establish a modifier to be reported with every code that is adjunctive to a comprehensive service, but is billed on a different claim to initiate collection of information that would allow them to begin to assess the accuracy of the claims data used to set payment rates for C-APC services.
- Based on their findings, CMS will then discontinue separate payment for any of these packaged adjunctive services in the future, even when furnished prior to delivery of the
primary service. CMS is proposing to use the modifier to identify planning and preparation services for stereotactic radiosurgery primary procedures starting in CY2016 with this goal in mind. This proposed provision is also indicative of evolving payment methodologies, notably payment for episodes of care versus component and traditional fee-for-service payment.

**Lung Cancer Screening:**

In the rule CMS announced a new Healthcare Common Procedure Coding System (HCPCS) code will be established, GXXX2 for low-dose CT scanning for lung cancer screening and have proposed to assign it to APC 5570 (Computed Tomography without Contrast) with a payment rate of $118.15 for the –TC in the hospital outpatient setting.

- No announcement has been made on how they will handle payments for CY2015, but does reiterate that the current APC for a CT code without contrast is APC 0032 at a payment rate of $120.02.
- This proposal should put providers on alert to watch for future guidance on the GXXX2 HCPCS code and instructions for usage.

**Technical Payments for CT (PAMA 2014):**

The Protecting Access to Medicare Act of 2014 (PAMA) mandated that for the -TC of applicable CT services paid under the physician fee schedule and HOPPS, a 5% reduction would be implemented in 2016 and a 15% reduction in 2017 and subsequent years for services provided using equipment that does not meet the requirements of the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.

CMS has proposed to establish a new modifier to be used on claims for CT services furnished using equipment that does not meet this standard. The applicable CT services are identified by HCPCS codes: 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes).

- Beginning January 1, 2016, hospitals and suppliers would be required to use this modifier on claims for applicable CT services that are furnished on non-NEMA Standard XR-29-2013-compliant CT scanners which would trigger the applicable -TC payment reduction. The proposed modifier will be published in future guidance.
- This proposal should put providers on alert to watch for future guidance on the new modifier and instructions for usage.

See related CMS fact sheet for details.
ACR Summary of HOPPS proposed rule.
The proposed rule is available online at the Federal Register website and can be downloaded here.
On July 15, 2015 the Centers for Medicare and Medicaid Services (CMS) published the 2016 Medicare Physician Fee Schedule Proposed Rule (MPFS) in the Federal Register. This proposed rule contains all of CMS’ intended payment policy revisions under the MPFS for Medicare Part B payments. In addition to updating the Relative Value Units (RVUs) that are used to determine what Medicare pays for each medical service, this proposed rule also contains other major Medicare payment policy changes that span the full spectrum of Medicare Part B.

To read a more detailed summary, go to ACR.org.

Impact

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 established the update factor for calendar years 2015 through 2025. CMS estimates the CY 2016 MPFS conversion factor to be $36.1096, which reflects a budget neutrality adjustment of 0.9999 and the 0.5% update factor specified under MACRA. Separate from the Conversion Factor, CMS estimated impacts from proposed CY 2016 policy changes for select specialties:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (mil)</th>
<th>Impact of Work RVU Changes</th>
<th>Impact of PE RVU Changes</th>
<th>Impact of MP RVU Changes</th>
<th>Combined Impact**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventional Radiology</td>
<td>$296</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>$46</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>$1,769</td>
<td>0%</td>
<td>-3%</td>
<td>0%</td>
<td>-3%</td>
</tr>
<tr>
<td>Radiation Therapy Centers</td>
<td>$52</td>
<td>0%</td>
<td>-9%</td>
<td>0%</td>
<td>-9%</td>
</tr>
<tr>
<td>Radiology</td>
<td>$4,472</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>IDTFs</td>
<td>$719</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Your practice’s impact may vary from CMS’ estimates depending on such factors as: (1) procedure mix and (2) hospital-based vs. imaging center/IDTF site-of-service. ** The estimated combined impact may not equal the sum of the other changes due to rounding.

Misvalued Codes - Target Reductions and Fee Schedule Changes

Pursuant to statutory directives in The Protecting Access to Medicare Act (PAMA) and the Achieving a Better Life Experience (ABLE) Act, CMS proposes a methodology for implementing targeted fee reductions and how net reductions would be calculated.

- PAMA established an annual target for reductions in MPFS expenditures resulting from adjustments to RVUs of misvalued codes. If the estimated net reduction in expenditures for a year is equal to or greater than the target for that year, the provision specifies that reduced
expenditures attributable to such adjustments shall be redistributed in a budget-neutral manner within the MPFS.

- The PAMA originally applied the target to CYs 2017 through 2020 and set the target amount to 0.5%; ABLE accelerated that process and specified that targets would apply for CYs 2016, 2017 and 2018 and set a 1% target for CY 2016 and 0.5% for CYs 2017 and 2018.

According to CMS, the current RVU recommendations would result in savings of .25%, meaning additional savings will be necessary. CMS believes that between now and adoption of the final rule, they will identify the additional misvalued code savings. If further reductions are not proposed or implemented, an across-the-board decrease may be made to fulfill the 1% mandate.

**Phase in of RVU Reductions for Services that are Not New, or for Revised Codes:**

Additionally, PAMA specified for services that are not new or revised codes, if the total RVUs for a service for a year would otherwise be decreased by an estimated 20% or more, as compared to the total RVUs for the previous year, the applicable adjustments in work, PE and MP RVUs shall be phased-in over a 2-year period.

- Originally scheduled to begin in 2017, ABLE again accelerated the phase in methodology, and this policy will be implemented in 2016.

- Instead of applying a 50%-50% phase in methodology of RVU decrease over the two years, CMS proposes to implement a -19% reduction in year 1, and the remaining RVU decrease in year 2.

**Review of Potentially Misvalued Codes**

CMS has identified 118 codes (listed in Table 8, in the MPFS) as potentially misvalued codes, using the high expenditure screen, (i.e., “codes that account for the majority of spending under the MPFS”).

- CMS excluded all codes with 10- and 90-day global periods since they believe these codes should be reviewed as part of the global surgery revaluation.

- According to the ACR, approximately 30 of those 118 identified relate to radiology or radiation oncology to include CT, MR, plain film X-ray and radiation therapy planning.

**Other Key Radiology Proposed Provisions**

**Proposed Relative Values for New or Revised Codes for CY 2016:**

For CY 2016, CMS is proposing new values in the proposed rule for new or revised codes for which the agency received complete RUC recommendations by February 10, 2015. New or Revised Codes for CY 2016 of interest to radiology Include:

- New bundled codes for intravascular ultrasound (noncoronary vessel) (3725A-B)
- New bundled codes for genitourinary interventions (5039A-5039M; 5069G-5069I)
Radiation Oncology

CMS is proposing to adjust the equipment utilization rate assumption for the linear accelerator to account for a significant increase in usage. Instead of applying the default 50% assumption, CMS is proposing to use a 70% assumption, phased in over 2-years.

- CMS continues to seek evidence to ensure that the usage assumptions, both the utilization rate and number of available hours, used to calculate equipment costs are as accurate as possible. If implemented, the equipment utilization rate change would result in a reimbursement decrease for radiation oncology services that utilize this equipment.
- CMS recognizes that there would be, “...value in following precedent to transition changes in utilization assumptions over several years.”

Therefore, in developing Practice Expense (PE) RVUs for these services, they are proposing to use a 60% utilization rate assumption for CY 2016 and a 70% utilization rate assumption for CY 2017.

XR-29 Reporting – In accordance with PAMA, the proposal would reduce payment for the technical component (TC) (and the TC of the global fee) of the MPFS service and the HOPPS payment for specified computed tomography (CT) services furnished using equipment that does not meet the National Electrical Manufacturers Association’s (NEMA) XR-29 standards by 5% in CY 2016 increasing to 15% in CY 2017. To implement this provision, CMS will create modifier “CT” to be applied to claims for CT services in 2016 that are furnished on non-XR-29-compliant CT scanners, resulting in the applicable payment reduction for the service.

Low-Dose CT for Lung Cancer Screening – CMS disagreed with an ACR recommendation to crosswalk GXXX1 (Low-dose CT, lung, screening) to 71250 (CT, thorax; without contrast material) with additional physician work added to account for the added intensity of the service. Instead, CMS concluded that physician work (time and intensity) is identical in both GXXX1 and 71250, and is proposing a work RVU of 1.02 for GXXX1. They are ultimately proposing to value the lung cancer screening service the same as the non-contrast chest CT service.

Transition from Film to Digital Imaging – CMS proposes to update the PE value associated with the transition from film based radiology to PACS; the PE value for the PACS workstation will move from $2,501 currently to $5,557 in 2016 based on new information. Therefore, the RVUs will be positively impacted and reflect the higher cost value.

Incident-To Policy Revisions for CY2016 – CMS is proposing to clarify that the billing physician or practitioner for “incident-to” services must also be the supervising physician or practitioner. Additionally, CMS is proposing to require that auxiliary personnel providing “incident-to”
services and supplies cannot have been excluded from Medicare, Medicaid or other Federal health care programs by the Office of Inspector General (OIG), or have had their enrollment revoked for any reason at the time that they provide such services or supplies.

**Appropriate Use of Advanced Diagnostic Imaging, Additional Imaging Provisions** – Pursuant to PAMA’s clinical decision support provisions, CMS begins the implementation process proposing “definitions for areas of the statute that require clarification” such as “provider-led entity,” which pertains to organizations eligible to develop or endorse appropriate use criteria.

CMS describes the four major components of the Appropriate Use Criteria (AUC) Program

1. Establishment of AUC for Advanced Imaging Services by November 15, 2015
3. AUC consultation by ordering professionals and reporting on AUC consultation by furnishing professionals by January 1, 2017
4. Annual identification of outlier ordering professionals for services furnished after January 1, 2017. Outlier ordering professionals under this section facilitates a prior authorization requirement for outlier professionals beginning January 1, 2020

**Physician Quality Reporting System**

The MPFS also contains CMS proposed requirements for the Physician Quality Reporting System (PQRS) 2016 reporting year which will determine potential payment adjustments in 2018. As a reminder, 2018 is the last year that payment adjustments will be made under the PQRS program.

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) consolidates PQRS into a new value-based payment program, the Merit-based Incentive Payment System (MIPS) starting in 2019 along with the Value-Based Modifier (VM) and the EHR Meaningful Use (MU) incentive program.
- Following the 2018 PQRS payment adjustment, adjustments to payment for quality reporting and other factors will be made under MIPS, as required by MACRA. CMS is seeking comments on the implementation of MIPS under MACRA.

CMS outlines proposed requirements for satisfactory reporting to avert the 2018 payment adjustment (-2.0%), which it says are aligned with the prior-year criteria. According to CMS, there are “no proposed changes for claims and registry-based reporting for individual EPs.”

- Individual EPs would have to report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50% of the EP’s Medicare Part B FFS patients seen during the reporting period to which the measure applies.
- The full list of updates to PQRS measures across all reporting mechanisms can be viewed in Table 20 in the proposed rule. The Measure-Applicability Validation (MAV) (same process as in 2015) will apply to those who report on <9 measures or covers <3 NQS domains.
The proposed rule also seeks to finalize a set of 19 cross-cutting measures, listed in Table 22 in the proposed rule as well as new individual quality measures, listed in Table 23 of the rule. If the EP sees 1 Medicare patient in a face-to-face encounter they must report on at least 1 cross-cutting measure (included in the 9 measures), which mimics the prior year criteria.

CMS is proposing changes to the Qualified Clinical Data Registry reporting (QCDR) and qualified registry reporting mechanisms. Specifically, CMS is proposing to clarify who is able to self-nominate to become a QCDR and qualified registry, updates to the attestation statement process and updates for the data validation requirements. Additionally the Group Practice Reporting Option (GPRO) is proposed to be available through the QCDR as it would then support TIN level reporting.

Value-Based Modifier

The proposed rule delineates updates to the Value-Based Payment Modifier (VM), authorized under the Affordable Care Act (ACA), which applies a VM (based on performance on quality and cost metrics) under the MPFS to physicians and EPs. The VM is slated to expire in CY 2018, in light of the agency’s broader transition to a MIPS in CY 2019, pursuant to the latest doc fix (MACRA). To ultimately ease the transition to MIPS, CMS proposes a number of changes to the VM. The proposed rule sets the maximum upward/downward adjustment under the VM quality-tiering methodology for the CY 2018 VM respectively to +4.0/-4.0 times an upward payment adjustment factor for groups with 10 or more EPs; +2.0/-2.0 times for groups with between 2 to 9 EPs and physician solo practitioners; and +2.0/-2.0 times for groups and solo practitioners that consist of solely of non-physician (NPP) EPs who are PAs, NPs, CNSs and CRNAs as this is in alignment with all new groups who entered into the VM program for the first year.

The Group Size of Any TIN is Determined as Follows:

As indicated on the PECOS-generated list for the group which is not consistent with the size of the TIN based on CMS’ analysis of the claims data, a TIN’s size for the CY 2016 payment adjustment period would be based on the lower of the number of EPs indicated by the Medicare PECOS-generated list or CMS’ analysis of the claims data. Of note, various NPPs such as certified nurse midwives, therapists, etc., will be included in the size computation, but only certain NPPs will be subject to the VM in 2018.

Among the more noted policy changes:

- Performance year is 2016;
- Applies to physicians, PAs, NPs, CNSs and CRNAs in groups with 2+ EPs and those who are solo practitioners, as identified by their TIN (the listed NPPs will be subject to the VBM in 2018);
- Quality-tiering is mandatory;
  - TINs that consist of non-physician EPs will be held harmless from downward adjustments; and
All other TINs will be subject to upward, neutral or downward adjustments.

The diagram below is representative of the VM proposed policy for 2018, which does incorporate the listed changes as noted above:

**Physician Compare; Benchmark** (page 370) – Key proposals include the addition of a publicly reported indicator for EPs who satisfactorily report the PQRS Cardiovascular Prevention measure group, which is aligned with Million Hearts, and for group practices that attain an upward adjustment under the value modifier. CMS also proposes, among other policies to, “…include in the downloadable database the Value Modifier tiers for cost and quality, noting if the group practice or EP is high, low or neutral on cost and quality; a notation of the payment adjustment received based on the cost and quality tiers.”

The agency also proposes to publicly report a measure-level benchmark stemming from the Achievable Benchmark of Care (ABC) methodology that, on Physician Compare, would appear as a five-star rating.