1. AUC Discussion (presented by American College of Radiology and American College of Cardiology)

The Appropriateness Use Criteria (AUC) program was mandated in the Protecting Access to Medicare Act (PAMA) of 2014. Under PAMA, beginning in 2017, Medicare payments to the providers performing/interpreting an advanced imaging scan (i.e., “rendering physician”) will only be made if physicians or other professionals ordering the imaging service first consulted with AUC. The policy provides clinical flexibility by requiring the ordering physician consultation with AUC, but not mandating strict adherence to the criteria (unlike RBMs). PAMA also provides that prior authorization will be applied to “outlier physicians” whose imaging ordering patterns indicate low adherence to CDS clinical guidelines, relative to their peers. A timeline of key dates is listed below.

- November 15, 2015, CMS must specify one or more AUC. CMS must select AUC that has been developed or endorsed by a national professional medical society or other provider-led entities, such as the American College of Radiology (ACR).
- April 1, 2016, CMS must publish a list of qualified Clinical Decision Support (CDS) mechanisms that ordering professional may use to consult with the applicable AUC. The CDS mechanisms may be modules in EHRs, private sector mechanisms available from medical specialty organizations, or mechanisms established by the Secretary.
- January 1, 2017, Medicare will no longer pay claims for technical/professional component reimbursement to rendering providers for advanced imaging services in the FFS, HOPPS, and ASC PPS, unless the ordering physician has consulted with AUC before making the order.
- January 1, 2020, ordering professional that CMS has identified as “outliers” with low rates of AUC adherence relative to their peers, based on the previous two years of data, will be required to obtain prior-authorization from CMS before advanced imaging orders can be furnished (no more than 5%).

ACR wanted to come up with a policy to get ahead of the issue of over utilization as well as address issues such as pay cuts, prior authorization, etc.; the end result was appropriate use. The ACR and ACC have made recommendations on design/implementation of AUC to CMS. By November CMS will designate what it considers appropriate use (likely to have idea this summer) and the appropriate vehicle (CDS support tools). To that end, the ACR has created a web based portal, known as ACR Select, to help all providers easily utilize AUC. ACR Select is the web service version of the ACR Appropriateness Criteria. The idea is that the ACR Select platform can be integrated with computerized ordering and EHR systems to providers can consume ACR AC guidelines.

General comments made by participants, included: concerns regarding implementation; whether CMS consults specialty societies in choosing the standard AUC or consults RBM companies (which arguably is against the intent of the statute); data used by CMS (may be partially alleviated if the data used by CMS is allowed to be distributed to the physicians/societies and if potential outliers are warned before prior
authorization is required); and the tendency for these initiatives to quickly rid the data of any true outliers given that the implementation of the initiative and identification of “outliers” is likely to continue long after any true outliers have disappeared from the dataset.

Click here to view the background materials.

3. Pre-authorization Discussion (presented by Oncology and Ophthalmology)

Because AUC has been seen as a potential alternative to prior-authorization, current prior-authorization requirements and potential expansion were also discussed. Of particular note, providers in Oncology and Ophthalmology are experiencing prior authorization issues with private payers and Medicare Advantage (MA) plans (e.g., 6 hour wait times for medication and treatments, etc.). Further, possible implications for ENT physicians were mentioned. It has been suggested that prior authorization may be required for any procedure with an improper payment rate higher than 20% as recorded in the CMS Comprehensive Error Rate Testing (CERT) report. If so, several key procedures for otolaryngology, including esophagus procedures, may fall in that category. Because this likely will greatly impact Ophthalmology, other societies were asked by it to provide support against prior authorization.

In addition, discussion noted the implementation pattern taken by the CMS for different prior authorization initiatives. The first initiative was prior authorization for power mobility equipment and started as a pilot in seven states that was then expanded to twelve states. Unfortunately, the methodology used does not take into regional patient population differences and is an administrative burden that is used across the board instead of targeting outlier physicians. Partially because Congressional Budget Office scores prior authorization as a savings, this first pilot was deemed a success and CMS has moved onto two new initiatives.

It was noted by participants that because prior authorization appears to be the alternative to AUC, it would appear that the requirement to consult an AUC may be the better choice especially given that the statute only requires prior authorization for outliers. The general consensus was that a proactive approach would be best in order to address the potential implications of this statute.

3. Next Steps

a) Sign-on letter to be drafted by the ACR and then circulated by the AMA
b) Follow-up meeting with the possible creation of a task force