Imaging Services Steerage Programs

Introduction

The payer community's need for medical cost containment has been recognized for more than twenty years. Payers have frequently implemented programs to control the utilization and the cost of high technology imaging modalities, primarily magnetic resonance, computed tomography, nuclear medicine and nuclear cardiology studies, performed in the hospital outpatient, physician office and free-standing imaging center settings. These utilization management programs, whether internally managed or outsourced to a Radiology Benefit Management company (RBM), typically use some combination of medical need determination and pre-authorization or pre-notifications strategies. Once the imaging study is authorized, Imaging Services Steerage Programs (ISSP) attempt to direct the patient to "preferred imaging providers."

The purpose of this paper is to define and discuss the current use of ISSP in the United States. Aspects of ISSP affecting patients, payers, and providers are analyzed. The concepts of an "Imaging Patient Bill of Rights" and a "Steerage Bill of Rights" are introduced to outline reasonable ISSP patient expectations in the marketplace.

Background

It is well documented that the price of similar imaging services can vary widely in many communities; hospitals usually are the higher cost providers while physician offices and free-standing imaging centers tend to have lower prices. When payers try to directly influence the patient's or treating physician's choice of imaging providers, this strategy is generally referred to as "steerage." Imaging steerage programs try to influence the treating physician or patient's choice of imaging providers with a goal of lowering service costs. Quality equivalence is claimed but quality improvement is not a goal of these programs. ISSP take many forms but can be broadly classified as either active or passive. Active steerage occurs when the patient or physician is contacted to direct approved service requests to a payer preferred provider. A few programs provide immediate incentive rewards such as gift cards or cash for choosing certain providers. Passive steerage typically consists of payer provided information on facility costs and other data. The patient or treating physician can consult this database and voluntarily choose a provider as they see fit. Variable co-payment levels are designed to incentive these choices.

Patient "consumerism" is another factor behind steerage. Before the widespread adoption of high-deductible and high co-payment health plans, most patients had little incentive to compare prices. Now, because of the increase in high-deductible health plans, more Americans are checking prices in their medical decision-making.[1] Historically, competitive medical pricing information and quality data were very difficult to obtain. This lack of access to relevant information helped mask the variation in service pricing. Increasingly, insurers and Employee Retirement Income Security Act **(**ERISA**)** private health plans are providing such information, as are some independent websites and referral services.

The Patient Protection and Affordable Care Act (PPACA) has already triggered substantial insurance price increases in the private coverage market, making health insurance less affordable for individuals and businesses alike. Health care has become more expensive and harder to afford. According to its May Health Tracking Poll, the Kaiser Family Foundation found that nearly one-quarter of Americans had trouble paying medical bills and another 25 percent skipped a recommended medical treatment or test for financial reasons.[2] There are now websites with quality, booking and price informationabout radiology facilities, similar to those , common in the hospitality industry (e.g., hotels, restaurants). One such website (www.bidonhealth.com) provides price information and allows a patient to schedule an exam online. The facilities offered through BidOnHealth.com are American College of Radiology (ACR) accredited and the radiologists are board-certified.

As long as basic quality standards are met, many ISSP treat imaging as an undifferentiated commodity and use pricing alone as the provider discrimination criterion. Other important value information including the age and performance level of the imaging equipment, subspecialty training of the radiologists, integration of the imaging provider into the physician care network serving that patient, practical access to pertinent patient clinical information (including prior imaging studies and the longitudinal imaging record), and individual patient needs are often not presented. Substantial investments in network development and provider integration, patient care management and safety, and physician communication and consultation are frequently ignored. Many ISSP redirect imaging provider appointments after the patient leaves the referring physician's office, without the knowledge or input of that responsible physician. In many cases, the economic interests or motivation of the benefit management company are not transparently disclosed to the patient who is being contacted. Referring physicians are often not provided with an opportunity to review the information given to the patient to ensure accuracy, and the caller scripts used by the companies to call patients are also undisclosed. Many patients have difficulty making fully informed decisions in these situations.

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[1] http://www.npr.org/blogs/health/2012/05/31/154082530/more-americans-are-checking-prices-before-getting-health-care

[2] http://www.kff.org/healthpollreport/CurrentEdition/security/upload/8322.pdf

The traditional way that radiologists "earn" patient referrals is by offering clinical expertise and convenient service to patients and referring physicians. Over a number of years, communication between the referring physicians and the radiologists becomes refined so that both physicians know each other's needs and understand the standard order and report language, resulting in optimized patient care. Steerage devalues these time-honored relationships.

The ACR and Radiology Business Management Association (RBMA) have no data on overall patient perceptions and satisfaction with either active or passive steerage programs. We assume that patients who save out of pocket expenses while receiving good service from their imaging provider are generally pleased. Regardless of steerage, if patient service is deemed to be poor, if the imaging facility is deemed substandard, or the quality of the diagnosis is presumed to be reduced, patients will be less satisfied. The use of gift cards or rebate payments to encourage patients to change imaging providers has occurred in some markets, particularly where direct patient savings do not occur related to imaging site of service. All of these incentive situations create the risk that patients make vital medical decisions on the basis of non-medical incentives rather that what may be medically best for that patient. As indicated below, those incentives also present a legal risk under the federal anti-kickback statute because they could represent improper inducements to patients to undergo imaging care for which a federal health care program might pay.

Physician self–referral often involves a form of active patient steerage to their personally owned imaging services. Patients are usually not informed of other available facilities, and are often discouraged from using other facilities in their communities. Quality ranges from excellent to very poor at these sites. Insurers are typically reluctant to confront this situation because they need these doctors in their physician networks. Self-referral steerage is not a topic of this paper.

Scope

Prevalence

In an informal survey conducted by the RBMA in September 2012, 65 percent of the respondents indicated that they were experiencing active steerage by RBMs, commercial insurers, or both. Active steerage is occurring in many states. Passive steerage, on the other hand, is less prevalent or more difficult to discover, with approximately 47 percent of respondents indicating that they were seeing it.

Patient Health Coverage

The patient's health plan has a role in steerage. Of those practices that knew the characteristics of their actively steered patients, 62 percent reported they had high deductibles and 55 percent had high co-payments. Thirty percent of actively steered patients had health savings accounts; a similar percentage was offered some financial incentive to change imaging providers. Patients who were more likely to be passively steered had high deductibles (91 percent), high co-payments (65 percent), and health savings accounts (48 percent).

Impact

Operating Burden

Active steerage occurs during (40 percent) or after (52 percent) pre-authorization according to the RBMA's survey. This translates into time wasted by the initial imaging provider in the pre-authorization process, patient scheduling, and a loss of productivity/vacant appointment slots when the patient is redirected elsewhere. Additional administrative time is expended resolving patient and referring physician questions and concerns. It follows then that approximately 56 percent of radiology practices that knew of the impact reported that active steerage has resulted in an increased operating burden (e.g., added complexity, higher costs). When asked about passive steerage, 60 percent of the responding radiology practices knowing its impact indicated that their operating burden had increased. Particularly costly is a failure to notify the initial imaging provider after the patient is redirected, resulting in an unfilled appointment and the associated loss of revenue to that provider.

Procedure Volume

Responding practices that were able to provide an impact also indicated that steerage (78 percent for active and 82 percent for passive) resulted in decreased procedure volumes. Approximately 14 percent of respondents indicated that active steerage increased their procedure volume, while 9 percent reported increased procedure volume from passive steerage.

Potential Legal Issues

Steerage programs raise numerous potential legal issues. Depending on circumstances, federal and state laws and regulations apply to payers, providers and patients. While little legal precedent exists for medical benefit management programs, broad areas of legal concern could include:

Medical Liability: In a case where a patient is actively steered to an imaging center, and a lung cancer is missed by the diagnostic imager, not only may the imager, the imager's corporation, and the imaging center be sued, but also there may be grounds for liability not only on the part of the RBM, but also on the part of the insurance company for which the RBM served as an agent. Charges could be made that since the RBM was chosen on the basis of price, examination quality was a secondary consideration to financial incentives.

Anti-kickback/Fraud and Abuse: The federal anti-kickback law prohibits one from offering, paying, soliciting or providing something of value in exchange for referring – or accepting referrals of – federally payable health care items or services. Patient steerage to a "more economical" practice that agrees to cut its prices in return for obtaining referrals might violate the anti-kickback statute. Any legal challenge would have to prove intent to offer, pay or accept remuneration. These concepts remain unresolved legal issues.

Breach of Contract: Would an RBM or payer ISSP violate a physician's contract with that entity? Could a radiologist, or other physician who interprets images, claim that the steerage breaches their contract with the payer to receive referrals? The excluded radiologist or diagnostic imager might assert that they should maintain equal "preferred provider" status in a payer's network in return for making certain concessions (e.g., fees). Some provider contracts have anti-steerage clauses; how would these actually be enforced?

Antitrust: Does steerage unlawfully restrain a radiologist's opportunity to practice their profession? While most physicians who bring antitrust cases lose them, there is a notable exception. In December 2010, a radiology group won a $34 million judgment against CareCore in New York federal court. The jury found that CareCore, in combination with New York-area radiologists and radiology practices that owned and/or governed CareCore, conspired to unreasonably restrain trade in the market for commercially insured outpatient radiology procedures. Illegal practices included CareCore steering patients to particular imaging providers.[3]

Defamation: A radiologist might claim that the RBM or payer libeled or slandered them by maligning their reputation – specifically by "demoting" the radiologist to a lower tier, or excluding them altogether from the provider network. This analysis of legal claims against managed care organizations notes the legal burden of proof that a plaintiff physician must meet in Pennsylvania, among other states.[4]

Discussion

Value

In their stated quest for "Value Based" Purchasing, payers typically use cost as the primary discriminator, with little or no consideration to other important factors. Focusing on price alone engenders the commoditization of Diagnostic Imaging. Provider expertise, continuity of care, patient safety and convenience, quality assurance programs, self-referral incentives, examination protocols, access of reports and images to patients, referring physicians and unaffiliated providers, as well as customer satisfaction are all important considerations in the choice of provider. These value factors are largely ignored when price is the primary factor used in the direction of patients to certain provider sites. In fact, a case can be made that these other factors are inversely related to the cost of providing an examination. Any credible determination of "value" must take these other factors into consideration. In deciding the value of health care, the best care and the lowest cost may not be the same choice.

[3] http://www.auntminnie.com/index.aspx?sec=sup&sub=imc&pag=dis&ItemID=93448

[4] http://www.crowell.com/documents/tiered_physician_networks_ahla_rinnpdf.pdf

Hospital-based radiologists are often adversely affected by ISSP because hospitals are typically high cost imaging providers in their community. These hospital-based radiologists may be inappropriately excluded by ISSP that use rankings based on price alone.

ACR accreditation is the most rigorous program for assuring the basic quality of an imaging provider facility. ACR accreditation was never intended or designed to be a hallmark of equivalency between providers. Many ISSPs use ACR accreditation as an equivalency metric. As previously discussed, many other operational aspects not measured by ACR accreditation are important parts of the complete value proposition for each patient.

Appropriate imaging is the foundation of value and has been the focus of the ACR, individual radiologists, and the RBMA for many years. Notable features that distinguish radiologists' care include radiology computer order entry, clinical decision support (CDS) software scores appropriateness or medical necessity for the requested examination on the basis of clinical information. CDS is a higher value tool than RBM programs because it can produce competitive utilization management results seamlessly, in all patient settings, and at a lower cost. CDS also supports a continuous quality improvement process not provided by the RBM business model. ACR Select is a currently available CDS tool to guide treating physician imaging requests at the time of the order entry. It is based on the ACR Appropriateness Criteria®, and is continuously updated.

There is an emerging awareness among patients, physicians and regulators of the importance of appropriate imaging, specifically in relation to radiation dose. Launched by the ACR and medical specialty societies, Image Gently® (www.imagegently.org) and Image Wisely® (www.imagewisely.org) are successful multi-organizational campaigns focused on as low as reasonably achievable (ALARA) techniques to reduce radiation doses for children and adults, respectively. A key quality metric is a practice's participation in the various ACR Registries, such as the Dose Index Registry, which allow for provider sites to measure and compare their CT doses, and to eventually reduce dose. Unfortunately, this type of physician and imaging provider site participation is often not recognized in the ISSP active decision to steer patients. Passive steerage programs have difficulty conveying this level of detail and its importance as patients make their individual decisions.

Referring Physicians

Steerage disrupts the relationship between the referring physician and the initially selected imaging provider. The treating physician's imaging site selection is typically determined by factors that include quality, service and their confidence in the interpretation of the requested study. Institutional affiliation and self-referral arrangements can also be major factors in provider selection. The referring physician's office incurs the cost of compliance with the required pre-authorization protocols. Steerage introduces additional administrative costs to forward appropriate medical information and to obtain out of network images as well as the study report.

Additional patient conversations may also be needed. This disrupts the integrated health care models which are designed to promote better quality, efficient processes, and hopefully, better patient outcomes.

Patients

Patients trust their treating physician's choice of imaging provider. ISSP for some patients causes confusion and anxiety. Patients assume the alternate facility has equivalent capabilities, access to their records, that their treating physician and health care system have access to their imaging findings, and that the provided steerage information is accurate. The RBMA survey indicated that inaccurate information and patient assumptions are occurring with ISSP. An ISSP should not cause an inappropriate delay in patient care. Some ISSP show little concern for patient travel times, appointment availability, waiting times for generating image CDs, and actual patient satisfaction with services data. Occasionally, unsatisfactory studies result in repeated examinations. If a second opinion is needed, the patient may incur additional costs.

Radiologist

The radiologist and imaging facility where the initial examination is scheduled is frequently not notified that the patient has been redirected to another facility. This results in increased costs particularly if the appointment slot given goes unused. Many ISSP are not providing a change of appointment notification. The radiologist and imaging facility where the patient is redirected frequently do not have easy access to prior imaging studies and a complete patient medical history. Obtaining this information may be difficult, increases their costs, and may not be accomplished. This can lead to sub-optimal interpretation, inappropriate follow-up recommendations, etc. In some cases, the referring physician needs to have a second interpretation done because of incomplete clinical information, lack of comparison studies, and other legitimate concerns. The radiologist providing a second opinion is often denied payment for their service to the steerage patient. These are appropriate medical services for that steerage patient. Professional component payment for the second opinion services is appropriate and should be paid when a request by the referring physician is made.

Macroeconomics

ISSP typically present a global savings economic value proposition which focuses on the differential cost savings related to their steerage (cost of site A – cost of site B x the number of imaging studies redirected = savings). These payment savings are real but overstated. The cost of the ISSP itself is usually undisclosed. The treating physician provider costs and information transfer costs are ignored. Costs related to patients' time and convenience are often disregarded. Professional component payments for second opinion interpretation are frequently denied even when active steerage is employed. It is interesting that ISSP do not actively redirect patients from lower quality to higher quality facilities except due to price. No quality outcomes data are collected to ensure that patients are not harmed. Patient satisfaction data may be collected as

part of the overall quality perception process. Imaging providers receive no quality improvement data related to site operations, imaging quality and protocols, or their interpretations. Integrated health care networks, which are costly to develop and operate, are typically ignored.

Payer/RBM patient imaging steerage strategies must be transparent, ethical and foremost beneficial to the patients

The ACR has developed a toolkit, called Imaging 3.0, that educates radiologists, patients and providers on the complete process and steps involved in the high value and high quality imaging services provided by radiologists. Greater patient engagement in their imaging care is a key component of Imaging 3.0. Our patients have the reasonable expectations that they are receiving the right imaging examination, properly performed, appropriately interpreted, and the results communicated in a timely fashion. Our patients also have a reasonable expectation that the information that they are given about imaging providers and the costs of their examinations are accurately presented to them.

ISSP arrangements must be fully disclosed to providers and patients alike. Providers have the right to verify the accuracy of the ISSP information given to patients. Identified inaccuracies should be promptly corrected. Caller scripts should be disclosed to providers. Additionally, steerage of patients to facilities meeting requisite quality measures, disruptions to the continuity of patient care – including disruptions to the physician-patient relationship and changing physician orders – must be avoided. When a patient is redirected, the responsible treating physician should be notified so that an appropriate patient discussion can occur if needed. The patient-physician relationship must be maintained in this way to facilitate proper care for the patient.

Not all ISSP arrangements are ethically acceptable. Direct cash, gift card or equivalent payments to a patient or a physician from a payer for choosing a particular imaging provider are inappropriate incentives in healthcare. Health plan or RBM employees should not be directly compensated based on patient steerage success unless they fully disclose this to the patient. Payments from a provider to the payer or their agent for an increased volume of referrals are unethical and potentially illegal. Misleading caller scripts and the intentional presentation of inaccurate information designed to steer a patient to a particular provider is an unacceptable business practice. Failure to promptly correct inaccurate information after appropriate notification is also a breach of ethical business practices.

Conclusion

The ACR and RBMA support accurate and complete dissemination of information to all patients. Less than fully transparent ISSP may lead to suboptimal patient care. ISSP that undermine the physician-patient relationship, ignore integrated health care processes, and/or ask patients to make decisions without access to complete information, are detrimental to providing the high

quality care patients both expect and deserve. A significant number of patients find appropriate assessment of ISSP information difficult, and therefore, will tend to use price alone in making their personal medical decisions. Appropriate ISSP should respect these less tangible values, recognizing that best patient care and lowest price are not always synonymous.

Appendix A

The Imaging Patient Bill of Rights

Our patients have the reasonable expectation of receiving the right imaging examination, properly and safely performed, appropriately interpreted, and the results communicated in a timely fashion. Their treating physician relationship should be fully maintained.

The value of the imaging service(s) provided is complex and includes appropriateness, quality, convenience and cost. Our patients have the reasonable expectation that the information provided to help them make that value determination is accurate, up-to-date, and unbiased.

Appendix B

Steerage Bill of Rights

- Transparency/disclosure – the process is disclosed to the patient and the referring physician is notified of the change in imaging provider contemporaneously
- The quality of the facilities must be accurately represented
- The quality of the exam shall be maintained
- The costs/savings must be accurately disclosed to the patient
- The process shall not cause a meaningful delay in diagnosis
- Continuity of care shall be maintained