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June/July
2017

Letter from the President

Susan Reichert, FACMPE
President, MGMA-MO

Each year that I attend MGMA-MO's spring conference I always leave with a new idea or two that I put into practice and this year was no different! In this ever-changing career that we have chosen, it is essential that we take advantage of good quality education that gives practical tools to use as well as finding ways to reenergizing our spirits. Attending the conference is also a great opportunity to meet new friends, see old ones and network with valued business partners. For those of you able to attend this year's conference I hope you, too, found it very beneficial and for those of you that were not able to make it this year please consider adding this to your schedule for next year!

Please join me in welcoming your 2017-2018 MGMA-MO Board of Directors: President – Sharon Sagarra, FACMPE; President-Elect – Brad Carney, CMPE; Treasurer – Ashley Petty; and Secretary – Kyle Adkins. They will begin their new offices effective July 1st. I have the utmost confidence that they will continue to lead and provide exceptional leadership for our organization.

It truly has been an honor for me to serve a second term as MGMA-MO's president and the experiences and the people that I have come to know are truly cherished. I know that those following me will continue developing and offering educational programs and events to develop each of you personally and professionally. Thank you for the opportunity to be a part of such a wonderful and evolving state organization.

Susan Reichert, FACMPE
President, MGMA-MO
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MGMA-MO 2017 Spring Conference
Leader Champions / Practice Champions
May 7 - 9, 2017 • Tan-Tar-A Resort

I want to thank all who attended the 42nd annual MGMA-MO Conference ***Leader Champions Practice Champions***! The conference was filled with great speakers and topics in the general and breakout sessions as well as time for fun and networking with colleagues, peers and exhibitors. The Conference Planning Committee worked very hard to bring this conference to you and hope you obtained pertinent information to take back to your practices.

The Conference began on Sunday with pre-conference sessions for New and Upcoming Managers, ACMPE Certification and Seeing into the Future of Human Resources. There was also a Local Chapter Leadership Symposium for the leaders of Missouri's seven local MGMA chapters. A reception and networking event gave First Time Attendees a chance to make new connections prior to the evening's Kentucky Derby inspired opening night dinner and drinks. After dinner, inspiring general session speaker, Jay Rifenbary, taught there is No Excuse! Incorporating Core Values, Accountability and Balance into our Lives and Careers. After the general session, a large group ended the evening at the cocktail party at Mr. D's lounge.

Donn Sorensen started our Monday with a general session on Big Hearted Leadership and the trending "buzzwords" of Healthcare today. The rest of the morning was devoted to spending time getting to know the Exhibitors and breakout sessions encompassing topics from the MGMA Body of Knowledge components. After lunch, we were treated to Richard Sanders' take on The Early Days of the Trump Administration and Its Impact on Healthcare followed by additional breakout sessions and time with Exhibitors. After a Networking Reception in the Exhibit Hall, attendees had the opportunity to rest, shop and enjoy dinner with new and/or old friends.

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Leader Champions / Practice Champions

Tuesday morning the Annual Membership Business Meeting was followed by Suzanne Falk updating us on the happenings in Washington as well as MGMA's available resources to assist practices in successfully navigating numerous changes and federal initiatives. To close out the conference, the energetic and dynamic Joe Mull taught us clear strategies for Motivating Healthcare Teams in an Era of Change, More Work, and Fewer Resources.

I want to thank our Exhibitors for their time and support, without whom we would not be able to put on a conference of this caliber year after year. I also want to thank everyone for walking the Exhibit Hall and getting to know the Exhibitors. I would be remiss if I did not thank each person who served on the Conference Planning Committee. Your commitment and dedication made the conference the success it was. And last, but never least, I want to thank Rebekah Francis, the glue who keeps us all together and on track. I am forever grateful for all the hard work, support and sacrifice she not only gave me this past year but gives to MGMA-MO as an organization throughout the year, year after year.

Lastly, it has been an honor and privilege to serve as the MGMA-MO Conference Chair this past year and I look forward to continuing to serve MGMA-MO in the coming years. Based on his awesome preview video shown at the end of the conference, Brad Carney has already started planning for another great conference in 2018. I encourage every member as well as future members to attend the 2018 conference and invest in becoming the Leader Champion of your Practice.

- Sharon E. Sagarra, MBA, FACMPE
2017 Conference Chair and President-Elect
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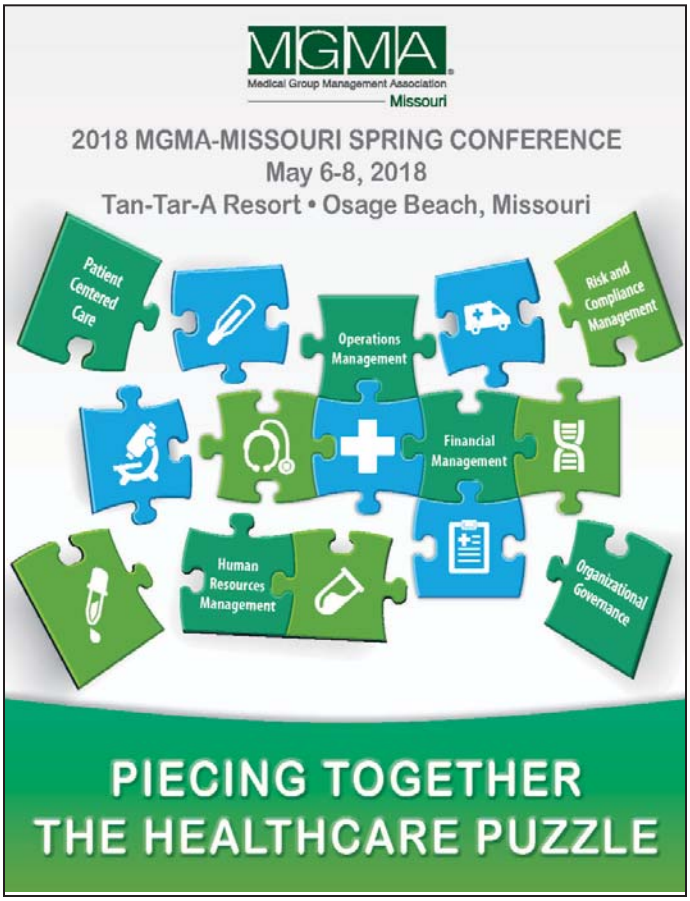
MGMA-MO 2017 Spring Conference Pictures

Leader Champions / Practice Champions

MGMA-MO 2017 Spring Conference Pictures

Leader Champions / Practice Champions



Scholarship Committee Report

On Tuesday, May 9, 2017, MGMA Missouri announced and awarded the following scholarships:

Judith Hillyard Professional Development and Presidential Scholarships
Chrison Sitton, SSM Medical Group - West

Professional Enrichment Scholarship
Barbara Faupel, Allergy Consultants

Dependent Scholarship
Kristina Taylor, Springfield

Also, with the help of many the scholarship committee raised $900 through our 50/50 raffle and other donations. The committee and the board want to express their appreciation for all the support this program received this year.

A Special Thank You to the following Contributors:

Keane Insurance Group
MGMA Northwest Missouri
Mid Towne Consulting, LLC
Southeast Missouri MGMA

ProAssurance Practice Manager of the Year Award

The ProAssurance Practice Manager of the Year Award was established to recognize a practice manager member of MGMA Missouri who has demonstrated a noteworthy achievement of exceptional leadership and management proficiency to enhance strategic and operational effectiveness of health care delivery in his or her practice and community. The $2,000 award will support the personal advancement and development of the practice manager by covering the expenses to attend the national MGMA Annual Conference. Congratulations to this year's award recipient **Michelle Yarnell, CMPE**.

Q&A: MIPS Advancing Care Information

This article answers common questions related to the Advancing Care Information (ACI) category of the Quality Payment Program's (QPP) Merit-based Incentive Payment System (MIPS) payment track. The ACI category of MIPS in essence replaces the former Meaningful Use Electronic Health Records (EHR) Incentive Program.

Most of these answers are lightly edited from information provided by the Centers for Medicare & Medicaid Services (CMS) QPP Support Center. You can find more information in the MIPS Fact Sheet: Advancing Care Information document available on our website at tmfqin.org.

Performance Score

Question: How do you calculate ACI scores for a multi-specialty group with multiple practice locations that include hospitalists?

Answer: When reporting as a group for the ACI performance category, the group will combine its clinicians' performance under one Taxpayer Identification Number (TIN). The group would aggregate the data by adding together the numerators and denominators for each practice/location at which the group has data captured in its certified EHR technology (CEHRT). The group would then submit one numerator and one denominator for each measure.

Question: For two measures, the measures are 0–20 percent. The table listed is based on 1–10. Is this just doubled for 1–20, or can you direct me to where the table is located?

Answer: If you are doing the 2017 ACI Transition Objectives and Measures (called "Option 2" for ACI), then two of those measures are worth up to 20 percent: Provide Patient Access and Health Information Exchange (HIE). For either of those two measures, you would first calculate your performance score (based on the 1–10 scale detailed on page 5 of the ACI Fact Sheet), and then you would multiply by two.

Submission

Question: Can a qualified clinical data registry (QCDR) submit the clinician's numerator and denominator?

Answer: Yes. Please see below for all of the available submission methods for the ACI performance category of 2017 MIPS.

- MIPS eligible clinicians reporting individually may submit data for the ACI performance category in the following ways: attestation, QCDR, qualified registry or EHR.
- MIPS eligible clinicians reporting as a group may submit data for the ACI performance category in the following ways: attestation, QCDR, qualified registry, EHR or the Web Interface.

Billing Under Two TINs

Question: If a clinician bills under two TINs, with one being his practice TIN and the other a larger group practice, under the ACI category, will this clinician be responsible for attesting under both TINs to avoid penalty? Specifically, for the large group, if they do not decide to report as a group for that TIN, will the clinician then have to report as an individual under the large TIN and for his own TIN? He would like to focus only on reporting under his individual clinic's TIN.

Answer: If an eligible clinician meets the volume threshold at each TIN, then that clinician will have to report for each TIN he or she works at.

Re-weighting ACI and Exemptions

Question: We are a new critical access hospital (CAH) in 2017 and have previously been unable to meet meaningful use based on EHR capabilities. Based on this scenario, it does not appear possible for us to meet ACI measures this year; for example, our current EHR charges more than $150,000 for a patient portal. We have heard about the possibility of the ACI percentage becoming part of Quality scoring if unable to meet ACI. Where would we find the location of the ACI exemptions for this year 2017?

Answer: You will be able to follow an application process to request that the ACI category be reweighted to the Quality category. How and when this will be done has not been released. Please watch the CMS QPP website for this information to be released.

Q&A: MIPS Advancing Care Information

Question: If a practice is paper only, can it still qualify for the MIPS incentive, knowing it will receive zero points in the ACI category?

Answer: The clinician can apply to have the ACI category reweighted for this 2017 transition year. More information will be posted on QPP.CMS.gov.

Question: What is the list of exemptions for the ACI score to be reweighted to Quality?

Answer: MIPS eligible clinicians must use certified electronic health record technology (CEHRT) to report to the ACI performance category. If clinicians do not have CEHRT, they must meet certain criteria in order to qualify for a reweighting of the performance category to zero percent so that it is not included in the total score. Simply lacking CEHRT is not sufficient to qualify to have the ACI performance category weight to be set at zero percent of the MIPS final score.

A MIPS eligible clinician's performance score may be reweighted for the following reasons:

1. They apply for reweighting by submitting an application to CMS and citing one of three specified reasons:
- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of CEHRT

2. They are one of the following MIPS eligible clinicians that qualify for an automatic reweighting (no application required):
- Hospital-based MIPS clinicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinicians who lack face-to-face encounters with patients (non-patient facing clinician)

These MIPS eligible clinicians can still voluntarily report for this category if they would like. If no data is submitted, they will automatically get this category reweighted to zero percent. However, if they choose to submit data, CMS will score their performance and weight their Advancing Care Information performance accordingly.

For these two groups of MIPS eligible clinicians, CMS will reweight the ACI category to zero and assign the 25 percent to the Quality performance category to maintain the potential for participants to earn up to 100 points in the MIPS final score.

If the ACI performance category does apply to you, and you do not submit the minimum required base measures, then CMS will give you a zero performance score for the ACI category. (This is generally worth 25 points for your MIPS final score.)

Question: Is it possible to score enough points in Quality and Improvement Activities (and no points in ACI) to still make the incentive?

Answer: Yes, those two categories alone create 70 percent if you get perfect scores, making you eligible for an incentive.

Question: Is this reweighted scoring expected to be the same next year or in the future?

Answer: We do not have any information thus far regarding future years beyond 2017.

Non-patient-facing Clinicians

Question: Where can I find more information on the reporting requirements for non-patient-facing clinicians?

Answer: In the final rule, CMS defines a non-patient-facing MIPS eligible clinician as an individual MIPS eligible clinician who bills 100 or fewer patient-facing encounters during the non-patient-facing determination period. This would also include the group provided that more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient-facing individual MIPS eligible clinician during the non-patient-facing determination period.

- Rachel Jordan-Shuss
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June 2017 MGMA-MO Legislative Report

State government issues

A total of 55 policy bills were passed in the 2017 legislative session, which is a 63% decrease in the annual average. While some of Governor Greitens major policy initiatives were passed - Right to Work, Expert Witness, Collateral Source, Uber/Ridesharing, Real ID, and a few others, many of his priority items never made it to his desk. The real story this summer is that Governor Greitens has called a special session to address an energy bill relating to an aluminum smelter in southeast Missouri and is expected to call more special sessions to address one or more of the following: Venue – Lawsuit Reform, Prevailing Wage Repeal, Paycheck Protection and Labor Reform.

Be that all as it may, following are the summaries of just a few of the more significant healthcare related bills passed in this year's session.

HB 153 – Tort Reform - *EXPERT WITNESS* - This bill specifies that a witness who is qualified as an expert may testify in the form of an opinion or otherwise if the expert's specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue, the testimony is based on sufficient facts or data, the testimony is the product of reliable principles and methods, and the expert has reliably applied the principles and methods to the facts of the case.

SS/SB 31 – Tort Reform - *COLLATERAL SOURCE RULE – HEALTH CARE COSTS* - Parties may introduce evidence of the actual cost, rather than the value, of the medical care or treatment to the plaintiff, and the act repeals a provision of law which provides that there is a rebuttable presumption that the value of the medical treatment provided is represented by the dollar amount necessary to satisfy the financial obligation to the health care provider.

SS HCS HB 452 – Tort Reform - *ACTION AGAINST HEALTH CARE PROVIDERS* - This bill creates a definition for the term "employee" and repeals the definition for the term "physician employee" in provisions relating to causes of action for damages against a health care provider for personal injury or death. With certain exceptions, no health care provider shall be liable to any plaintiff for the negligence of another entity or person who is not an employee of the health care provider.

CCS/SB 50 – *Health Care* - This act modifies several provisions relating to health care, including:

John Marshall
Legislative Liaison

NEWBORN SCREENING - This act requires the Department of Health and Senior Services, beginning January 1, 2019, and subject to appropriations, to expand current newborn screening requirements to include spinal muscular atrophy and Hunter syndrome.

NEONATAL AND MATERNAL LEVELS OF CARE - Under this act, the Department of Health and Senior Services shall hold public hearings and establish criteria for levels of maternal care designations and neonatal care designations for birthing facilities.

HEALTH CARE DIRECTIVES REGISTRY - This provision requires the Department of Health and Senior Services to contract with a third party for the establishment of a health care directives registry for the purpose of providing a place to securely store an advance health care directive online and to give authorized health care providers immediate access to the directive.

HOSPITAL LICENSURE - Under this act and beginning July 1, 2018, compliance with Medicare conditions of participation shall be deemed to constitute compliance with the standards for hospital licensure in this state.

HOSPITAL EMPLOYMENT OF DENTISTS - Under this act, licensed hospitals shall be permitted to employ any of the following providers to treat certain conditions for hospital patients: (1) licensed dentists, (2) licensed oral and maxillofacial surgeons, and (3) licensed maxillofacial prosthodontists.

ASSISTANT PHYSICIANS - This act modifies the definition of "assistant physician" to allow any medical school graduate who has met the requirements to be an assistant physician between August 28, 2014, and August 28, 2017, to be deemed to be in compliance with the requirements of becoming an assistant physician.

SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS - This act provides that license renewal for speech-language pathologists and audiologists shall occur no less frequently than every three years.

SCS/SB 52 – Suicide Prevention - *SHOW-ME COMPASSIONATE MEDICAL EDUCATION*

This act requires each public institution of higher education to develop and implement a policy to advise students and staff on suicide prevention programs available on and off campus that includes, but is not limited to crisis intervention access, mental health program access, multimedia application access, student communication plans, and post intervention plans.

HCS/SS/SCS/SB 66 – *Workers' Compensation S CORPORATIONS*

This act authorizes, beginning January 1, 2018, a shareholder of an S corporation with at least 40% or more interest in the S corporation to individually elect to reject coverage under the workers' compensation laws.

MAXIMUM MEDICAL IMPROVEMENT

Under this act, for the purposes of workers' compensation laws, the term "maximum medical improvement" is defined as the point at which the injured employee's medical condition has stabilized and can no longer reasonably improve with additional medical care, within a reasonable degree of medical certainty.

REDUCTION OF WORKERS' COMPENSATION AWARD BASED ON USE OF DRUGS

This act provides that any positive test for a nonprescribed controlled drug or the metabolites of such drug from an employee shall give rise to a rebuttable presumption that the tested nonprescribed controlled drug was in the employee's system at the time of an accident or injury.

CCS/HCS/SCS/SB 139 – Health Care (Omnibus)

EMERGENCY ADMINISTRATION EPINEPHRINE (Section 196.990)

This act allows a physician to prescribe epinephrine (EPI) auto-injectors in the name of an authorized entity for use in certain emergency situations. Pharmacists, physicians, and other persons authorized to dispense prescription medications may dispense EPI auto-injectors under a prescription issued in the name of an authorized entity. An "authorized entity" is defined as any entity or organization at or in connection with locations where allergens capable of causing anaphylaxis may be present, including but not limited to restaurants, recreation camps, youth sports leagues, amusement parks, and sports arenas.

POLYPHARMACY & ANTIPSYCHOTIC MEDICATIONS - This act repeals existing language relating to psychotrophic medications and adds new language relating to the establishment of a polypharmacy program and the prescribing of antipsychotic medications.

RX CARES FOR MISSOURI PROGRAM - This act also creates the Rx Cares for Missouri Program to be administered by the Board of Pharmacy in consultation with the Department of Health and Senior Services. The goals of the program are to promote medication safety and prevent prescription drug abuse. The Board may expend funds appropriated to the Board to private and public entities for the development of programs and education in order to meet these goals. Funds shall not be used for any state prescription drug monitoring program.

CCS/HCS/SB 501 – Health Care (Omnibus)

This act modifies several provisions relating to health care, including:

HEALTH CARE RECORDS - This act changes the fees for the search, retrieval, and copying of a patient's health care records by a health care provider.

DRUG OR ALCOHOL OVERDOSES - Under this act, a person who, in good faith, seeks or obtains medical assistance for himself or herself or someone else who is experiencing a drug or alcohol overdose or other medical emergency shall not be arrested, charged, prosecuted, convicted, or have his or her property subject to civil forfeiture or otherwise penalized for offenses specified in the act if the evidence, charge, prosecution, conviction, seizure, or penalty was gained as a result of seeking or obtaining medical assistance.

SPORTS MEDICINE - This act permits a physician to travel into Missouri with an athletic team and provide sports-related medical services to specified individuals related to the athletic team, band, dance team, or cheerleading squad, so long as the physician is cur-

rently licensed to practice medicine in another state and has a written agreement with an athletic team located in the state where the physician is licensed. The act prohibits such physician from providing medical services at a health care facility in Missouri.

PHYSICIAN ASSISTANTS - Under current law, physician assistants may only dispense drugs, medicines, devices, or therapies pursuant to a physician supervision agreement. This act removes this requirement.

MEDICATION-ASSISTED TREATMENT - This act allows participants in drug courts, family courts, and veterans courts to receive medication-assisted treatment under the care of a licensed physician if the participant requires such treatment for substance abuse dependence. A participant assigned to a substance abuse treatment program for substance abuse or dependence shall not be in violation of the terms or conditions of the program on the basis of his or her participation in medication-assisted treatment.

DRUG TAKE-BACK PROGRAM - This act gives the Missouri Board of Pharmacy the ability to allocate funds to develop a drug take-back program to collect and dispose of Schedule II and III controlled substances.

Federal issues

On the federal legislative front, the House passed the American Healthcare Act (AHCA) on May 4 in the latest effort to repeal the Patient Protection and Affordable Care Act (ACA, Obamacare).

But the bill's passage is far from certain. The Senate seemed cool toward the legislation, which could leave more than 23 million people uninsured by 2026, according to an estimate from the Congressional Budget Office. The Senate is likely to produce a vastly different version of the bill but how long that will take is unclear.

Also unclear is how many provisions federal agencies can or will strip from the ACA before a new healthcare law takes effect.

On another matter, the Centers for Medicare and Medicaid (CMS) wants to eliminate the global surgical package. That would end a key coding concept and the blizzard of modifiers and related policies that have long bedeviled physicians and coders. CMS and most commercial payers have struggled to adjudicate the coding complexities they created by introducing the global period, and the agency has been seeking the best way to solve the cost problem without the global period. The strategy currently in motion is to eliminate the global period, allowing physicians to once again bill separately for postoperative care.

To keep the cost-saving intentions of the global period intact, CMS would also significantly cut payment for all surgical CPT codes that currently carry global days, by reducing their Relative Value Units (RVUs). The trick is to balance these pay cuts with the expected additional payments that will occur when physicians start to bill for post-op care.

Having stated all of this, CMS and Health and Human Services (HHS) are adjusting to new leaders as President Donald Trump's administration transitions into power. Such as CMS now being led by Seema Verma, the founder and CEO of SVC Inc., a health policy consulting firm, as well as the new HHS leader, Tom Price, a former Republican congressman and orthopedic surgeon from Georgia.

John Marshall
MGMA-MO Legislative Liaison
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Imaging Clinical Decision Support: One more item for your 2017 To Do List

Understandably, thus far in 2017 most practice managers have been focused on MACRA, MIPS and APM's. However, there is another looming requirement which is slated to impact any provider who orders advanced imaging studies covered by Medicare Part B beginning January 1, 2018.

PAMA

You may remember the Protecting Access to Medicare Act of 2014 (PAMA) as the legislation that eliminated the annual threat of Medicare payment reductions associated with the Sustainable Growth Rate (aka the "doc fix"). One of the "pay-fors" in PAMA to was an effort to reduce imaging costs through use of Appropriate Use Criteria and Clinical Decision Support Mechanisms for CT, MRI, Nuclear Medicine and PET.

Since PAMA was passed in 2014, the Centers for Medicare and Medicaid Services (CMS) has been slowly issuing regulations working towards implementation of these provisions. While PAMA originally called for implementation of Clinical Decision Support by January 1, 2017, last year CMS delayed implementation to January 1, 2018.

Appropriate Use Criteria

PAMA called for providers ordering advanced imaging studies to consult Appropriate Use Criteria (AUC) developed by Provider Led Entities (PLE). Last year, CMS approved AUC's developed by the following PLE's:

1. American College of Radiology
2. American College of Cardiology
3. National Comprehensive Cancer Network
4. Society of Nuclear Medicine and Molecular Imaging
5. Brigham and Women's Physician Organization
6. CDI Quality Institute
7. Intermountain Healthcare
8. Massachusetts General Hospital
9. University of California Medical Campuses
10. University of Washington Physicians
11. Weill Cornell Medicine Physicians Organization

Clinical Decision Support Mechanisms

Approved Clinical Decision Support Mechanisms (CDSM's) allow ordering providers to electronically consult AUC when ordering advanced imaging studies. In late 2016, CMS issued regulations outlining requirements that CDSM's must meet in order to qualify. Among the requirements are:

1. Incorporate AUC from multiple PLE's.
2. Document each consultation with a unique session number
3. Deliver aggregated feedback to the ordering provider

CDSM venders were invited to apply each year by March 1, and approvals are due to be issued by June 30, beginning in 2017.

Scope

These requirements apply to CT, MRI, Nuclear Medicine and PET studies covered by Medicare. There are exclusions for inpatients, and "emergency cases" in which the ordering clinician "determines that the medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual (or a woman's unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part". CMS has specifically stated that many emergency department cases are not "emergency cases".

Consultation Process

AUC consultation must be performed by the ordering provider. It can't be done by the imaging provider. There are two main pathways to consult AUC:

1. Integrate an approved CDSM into your EHR.
2. Consult AUC via a web portal

Based on review of one prominent CDSM (pending

Imaging Clinical Decision Support: One more item for your 2017 To Do List

approval by CMS as of this writing), the patient's age and sex are provided by the EHR, or user selected in the web portal. Ordering providers select clinical indications for the proposed study, and receive information about imaging options including appropriateness, cost, radiation exposure, and supporting evidence.

Once a specific study is selected, a unique Decision Support Number (DSN) will be generated to document the consultation. The DSN must be passed to the provider furnishing the technical component service, along with the order. In turn, technical and professional component providers must report the DSN on their claim to be paid by Medicare. While consultation of AUC is required for Medicare payment, conformance with AUC recommendations is not.

What Now?

If you have an EHR, reach out to your vendor to find out if they will be offering a CDSM module. Be mindful of the fact that CMS is supposed to approve the first batch of CDSM's by June 30, 2017.

If you don't have an EHR, or your EHR vendor isn't offering an approved CDSM module at an affordable price, you will want to explore the web portal option. CMS plans to offer a free web portal. Some CDSM vendors are also offering a web portal along with their CDSM modules. One challenge with web portals is likely to be accurate recording and transfer of the DSN with the order.

If you have HL7 interfaces for imaging orders (ORM), ensure that the DSN populates and transfers correctly prior to January 1.

If your facility provides CT, MRI, Nuclear Medicine, or PET services to Medicare Part B patients, be sure that you are prepared to receive DSN's from ordering providers, and also transfer them to any outside providers who bill separately for the professional component.

Last, but not least, if you bill for CT, MRI, Nuclear Medicine or PET, watch for CMS to issue instructions this summer on how to report DSN's on claims.

Future Considerations and Opportunities

CMS intends to track conformance with AUC recommendations by ordering providers. Beginning in 2020, those who order a very high percentage of studies deemed inappropriate will be required to obtain pre-authorization for advanced imaging studies on Medicare patients.

While Clinical Decision Support might seem like one more headache, there is a potential silver lining. Once a CDSM is in place, providers will have a strong case to make to commercial payors to be excused from pre-authorization requirements, at least in those cases where you can document conformance to recognized AUC. This would obviously be a win-win for providers and payors.

- David Smith, FACMPE

David Smith, FACMPE, is Executive Director of United Imaging Consultants, a group of 35 radiologists serving hospitals, clinics and imaging centers in Missouri and Kansas. David can be reached at dsmith@uickc.com.

Welcome New Members

Encourage your colleagues to become members of MGMA-Missouri. They will reap the benefits of education, valuable networking, and learn about many issues dealing with practice management, legislation, and professional growth. To obtain a membership application, call the MGMA-MO office at (573) 556-6111, or sign up for membership on-line at www.mgma-mo.org.

MGMA-Missouri
Membership Figures For June 2017

191	Active Members	4	Faculty/Student Members
38	Business Partner Members	29	Life Members
5	Associate Members		

Total Membership - 267

Active Member

Marguerite Akins
Signature Medical Group
Saint Louis

Kathie Fedak
Anders
Saint Louis

Toniann Richard
Health Care Collaborative of Rural Missouri
Lexington

Renee Sexton
CHC Strategies
Springfield

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