Imaging Appropriate Use Criteria: A Proven Replacement for Prior Authorization

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CEO, American College of Radiology

eHealth Initiative Roundtable
Oct. 31, 2018
Washington DC

DISCLOSURES

- The American College of Radiology has been developing Appropriateness Criteria since 1993 for diagnostic imaging and is a CMS approved "Qualified Provider Led Entity" and is one provider of AUC to the National Decision Support Company who have developed "Care Select Imaging", a CMS approved "Qualified Clinical Decision Support Mechanism"

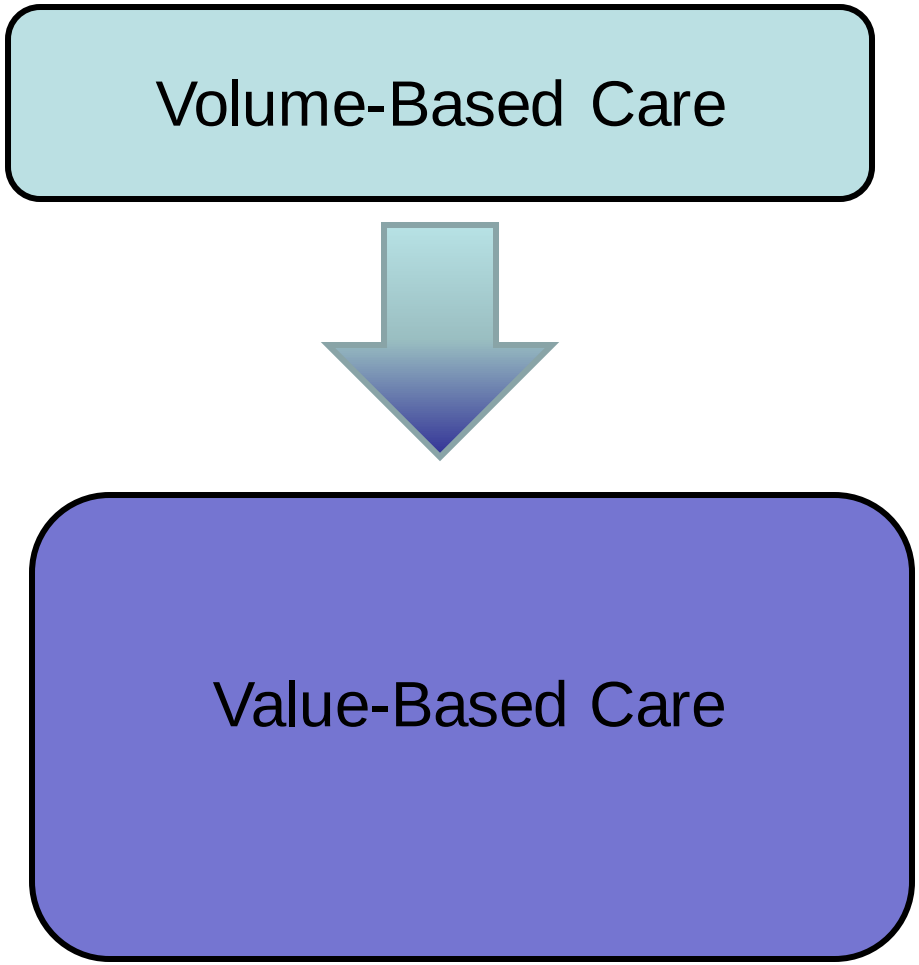
Time for Action: PAMA Mandate

- Starting Jan. 1, 2020 -- referring providers **must** consult appropriate use criteria (AUC) prior to ordering advanced diagnostic imaging services (ADIS: CT, MRI, NM, PET) for Medicare patients.*
  - This must be done (**and documented**) via a CMS approved qualified clinical decision support mechanism (qCDSM) using AUC from qualified provider led entities (qPLE).
  - Calendar year 2020 an "Education and Operations" period.

**Exemptions: Inpatient and EMTALA services; lack of Internet connectivity.*

Key Goals for Imaging AUC Policy

- **Evidence-based point of care** alternative to prior authorization.
- Aids movement towards **value-based care** rather than Fee-for-Service.
- **Protects patients** from unnecessary procedures and radiation.
- **Promotes care coordination and referrer education**.



AUC and Congress

- Imaging AUC provisions enacted into law with Protecting Access to Medicare Act (PAMA) of 2014
  - **No national medical specialty society opposed** the AUC approach during legislative process
  - Policy received **strong bipartisan, bicameral support** on Capitol Hill
  - AUC designed to be the first of many "system-wide" changes in health care **focusing on value-based care**

Fundamentals

- Requires ordering physicians to ***consult*, *but not adhere to***, imaging AUC prior to referring Medicare beneficiaries for advanced diagnostic imaging services (ADIS).
  - Rendering physician/facility (e.g. radiologist, hospital) bears all financial risk
  - Law and CMS regs give preference to AUCs developed by **"qualified Provider-Led Entities"** (e.g. national medical specialty societies, NCCN, some academic facilities)
  - Promotes use of electronic **"Clinical Decision Support Mechanisms (CDSMs)"** for seamless integration within electronic order entry

CMS Rules for AUC Program

- **Ordering professionals must consult AUC**.
  - Via qCDSM software integrated in EHRs or via stand-alone web-based portals
  - CDS mechanisms **must offer no cost web-based portals**
  - ACR anticipates qCDSM will provide **unique identifier for the exam order**
- **Exemptions**: Inpatient and EMTALA services; lack of Internet connectivity.
- Tool must provide **immediate feedback** to ordering professional on appropriateness guidance (no delay like PA)
- Multiple qCDSMs **integrate directly into, or operate seamlessly with, existing health IT systems**.

AUC Implementation Now Imminent

- **CMS has moved *steadily* to get feedback** from stakeholders to ensure minimal burden to implement.
- **Latest implementation schedule:**
  - **July 2018-December 2019:** Voluntary reporting period for early AUC adopters (**with MIPS credit!)**
  - **January 2020:** New start date for AUC program beginning with one year "Educational and Operations" testing period (AUC required but no penalties on rendering physicians)

AUC is Ready for Prime Time

- CMS allowed ordering physicians **six years** to prepare for implementation (*PAMA 2014 – 2020 start date*).
- Meanwhile, AUC-qCDSMs successfully adopted EHR integration in over 500 *health systems and 2,000 acute care facilities in all 50 states.*
- Available via a free web portal.

Collaboration between CMS, CDSM vendors, as well as ordering and rendering physicians, helped piece together an effective AUC policy.

CareSelect Imaging Adoption

Epic

Cerner

MEDITECH

Allscripts

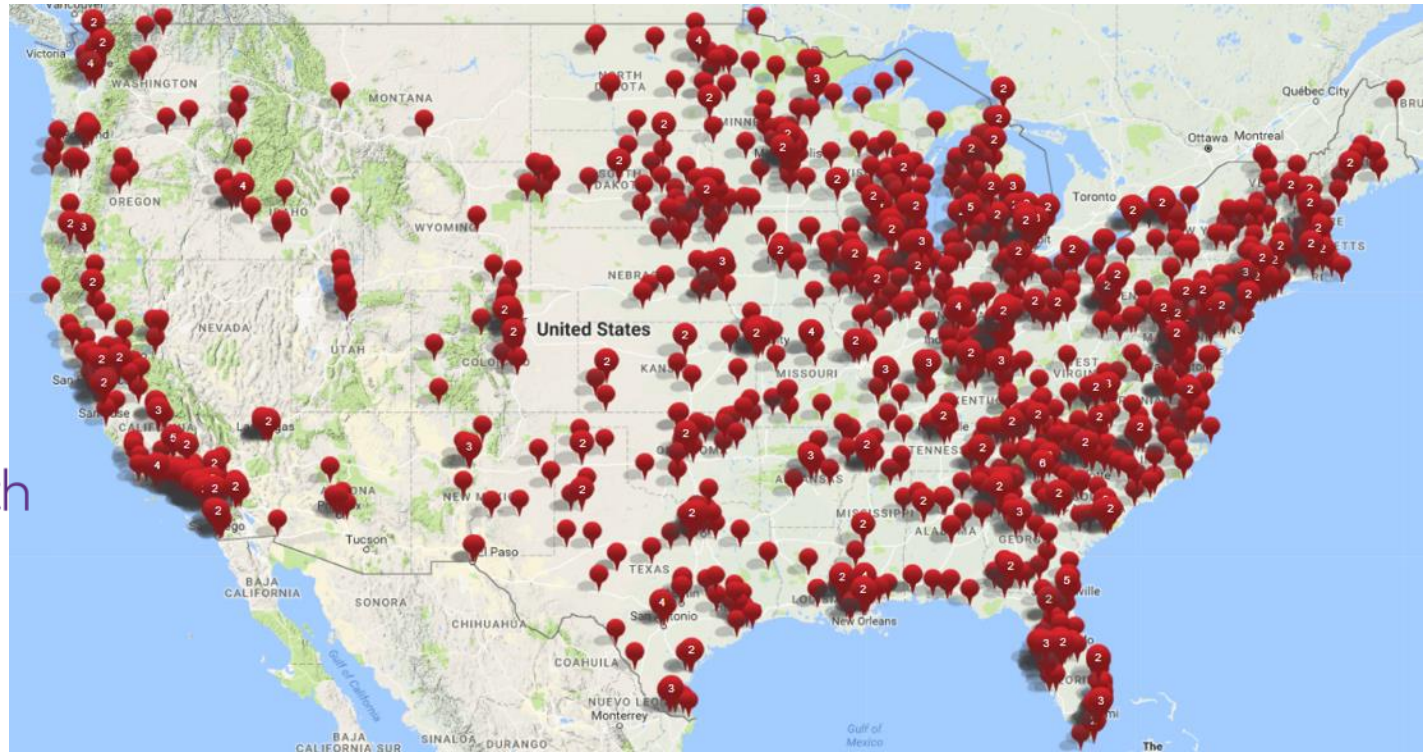
athenahealth

eClinicalWorks

MEDENT

MEDHOST

NEXTGEN HEALTHCARE



More than 500 Health Systems, 5000 Hospitals

Informing more than 5 million monthly decisions

Confidential © 2011-2016 National Decision Support Company

This is NOT Prior Authorization!

- **Ordering physicians prefer CDS to prior authorization** programs of radiology benefit management companies (RBMs):
  - Point of care, **NO DELAYS**
  - No FTEs sitting on phones
  - No “hard stop”
  - An educational tool for physicians and patients

Physicians Fed Up With Prior Authorization

Patient Clinical Outcomes Shortchanged by Prior Authorization, Says AMA Physician Survey
https://www.ama-assn.org/survey-patient-clinical-outcomes-shortchanged-prior-authorization

AMA
AMERICAN MEDICAL ASSOCIATION

FOR IMMEDIATE RELEASE

March 19, 2018

Physicians Fed Up With Prior Authorization

Patient Clinical Out Survey

https://www.ama-a horization

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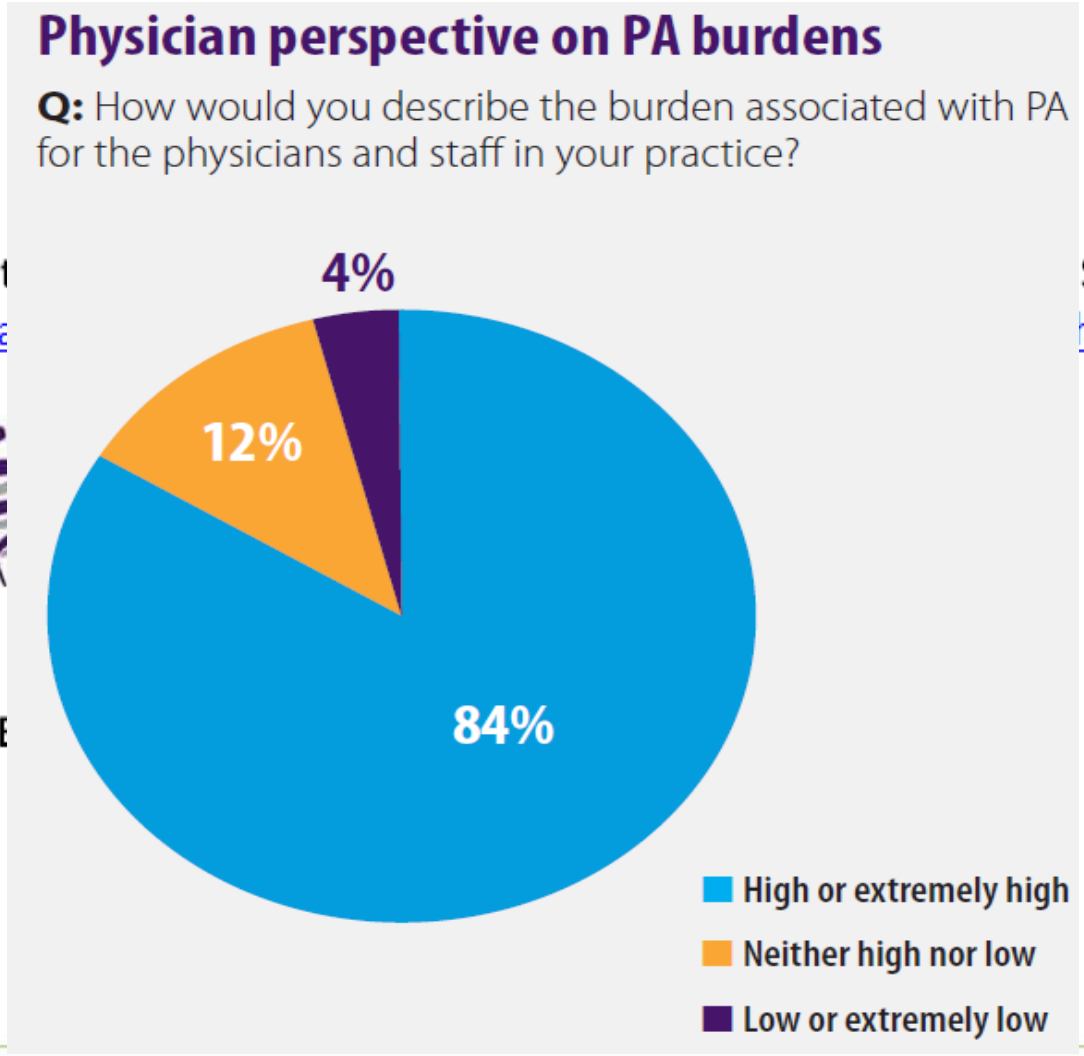
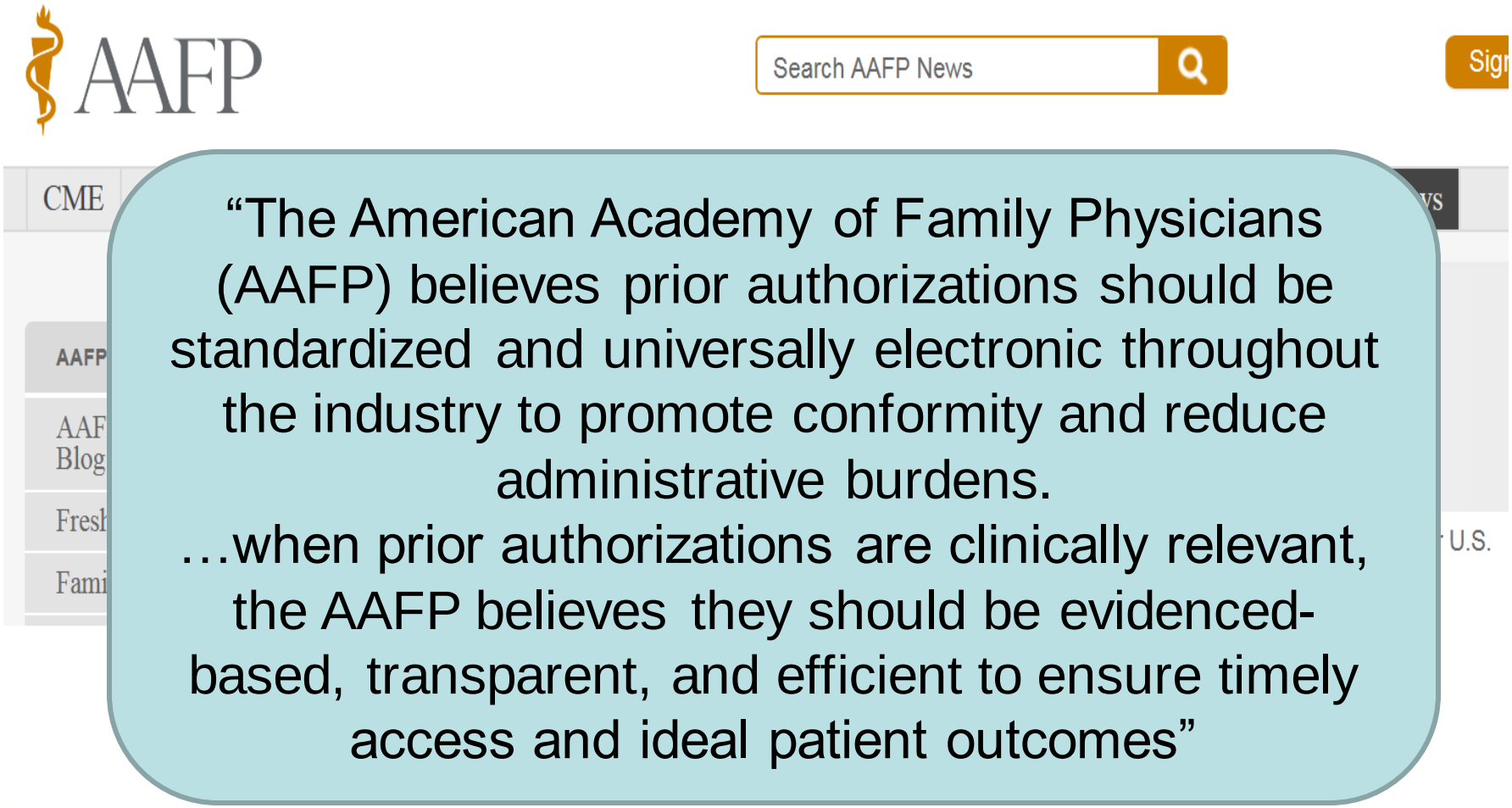
FOR IMMEDIATE RE March 19, 2018



AUC CONSULTATION VIA CDS CONFORMS TO AAFP POLICY

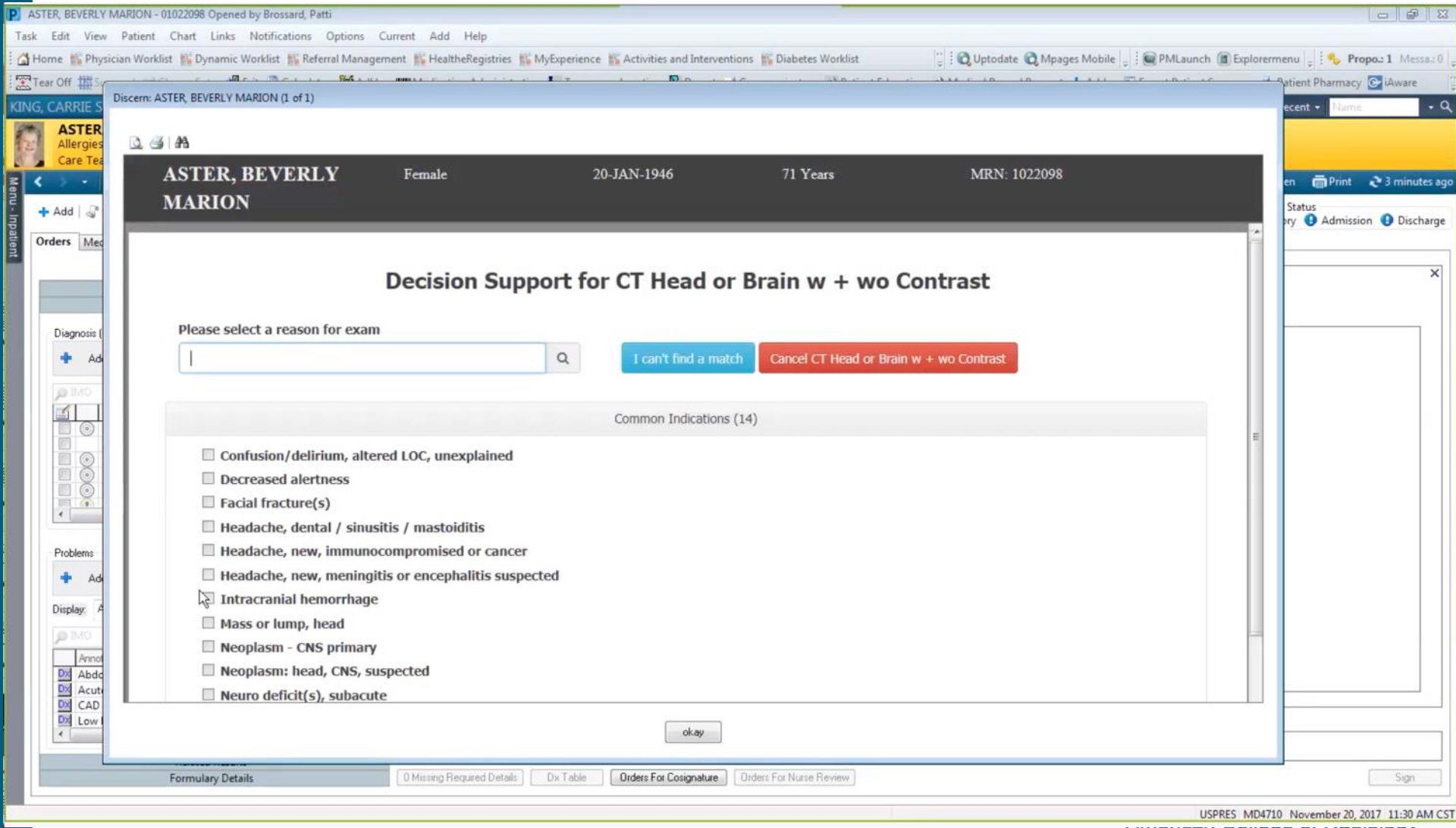
Physicians Fed Up With Prior Authorization



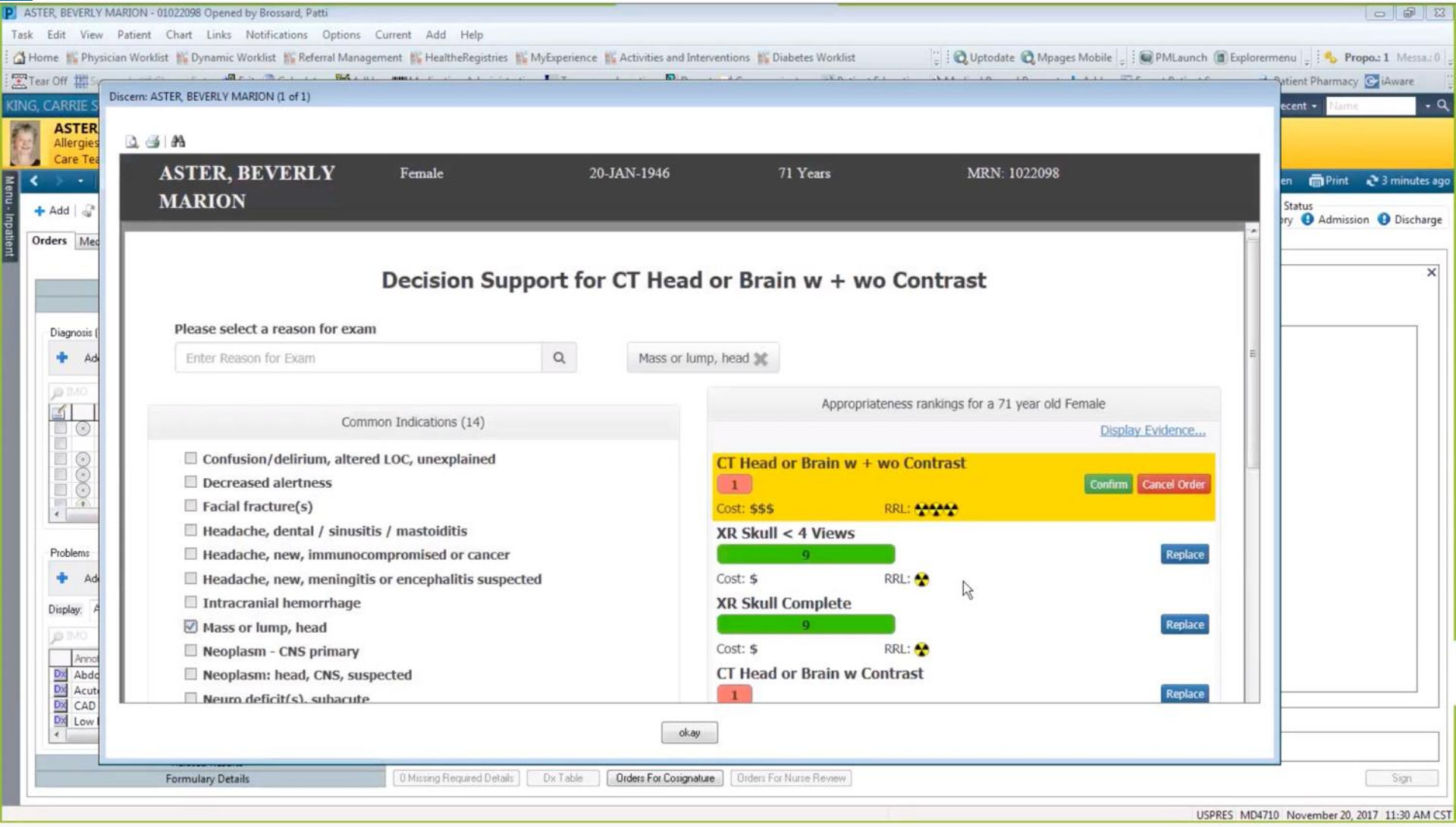
"The American Academy of Family Physicians (AAFP) believes prior authorizations should be standardized and universally electronic throughout the industry to promote conformity and reduce administrative burdens.

…when prior authorizations are clinically relevant, the AAFP believes they should be evidenced-based, transparent, and efficient to ensure timely access and ideal patient outcomes"

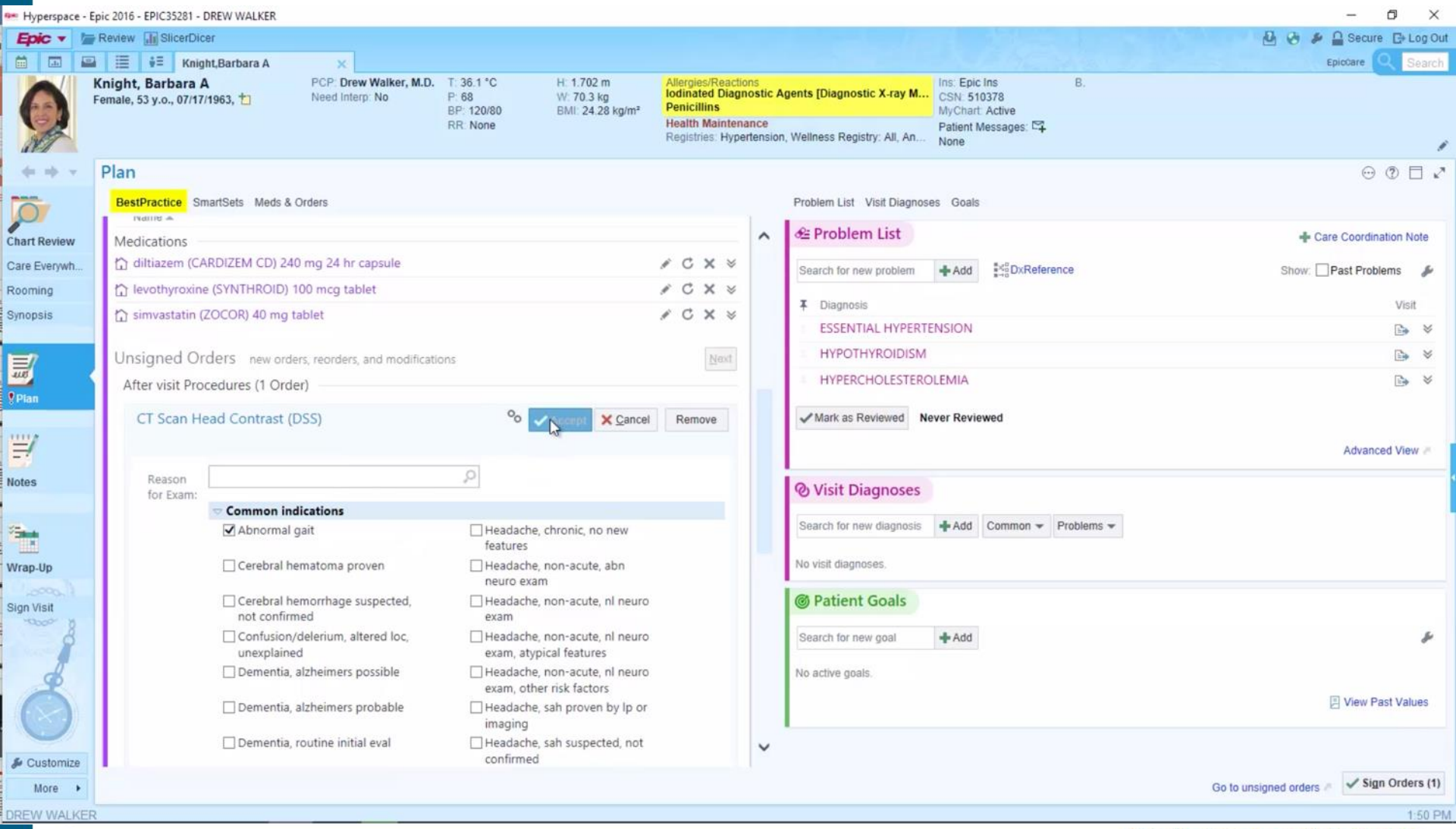
Cerner EHR integration



Feedback and Alternate Test Selection



Epic EHR Integration



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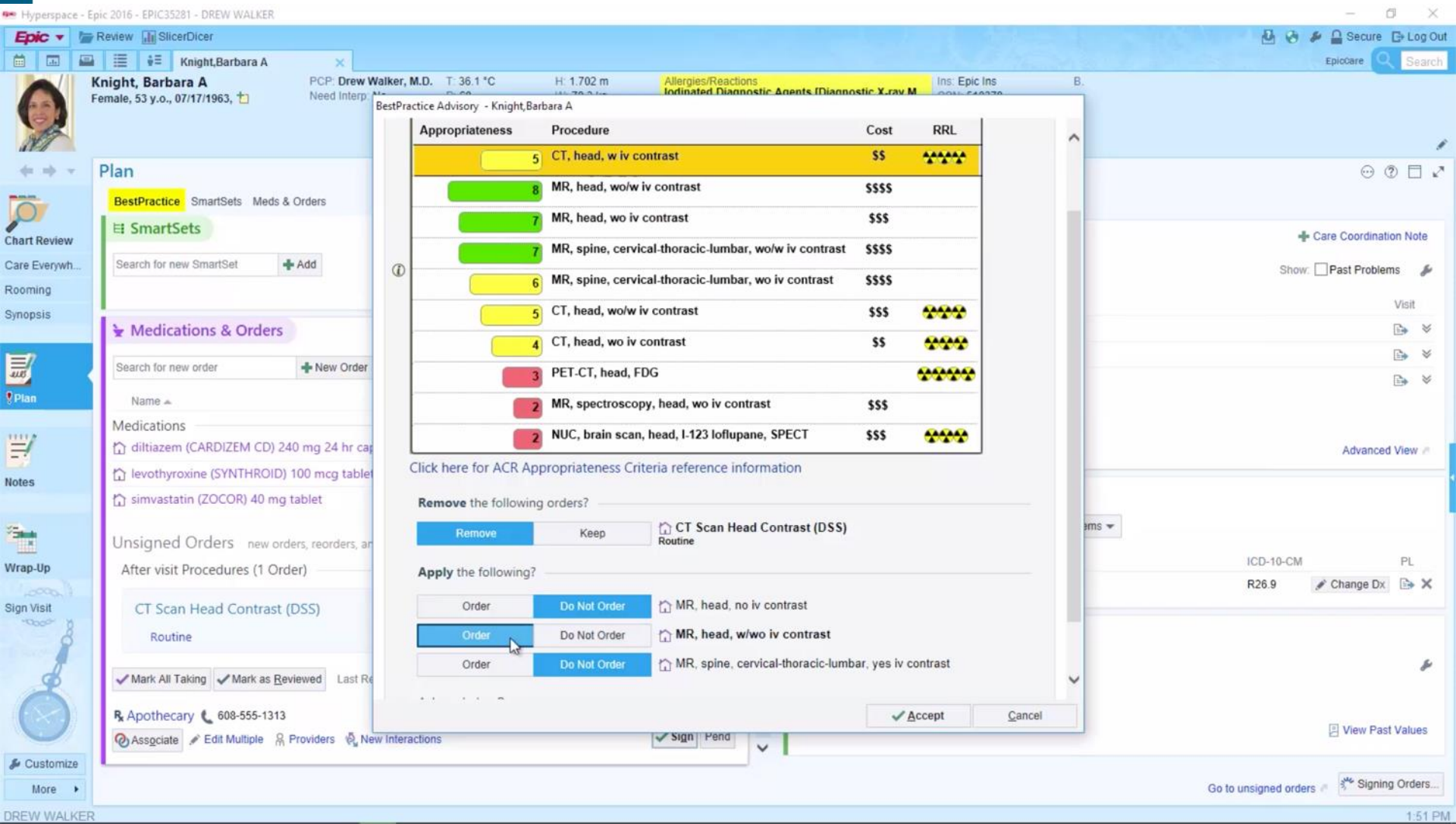
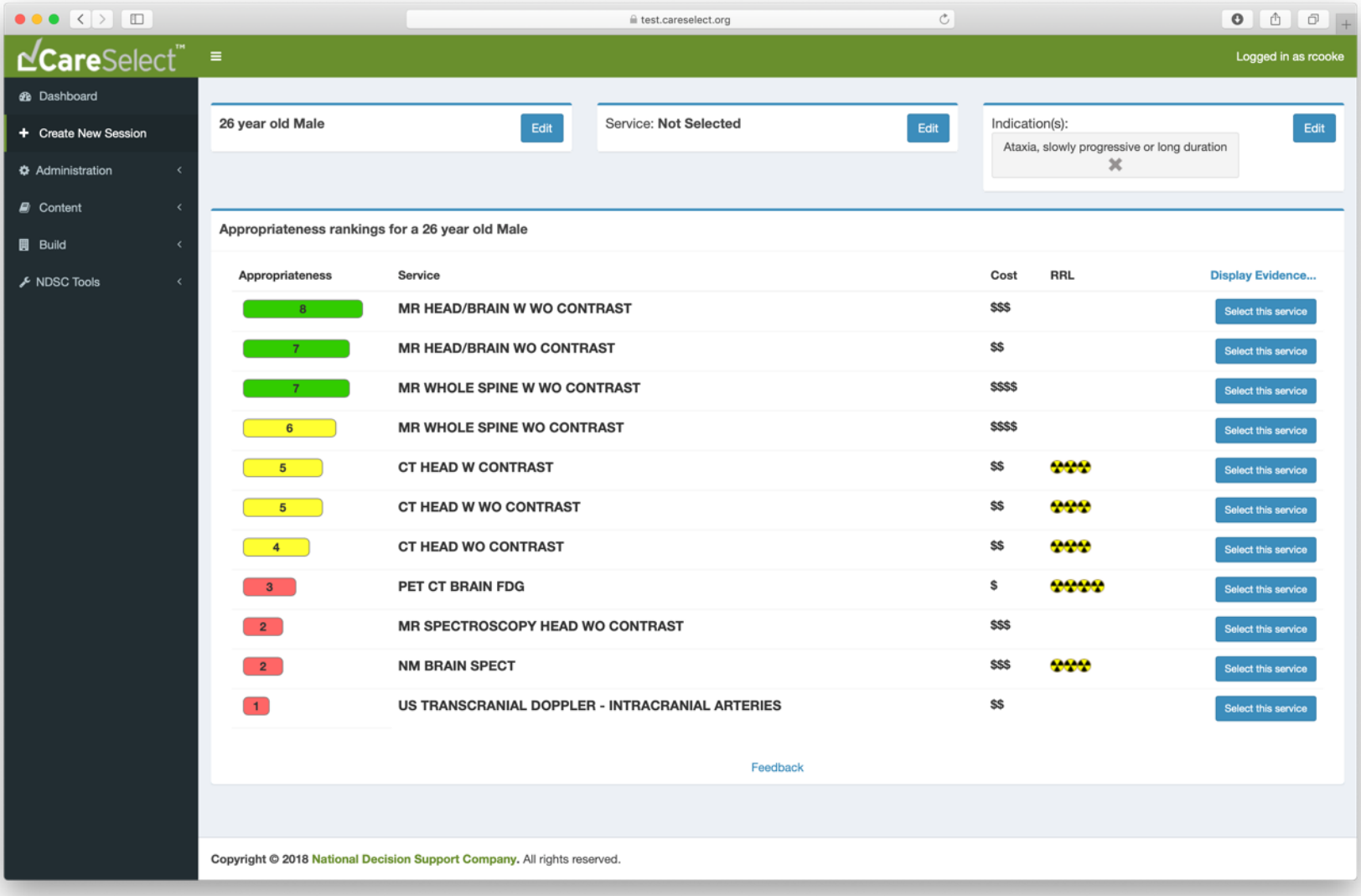


No Fee Web site



Referrer Benefit: AUC Integration Within QPP

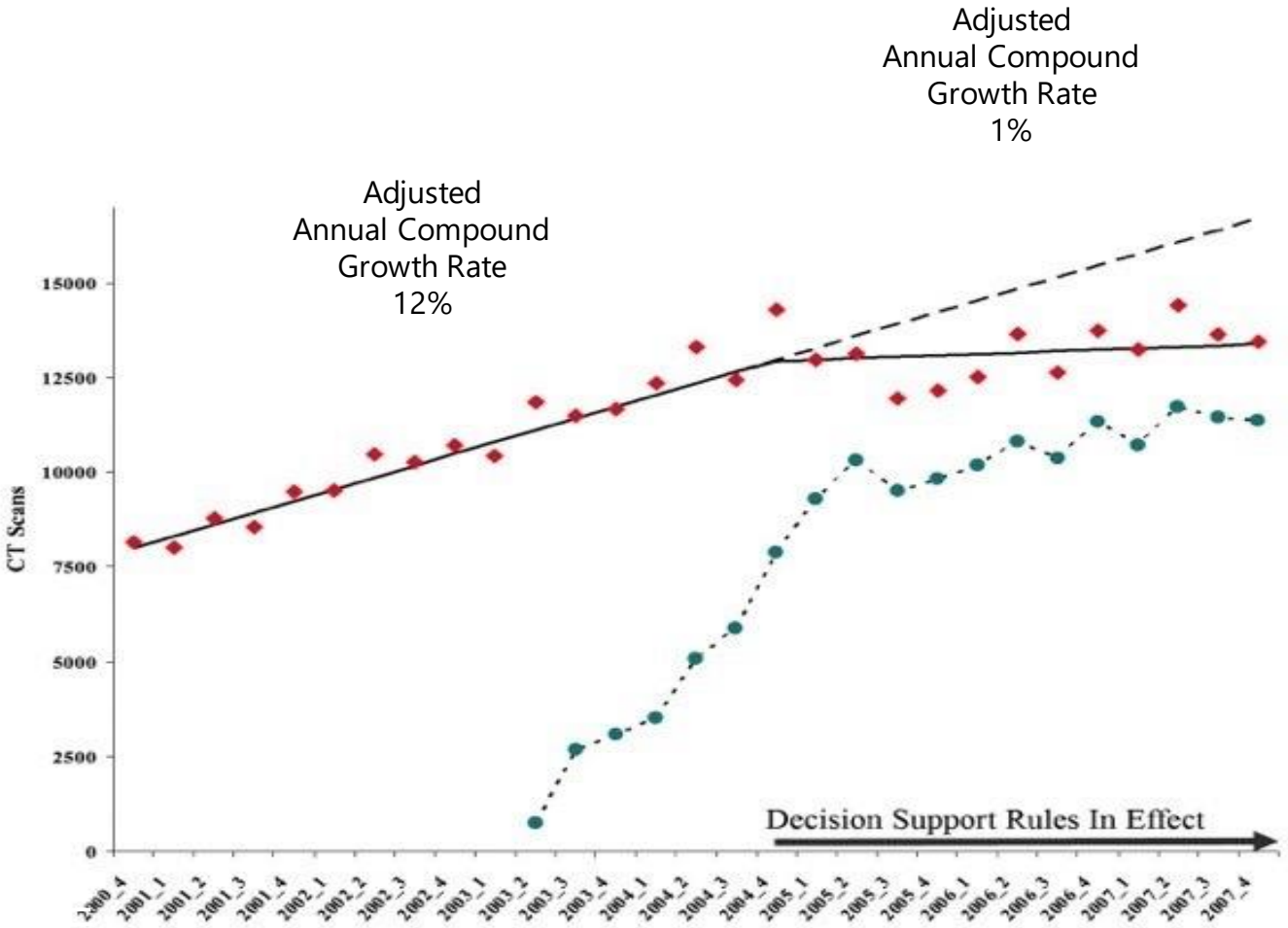
- 2018 Quality Payment Program (QPP) Final Rule **grants ordering physicians** who consult imaging AUC beginning in July 2018 **"high-level" MIPS improvement activity credit**.

The Best News

- It really works
  - Optimizing Imaging Utilization
  - Protecting patients from unnecessary or inappropriate tests
  - Educates referring providers
  - Empowers referring providers to address patient insistence

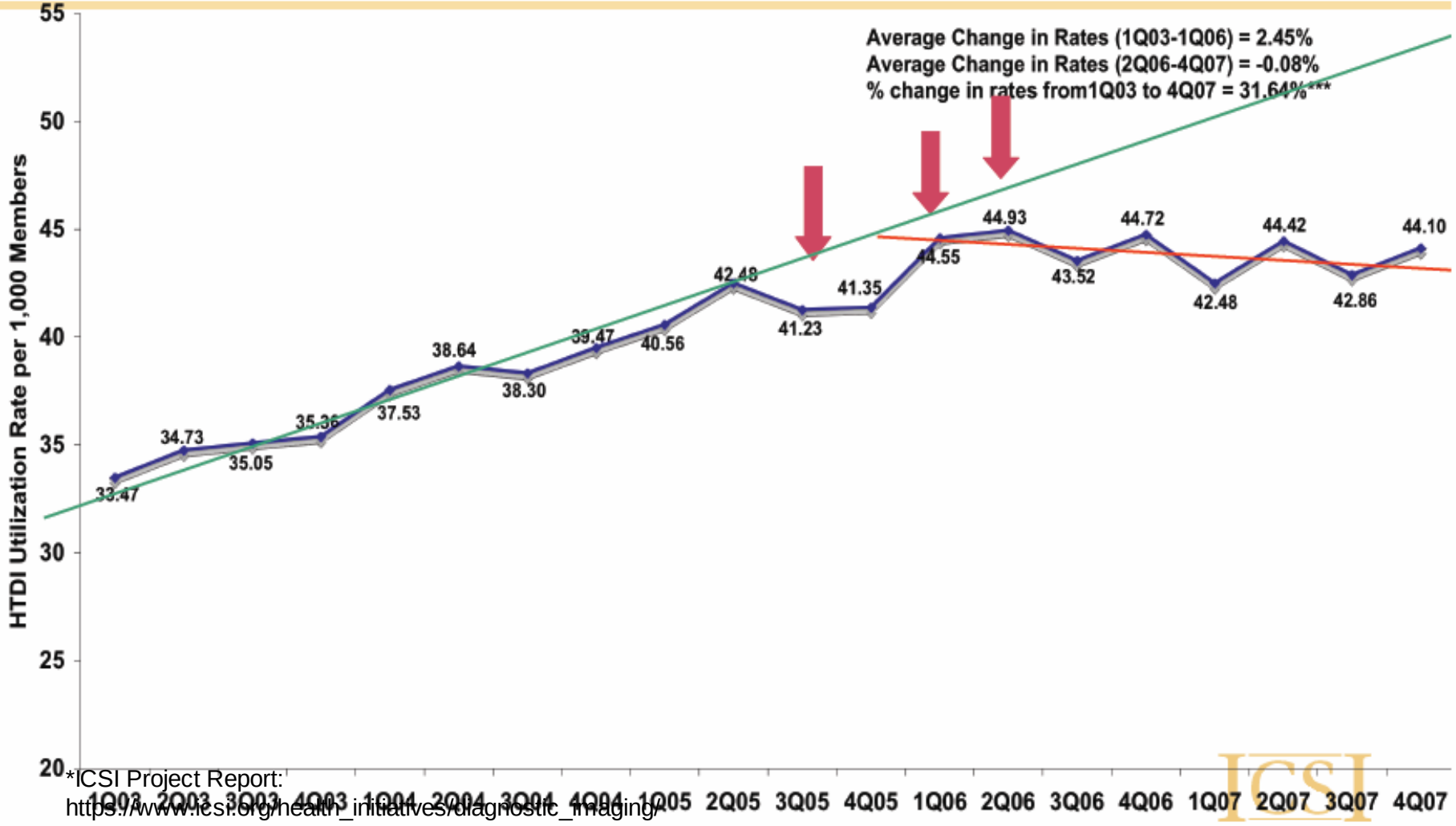
Massachusetts General Hospital
High Cost Imaging

Effects of CDS
2000 - 2007



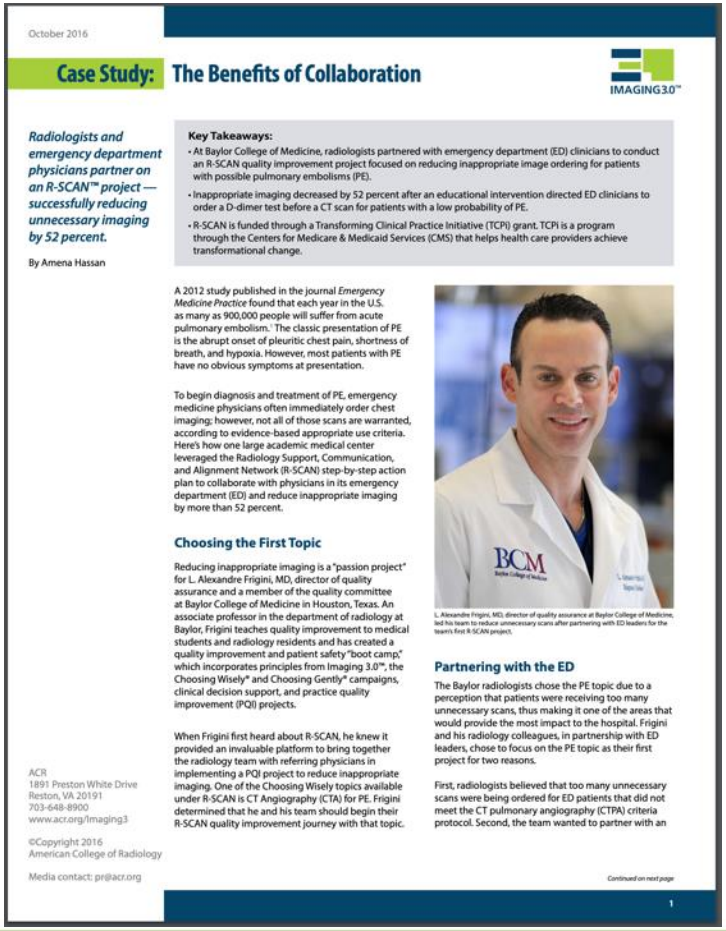
Institute for Clinical System Improvement (ICSI)

Impact on HITech Diagnostic Image Ordering



*ICSI Project Report:
https://www.icsi.org/health_initiatives/diagnostic_imaging/

RSCAN Example Results



October 2016

Case Study: The Benefits of Collaboration

IMAGING3.0™

Radiologists and emergency department physicians partner on an R-SCAN™ project — successfully reducing unnecessary imaging by 52 percent.

By Amena Hassan

Key Takeaways:

- At Baylor College of Medicine, radiologists partnered with emergency department (ED) clinicians to conduct an R-SCAN quality improvement project focused on reducing inappropriate image ordering for patients with possible pulmonary embolisms (PE).
- Inappropriate imaging decreased by 52 percent after an educational intervention directed ED clinicians to order a D-dimer test before a CT scan for patients with a low probability of PE.
- R-SCAN is funded through a Transforming Clinical Practice Initiative (TCPi) grant. TCPi is a program through the Centers for Medicare & Medicaid Services (CMS) that helps health care providers achieve transformational change.

A 2012 study published in the journal *Emergency Medicine Practice* found that each year in the U.S. as many as 900,000 people will suffer from acute pulmonary embolism.[1] The classic presentation of PE is the abrupt onset of pleuritic chest pain, shortness of breath, and hypoxia. However, most patients with PE have no obvious symptoms at presentation.

To begin diagnosis and treatment of PE, emergency medicine physicians often immediately order chest imaging; however, not all of those scans are warranted, according to evidence-based appropriate use criteria. Here's how one large academic medical center leveraged the Radiology Support, Communication, and Alignment Network (R-SCAN) step-by-step action plan to collaborate with physicians in its emergency department (ED) and reduce inappropriate imaging by more than 52 percent.

L. Alexandre Frigini, MD, director of quality assurance at Baylor College of Medicine, led his team to reduce unnecessary scans after partnering with ED leaders for the team's first R-SCAN project.

Choosing the First Topic

Reducing inappropriate imaging is a "passion project" for L. Alexandre Frigini, MD, director of quality assurance and a member of the quality committee at Baylor College of Medicine in Houston, Texas. An associate professor in the department of radiology at Baylor, Frigini teaches quality improvement to medical students and radiology residents and has created a quality improvement and patient safety "boot camp," which incorporates principles from Imaging 3.0™, the Choosing Wisely® and Choosing Gently® campaigns, clinical decision support, and practice quality improvement (PQI) projects.

When Frigini first heard about R-SCAN, he knew it provided an invaluable platform to bring together the radiology team with referring physicians in implementing a PQI project to reduce inappropriate imaging. One of the Choosing Wisely topics available under R-SCAN is CT Angiography (CTA) for PE. Frigini determined that he and his team should begin their R-SCAN quality improvement journey with that topic.

Partnering with the ED

The Baylor radiologists chose the PE topic due to a perception that patients were receiving too many unnecessary scans, thus making it one of the areas that would provide the most impact to the hospital. Frigini and his radiology colleagues, in partnership with ED leaders, chose to focus on the PE topic as their first project for two reasons.

First, radiologists believed that too many unnecessary scans were being ordered for ED patients that did not meet the CT pulmonary angiography (CTPA) criteria protocol. Second, the team wanted to partner with an

Continued on next page

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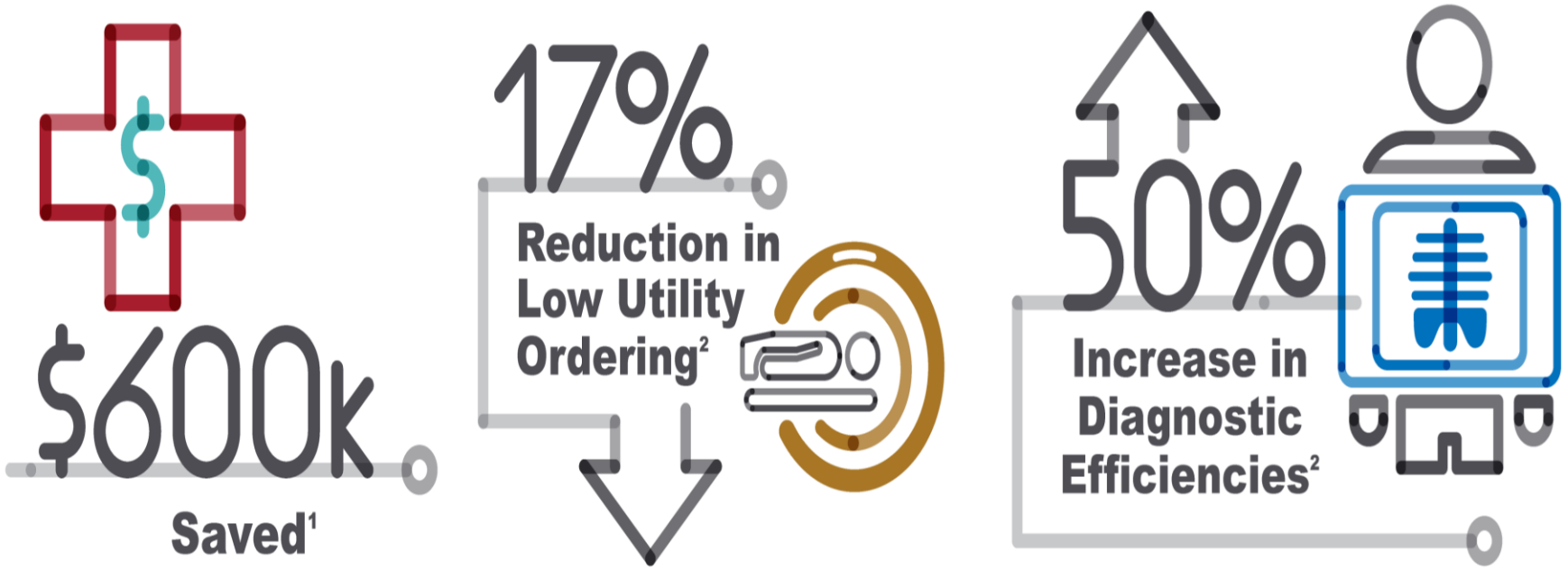
Radiologists and emergency department physicians partner on an R-SCAN™ project.

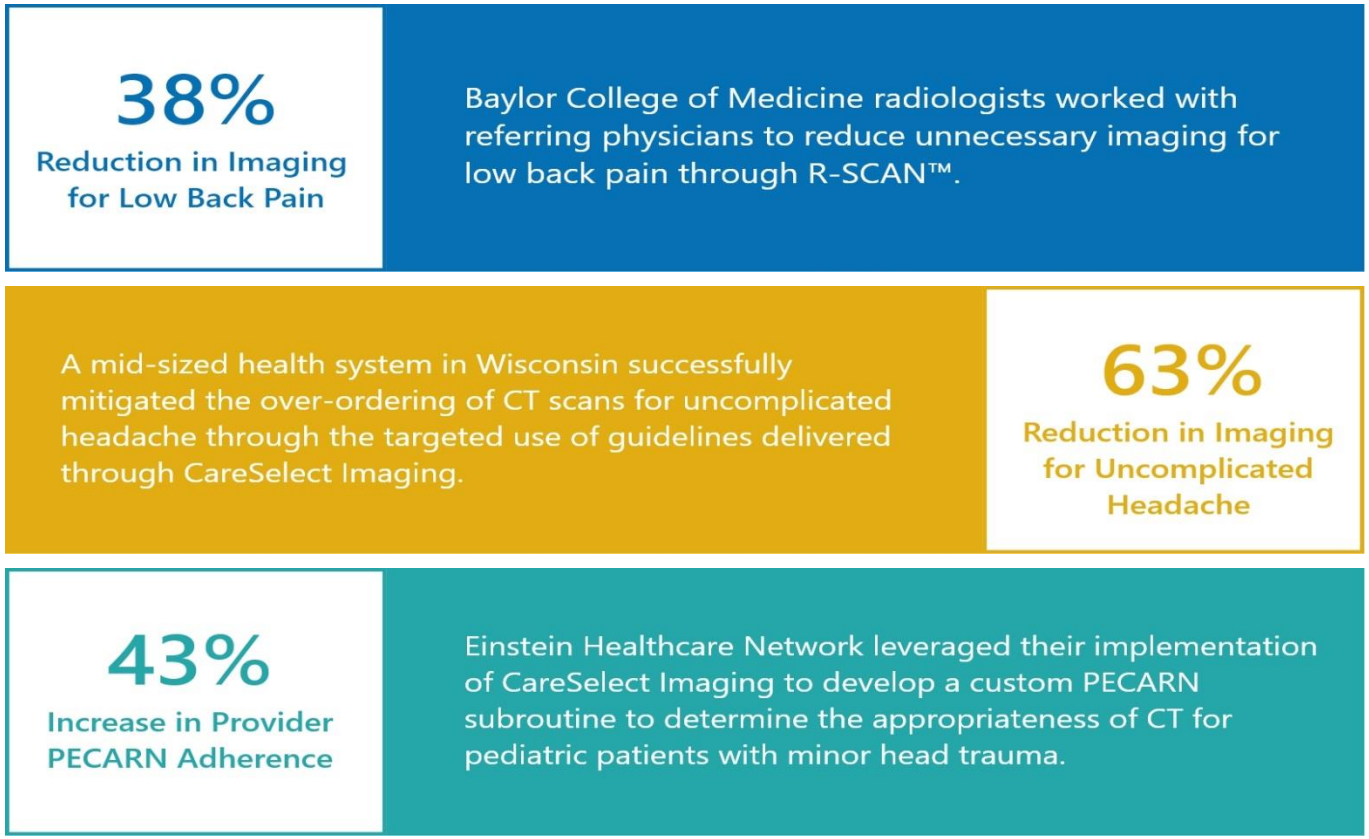
More than 18% of CTPE exams were in appropriately being ordered without a D-Dimer test. In many cases, receiving a scan despite a negative D-Dimer test.

As a result of the practice improvement initiative and intervention a reduction in CTPE of over 52% was achieved.

AUC Delivers Real Results



AUC Delivers Real Results



It's time to unleash the benefits of AUC!

Example results

- University of Virginia

Table 1. Frequencies and percentages for the number of low utility, marginal utility, and indicated appropriateness score categorizations observed during the pre-intervention (ie, silent mode) study period and during the intervention (ie, feedback mode) study period

Appropriateness Score Categorization	Study Period			
	Pre-Intervention	%	Intervention	%
Low utility	746	11.0	918	5.4
Marginal	1655	24.5	2134	12.6
Indicated	4353	64.5	13857	82.0
Total	6754	100.0	16909	100.0

https://www.jacr.org/article/S1546-1440(18)30387-9/pdf

- IL Hospital

2018 Ambulatory Prior Authorizations Benchmark	CDS Scores			
	Not Appropriate 1 - 3	May Be Appropriate 4 - 6	Appropriate 7 - 9	Total Scored
Approved	308	314	1346	1968
Denied	3	3	1	7
Withdrawn	0	4	7	11
Grand Totals	311	321	1354	1986

- 1,986 exams were scored by CDS
- 68% met AUC with scores 7-9, and the PA was Approved (1346 of 1986)
- 16% met AUC with scores 4-6, and the PA was Approved (314 of 1986)
- 16% did not meet AUC with scores 1-3, yet the PA was Approved (308 of 1986)

Aggregate Results

- Directly Eliminating over $170m annually in wasteful advanced imaging services
  - Provider acted on feedback
- Identified more than $4.5b in potential savings across all consultations
  - Potential savings through feedback
- Being adopted by many health systems and plans in support of ‘gold card’ initiatives based on data indicating UM effect of CDS to be equivalent or better than current UM approach
  - Payer supported gold card based on effect of evidence based medicine into the workflow

Unmanaged Imaging Utilization Is Not An Option

- Payment cuts and prior authorization threaten patient access to imaging and create huge headaches for referrers.
- Failure to address this through AUC/CDS will lead to more widespread use of prior authorization, interfere in the doctor-patient relationship and delay patient care.

Let's work together to make this happen.

Thanks

Questions?