Good health policy: The marriage of reimbursement and professional societies' appropriate use criteria

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In this issue of the *Journal of Nuclear Cardiology*, Wolinsky et al present the updated ASNC Model Coverage Policy for SPECT myocardial perfusion imaging. The innovative formatting of this manuscript highlights contemporary insightful thinking in the delivery of medical testing and will be an outstanding aid to practitioners in their local discussions with third party payers and Medicare Carrier Advisory Committees.

Unto themselves, model coverage policies generated by medical professional societies are common. Representing national clinical expertise, they create vehicles to help standardize the delivery of care by answering the ''medically reasonable and necessary'' question (the bar by which Medicare measures reimbursement for procedures). In the past, these documents have provided ways to link CPT codes with a list of ICD-9 indication codes (as seen in the old ASNC Model Coverage Policy of 2005). However, as coverage by insurers has become based on local standards and prior authorization reviews performed by contracted radiology benefits managers (RBMs); national documents have been helpful in focusing local discussions related to coverage and reimbursement of medical services.

Yet, it is clear that these are not the simpler times of years past. The current cost containment pressures on a fee for service healthcare system means that two parameters will always be under incredible scrutiny: the cost per service, or relative value units (RVU) assigned to a service, and the ''allowable'' or ''acceptable'' volume of that service. This shift in reimbursement philosophy has spawned at least 5 radiology benefit managers, each with their own proprietary non-transparent authorization criteria and extremely burdensome approval processes required to ''preauthorize'' the use of diagnostic imaging studies. Further, this shift prompted the Centers for Medicare & Medicaid Services (CMS) to explore a demonstration project to assess tools for managing Medicare radiologic benefits, specifically to assess physician adherence to appropriate use criteria when ordering certain imaging services. CMS has and awarded several pilot projects as part of this demonstration.[1] Some of this activity has been fueled by reports that not all diagnostic testing may meet the ''medically reasonable and necessary'' bar nor adhere to evidence-based appropriate use criteria.[2]

In this environment, it is vital that clinicians act as patient advocates for access to high quality and medically necessary care and that the physician community speak with clear, loud, and credible voices. To do so, society-driven model coverage policies must be evidence-based. They must reference a clear, broad body of accepted literature that highlights improved clinical outcomes which are economically reasonable in light of downstream resource use. Moreover, they must link this literature into more easily digested patient clinical scenarios or vignettes of use. These vignettes must represent expert consensus on appropriate and inappropriate use of procedural techniques. ASNC and the American College of Cardiology (ACC) can be ''appropriately'' proud of their pioneering work on this latter concept.[3] Additionally, achieving ''appropriateness'' should include a commitment to performance improvement initiatives including continual updates to guidelines and criteria to add what is supported by new evidence and to eliminate complexity or incorrect earlier conclusions.[4] Once the literature and resulting AUC categories have been defined, ICD-9 codes simply become additional justification for providing the service. The more rigorous this process, the stronger the evidence-based arguments, and the more easily the reimbursement for services will align with the definition

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of providing a medically necessary and appropriate service. It is critical in the current environment that medical necessity and appropriateness be defined by active clinicians who understand the importance of the physician-patient relationship and high quality patient care rather than basing these decisions on detached administrative criteria.

The innovative layout of this updated model coverage policy creates clear crosswalks between evidence-based publications, updated appropriate use criteria indications, and ICD-9 codes in a clear, concise manner aimed at streamlining reimbursement by payers. The logical construct points to the three critical aspects of coronary management through the use of myocardial perfusion imaging: diagnosis, prognosis, and response to therapy. This manuscript reiterates ASNC's commitment to appropriate, high quality care for patients.

Two important points are made in the ''Policy Disclaimers'' section. First, patient management in this nation remains driven by the physician-patient relationship and individual physician judgment based on the individual patient's circumstances. As such, one can envision occasional circumstances when an ''inappropriate'' classed study may be appropriate based on the physician's expert clinical judgment and in such cases, the clinician should be allowed the opportunity to justify the use of the imaging study. Second, in the appropriate use criteria categories labeled as ''uncertain'' where there is mixed clinical opinion, the patient and clinician decision should be accepted until new evidence-based data demonstrates the study should otherwise be labeled as clearly inappropriate.

The authors of the new model coverage policy should be thanked for their hard work in creating a credible and well-presented document based on sound literary evidence and evidence-based appropriate use criteria. It is now up to the membership to make it a living, breathing document and to incorporate these practices into their patient care and their patient advocacy discussions with local payers.

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