

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-09)
Radiology Benefits Managers
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2009 Annual Meeting, the House of Delegates adopted as amended Resolution 231, which asked that the American Medical Association (AMA) address the intrusion of radiology benefits managers (RBMs) into the doctor-patient interaction (e.g., denying one diagnostic test in favor of another) by (a) studying the prevalence of forced test substitution and denial of requested imaging services by RBMs contracted by third party payers; (b) advocating against such practices; (c) supporting the use of appropriate use criteria (AUC) developed by medical societies and physicians with expertise in the specialty relevant to the condition of the patient as an alternative to RBMs; and (d) reporting back progress on this issue at the 2009 Interim Meeting.

There has been a growing concern with increasing utilization and costs of imaging services in recent years and a common strategy used by private health insurance companies to control imaging growth is the use of radiology benefits managers (RBMs). Some of the nation's largest insurers contract with RBMs in the provision of imaging services to patients. The three largest RBMs are CareCore National; American Imaging Management, a WellPoint subsidiary; and National Imaging Associates, a unit of Magellan Health Services. While Medicare has historically used retrospective payment safeguards, such as identifying medical claims that do not meet certain billing criteria, there has been recent focus on having Medicare follow the private health insurers' trend of controlling utilization and costs using RBMs and other prospective strategies. Although RBMs are commonly used to control imaging use, there are better alternative mechanisms for private payers and Medicare to monitor and control imaging utilization.

The main concerns physicians report with the use of RBMs are denial or delays of payment for medically warranted imaging studies; lack of proper administrative cost assessments; inconsistent rules and practices; lack of clinical guideline transparency; interference in the patient-physician relationship; acceptance of tests or studies contingent upon referral to other physicians or practice groups; and forced test substitution.

This report describes the increasing use of RBMs, reviews the prevalence of RBM interference, identifies claims denial management practices, outlines related AMA advocacy and policy, and discusses alternatives to RBMs. The report recommends that RBMs adhere to uniform physician-developed best practice guidelines by radiology benefits management programs (RBMPs). The report also recommends that the AMA support the use of appropriate use criteria (AUC) developed by physicians with relevant expertise working in a collaborative process involving all national medical specialty societies that provide and/or order the service in question. In addition, the report suggests that an independent study be conducted to assess the burden of imaging utilization strategies on physicians and patients, and that the AMA advocate against the practice of forced test substitution and denial of requested imaging services by RBMs, which should be held accountable for harm caused by substitution or delay of requested studies. In addition, the report recommends that the AMA encourage the Physician Consortium for Performance Improvement[®] to continue to develop patient-centered measures, including those that address the appropriate use of imaging.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-09

Subject: Radiology Benefits Managers

Presented by: Barbara L. McAneny, MD, Chair

Referred to: Reference Committee J
(William J. Holt, MD, Chair)

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2 asked that the American Medical Association (AMA) address the intrusion of radiology benefits
3 managers (RBMs) into the doctor-patient interaction (e.g., denying one diagnostic test in favor of
4 another) by (a) studying the prevalence of forced test substitution and denial of requested imaging
5 services by RBMs contracted by third party payers; (b) advocating against such practices; (c)
6 supporting the use of appropriate use criteria (AUC) developed by medical societies and
7 physicians with expertise in the specialty relevant to the condition of the patient as an alternative to
8 RBMs; and (d) reporting back progress on this issue at the 2009 Interim Meeting. The Board of
9 Trustees assigned the requested study to the Council on Medical Service.

10
11 This report describes the increasing use of RBMs; reviews the prevalence of RBM interference;
12 identifies claims denial management practices; outlines related AMA advocacy and policy;
13 discusses alternatives to RBMs; and presents a series of recommendations.

14 15 USE OF RADIOLOGY BENEFITS MANAGERS (RBMs)

16
17 There has been a growing concern with increasing utilization and costs of imaging services in
18 recent years. Although Medicare growth in imaging spending has subsequently declined, the
19 Government Accountability Office (GAO) found in a 2008 report that, from 2000 to 2006,
20 Medicare spending for physician imaging services doubled from \$7 billion to \$14 billion. An
21 increasingly common strategy used by private health insurance companies to control imaging
22 growth is the use of radiology benefits managers (RBMs). While Medicare has historically used
23 retrospective payment safeguards, such as identifying medical claims that do not meet certain
24 billing criteria, there has been recent focus on having Medicare follow the private health insurers'
25 trend of controlling utilization and costs using RBMs and other prospective strategies.

26
27 The June 2008 GAO report recommended that the Centers for Medicare and Medicaid Services
28 (CMS) examine the feasibility of expanding its payment safeguard mechanisms by adding more
29 prospective approaches, such as prior authorization, which is often used by RBMs. President
30 Obama's proposed 2010 budget includes the use of RBMs to control payments for Medicare
31 imaging services, which would result in an estimated ten-year savings of \$260 million.

32
33 Some of the nation's largest insurers contract with RBMs in the provision of imaging services to
34 patients. The three largest RBMs are CareCore National; American Imaging Management, a
35 WellPoint subsidiary; and National Imaging Associates, a unit of Magellan Health Services.
36 According to Robert LaGalia, president of National Imaging Associates, quoted in a November
37 2008 *Wall Street Journal* article, approximately 90 million consumers, or more than half of all

1 Americans with private insurance, are now covered by RBMs. With such numbers, it appears that
2 RBMs have become a central part of the imaging benefits for many health plans. Efforts are
3 needed to address the policies of RBMs that may restrict appropriate access to care for patients and
4 appropriate payment for physicians.

5
6 The main concerns physicians report with the use of RBMs are denial or delays of payment for
7 medically warranted imaging studies; lack of proper administrative cost assessments; inconsistent
8 rules and practices; lack of clinical guideline transparency; interference in the patient-physician
9 relationship; acceptance of tests or studies contingent upon referral to other physicians or practice
10 groups; and forced test substitution, a concern expressed in Resolution 231 (A-09).

11 12 PREVALENCE OF RBM INTERFERENCE

13
14 While RBMs exist to intervene with physician decision-making, detailed rates of denials and test
15 substitutions do not appear to be tracked by any independent source. Anecdotal reports have been
16 published in the press and professional journals. A November 2008 *Wall Street Journal* article
17 reported that the three largest RBMs stated that they approve 70% or more of requests for imaging
18 tests, which is generally consistent with reported denial rates ranging between 15% to 30%. For
19 example, Gregg Allen, MD, the chief medical officer of MedSolutions, an RBM that provides
20 services for CIGNA Corp., Aetna Inc., and several other health plans, stated that the company
21 approves 80% to 85% of imaging requests. Dr. Allen reported that half of the approvals are
22 immediate, and the rest are approved within 24 hours. The remaining 15% to 20% typically are
23 questioned for appropriateness, or are withdrawn or denied.

24
25 The Radiology Business Management Association (RBMA) conducted a January 2009 survey of
26 radiology practices in order to assess the impact of RBMs on radiology practices, specifically
27 looking at revenue, cost, and network inclusion or exclusion. Almost two-thirds of the respondents
28 reported that they have RBMs in their markets. Ten percent of denials were reportedly related to
29 RBM preauthorization. In addition, the survey found that 87% of responding practices stated that
30 the use of RBMs caused their administrative costs to increase. While this survey sheds some light
31 on the details of this issue, the small sample size does not allow for a comprehensive picture, which
32 limits widespread application. The American College of Radiology (ACR) and the RBMA have
33 recommended that an independent study be conducted on the magnitude of the cost burden of
34 imaging utilization strategies on ordering physician offices and imaging providers.

35 36 CLAIMS DENIAL MANAGEMENT

37
38 With the increased use of RBMs, payment for imaging services has become increasingly
39 challenging. Practices need to take proactive measures to prevent internal billing errors and
40 increase the acceptance rate of submitted claims. The following examples highlight two strategies
41 that radiology groups have found helpful.

42
43 The Radiology Group of Abington (RGA) in Abington, Pennsylvania has identified strategies to
44 ensure the highest percentage of accepted Medicare radiology claims, which has increased revenue
45 and assured that patients receive needed tests. Since contracting with an outside billing company
46 to handle claims submissions, RGA has considerably reduced its magnetic resonance imaging
47 (MRI) and computed tomography (CT) denial rates for Medicare claims. RGA's Medicare denial
48 rates decreased for outpatient MRI from 8.9% to 1.3%, for inpatient MRI from 7.3% to 2.5%, for
49 emergency department CT from 4.8% to 1.1%, and for inpatient CT from 7.3% to 2.3%. The key
50 strategies that achieved these reductions in denials were correct coding of claims, accurate
51 documentation, detailed report dictation, and ensuring that diagnostic data were consistent between

1 a hospital's information system and the radiology group's information system. In addition, RGA
 2 makes sure to follow payer requirements for claims submissions, such as the preferred format of
 3 submission, and when and how to use modifiers.

4
 5 St. Paul Radiology is the largest private-practice radiology group in the United States, with 96
 6 radiologists providing diagnostic imaging and interventional radiology services at six imaging
 7 centers and eleven hospitals in Minnesota, North Dakota and Wisconsin. Using improved
 8 strategies for coding and claims submission, St. Paul Radiology has reduced its denial rate for
 9 Medicare claims from 35% to below 1%. The practice credits the use of ClaimStaker, a claims
 10 editing application, from Alpha II for its improved claims acceptance. This type of software
 11 product edits claim files for validity prior to submission and gives the practice's coders additional
 12 information on issues like proper modifiers and code pairing, which assists the practice in
 13 successful claim submissions.

14
 15 **AMA ADVOCACY AND POLICY**

16
 17 Physicians are encouraged to notify the AMA of instances of inappropriate interventions by health
 18 insurance plans and RBMs (Policy H-320.947, AMA Policy Database), because the AMA works
 19 with specialty societies to correct payer and RBM policies that unfairly exclude qualified
 20 physicians from providing imaging services (Policy H-410.995[4]). The AMA opposes attempts to
 21 restrict reimbursement for imaging procedures based on physician specialty, and continues to
 22 support the reimbursement for imaging procedures being performed and interpreted by physicians
 23 based on the proper indications for the procedure and the qualifications and training of the imaging
 24 specialists in that specific imaging technique regardless of their medical specialty
 25 (Policy D-385.974).

26
 27 The AMA has been working with the American Academy of Neurology (AAN) and the American
 28 Society of Neuroimaging (ASN) since 2008 to address the wholesale exclusion of neurologists
 29 from providing imaging services by one of the largest RBMs, CareCore. Following long-term
 30 discussions with the AAN and ASN regarding CareCore's policies, the groups collaborated with
 31 the AMA on a March 2009 letter to the RBM. The letter expressed concern that CareCore's policy
 32 regarding neurologists has the potential to arbitrarily prevent qualified physicians from providing
 33 important imaging services. In addition, the letter requested a dialogue with CareCore to discuss
 34 alternative ways to ensure that only trained and qualified physicians provide imaging services. As
 35 a result, the AMA facilitated a joint conference call in August 2009 with the AAN, ASN, and
 36 CareCore to further discuss CareCore's privileging policies for neurologists. The AMA plans to
 37 continue discussions with CareCore, other RBMs, and affected specialty societies in an effort to
 38 ensure increased quality, efficiency and fairness in the provision of imaging services.

39
 40 The AMA encourages collaborative specialty development and review of any appropriateness
 41 criteria, practice guidelines, technical standards, and accreditation programs, particularly as
 42 Congress, federal agencies and third party payers consider their use as a condition of payment, and
 43 to use the AMA Code of Ethics as the guiding code of ethics in the development of such policy
 44 (Policy D-385.974).

45
 46 Board of Trustees Report 8-A-09 was the first in a series of annual reports detailing the actions the
 47 AMA is taking to oppose efforts by payers, RBMs, and others to deny patients' access to
 48 appropriate, high quality imaging services provided by qualified physicians regardless of their
 49 medical specialty. Recommendations from Board Report 8-A-09 ensure that the AMA will
 50 monitor a two-year Medicare "Appropriate Use of Imaging Services" demonstration project,
 51 scheduled to begin in 2010, and work with CMS to develop appropriateness (and exceptions)

1 criteria if it decides to move forward with a permanent program. In addition, the AMA encourages
2 Congress and the Administration to allow the Medicare Improvement for Patients and Providers
3 Act (MIPPA) mandated Medicare accreditation program to be fully implemented and evaluated
4 before further changes to Medicare's imaging standards and payments are made. The AMA will
5 work with CMS to ensure that fair Medicare accreditation standards for advanced imaging services
6 are adopted by the selected accrediting organizations. (Policy D-410.995[1-3])
7

8 The AMA opposes efforts to preauthorize, precertify or otherwise restrict the application of
9 advanced imaging services when such services are provided by qualified physicians in accordance
10 with appropriateness guidelines, practice guidelines and technical standards for the imaging
11 modalities utilized, as developed by specialty societies involved with the diagnosis and treatment
12 of such patients (Policy H-410.956). The AMA also opposes efforts to impose policies designed to
13 control utilization and costs of medical services unless those policies can be proven to achieve cost
14 savings and improve quality while not curtailing appropriate growth and without compromising
15 patient access or quality of care. In addition, the AMA condemns efforts to require patients to
16 receive imaging services at imaging centers that are mandated to require specific medical specialty
17 supervision and supports patients receiving imaging services at facilities where appropriately
18 trained medical specialists can perform and interpret imaging services regardless of medical
19 specialty (Policy D-385.974).
20

21 PERFORMANCE MEASURES

22

23 The AMA-convened Physician Consortium for Performance Improvement® (PCPI) is committed to
24 enhancing the quality of care and patient safety by taking the lead in the development, testing, and
25 maintenance of evidence-based clinical performance measures and measurement resources for
26 physicians. The following eight PCPI performance measures have been developed for radiology
27 through collaboration by ACR and the National Committee for Quality Assurance (NCQA):
28

- 29 • Stenosis measurement in carotid imaging reports
- 30 • Mammography assessment category data collection
- 31 • Inappropriate use of "probably benign" assessment category in mammography screening
- 32 • Communication of suspicious findings from the diagnostic mammogram to the practice
33 managing ongoing care
- 34 • Communication of suspicious findings from the diagnostic mammogram to the patient
- 35 • Reminder system for mammograms
- 36 • CT radiation dose reduction
- 37 • Exposure time reported for procedures using fluoroscopy
38

39 These measures have been designed for radiologists and other physicians directing or performing
40 the selected imaging examinations (i.e., carotid imaging studies, screening and diagnostic
41 mammograms, CT examinations, procedures which use fluoroscopy). The intended use is for
42 individual physician quality improvement and for calculating reporting or performance
43 measurement at the individual physician level.
44

45 ALTERNATIVES TO RBMs

46

47 The ACR has developed Appropriateness Criteria®, which contains evidence-based guidelines
48 intended to assist referring physicians, radiologists and other providers in making initial decisions
49 about diagnostic imaging and therapeutic techniques. Currently, the guidelines include 159 topics
50 with more than 800 variants. The ACR advocates that this systematic process of criteria

1 development will provide credible guidelines for radiology decision-making based on scientific
 2 analysis and broad-based consensus techniques.

3
 4 A 2008 study by researchers from the University of Florida Health Center and Massachusetts
 5 General Hospital found significant benefits in controlling high cost imaging growth rates with the
 6 implementation of a computerized radiology order entry and decision support system. Physicians
 7 were provided with an appropriateness score ranging from one to nine for their diagnostic
 8 recommendation after clinical indications for the patient had been provided. Appropriateness
 9 scores were based on the existing ACR Appropriateness Criteria®. Statistical analysis showed
 10 significant benefit in controlling high cost imaging growth rates with this implementation. The
 11 most noticeable procedural decreases were in annual outpatient CT growth, from 12% to 1%,
 12 followed by MRI from 12% to 7%, and ultrasonography (US) from 9% to 4%. This system is now
 13 used throughout the Partners HealthCare integrated healthcare system, which along with
 14 Massachusetts General Hospital, includes Brigham and Women's Hospital in Boston. Reportedly,
 15 all major health insurance companies in Massachusetts accept this system and allow users to
 16 bypass the RBM preauthorization process.

17
 18 The American College of Cardiology Foundation (ACCF) issues a series of clinical documents that
 19 include guidelines, performance measures and appropriate use criteria to ensure that cardiovascular
 20 professionals provide evidence-based, high quality care. The ACCF, the American Society of
 21 Nuclear Cardiology, and United Healthcare (UHC) collaborated on a pilot study to determine if
 22 ACCF appropriateness criteria for single-photon emission computed tomography myocardial
 23 perfusion imaging (SPECT-MPI) could be used as an alternative to UHC's Radiology Notification
 24 Program. The study focused on SPECT-MPI usage at six sites of varying sizes and locations
 25 nationwide. A total of 6,351 patients were involved in the study and a computer-based algorithm
 26 determined test appropriateness using ACCF appropriate use criteria. The results, presented in July
 27 2009, indicate that 66% of SPECT-MPI tests were performed for appropriate indications, 13.4%
 28 for inappropriate indications, and 13.9% were of uncertain appropriateness. The lead investigator
 29 stated that once the practices became aware of their utilization pattern, the physicians were quickly
 30 able to correct any inappropriate use. As a result, the system is being refined and plans are in place
 31 for widespread implementation.

32
 33 **DISCUSSION**

34
 35 RBMs frequently interfere with patient care, place an unnecessary burden on physicians, and
 36 compromise patient health by substituting tests or denying approval for tests. While RBMs are
 37 commonly being used by private health insurance companies, and are being considered for use by
 38 Medicare, mechanisms exist that provide better alternatives for private payers and Medicare to
 39 monitor and control imaging utilization.

40
 41 Best practice guidelines for RBM Programs have been developed through a joint effort of the ACR
 42 and the RBMA. The guidelines are intended to provide guidance to payers, managed care
 43 organizations, RBMs and radiology providers on best practices to consider when implementing a
 44 radiology benefits management program. The guidelines apply to many provider-payer
 45 relationships and can serve as a benchmark for RBM performance. Acknowledging the widespread
 46 use of RBMs to control imaging, the Council strongly believes that RBMs should adhere to
 47 uniform physician-developed best practice guidelines to ensure that that the RBMs do not interfere
 48 with physician decisions and infringe on the patient-physician relationship.

49
 50 Several specialty societies are taking steps to ensure that only medically necessary imaging
 51 procedures are performed and that any inappropriate utilization is eliminated through widespread

1 use of appropriate use criteria. As some health insurance companies seek alternatives to costly and
2 time consuming RBMs, appropriate use criteria is an available option, with successful results and
3 increasing credibility. Supporting the use of appropriate use criteria developed by medical
4 societies and physicians with expertise in the specialty relevant to the condition of the patient as an
5 alternative to RBMs is consistent with AMA policy. Properly designed and non-punitive programs
6 that rely on appropriate use criteria could provide a less intrusive and more patient-centered
7 alternative to RBMs.

8
9 Given the lack of comprehensive data from a neutral source on the impact of RBMs on physician
10 practices, specifically denial and test substitution rates, the Council agrees with the ACR and
11 RBMA that an independent study is needed to determine the burden of imaging utilization
12 strategies on physicians and patients. The organizations recommend that the Center for Health
13 System Change or other comparable independent organization perform this study. In addition, the
14 Council believes that the AMA should advocate against the practice of forced test substitution and
15 denial of requested imaging services by RBMs contracted by third-party payers that meet
16 appropriate use criteria, and that RBMs should be held accountable for harm caused by substitution
17 or delay of requested studies.

18
19 Ensuring appropriate use of imaging requires widely accepted evidence-based performance metrics
20 in order to enable quality improvement and further accountability. The AMA-convened PCPI has
21 worked closely with the ACR to develop and adopt the use of evidence-based performance
22 measures, and the Council encourages their use. In late 2009 and in 2010, the PCPI will continue
23 to expand its portfolio of measures. Specifically, measures targeting appropriateness and overuse
24 of imaging services will be developed on areas including diagnostic imaging, sinusitis (including
25 sinus radiography) and back pain.

26 RECOMMENDATIONS

27
28
29 The Council on Medical Service recommends that the following be adopted and that the remainder
30 of the report be filed:

- 31
32 1. That our American Medical Association strongly encourage radiology benefits managers
33 (RBMs) to adhere to uniform physician-developed best practice guidelines. (New HOD
34 Policy)
- 35
36 2. That our AMA support the use of appropriate use criteria developed by physicians with
37 relevant expertise working in a collaborative process involving all national medical
38 specialty societies that provide and/or order the imaging service in question. (New HOD
39 Policy)
- 40
41 3. That our AMA support an independent study assessing the magnitude of the cost and
42 administrative burden of imaging utilization strategies on ordering physician offices,
43 imaging providers, and patients and the impact these strategies have on patient safety and
44 outcomes. (New HOD Policy)
- 45
46 4. That our AMA strongly encourage each radiology benefit manager (RBM) to publish and
47 distribute the specific diagnostic codes used by their firm to approve or disapprove specific
48 imaging procedures. This information should be distributed by the RBM via electronic or
49 paper means to each physician who is credentialed to participate on health plans that utilize
50 that particular RBM.

- 1 5. That our AMA oppose the practice of forced test substitution and arbitrary denial of
2 requested imaging services by RBMs contracted by third-party payers that meet
3 appropriate use criteria, and that RBMs be held accountable for harm caused by
4 substitution or delay of requested studies. (New HOD Policy)
5
- 6 6. That our AMA encourage the Physician Consortium for Performance Improvement[®] to
7 continue to develop patient-centered measures, including those that address the appropriate
8 use of imaging. (New HOD Policy)

Fiscal Note: Staff cost estimated to be less than \$500 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.