

Imaging Utilization: The Radiology perspective

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Questions

- Does the experience of private payers mirror that of Medicare with respect to the utilization of and spending for imaging services
- What are the most effective methods to ensure more appropriate use and better quality of imaging services?
- How important is specialization in the performance and interpretation of medical imaging services. How can the health care system adapt to increasing subspecialization while maintaining appropriate access?
- How can Medicare be a prudent purchaser when medical technology, and imaging in particular, changes rapidly?

What is driving increasing utilization?

- **Positive**
 - Imaging replacing more invasive procedures
 - Expanded role of imaging, e.g acute stroke
 - More effective screening e.g breast cancer
 - Aging, more informed beneficiary population
- **Negative**
 - Incentives for inappropriate self referral
 - Knowledge gap
 - Duplicative studies
 - Additional tests
 - Defensive medicine
 - Patient demand

Decreased Unit Cost has not produced desired results

- DRA did not halt growth in imaging utilization and will not drive out inappropriate utilization
- Inappropriate utilization may in fact increase as non-radiologist providers generate more volume to meet their revenue goals
- Quality will inevitably decrease

How can utilization be managed most effectively?

- Removal of incentives for self referral
- Education and support of referring physicians
- Use of appropriateness guidelines
- Increased awareness of radiation risk
- Recognition of and payment for quality
- Medical liability reform

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How can utilization be managed most effectively?

- Radiology has taken a leadership role in:
 - Appropriateness guidelines
 - Accreditation
 - Physician education
 - Educating the public
 - Radiation dose reduction

ACR Appropriateness Criteria

Procedure List

Topic: Suspected Liver Metastases

Variant: Surveillance following treatment of primary tumor.

Procedure	Rating	RRL
CT abdomen with contrast	8	Med
MRI abdomen with contrast	7	None
FDG-PET whole body	6	High
MRI abdomen without contrast	4	None
CT abdomen without contrast	4	Med
NUC In-111 somatostatin receptor scintigraphy	4	High
US abdomen with or without Doppler	4	None
CT arterial portography liver	2	Med
CTA abdomen	2	Med

Appropriateness Criteria Scale

1 2 3 4 5 6 7 8 9

1=Least appropriate

9=Most appropriate

Real time decision support

- MGH real time decision supported order entry system
- Reduced “low utility” studies by 2/3 in Y1
- 20% of orders for “low utility” studies were cancelled
- Requires EMR
- Real time scheduling key to success
- Potential long term effect on quality



Accreditation / Quality Improvement



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Specialization versus Access

- Radiology training programs deliver excellence
- Younger and fellowship trained radiologists tend to specialize more
- Value of the onsite radiologist
- Accreditation programs measure training and expertise
- Challenge to support radiologists in small and rural practices

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Adapting to changing technology

- Understanding practice patterns
 - billing clarity and transparency
 - e.g. itemized billing of PC and TC
- CPT code development process
 - Collaborative efforts to develop robust evidence based proposals
 - Providers/CMS/Vendors
- RUC new technology review and 5 year review
 - Evaluates changing practices

How can utilization be managed most effectively?

- Unit cost reduction will encourage inappropriate utilization and drive down quality
- Beneficiaries deserve high quality and real time decisions on appropriate imaging
- Physician education is critical for long term benefits
- Continued efforts to weed out inadequate equipment and reduce radiation risk
- Imaging innovations are increasing quality of life for Medicare beneficiaries but must be used wisely