One eye on the image and the other on the wallet

Plans use guidelines, education to help providers determine when high-tech imaging is appropriate

by **Ken Krizner**

THERE IS NO question in anyone's mind that the increased use of high-tech diagnostic imaging has significantly improved the diagnosis and treatment of patients during the past decade.

These imaging services—such as positron emission tomography (PET) and single photon emission computed tomography (SPECT)—have, in many cases, offered physicians an alternative to invasive procedures such as surgery or biopsy. Imaging services that have been around for decades, such as computed tomography (CT) scanning and magnetic resonance imaging (MRI), also have undergone technological improvements.

"These tools can reduce unnecessary or risky procedures," says Bruce Niebylski, MD, senior associate medical director for the Health Alliance Plan (HAP) in Detroit. "That's a wonderful thing."

Such tests also have become more accessible thanks to an increase in the construction of freestanding radiology centers during the past decade.

Many physicians, especially those trained prior to 1990, lack the necessary skill sets to know when to order (and not to order) a high-tech diagnostic imaging service. As a result, physicians order these services when they are not appropriate, driving up the cost of healthcare.

"There are various estimates out there that say as many as one-third of the high-tech imaging services ordered are fairly discretionary, meaning they are nice to have, but they don't affect clinical management," says Keith Folkert, MD, medical director of health management for Minneapolis-based Blue Cross Blue Shield (BCBS) Minnesota.

Gregg P. Allen, MD, executive vice president and chief medical officer for MedSolutions, a Franklin, Tenn.-based company that provides radiology management products to health plans, says there is a "knowledge gap" among physicians about when to order what test at what point in a patient's workup. More training, he maintains, is needed.

FASTEST GROWING SEGMENT

This knowledge gap has produced an explosion in the amount that health plans pay for these services. For example, HAP, which has more than 500,000 members in Michigan and has 25 different networks of physicians, was paying $4 per-member per-month (2% of the healthcare premium) for radiology in 1999. Today, it is paying $15 per-member per-month (6% of the healthcare premium).

Highmark Inc., a Pittsburgh-based health plan, pays more than $600 million annually for outpatient imaging services. The company's payments increased by more than 20% annually in 2002, 2003 and 2004. Preliminary figures show a percentage increase around 15% for 2005, says Michael Weinstein, a spokesman for Highmark.

These cost increases are directly attributable to the growing utilization of high-tech imaging services.

"Earlier in [the] decade, pharmaceuticals was the leading area in which we were seeing tremendous cost growth," Weinstein says. "Imaging doesn't represent the highest proportion of every dollar of healthcare, but it is an area that represents one of the fastest-growing segments, especially in the outpatient side."

Recognizing that the costs of high-tech imaging services have to be brought under control, health plans have taken the lead by establishing clinical guidelines for their use—and making sure their providers know what those guidelines are. Some are teaming with radiology management companies to implement educational and prior authorization programs.

These programs are not being implemented solely to cut costs. Health plan executives say they are willing to spend

the money on high-tech imaging, they just want to make sure that the money is being spent appropriately.

"We want to be sure that the right studies are being done for the right patients," Dr. Niebylski says. "We don't want redundant care or wrong care."

Adam Ciesielski

EDUCATION IS IMPORTANT

Highmark, which has many senior citizens among its membership, is implementing a program with National Imaging Associates.

The program focused on reprivileging radiologists and other physicians that perform imaging services and are participants in Highmark's managed care network in western Pennsylvania (and privileging providers who want to join the network), using stringent quality and patient safety guidelines.

To receive Highmark reimbursement, all network providers who perform imaging services outside of the hospital must become privileged. A committee of independent physicians and healthcare professionals, who provide, perform or order an imaging service, review the guidelines. The privileging process began in July 2004.

In the second phase of the program, which began in April, providers ordering outpatient, non-emergency advanced imaging tests are being asked to provide notification when they order certain MRI, CT and PET studies. The focus is on selected services that are high cost, or at high risk for inappropriate use.

The policy is intended to help Highmark evaluate data to identify both appropriate and inappropriate patterns of ordering advanced imaging tests and for physician consultation purposes, Weinstein says.

"It's a challenge for the medical community to be up to speed from a continuing education point of view," he points out. "There is a responsibility by all stakeholders in the healthcare industry to work with the physician community to make sure the uses of technology are understood before the services are ordered."

HAP began recognizing the skyrocketing costs of radiology services about six years ago. "When we investigated as to why, we saw that more than 95% was because of high-tech imaging," Dr. Niebylski says.

HAP found various patterns when it began to review charts and examine ordering habits of its provider community.

"We realized that physicians were ordering these tests because they thought there was an appropriate reason, but they were never trained in that area," Dr. Niebylski says. "We thought what we needed were guidelines for when to use an MRI vs. CT vs. PET scan."

By 2001, HAP knew that the high-tech imaging costs needed to be addressed based on its own data. HAP contracted with American Imaging Management, which began prior authorization for high-tech imaging services and provided guidelines for physicians in May 2003.

HAP does not tell providers whether they can order a test, but offers references and recommendations on what they should do instead.

"We just didn't want to say 'no,' we wanted to make sure patients get the right tests and doctors learn why based on studies and evidence-based medicine," Dr. Niebylski says.

HAP saw immediate dividends in the examinations of headaches and back pain, where the health plan knew there was an inappropriate use of MRI studies, Dr. Niebylski says.

"The reason for doing an MRI for back pain is because you're planning to do surgery, or you're looking for cancer or an infection," he notes. "But the typical request coming in was somebody twisted his or her back, went to the doctor and the doctor ordered an MRI. The standard

of care dictates that patients without any evidence of trauma or possibility of cancer or infection, should get six weeks of conservative therapy."

After the guidelines were implemented, HAP saw an immediate 20% decrease in the monthly utilization of MRIs, from more than 500 to 400.

An educational component has helped HAP's providers recognize the appropriate time to order a high-tech imaging study.

"Since May 2003, the number of studies denied has dropped dramatically and that means the requests are more appropriate," Dr. Niebylski says. "Our providers have learned when to order such tests."

BCBS Minnesota is bringing evidence-based medicine to high-tech imaging.

"In other words, what do you need to make a diagnosis?" Dr. Folkert says. He says an example of how a physician might overuse a high-tech imaging service is by ordering an MRI test as part of a breast examination.

When a woman has a mammogram and her doctor finds something that looks suspicious, the doctor will likely order an ultrasound. If it still looks suspicious, the next step would be a biopsy.

Now, many times a doctor will order an MRI before the biopsy, Dr. Folkert says. But there isn't enough clinical evidence to show that an MRI can take the place of a biopsy.

"We know that MRI is not a perfect test for breast cancer," he says. "It only gives you a few more percentage points of certainty that there may be something malignant. So, when a biopsy is ordered anyway, you have just added another test to the process."

That's why guidelines are important, Dr. Folkert adds. "Virtually every health plan is looking at what we can do to insure that our providers are following guidelines," he says. "It's not an easy process because [the technology] is evolving so fast. The question is: How can we get the physician community to be more discretionary?"

Not only is the educational component for providers important in the quest to curb high-tech imaging costs, but so is a health plan's ability to recognize when a provider might need more guidance.

Fallon Community Health Plan, which covers about 172,000 members in central and eastern Massachusetts, was finding that many pediatric and family physicians in its network were ordering several tests to get to the one correct test, says Dan Concaugh, vice president of network development and management.

EXECUTIVE VIEW

- **Physicians might not have enough information to determine correct use of diagnostic imaging studies.**
- **Guidelines and prior authorization can help reduce unnecessary use.**
- **Guidelines should stem from evidence-based medicine.**

To stem that tide, Fallon partnered with MedSolutions to develop a voluntary program where physicians can find the right protocols for particular conditions and order the correct test.

A physician examining a teenager with a sprained knee can go MedSolutions' Web site or call and receive all pertinent information regarding a course of treatment.

The program has been so successful that Fallon has stopped requiring preauthorizations for all high-tech imaging studies except PET. Concaugh says he expects preauthorization for PET to be dropped in the future.

Fallon also will study the data compiled, and if it finds that some physicians are two or three standard deviations outside the norm for their peer group, it will approach that physician or the administration of the group and ask if there is a valid reason.

"We'll work to help them be more in line with their peer group," Concaugh says. "Ordering extra tests drives up everybody's costs and isn't good [patient] care."

Fallon also is piloting a pay-for-performance system for its providers. If an imaging service trend flattens out to a managed norm, the health plan will reward the provider for good practice.

COST ISSUE ISN'T GOING AWAY

One of the concerns for health plans as they face the high costs of high-tech diagnostic imaging studies is that there is only so much money in the system. If the cost of imaging continues to increase, something else will be shorted, such as hospital reimbursement or physician reimbursement, BCBS Minnesota's Dr. Folkert says. "The patient might have to foot more of the bill," he points out.

The issue is not going to go away anytime soon because nobody expects a slowdown in the advancement of the technology during the next decade.

"If we are paying a lot of money for the use of the technology, we have to show that the use is resulting in some savings downstream," Dr. Allen of MedSolutions says. "If physicians and those who manage these services can get clear about this, then the costs can be managed. If physicians only order these tests because they are available, then we won't be able to sustain the costs."

That means imaging is going to play a large role in cost-containment strategies because it will stand out as one of the items that is driving premium and employer costs higher.

"It is going to require continued appropriate management," Dr. Allen says. MHE

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