By Zac Haughn, Associate Editor

All the Right Moves: Play the Neuroimaging Precertification Game to Win

Do third-party plans have you in a stalemate? Here's how to control the board like a grandmaster.

Neurologists can be excused if they flash a slight thank-goodness-that's-not-us smile when they look back at outdated medical techniques. After all, the first neuroimaging technique—pneumoencephalography—was extremely risky and painful for patients, and would be seen as unethical practice today. But think what the neurologists performing that procedure in the early 1900s would say about what you have to do just to order imaging studies today. Odds are the roles would be reversed.

Today's medical practice is clearly better suited for treating patients than that of a century ago, but it's now the elements outside of the examining room that can make life more difficult. It's a vicious cycle: high health care costs and heavy reliance on diagnostic imaging leads to precertification requirements that most neurologists feel are a road block to the care they provide; meanwhile, a contentious legal environment leads to physicians practicing defensive medicine by ordering unnecessary images, which takes everything right back to high health care costs and outside forces trying to limit them. However, there are several ways you can streamline your practice and make the imaging aspect more efficient so you can avoid and work around any hang-ups that surround image ordering.

While more likely described as a nuisance by physicians, a more official way of describing the precertification process is provided by the Utilization Review Accreditation Commission, which says it evaluates the medical necessity, appropriateness, and efficient use of health care services (among other things) under the provision of the patient's health benefits plan.[1] But don't expect neurologists to necessarily cheer the notion that precertification is in place as a cost control measure. Says one neurologist: "One way to control utilization is to put up a big hoop." Here's how to be more on target when you need to jump through.

Precertification

The road to precertification is an oft-traveled ground, and you're likely to be all-too-familiar with the well-worn path. It typically begins with a health plan's nurse carrying out an initial review of the patient's clinical information that you have provided, so to ensure the test you're requesting is in compliance with the established guidelines. If it meets the requirements, the nurse will authorize your test and the health plan will cover it. If it doesn't, you will take a step deeper into a world of appeals, denials and extra time spent explaining your case. The nurse will then refer the case to a physician reviewer employed by the health plan—normally, the medical director or a physician consultant—who will decide whether or not to approve your request. Before it's denied or approved, it may be put on "pending" status by the physician reviewer, who will likely ask you for more information before issuing his or her judgment.

What it takes to go through this process has left some jaded, believing precertification has become routine and unnecessarily time consuming for the neurologist and their office. "The vast majority of scans requested by neurologists are approved after a huge waste of time," says Randolph Evans, MD and Chief of Neurology at Park Plaza Hospital and Clinical Professor at Baylor College of Medicine in Houston. But according to those in the utilization and insurance industry, the vast majority are approved. In most of the American Imaging Management—an imaging company with 24 health plan partners in 23 states—the percent of cases that are approved at the initial intake level is

between 75 percent and 80 percent, according to E. Maureen White, MD and Chief Medical Officer of AIM. "Of the cases that are not approved at intake, most are approved after additional clinical review. On average only one percent to two percent of requests are denied," she says. But selling the very reasoning behind precertification is a tough task. "Insurance companies are trying to discourage necessary scans by requiring precertifications and making them as onerous as possible to save money at our expense while physician reimbursement continues to decrease," says Dr. Evans. Feeling slighted by the process has left another neurologist to find a way around it: "I've trained my staff to look at the drop down menu on the Web site and just pick the right diagnosis and the right set of symptoms."

The way you diligently approach having all the necessary patient information during office visits is the same attitude you should hold when your office makes the initial test request to the health plan's nurse. Having the correct information can make the difference between test approval and extra time spent trying to convince someone you need the test. Dr. White says her organization recommends several pieces of patient information be available, including:

- Member identification number, name and date of birth
- Ordering physician information
- Imaging exam being requested (including body part, right, left or bilateral)
- Patient diagnosis (suspected or confirmed)
- Clinical symptoms/indicators (including intensity and duration)
- Results of past treatment history (including previous tests, duration of previous therapy, and relevant medical history)

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"In most instances, when a request is not approved at the initial intake level it is due to the fact that some important piece of clinical information was not submitted with the request," Dr. White says. "Providing the information needed to fully evaluate a request will result in a higher initial approval rate."

Familiarize yourself with guidelines. There are several other avenues neurologists can utilize to ease the process; one is gaining a familiarity with clinical guidelines, especially for conditions your practice deals with frequently. Sources such as www.guideline.gov and www.ahrq.gov/clinic/uspstfix.htm can provide a wealth of information. If you wish to learn the conditions of what Medicare will cover, you can look for their specific services through a database of Medicare's National Coverage Determinations at www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd.1 Additionally, your health plans may provide you with the guidelines they use, though some will not. "Health plans have medical policies regarding imaging studies, especially those that may be considered to be experimental and investigational," Dr. White says. "Having a clear understanding of those policies can clarify when a study is inconsistent with the health plan's medical policy and should be reviewed with the health plan prior to submission for preauthorization."

Clearly submit all documentation. This can be a two-way street for some physicians. If your hand-written notes look closer to that of a foreign language, others aren't likely to have the skill, or time, to interpret them and you may put your request at risk. Also, even when the amount of documentation required by the health plan seems undue, register a complaint later, but don't holdback the information as it may put your request on the fast track to a "pending" status or even denial.

Precertify patients online. Many companies will allow you to submit requests through their web sites, giving physicians—or staff members likely to place the request to save you time—24/7/365 access to obtain and confirm preauthorization, check patient eligibility and locate imaging centers through a secure information exchange, Dr. White says. "Currently, AIM receives 40 percent of its total preauthorization volume through the web, with some clients sending as much as 80 percent of their preauthorization requests through the web," she says. Referring physicians complete a brief online questionnaire to identify the reasons for the imaging exam request. The clinical logic and scripting on the AIM Web site is similar to the script that the provider would receive through a preauthorization request submitted through the phone, she adds.

Follow up tardy responses. Though skeptical neurologists will already feel their very dealing with precertification is a time waste, don't hesitate to follow up with the health plan if you don't feel they've responded in a timely manner—and follow up effectively. Many large health plans receive accreditation or cer-

tification through the National Committee for Quality Assurance and are required to follow their standards that state a decision on precertification must be made within 15 calendar days of receipt of non-urgent requests.[1] "If NCQA is contacted with a complaint about an NCQA Accredited or Certified entity, we will request, on the correspondent's behalf, that the organization handle the complaint in accordance with its established policies and procedures," says Jeff Van Ness, Communications Director at NCQA. The NCQA will check for any patterns of egregious behavior and take further action, if needed. You can e-mail complaints to customersupport@ncqa.org.

In Denial

If you find yourself with the short straw in the precertification process, health plans must say precisely why your request was denied and afford you time to speak with the reviewer. (However, this only extends to cases that are judged as without medical necessity, not benefits that aren't covered in the patient's contract.[1]) A 2005 web survey[2] laid out the reasons for denials:

- The services are not medically appropriate: 47 percent
- The health plan lacks information to approve coverage of the service: 23 percent
- The service is a non-covered benefit: 17 percent

Denials can vary among the physician demographics. According to a 2006 article, MedSolutions—a radiology management company that provides utilization services—said its MRI denial rate was nine to 12 percent for neurologists and 25 to 30 percent for primary care physicians.[3]

Determine common service denials. Keeping a log organized by health plan and of the various denials that have occurred in the previous six to 12 months will help you analyze the data and find trends. If an imaging test faces repeated denials by several health plans, you may have a problem with your coding or another systems problem. If the denials of one plan are significantly higher or have any inconsistencies, open a dialogue with someone in the company to try to nail down their positions on particular tests. However, keeping the log is a job better suited for someone on your staff. It's "too much bureaucratic burden for a physician," says Antonio Culebras, MD and Professor of Neurology at SUNY Upstate Medical University.

When you are denied a test you feel is necessary and the patient wants to appeal, you will need to make a decision: get involved and appeal on behalf of the patient or let the appeal run its course. "It's good clinical medicine to be the patient's advocate if the procedure is well indicated," Dr. Culebras says. There are several factors to take into consideration before you get involved. First, know that the appeal process can be time consuming. Because most patients don't take out their coverage policies for leisurely reads before bed, you will want to analyze their contract (typically the summary of benefits[1]) to determine if your role will increase the chances of winning the appeal. However, some scenarios will require your aid. You hold some accountability if, for example, you are unable to fit a patient with an acute problem into your schedule and you lead them to the emergency department. Also, be aware that appeals are categorized into three groups: pre-service appeals, post-service appeals or expedited appeals. When health plans agree to expedite an appeal—you may request one when it is medically necessary to get a test quickly—a decision must come within 72 hours of a request.[1]

Finally, take several issues to heart. You won't be able to reverse every decision, but don't hesitate to simply make a phone call to the medical director; additional information and speaking to a colleague one-on-one can't do anything but help. Provided, of course, you keep your cool. Raising your voice, questioning physician credentials or threatening legal action is not likely to help your patient–or future patients. And before going to bat for a patient, make sure the denied request isn't excluded by their contract; health plans rarely reverse such matters.

Streamlining Your Practice

With imaging, you might find a case where you have to walk the fine line that borders defensive medicine. Often times physicians are faced with the dilemma of providing a cost effective treatment for their patients by refraining from ordering a test that won't significantly help with diagnosis against ordering a test as precaution so the physician can protect their livelihood against the threat of legal proceedings.

Many scans are in a sense not medically necessary because the yield may be quite low or outcome may not be changed, Dr. Evans says, but are ordered anyway because in the current medicolegal setting, physicians are not protected if a rare abnormality is not detected and a scan is not performed. "We can get sued for missing an incidental finding not related to the presenting symptoms. The insurance company may not get sued but we do," he says. Secondly, he adds many patients want scans for peace of mind or out of curiosity and it can be difficult to convince them that a scan is not necessary.

Dr. Evans will explain the reason why a scan may not be indicated and let the patient and family decide. "If, for example, they have migraine and are concerned about a possible saccular aneurysm, I explain that they have migraine but could also have a saccular aneurysm which is not related to their migraine. Their risk of saccular aneurysm is about 2 two percent, the population risk for unruptured aneurysm, and an MRA may detect an aneurysm with a sensitivity of about 90 percent. If they have low back pain which is probably not surgical, I explain how common back problems are and that most are non-surgical and that it is very unlikely that the scan would change management."

Some companies track profiles or ordering habits of physi-

Certifying Your Expertise

In July 2006, neuroimaging was designated as a neurological subspecialty area of the United Council of Neurological Subspecialties, based on the acceptance of the application put forward by the American Society of Neuroimaging. Certification can provide recognition of expertise and experience within a subspecialty and can be used as an instrument to judge that a physician has the "knowledge, experience and skills for providing quality healthcare within a given specialty," according to Mary Post UCNS Executive Director.

The UCNS has established general eligibility criteria that each applicant must satisfy when applying for admission to their examinations. In addition to the general eligibility criteria, each subspecialty provides two pathways for an applicant to qualify for the exam. "The applicant can have successfully completed a fellowship in the subspecialty that is accredited by the UCNS. This fellowship must be completed by the date of the application," Post says. "The other pathway to qualify is the Practice Track process, which allows physicians who initiated the subspecialty prior to the availability of accredited training programs to qualify for the examination by meeting a defined set of criteria." The application for certification in neuroimaging requires a completed application, supporting documentation and all fees sent to the UCNS Executive Office by September 15, 2007 while testing will take place February 4th through 8th in 2008. UCNS cannot accept late applications, but next year's deadline is planned for the time, according to Post.

The first set of certification examinations has been offered in the subspecialties of Behavioral Neurology & Neuropsychiatry and Headache Medicine in September of 2006. There are currently 59 diplomates in Behavioral Neurology & Neuropsychiatry and 105 diplomates in Headache Medicine. Also, two new subspecialties have been approved for membership. The subspecialty areas of Autonomic Disorders and Geriatric Neurology were given the green light, raising the number of subspecialty areas with membership to eight.

cians to give back to payers. Dr. White says in AIM's experience, health plans do not focus on the volume of services ordered, but on the results of the preauthorization process. "Which physicians are not achieving authorizations during their first time through the process? Which physicians are receiving denials? Which E&I procedures are being ordered the most often?"

Dr. Culebras says some physicians operate under the theory of "get everything to cover all bases. I find that conventional angiograms are underused, whereas MRI/A of the head and neck are overused," he says. "Why should patients get CT and MRI of the head almost concurrently? It represents excessive medicine. Physicians should have clear indications for CT head and MRI head, with or without contrast enhancement. Most physicians are unclear about the indications and this leads to excessive use." For instance, many believe that contrast enhancement always reveals more pathology, Dr. Culebras says, but this is not the case. He delineates: "For instance, a CT head with contrast enhancement may obstruct or confuse the view of a small cerebral hemorrhage. Furthermore, contrast-enhancement may have adverse effects in patients with renal disease or when dehydrated, conditions that concur often enough in patients who need neuroimaging."

Neurologists must also be watchful about having the radiologist interpret scans in a timely fashion and calling with significant abnormal results. "It is easy for a patient to fall through the cracks," Dr. Evans says. "For example, a patient could present with recent-onset headaches with a normal exam and have an outpatient scan on Friday afternoon. The scan could show a chronic subdural with mass effect or a posterior fossa neoplasm with mass effect. If the patient were to deteriorate neurologically or die between Friday and when the scan was interpreted on Monday afternoon, the physician could be liable."

To provide a legal safeguard you should take steps to ensure you read over every scan you order, personally. According to a 2005 survey,[4] seven percent of neurologists rely exclusively on someone else's reading of CT and MRI for their clinical decision-making. Most relied on their interpretation alone (38 percent for CT scans, 33 for MRI) or a combination of their own and someone else's reading (54 percent in CT scans and 60 percent for MRI).

Not all neurologists have the time or opportunity to review every scan, but it should be the goal, says Stephen Gollomp, MD and Chief of Neurology at Lankenau Hospital and Clinical Professor of Neurology at Thomas Jefferson Hospital. "I personally try and review all the images I order because I've learned from experience, (a) radiologists may over-interpret, (b) they don't know what's going on with the patient clinically [and] I do and I know what I'm looking for so I'm going to be much more intuitive to what's needed." Dr. Gollomp says radiologists may over-interpret for their own legal reasons. "Radiologists frequently, depending on their skill set, will over-interpret things in order to cover themselves and that will of course come back to the clinician for them to sort out what the interpretation really means. It can be a bit of a pain." **PN**

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