

Best Practices Guidelines on Radiology Benefits Management Programs

The principles described in this white paper apply to many provider-payor business and professional relationships. The development of this document is necessitated by business practices by some payors, radiology benefits management companies (RBMs), and providers that are arguably creating excessively restrictive and burdensome obstacles to the delivery of patient care. The purpose of this paper is to create a benchmark against which Radiology Benefits Management Programs (RBMPs) can be measured. This paper is not an endorsement of RBMs or their approach to the marketplace. The American College of Radiology (ACR) and the Radiology Business Management Association (RBMA) believe that alternative processes, including order entry decision support and referring physician education, can provide a similar or greater economic and quality impact without the administrative complexities and economic burdens created by many of the RBMPs in place today.

Background

These best practice guidelines for RBMPs were developed through a joint effort of the ACR Managed Care Committee and the RBMA Payor Relations Committee and are intended to provide guidance to payors, RBMs, and radiology providers on best practices to consider when implementing an RBMP.

Third-party payors often implement programs to control the utilization of high-tech imaging modalities (e.g., MRI, CT, PET, Nuclear Cardiology) in the outpatient hospital and freestanding imaging center setting. Currently, these are often managed by independent RBMs retained by payors. RBMs are contracted to determine the appropriateness of ordering high-tech imaging procedures based on the patients' clinical indications (signs, symptoms, or diagnoses). Some payors also implement their own internal RBMP, usually in the form of prior-authorization*. Prior-authorization of outpatient services prior to performance of the imaging study is often required for payment, and may involve selection of the imaging provider by the RBM.

Based on member feedback and a review of utilization management practices used by RBMs, payors, the ACR and RBMA make the following guideline recommendations that, if implemented, would help ensure a uniform process that would ease the administrative burden on payors, ordering physicians, and radiology providers alike. These guidelines could function as benchmarks for RBM performance.

Clinical Patient Care Guidelines:

- **The prior-authorization process should cover a "family" of codes and not a specific CPT[®] code**

For many imaging services, "families" of CPT[®] codes exist to describe similar services which are unique with respect to the complexity of the examination or the use of intravenous contrast. For example, the CT head "family" of codes would consist of CT

* For the purposes of these guidelines, the authors consider "prior-authorization", "pre-certification", and "pre-authorization" as analogous terms.

head without contrast (CPT[®] code 70450), CT head with contrast (CPT[®] code 70460), and CT head with and without contrast (CPT[®] code 70470). An ACR-RBMA list of families of CPT[®] codes is appended to this document. Most payors have the ability to require the RBM to structure a high-tech imaging prior-authorization program that utilizes the “family” of codes approach rather than the CPT[®] specific approach.

The CPT[®] specific prior-authorization program employed by some RBMs does not promote quality health care. It allows the imaging provider to only perform the exam exactly as ordered and prior-authorized, not to tailor the exam to the patient/clinical situation and best answer the diagnostic question. Radiologists are physicians trained to interpret imaging studies and to determine the most accurate study to efficiently answer the clinical question at hand in order to best serve their patients. A CPT[®] specific prior-authorization approach does not allow a radiologist, who may: a) have access to previous imaging studies, or b) have the opportunity to discuss issues personally with a patient and/or the patient’s referring physician, or c) visualize an emergent condition during the pendency of a study, to timely and efficaciously make these determinations and use his/her clinical judgment. Thus, through the use of a CPT[®] specific prior-authorization approach, the patient may not receive the most appropriate study based on their clinical condition. This commonly leads to repeat studies, delays while attempting to revise an order to permit a more appropriate study, and potentially unnecessary or repeated exposure to radiation and contrast. Frequently, the findings at the time of the initial study will indicate the need for additional view(s), processing, or contrast (e.g., iodinated, Gadolinium) in order to ensure that the best possible imaging information is obtained for the radiologist to interpret the study and answer the clinical question at hand. In some cases, although the radiologist may indicate and prescribe the less expensive test, payment will still be denied. The radiologist who is providing clinical supervision is the person most qualified in, and should not be prohibited from, making these determinations.

This type of program also increases referring and rendering provider administrative costs, as well as mandating that they incur the burden and risk of the procedure not being paid if they determine additional studies are medically appropriate and/or necessary. Further, add-on codes which supplement an approved base examination (e.g., ejection fraction evaluation at the time of nuclear cardiac imaging, CPT[®] code 78480) should not require additional prior-authorization. These should be included in the family of codes that are initially prior-authorized.

- **There should be a mechanism for approval of outpatient studies scheduled or needed after-hours or on the weekends when the RBM may be closed**

Outpatient hospitals and freestanding imaging centers are open during hours that service the imaging needs of their communities. Often, such centers are open both before and after standard office hours and during the weekend in order to accommodate the emergent needs and/or work schedules of their patient population. In order to facilitate the best imaging study for patients outside regular business hours, approval centers must be appropriately staffed to match hospital and freestanding imaging center hours of operation. Sending the patient to the hospital emergency department as an alternative to unavailable RBM prior-authorization adds unnecessary costs, inefficiencies and delays and, in fact, degrades the quality of care delivered to the patient.

- **All prior-authorization policies must conform to applicable state and federal law. All specialty-specific guidelines for utilization management (e.g., ACR Practice Guidelines and Technical Standards, ACR Appropriateness Criteria®) and clinical literature should be available to the public**

The utilization management process should be transparent and evidence-based. The policies and procedures used in utilization management need to be available to the medical community and the public at large. They should be evidence-based (peer-review literature, specialty guidelines, and appropriateness criteria) so that they follow best medical practice. They also need to conform to state and federal law, where applicable.

- **RBMs should apply medical criteria for prior-authorization decisions consistently across similar clinical situations**

Physicians, their patients, and their practice personnel should expect consistent interpretation and application of prior-authorization criteria across geographic boundaries and authorizing entities in accordance with state law. Predictability in the prior-authorization process will promote compliance, help mitigate burdensome administrative cost and promote the delivery of a uniform higher quality of patient care. Conversely, inconsistent standards lead to uneven patient care, frustration on the part of physicians, their staff, and patients, and unnecessary administrative cost.

- **Individuals with a clinical background (physicians or nurses) with detailed and extensive training on imaging modalities should be the ones making the decisions at RBMs**

Efficient and timely prior-authorization requires that those making such decisions have a medical background and a demonstrated ability to use this background and experience in a patient care environment. Specially trained nurses can perform some review functions. Physicians possess the requisite clinical knowledge and are trained to apply this in the care of their patients. In difficult cases, matched specialty physician review is appropriate.

- **RBMs should educate referring physicians about the clinical information that needs to be submitted in the prior-authorization request**

In order to minimize prior-authorization delays, promote timely patient access to care, and avoid post-procedure denials, RBMs should instruct referring physicians as to the type and amount of clinical information that should be provided in a prior-authorization request. As previously mentioned, referring physicians and their practice personnel should expect consistency as to the type and amount of clinical information that should be provided across geographic boundaries and authorizing entities.

- **RBMs and payors should allow imaging providers to obtain prior-authorizations on behalf of referring physicians if the imaging provider elects to do so**

For a number of reasons, it is appropriate for imaging providers to be allowed to participate in the prior-authorization process. First, the knowledge and expertise of radiology providers in both the clinical and technological aspects of healthcare often aid the referring physician selecting the most appropriate study for patients based on the clinical knowledge that is shared between the providers. Second, the nuances of various RBMPs create barriers to efficiency for the referring physician offices which may be circumvented by the imaging providers' greater familiarity with each RBMP. Additionally, payments to imaging providers are contingent upon correct completion of the prior-authorization process and the referring physician offices sometimes complete

the process without regard to this contingency. While it is appropriate for imaging providers to be allowed to participate in the prior-authorization process, imaging providers that elect to forego participation in the prior-authorization process should not be forced by RBMs or payors to assume this responsibility. Furthermore, if the prior-authorization process required by the payor forbids imaging provider-obtained authorizations, that contract clause must be vigorously and consistently enforced to maintain market integrity. [See Appendix 1 for RBMA's Discussion Paper -- Prior-Authorization for Imaging Services in Outpatient/Freestanding Centers Performance by Imaging Provider vs. Ordering Physician Office].

- **RBMs and payors should give consideration to the role of for-profit self-referring imaging providers when designing their RBMPs.**

Payors and RBMs must also recognize that physicians with for-profit self-referral imaging arrangements enjoy an intrinsic market advantage over other for-profit providers in this situation (i.e.: all clinical data required for prior-authorization is readily available to the entity) and such self-referral arrangements may lead to over-utilization of the nature that RBMs and payor are, by the prior-authorization process, seeking to address.

- **Accreditation of imaging equipment, technologists, professional coverage, services, etc. should be required**

RBMs should require facilities with high-technology imaging equipment to be accredited by the ACR or equivalent organizations. These accreditation requirements should include standards applicable to the physicians who provide the interpretations of the high-tech imaging studies so as to ensure their proper training and experience in imaging interpretation. For the same reasons, the technologists performing the technical component of the study should be American Registry of Radiologic Technologists (ARRT) certified and registered. The equipment utilized should be current technology, well maintained and regularly inspected. Evaluation of the quality of the images themselves is an important part of any accreditation program.

Administrative Processes Guidelines:

- **Imaging services that are approved by the accepted prior-authorization process should not be denied after the fact**

Providers need confidence that their pre-authorized studies will be paid. Otherwise, participation in the process will be questioned and compliance will suffer. The prior-authorization process needs to be applied and administered consistently across geographic boundaries and authorizing entities, not only medically but also with respect to the payor's coverage and adjudication policies.

- **Payors and their contracted RBMs should make sure that all services pre-authorized by the RBMs can be properly and timely transferred to the insurance company for accurate claims processing**

Payors and RBMs should have sufficient claims adjudication, electronic connectivity systems and reconciliation processes in place so that pre-authorized/certified studies can be accurately expedited through the claims processing systems.

- **When the radiologist is not in control of the prior-authorization process (e.g., hospital-based in-patient imaging service) and the procedure is not billed globally by the imaging provider, the professional component of the procedure should be paid by the payor even if the claim is denied on the basis of prior-authorization reasons**

The ordering/referring physician is in possession of the patient's medical history and the clinical indications for the imaging study contained therein. In the hospital setting, administration of the prior-authorization process is beyond the radiologist's control. The radiologist relies only on the presenting clinical information in the performance of the ordered study. The professional component should be paid if the claim is denied for administrative reasons.

- **The prior-authorization policies should exclude all emergency room and those inpatient procedures in response to other life-threatening situations**

The prior-authorization process should not stand in the way of the delivery of patient care in emergency or other life-threatening situations. In these circumstances, providers are acting upon the medical information readily at hand to care for the patient. Therefore, it would be inappropriate to prospectively or retroactively deny payment for such care.

- **In most instances, prior-authorization should be provided with as little administrative burden to the referring physician's staff as possible. It is recommended that the prior-authorization validation period be from the date the prior-authorization for the exam is first issued, not from the date of service.**

The prior-authorization process should not stand in the way of the delivery of timely radiological care to patients. Additionally, in order to improve and encourage compliance while minimizing the administrative burden, the prior-authorization process should be quick and only require the clinical information necessary to evaluate the order. RBMs should facilitate and allow electronic submission of requests to perform high-tech imaging studies. RBMs should educate referring physicians in the use of such online reference tools. RBMs should provide the referring physicians with a reference guide listing each of the RBM's prior-authorization requirements with an appropriate explanation. The process and criteria for obtaining prior-authorization should be uniform and consistent across geographic boundaries and approving entities.

Once prior-authorization is approved, it should be valid for a period of 30 to 60 days "from the date the prior-authorization is first issued" in order to avoid re-application or even payment denial. Moreover, when RBMs issue prior-authorization that is so time limited (e.g., 60 days or less), both ordering physicians and patients should be clearly and appropriately informed, so as to avoid the need for re-application and inappropriate payment denial. Furthermore, in order to promote patient and provider convenience and efficiency, the prior-authorization should afford the flexibility of scheduling the patient anytime within the applicable validation period, as measured from the date the prior-authorization is first issued, if the opportunity presents itself, even if it means a date earlier or later than the date referenced in the application for prior-authorization.

- **Payors/RBMs should not apply a voluntary prior-authorization program for some product lines when there is a “mandatory” RBM program in place for other product lines with the same payor. For example, a payor implements a voluntary prior-authorization program for its PPO product line(s), when prior-authorization is required for its HMO(s) products. This creates confusion and burdens the providers of service with the responsibility for determining whether the member is under a voluntary or mandatory prior-authorization program.**

Payors should avoid “mixing” RBMPs for their product lines. This creates confusion since many patients do not know the details of their plans and the variability can be overlooked readily by referring physicians, their staff, or the staff of the imaging facility.

- **Payors/RBMs should use online prior-authorization or imaging requisition (e-requisition) products wherein the ordering physician can enter his or her patient’s clinical information and requested study and receive near instantaneous approval or guidance for the more appropriate study.**

Web-based prior-authorization processes greatly facilitate the ordering of appropriate studies, improve compliance, assure process consistency and quality across geographic boundaries and authorizing entities, and lower the administrative costs to payors and providers alike.

- **An independent study of imaging utilization strategies currently being employed by RBM and payors is recommended in order to address the magnitude of the associated cost burden on ordering physician offices and imaging providers. We further recommend that this study be performed by the Center for Health System Change or other comparable independent organization.**
- **Payors/RBMs should offset the additional costs associated with prior-authorization incurred by the ordering/referring physician**

A sound prior-authorization process relies upon the participation of referring/ordering physicians and/or imaging provider. The ability to comply with such programs without supplementing existing personnel to address the resulting additional administrative burden is a major obstacle. Since RBMPs are designed, in part, to help avoid inappropriate utilization which, in turn, saves the payor money, then a portion of the savings should be shared with the referring/ordering physicians and imaging providers to help offset their administrative costs.

Transparency Recommendations:

- **Payors/RBMs collection of quality and cost data from practices should be fair, consistent, and accurate**

Payors/RBMs increasingly are exploring the use of comparative statistics of practices based on quality and cost. While this could be a useful resource for patients and employers, the value of such a product will depend largely on the accuracy of the underlying data and the reliability of comparisons. Accordingly, Payors/RBMs should have processes in place to ensure that the data are collected consistently across practices, using a common methodology and equivalent data sets and predictive modeling techniques. Further, the data should be subject to review by the practices prior to release and allow for frequent and easy updating as information changes. If circumstances necessitate, there also should be an appeal process.

- **In order to provide the same degree of transparency currently asked of providers, improve process compliance, and assure process consistency and quality across geographic boundaries and authorizing entities, RBMs should benchmark themselves regularly against these guidelines and make the results available to the public.**

12/21/2010

Appendix 1: Discussion Paper - Prior-Authorization for Imaging Services in Outpatient/Freestanding Centers Performance by Imaging Provider vs. Ordering Physician Office

CPT® Code Families

CPT® Code Families

Code	Description	Corresponding Code Family
70336	MRI Temporomandibular Joint	70336
70450	CT Head/Brain	70450, 70460, 70470
70480	CT Orbit	70480, 70481, 70482
70486	CT Maxillofacial/Sinus	70486, 70487, 70488
70490	CT Soft Tissue Neck	70490, 70491, 70492
70496	CT Angiography, Head	70496
70498	CT Angiography, Neck	70498
70540	MRI Orbit, Face, Neck	70540, 70542, 70543
70551	MRI Internal Auditory Canal	70551, 70552, 70553, 70540, 70542, 70543
70544	MRA Head	70544, 70545, 70546
70547	MRA Neck	70547, 70548, 70549
70551	MRI Brain	70551, 70552, 70553
71250	CT Chest	71250, 71260, 71270
71275	CT Angiography, Chest	71275
71550	MRI Chest	71550, 71551, 71552
71555	MRA Chest	71555
72125	CT Cervical Spine	72125, 72126, 72127
72128	CT Thoracic Spine	72128, 72129, 72130
72131	CT Lumbar Spine	72131, 72132, 72133
72141	MRI Cervical Spine	72141, 72142, 72156
72146	MRI Thoracic Spine	72146, 72147, 72157
72148	MRI Lumbar Spine	72148, 72149, 72158
72159	MRA Spinal Canal	72159
72191	CT Angiography, Pelvis	72191
72192	CT Pelvis	72192, 72193, 72194, 74176, 74177, 74178
72196	MRI Pelvis	72195, 72196, 72197
72198	MRA Pelvis	72198
73200	CT Upper Extremity	73200, 73201, 73202
73206	CT Angiography, Upper Extremity	73206
73220	MRI Upper Extremity, other than Joint	73218, 73219, 73220
73221	MRI Upper Extremity Joint	73221, 73222, 73223
73225	MRA Upper Extremity	73225
73700	CT Lower Extremity	73700, 73701, 73702
73706	CT Angiography, Lower Extremity	73706
73720	MRI Lower Extremity, other than Joint	73718, 73719, 73720, 73721, 73722, 73723
73721	MRI Lower Extremity Joint	73721, 73722, 73723, 73718, 73719, 73720
73721	MRI Hip	72195, 72197, 73721, 72196, 73722, 73723
73725	MRA Lower Extremity	73725
74150	CT Abdomen	74150, 74160, 74170, 74176, 74177, 74178

CPT® Code Families

Code	Description	Corresponding Code Family
74175	CT Angiography, Abdomen	74175
74176	CT Abdomen+Pelvis	74176, 74177, 74178, 74150, 74160, 74170, 72192, 72193, 72194
74181	MRI Abdomen	74181, 74182, 74183, S8037
74185	MRA Abdomen	74185
75557	MRI Heart	75557, 75559, 75561, 75563
75635	CT Angiography, Abdominal Arteries	75635
76376	3D Rendering Not On Independent Workstation	76376
76377	3D Rendering On Independent Workstation	76377
77058	MRI Breast	77058, 77059
77012	CT Guidance	77011, 77012, 77013, 77014
76380	CT Limited or Follow-Up	76380
76390	MR Spectroscopy	76390
77084	MRI Bone Marrow	77084
78459	PET Scan, Heart	78459, 78491, 78492, G0030–G0047, G0230 [Also allow billing for the corresponding Cardiovascular Stress Test 9-range (93015–93018)]
78451	Myocardial Perfusion Imaging—Nuclear Cardiology	78451, 78452, 78453, 78454, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78494, 78496, 78499 [Also included are the corresponding 9-range (93015–93018) and the radiopharmaceutical charges (78990, and A9500–A9605)]
78608	PET Scan, Brain	78608, 78609, G0229
78813	PET Scan, Tumor Imaging	G0125, G0210, G0211, G0212, G0213, G0214, G0215, G0216, G0217, G0218, G0219, G0220, G0221, G0222, G0223, G0224, G0225, G0226, G0227, G0228, G0231, G0232, G0233, G0234, G0253, G0254, G0296, 78811, 78812, 78813, 78814, 78815, 78816

Appendix 1

**Discussion Paper: Prior-Authorization for Imaging Services in
Outpatient/Freestanding Centers Performance by Imaging
Provider vs. Ordering Physician Office**



Discussion Paper
Prior-Authorization for Imaging Services in Outpatient/Freestanding Centers
Performance by Imaging Provider vs. Ordering Physician Office

Background:

Medical imaging represents a substantial and growing portion of the costs of American health care.¹ When performed correctly and for the right reasons, medical imaging facilitates quality medical care that brings value to both patients and payers. When used incorrectly because of inappropriate economic incentives, unnecessary patient demands, or provider concerns for medical-legal risk, imaging costs can rise without increasing diagnostic yields. A number of methods have been tried to manage imaging utilization and achieve the best medical outcomes for patients without incurring unnecessary costs. The best method should combine a prospective approach; be transparent, evidence-based, and unobtrusive to the doctor-patient relationship and provide for education and continuous quality improvement. Combining the proper utilization of imaging and its inherent cost reduction, with improved quality through credentialing and accreditation, achieves the highest value and simultaneous best outcomes for patients.² In response to the double-digit rise in high-tech imaging utilization, the health care industry recognized a need to manage this growth by implementing imaging utilization controlled programs to reduce health care costs.

Prior-Authorization is a process utilized by many health plans to determine the appropriateness of medical imaging studies prior to actual study performance by the imaging provider. The primary intent of prior-authorization is to provide health plans a means by which to control imaging utilization. Payment for studies subject to prior-authorization is contingent upon health plan (or Radiology Benefits Managers (RBMs)) approval and Prior-Authorization number assignment. Approval of studies subject to prior-authorization is based, in part, upon patient clinical history which is generally maintained by the ordering physician office (OPO). For this reason, the prior-authorization process has historically been completed by ordering physician staff.

Over recent years, the number of imaging studies requiring prior-authorization has increased significantly and OPOs have become more disenchanted by the administrative burden and added staffing costs to complete prior authorization activities. As a result, many OPOs have become increasingly insistent that the responsibility for prior-authorization be redirected to imaging providers.

Some imaging providers view obtaining prior-authorizations as a means to improve the process, protect revenue, and differentiate it from other imaging providers. Factors influencing the imaging

¹ M. Bernardy, C. Ullrich, J. Rawson, B. Allen Jr, J. Thrall, K. Keysor, C. James, J. Boyes, W. Saunders, W. Lomers, et al., "Strategies for Managing Imaging Utilization", *Journal of the American College of Radiology*, Volume 6, Issue 12, Pages 844-850

² M. Bernardy, C. Ullrich, J. Rawson, B. Allen Jr, J. Thrall, K. Keysor, C. James, J. Boyes, W. Saunders, W. Lomers, et al., "Strategies for Managing Imaging Utilization", *Journal of the American College of Radiology*, Volume 6, Issue 12, Pages 844-850

providers' decision to accept or deny such requests are comprised of a myriad of issues including: customer service and operational considerations, regulatory compliance, MCO contract restrictions and risk of payment denials if the OPO fails to correctly manage the prior authorization process.

Concerns regarding regulatory compliance question whether the performance of prior-authorization on behalf of OPOs may constitute violations of federal Stark and anti-kickback regulations. This matter is complicated by varying legal opinions among highly regarded firms.^{3,4} While highly conservative counsel may criticize the appropriateness of the practice, more liberal counsel may advise that the practice is unquestionably acceptable. With convincing arguments on both sides of the issue, imaging providers may find legal counsel to support either approach.

Another challenge for some imaging providers considering performance of prior-authorization is managing the inconsistencies within health plan and RBM contracts/policies. This issue appears to be market specific - prevalent in some regions, but not in others. While some health plans within a given market may be indifferent regarding the imaging providers' performance of prior-authorization, others strictly prohibit the practice through contract language or policies. And, though they threaten, many health plans fail to follow through with imposing sanctions upon those providers who violate their contracts or policies. Where payors and RBMs issue contracts or policies which prohibit imaging providers from performing prior-authorization yet neglect enforcement of such constraints, the absence of enforcement may be construed by providers as allowing such practice. In these environments, compliant imaging providers struggle with competition, as some OPOs openly state that they direct referrals for imaging studies requiring prior-authorization to those imaging providers who are willing to complete the process on their behalf. Imaging providers who remain compliant despite loss of referrals to their non-compliant competitors cannot sustain their business long term without assistance from the health plans to either enforce or revise their policies.

Finally, requirements for prior-authorization are dynamic and imaging providers rely heavily upon their front office staff to maintain a working knowledge of updates to health plan policies, processes and systems related to prior-authorization. The financial penalty for failure of the OPO to properly secure the prior authorization is born solely by the imaging provider. And, it is unrealistic to expect that OPOs will stay abreast of the ever-changing prior-authorization requirements and the nuances of each health plan's processes and software since they have no vested interest in doing so. Because imaging provider reimbursement is contingent upon proper completion of the prior-authorization process, it is imperative that imaging providers be assured that prior-authorization is completed correctly.

For these and other reasons, many imaging providers struggle with the cost-benefit of prior-authorization performance. Under either model, imaging provider obtained or OPO obtained, it is important that a party be designated as responsible for completion of prior-authorization for imaging services through the establishment of an industry standard. All relevant issues should be considered in doing so.

³ T. Greeson, "Pre-authorization By Third Party Payors-Counterpoint", RBMA Bulletin, July-August, 2008, page 37

⁴ J. Wieland, "Pre-authorization By Third Party Payors-Counterpoint", RBMA Bulletin, July-August, 2008, page 34

- Scope: While both hospital-based radiologists and free-standing imaging providers may experience difficulties associated with prior-authorizations, resolution may be specific to the imaging provider type. This discussion paper addresses prior-authorization in the non-hospital (freestanding) environment.
- Purpose: The purposes of this discussion paper are to: (1) provide an over-view of prior-authorization and (2) present the issues related to freestanding imaging providers obtaining prior-authorizations for their referring physicians.
- Solutions: Given that prior-authorization is a current condition of payment for many imaging services, it is in the imaging providers' best financial interest that prior-authorization is completed timely and accurately. Moreover, the standard business practice for the acquisition of prior-authorizations is evolving and depending on local factors either approach below is recommended:
- (1) Imaging providers assisting OPOs with prior-authorizations with OPO taking primary responsibility for prior authorization or
 - (2) Imaging providers being allowed by payors and RBMs to perform prior authorization themselves should they so choose. However, imaging providers should not be required to perform prior authorizations should they choose not to perform the prior authorization function.
- Finally, if payors and RBMs have contract language or policies that prohibit imaging providers from performing prior-authorization, then these policies/provisions should be universally and consistently enforced, otherwise an unlevel playing field is created.
- Objectives:
1. Educate health plans, RBMs and other stakeholders concerning the benefits recognized by allowing imaging providers to assume responsibility for the prior-authorization process
 2. Eliminate ambiguity regarding responsible party for prior-authorization process
 3. Provide assurance of compliance with federal regulations
 4. Establish industry standard accepted business practice to assist health plans, payors and RBMs in development or revision of policies to allow imaging providers to participate in or wholly accept responsibility for prior-authorization process
 5. Improve probability of payment to those imaging providers which participate in the process of securing prior-authorizations
 6. Demonstrate improved imaging utilization management when performed by imaging providers, especially by providers utilizing ACR Appropriateness Criteria[®] or decision support system data
 7. Provide benefit to patients by reducing time between referral and actual date of service and by reducing frustration and confusion in receipt of EOBs denying coverage related to prior-authorization
 8. Provide administrative cost savings to health plans, RBMs and providers related to efforts in correcting errors related to prior-authorizations which were initially performed incorrectly
 9. Relieve OPOs of administrative burden associated with prior-authorization process, allowing their focus to be directed to other components of patient care not associated with imaging
 10. Improve relationship between OPOs and imaging providers by eliminating resentment based upon prior-authorization responsibility
 11. Eliminate unfavorable dynamics in marketing prior-authorization services

Definitions:

- ◇ Prior Authorization – A requirement that a provider obtain approval from the health plan to order a specific medication, procedure or study. Without the prior approval, the health plan may not provide coverage or payment for the service
- ◇ Prior Authorization Number – A number assigned by health plans or RBMs to indicate that a procedure or study has been approved as a covered service
- ◇ Radiology Benefits Manager (RBM) – Organizations designed to assist health plans’ control imaging utilization and avoid making payment for imaging procedures which are ordered but not appropriate based on pre-determined guidelines for medical necessity
- ◇ Stark – A federal law, named after Congressman Stark, that prohibits a physician (or his/her immediate family member) from referring Medicare patients for Medicare covered designated health services to an entity that he/she has a financial relationship unless an exception is met
- ◇ Anti-kickback – Federal regulation prohibiting a compensation relationship between parties (defined as remuneration passed between the parties, either in the form of financial payment or the provision of some other benefit) for the purposes of influencing the referral of federal healthcare program business

Stakeholders:

- ◇ Medical practice managers & physician leaders
- ◇ IDTF Owners and operators
- ◇ Third-party medical billing agencies
- ◇ Health plans & third-party payors
- ◇ Centers for Medicare & Medicaid Services (CMS)
- ◇ Worker’s Compensation agencies
- ◇ Third-party administrators (TPAs)
- ◇ Self-insured employer
- ◇ State employee benefit plans
- ◇ Members of the United States Congress
- ◇ State elected and other officials
- ◇ State insurance commissioners
- ◇ Consumer advocacy organizations

Messages(Con Acquisition):

- ◇ The added administrative burdens and costs associated with the imaging provider’s performance of prior-authorization would be increased but would not be offset by any additional payment from payors
- ◇ Some health plans and RBMs would need to revise their policies and contractual language to facilitate imaging providers’ ability to perform prior-authorizations without constituting breach of contracts or policies
- ◇ The additional clinical information which would be obtained from the OPOs to facilitate imaging providers’ ability to complete prior-authorizations may potentially create additional liability exposure in interpretation services

Messages(Pro Acquisition):

- ◇ Performance of prior-authorization by imaging providers would:
 - Eliminate OPO dependence on imaging providers for direction concerning the nuances of the various health plan/RBM systems, processes, and criteria
 - Reduce or eliminate the need for Health plans/RBMs to make changes to prior-authorizations as a result of OPOs which are less familiar with the appropriate clinical requirements and criteria than imaging providers, thus resulting in administrative cost savings for all parties involved
 - Facilitate more effective, streamlined prior-authorization processes which would benefit patients both through reduction in time from referral to date of service and through reduction of frustration/confusion upon receipt of EOB denying coverage for unmet prior-authorization requirements
 - Allow ordering physicians to focus on patient care and treatment rather than administrative processes
 - Eliminate ambiguity during the referral process by establishing an acceptable standard practice for responsibility of the administrative process for imaging
 - Eliminate the prior authorization burden as an unfair competitive advantage among imaging providers competing for OPO referrals
 - Eliminate resentment of OPOs based upon their requirement to complete a process for which the imaging provider ultimately receives compensation, thus strengthening relationships between OPOs and their imaging provider colleagues
- ◇ The additional clinical information which would be received from the OPO for purposes of prior-authorization completion would provide better patient histories for use by radiologists in interpreting studies
- ◇ It is appropriate that the responsibility for obtaining prior authorizations fall upon the entity which would receive imaging reimbursement when the prior authorization is completed correctly and the financial penalty when the prior authorization is not completed correctly
- ◇ Control of the prior-authorization process by imaging providers would provide relief to the imaging provider over concerns relative to the probability (or improbability) of payment based upon whether or not the prior-authorization process was completed properly

Other Issues:

The prior-authorization process in its current form may be replaced in the future by use of decision support software driven by appropriateness criteria as determined by radiologist experts.⁵

⁵ M. Bernardy, C. Ullrich, J. Rawson, B. Allen Jr, J. Thrall, K. Keysor, C. James, J. Boyes, W. Saunders, W. Lomers, et al., "Strategies for Managing Imaging Utilization", Journal of the American College of Radiology, Volume 6, Issue 12, Pages 844-850