ADVANCED DATA SYSTEMS RCM

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*IN*SIGHTS FOR RADIOLOGY

Articles, Items, and News in Radiology

This Edition's Message from Steve: The No Surprises Act involves Radiology especially as a non-face-to-face specialty

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The No Surprises Act (NSA) affects radiology as much as any other specialty. The NSA might actually have more relevance to imaging especially if out-of-network (OON) patients didn't realize that imaging was provided as part of their treatment.

In a nutshell, you'll need to make sure patients or their guarantors/guardians/care-takers know to expect statements for radiology services vs. them receiving *surprise* statements for services about which they had no knowledge. It's really not any more complicated than that.

But ***how*** you comply with the NSA could be complicated unless you're working with an RCM/RIS that can identify OON cases in advance and, ideally, on scheduling appointments. Hand-in-hand with that, having access to a **patient responsibility estimator** in advance, also preferably on scheduling, is a powerful tool for managing patient balances well.

MedicsRIS supports OON alerts and access to our rules engine-driven patient responsibility estimator on scheduling or anytime in advance of appointments through MedicsRCM or by using MedicsRIS as an in-house platform. Note that these features are **independent of each other**. So, if you're not affected by OON issues, you can still use the patient responsibility estimator which is always helpful for controlling patient balances.

Extra MedicsRCM/MedicsRIS revenue generating and protection features include:

- ✓Immediate **eligibility verifications** on scheduling. MedicsRCM then performs up to four additional batch verifications through the MedicsRIS scheduler prior to appointments; you can also use MedicsRIS as an in-house platform for unlimited eligibility verifications.
- ✓**Insurance discovery** option when coverage information is partially or entirely missing.
- ✓**Proactive denial management** through our Denial Preventer®.
- ✓**Patient payments online** via the patient portal either through MedicsRCM or MedicsRIS.
- ✓**Automated prior authorizations** removing a tedious yet necessary in-house task.
- ✓**Appeals** handled by MedicsRCM.

You can **quickly master the NSA** and help **ensure being paid** as described above by engaging with MedicsRCM or by deploying MedicsRIS as an in-house platform!

Clinical Decision Support: The Onus is On U

Because of the public health emergency (PHE) created by COVID-19, the *clinical decision support (CDS) payment penalty phase deadline* was put on hold. But it's not going to go away. In fact, **the education and operations testing period continues** in an effort to ensure those who must adhere to CDS requirements are ready for the new deadline instead of waiting until the last minute to ensure compliance.

Who needs to comply are providers who refer Medicare/Medicaid patients for advanced imaging studies such as **MRI, CT, PET**, and **nuclear**. Who needs to be careful? ***You on the radiology side*** since you – not your referrers – will get denials! Please continue reading for how it all works.

CDS is a result of the Appropriate Use Criteria (AUC) initiative established by CMS. And since it places the onus on radiology, imaging centers must ensure they have the proper coding through a **qualified clinical decision support mechanism** (qCDSM) as used by the referrer.

Note the word "qualified," which is essential. Several CDSMs are available, but CMS only recognizes those that have passed CMS' qualification standards.

The mechanics: the referring provider enters the patient's diagnosis into their EHR. Ideally, the EHR has the qCDSM platform embedded or integrated into the EHR instead of having to use the qCDSM as a standalone system.

Let's say the referrer determines that a Medicare/Medicaid patient needs an MRI. On completing the encounter and suggesting the MRI, the EHR would instantaneously take the patient's history and healthcare factors into account. If the qCDSM agrees with the referrer's MRI decision, it (the qCDSM) will produce a code that's transmitted or made available to the imaging center as part of the order.

The imaging center attaches the code to the patient's record in the RIS for reference if needed, and then **uses that code** on the Medicare/Medicare claim in order to **be reimbursed** for the MRI.

How we can help: MedicsRIS, either through ADS RCM or ADS (when using MedicsRIS as an in-house platform), **supports connectivity to a qCDSM through its portal**. You can offer access to it by referrers who don't have a qCDSM, making it easy for them while helping protect you from getting denials on claims that should've had qCDSM codes. (FYI, our MedicsCloud EHR supports the qCDSM embedded into it and operates as described above.)

Extra thought: CMS must think expensive imaging studies are ordered too cavalierly, which is why they will require referrers, regardless of their experience and education, to use a qCDSM to confirm their reasoning for ordering CTs, PETs, MRIs, and nuclear.

The Ripple Effect: You have to assume at some point, **commercial payers** will follow CMS's lead to help them curtail reimbursements on expensive imaging studies as well.

Don't be caught off guard: a new AUC deadline will be announced, possibly as early as November 2022. ADS RCM and ADS, with the MedicsRIS, are ready right now to help ensure you're protected.

Automated Prior Authorizations can Come True, they can happen for you…

Is there anything more **time-consuming** for your staff than prior authorizations (PAs)? First, you have to **determine if/when they're needed**. Then, you have to **get them**.

MGMA reported that PA requirements had **increased by 80%** over the past twelve months (from March 2022) and how getting PAs has caused almost **paralyzing administrative challenges** for medical practices, including radiology.

MedicsRIS, through ADS RCM or ADS, supports access to an **automated PA** option removing that time-consuming task from your staff while ensuring PAs are gotten when needed.

You Can't Make This Up

When someone says their heart is in their throat, it means they're nervous or anxious about something. But what about when a person's **teeth** are in their throat? Please keep reading.

It's probably common for a denture wearer to fall asleep with their dentures still in their mouth. Then while sleeping, the dentures come loose and fall into their throat. You can see that happening, and it's precisely what happened In the case of patient John Doe.

But the circumstances were unusual because **John was a patient in a hospital's *surgery* suite** who went to sleep from the **anesthesia** administered as part of surgery to remove a benign lump in his abdominal wall. John's dentures weren't removed and ended up lodged in his throat.

Fine, even that could happen, but let's continue with the story.

Six days after the surgery, the patient **returned to the same hospital** with symptoms the ER physicians thought were anesthesia side effects such as odynophagia, dysphagia, or hemoptysis. He was discharged after being prescribed **mouthwash, antibiotics**, and **steroids**.

He returned **two days later**, complaining that **he couldn't swallow the medication**!

This time they thought it was **pneumonia** and sent him to their ENT department. The initial ENT exam uncovered a **metallic object in his throat over his vocal cords**. At this point, the patient mentioned he **lost his dentures while in surgery** at that same hospital eight days earlier. (Yes, you can't make this up.)

The **radiology image** showed the **dentures were in his throat**, so he was taken in for emergency surgery to remove them.

Hopefully, someone had the presence of mind to alert the hospital's Lost and Found Department to call off the denture search and cancel the reward. Or, maybe the radiologist got the reward.

The patient never expected his first trip to the hospital to end up as a **story with teeth**. The good news is that **the patient fully recovered after six weeks**.

Click here to see the images and story as reported by CBS News.

MGMA on Mammograms

According to MGMA in a June 2022 report, mammography appointments are returning at last to pre-COVID-19 numbers. The problem is that even before the pandemic, CDC reported compliance was far from ideal with **just 66.7% of women age 40 and older** getting mammograms in the previous two years.

MGMA says that apparently, **two obvious issues** are at play here: (1) **getting patients to schedule** their mammogram screenings, and (2) dealing with **no-shows** once appointments are scheduled.

We can help you overcome these with:

- ✓**automated recall alerts** to patients who should've scheduled their next screening by now but who haven't; they can be directed to our **patient portal to schedule online** or to call to schedule
- ✓**interactive appointment reminder texts** through which patients can **confirm or cancel**; either result is automatically posted onto the corresponding appointment in the MedicsRIS scheduler

Patients who cancel can be quickly contacted to **reschedule**, and you can attempt to **fill gaps with future or new appointments**. Patients who haven't confirmed or canceled can be contacted **as to their status**. Overall, texts work to **dramatically reduce no-shows**.

MedicsRIS supports **recalls and reminders for mammograms** and has a **built-in mammography tracking and management platform**. It's available through our MedicsRCM outsourced services or as an in-house system if preferred.

Humor is Serious in Breast Cancer Screening

On the heels of the previous article, **humor in breast cancer screening** is not a joke according to an October 2022 *study in the Cancer Imaging Journal*.

The study notes how breast cancer screening is **stressful** which is why it should come as no surprise that **a little humor from the radiology side** can be just what the doctor ordered.

But how does humor get injected? The study notes a few ways to **lighten the atmosphere** and how it actually worked on the humor-tested patient group vs. the traditionally-handled patient group.

You're encouraged to read the article for the humorous details and stats.

Taking Orders from your Referrers while keeping them as Referrers

No one likes to take orders. But if they're from your referrers, you want to make it as easy as possible for them to tell you what to do.

MedicsRIS, either through ADS RCM or ADS, does exactly that with its OrdersDirect utility. **Referrers can transmit orders from their patients' records in whatever EHRs they use** directly into MedicsRIS **without expensive HL7 interfaces!**

You can send **finalized reports** back to them, including **links to each patient's images** as supported by your PACS.

Seamless exchanges of incoming orders and outgoing reports **help keep your referrers referring** and perhaps to even **attract new referrers**. Of course, ultimately, it benefits the most important people of all: **your mutual patients**.

The False Claims Act is Self-Explanatory

Guess what the False Claims Act (FCA) does? If you said it makes it illegal for medical facilities or providers to submit false claims, you'd be correct, but let's dissect this a little.

Certain specialties - especially those involving **workers compensation/no-fault/accident** patients - appear to have **a particular inkling for submitting false claims**. Of course, **radiology** is one of those specialties.

This is **not to disparage radiology in any way**; the overwhelming majority of radiology centers are undoubtedly totally on the "up and up." That said, an internet search of the phrase "radiology false claims act" produces **pages of results**.

The point here is for you to:

- ✓ensure your claims are **valid** (for example, the person was a patient)
- ✓that you're not submitting and being paid on **duplicate claims** (and keeping multiple reimbursements on the same claim)
- ✓that you're not submitting claims for radiology services where there was no **medical necessity**

If you're using a billing or revenue cycle management (RCM) company, don't figure pointing fingers at them since **filing errant claims is on you**. However, a good RCM service (such as MedicsRCM) should be able to alert on possible invalid or duplicate claims.

But in the end, the **onus** (that word again) **will almost assuredly be on the radiology entity** unless it can be proven that the billing company was a **collaborator** in filing false claims.

So, be careful in submitting your claims, and if you work with an RCM company, make sure they "have your back" on this (think "MedicsRCM").

- ✓Popup multiple choice quiz question: when was the False Claims Act enacted?
  - a. 1864
  - b. 1932
  - c. 1965
  - d. 2006
  - e. None of the above
  - f. All of the above

If you answered "e," you don't get this week's allowance. If you answered "f," you don't get this week's **and** next week's.

You might be amazed to learn the answer is "a," as the *FCA was initially enacted to combat fraud involving government programs*. So, it's a bit of a trick question since Medicare and Medicaid, being government programs, weren't included under the FCA until 100 years later.

You can read about how many **billions of dollars** the US government generated via FCA fines related to **medical services**. And with workers compensation/no-fault/accident cases being a significant factor, no doubt radiology has had its share of fines.

One more thing: be **very careful about coding** in terms of not trying to obtain more revenue than the claim's actual value. We're referring to claims submitted legitimately but **coded for too much reimbursement** ("over-coding").

If you use a billing or RCM company, you still must assume the burden's on **you** to ensure claims aren't over-coded. If the billing company's in concert, you'll have to answer for it, at least by returning the overpaid amount to the insurance company and hopefully not being fined.

Neither should you **under-code** just to make sure you're not over-coding because that's **not fair to you**.

A reliable radiology RCM service (MedicsRCM) or in-house system (MedicsRIS with its rules engine) should be able to suggest the **highest value codes** to use per claim/per payer to return **as much revenue as possible without over-coding**. Unfortunately, radiology reimbursements aren't improving, so you'll want to maximize – not minimize – your claims.

Your Patients are often Attorneys' Clients

As mentioned earlier, Radiology is a **personal injury-laden specialty** with no-fault, workers compensation, and accident patients. Almost by definition, a good number of your patients have **high-maintenance and needy attorneys**. They **don't provide revenue to you**, yet you need to accommodate them. **Or do you**?

- ✓ The first thing needed is a way to manage patients' attorneys by having a **built-in attorney database in the RIS** for easy lookups and connecting attorneys to their clients (your patients) in the RIS. It should be **case-specific** since any patient may have **different attorneys for different accidents**. MedicsRIS supports a built-in, case-specific Patient Attorney database.
- ✓ The next thing you'll want is a **self-serve, secure, on-demand Attorney Portal** option **enabling attorneys to retrieve documents** and information on their clients (your patients) **without your staff** having to retrieve, copy, scan, fax, mail, etc., those documents.

Imagine how much **simpler life could be** with attorneys neatly organized and connected with patients in the RIS, and attorneys (or **their** staff) able to self-serve 24 x 7 on viewing and retrieving whatever is needed.

It's all available with MedicsRIS through ADS RCM or ADS if an in-house platform is preferred.

A Few Words on Radiology Staffing

Some of the words are sporadic, intermittent, weak, expensive, and untenable.

Part of MedicsRCM's services includes our **outsourced workforce team of over 300** EDI, claims, financial, operational, and workflow specialists who **operate behind the scenes** helping to **supplement and consolidate our clients' in-house staffing**.

When considering **the cost of maintaining an in-house staff** and how it can be bolstered by **our workforce who don't require raises or benefits**, it's no wonder we can dramatically impact those issues.

MedicsRCM also increases clients' **revenue by up to 20%**. Combining that with any staffing consolidations makes for a powerful argument in favor of RCM.

We're happy to provide an idea of how much we can increase your revenue based on your payer mix. You'd be able to determine any staffing savings and then see if MedicsRCM for your imaging setting would make sense to pursue.

Non-Physician Providers in Radiology have Expanded Opportunities

The American College of Radiology (ACR) has revised its CT and MRI facility accreditation criteria enabling non-physician providers (NPPs) administer contrast, although each state's licensing laws still override NPP-provided services.

The NPP can be an NP, a PA, or an RN trained, using a symptom-driven/sign-driven treatment algorithm.

As such, a radiologist performing the examination may differ from person who injected the contrast, although a radiologist must directly supervise the contrast administration. "Directly supervise' means a radiologist must be present and immediately available if assistance is needed.

Note that Medicare had allowed supervision requirements during the pandemic to include audio/video real-time communications, but that will expire at the end of the year in which the public health emergency ends unless it is extended permanently.

Claims submitted for NPP-performed procedures: depending on the circumstances, Medicare generally reimburses these claims at 85% of the physician fee schedule. When procedures are considered "incident-to" for the physician's services, reimbursement is 100%. Commercial payers will have their own policies on the level of reimbursement.

NPP claims more cost effective? NPP claims do have lower reimbursement rates. But *according to the Bureau of Labor Statistics*, the 2021 median cost of an NPP - $121,530 - is a fraction of that of a radiologist.

NPPs are providing more services than ever which may represent a cost-effective approach for your imaging center.

Contact us for more about MedicsRCM as an outsourced billing/staffing service or for MedicsRIS if you still prefer in-house automation. We can help either way!