

Accreditation, appropriate use criteria are better options than RBMs for Medicare and its beneficiaries

Imaging utilization has increased as our population ages and new imaging technology becomes available that can quickly and accurately diagnose conditions such as cancer, heart disease and other major illnesses. To help control imaging costs, it has been suggested that Medicare implement a prior-authorization process for imaging services by contracting with third-party, for-profit companies called Radiology Benefits Managers (RBMs). The cardiology community strongly disagrees with the use of RBMs, as they do not improve imaging quality, patient care or even utilization in the long term.

Wrong for patients

Today, when a cardiologist decides a patient needs a test, the patient often undergoes the procedure during the same office visit. However, with prior authorization, the patient may be sent home and return for the test another day because of the time associated with obtaining approval from the RBM. This involves taking more time off work, may include a long commute (especially for the rural patient), and can be time-consuming and inconvenient, especially for older patients.

“The patient who has to wait 1-2 days for prior authorization may decide he can’t afford another day off work, or he ‘feels better’ and cancels. Pretty soon he’s in the Emergency Department, then an inpatient, and the hospital ends up doing a nuclear study or cardiac catheterization. Is this saving the insurance company or Medicare money? Not by a long shot. More importantly, is this safe for the patient?

Absolutely, unequivocally, NO.”

Michael Foster, MD, FACC—South Carolina Heart Center

RBMs say their prior authorization decision pathways are based on quality indicators; however, they liberally interpret national guidelines in favor of not ordering tests and refuse to share their decision-making guidelines with physicians. RBMs traditionally develop guidelines based solely on a single specialty that do not apply for all diagnostic imaging services. Thus, certain procedures could be denied based on inappropriate standards. **No increase in the quality of patient care or improved service has resulted from programs based solely on utilization control.**

Wrong incentives

RBMs are for-profit companies that make money off their insurance company clients by reducing the insurers’ costs. RBMs accomplish this by denying tests ordered for patients by their physicians. Physicians cannot provide high-quality patient care if the very foundation upon which RBMs operate is denying care. It’s that simple.



(continued on reverse)

(continued from reverse)

Counterproductive management practices

Many RBMs are unwilling to share their prior authorization guidelines with physicians. They create a contentious relationship between physicians and health plans because RBMs often have been reluctant to review their data with physicians. They can be unpredictable with regard to approval and disapproval of tests.

RBMs can supersede the authority of local physicians, who have been educated extensively in their fields, have years of experience practicing medicine and know their patients' medical histories. They may increase medical malpractice risks for physicians and insurers that withhold care at the direction of an RBM company. They increase practice costs for physicians who have to use staff time to deal with RBMs and fight for patients who need critical diagnostic services.

"My practice's physicians continue to order the tests they know their patients need, regardless of any prior authorization process. Although more than 97 percent of the orders are eventually approved as requested, the administrative time for our office — and the health plans' — is substantial. We have numerous third-party prior authorizations a day and it takes 20-25 minutes on average to obtain them. Two or three staff are devoted simply to obtaining priors, with no impact on testing utilization. More aggressive RBMs can require peer-to-peer discussions that take up to 30 minutes of a physician's time — time that should be spent with patients."

Mark F. Victor, MD, FACC — Cardiology Consultants of Philadelphia

A better strategy: accreditation and use of appropriateness criteria

Medicare and physicians both have the best interests of the patient at heart. They both want patients to receive appropriate care, in the appropriate setting and at the right time. CAA strongly supports the accreditation of imaging facilities mandated by the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), as accreditation will help eliminate facilities unable to meet quality standards.

In addition, CAA supports specialty-specific appropriateness criteria such as those of the American College of Cardiology to address inappropriate imaging while ensuring that patients get the care they need. MIPPA also requires that a study be conducted on the impact that appropriateness criteria have on imaging utilization.

As long as the physicians who order and interpret tests are held to strict clinical standards and use equipment that meets rigorous quality accreditation requirements, RBMs would serve no purpose with regard to quality control or utilization appropriateness.

**RBMs and prior authorization:
WRONG incentives, WRONG for patients, WRONG for Medicare.**



CAA educates the professional cardiovascular community about regulatory and legislative issues that affect their ability to provide high-quality patient care, and represents the common interests of the cardiovascular patient and professional. For more information, visit our website: cardiologycaa.com.