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INDUSTRY UPDATES

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Study Finds That Physicians Largely Ignore CDS Imaging Algorithm

Researchers from the radiology department at Brigham and Women's Hospital in Boston developed a clinical decision support (CDS) algorithm to help physicians reduce overutilized imaging examinations in the emergency department (ED). The physicians, however, consistently disregarded its recommendations, reducing its impact (the study was published in Academic Radiology).
The authors, wanting to focus on a commonly overutilized examination, surveyed more than 200 emergency providers and determined CT angiography (CTA) to assess for pulmonary embolism (PE) was the perfect candidate. The researchers developed the CDS algorithm using feedback from ED physicians, ED radiologists and a pulmonologist.
Once the CDS determined it wanted to recommend an alternative option to a physician ordering a CTA PE study, the physician was allowed to ignore that recommendation, but was asked to explain why. The pilot study lasted from April 1 to Oct. 31, 2015, at the ED of a 1,500-bed tertiary healthcare center.
Overall, 872 CTA PE studies were ordered in the healthcare center's ED. For 55% of those orders, the CDS recommended the order be changed. However, just 1.3% of those studies were canceled. Another 2.7% were changed to a D-dimer blood test, an alternative to the CTA. Four D-dimer studies were positive, three of them lead to a follow-up CTA PE, and none of those CTA PAs were positive.

A total of 853 CTA PE studies were ultimately conducted in the healthcare center's ED during the pilot study period, and just 8.2% were positive for a PE. The authors noted that they worked closely with the physicians before the study began and even formed a "rapid response team" to address any concerns. However, physicians still largely ignored the system's recommendations. "Despite these efforts, studies that were identified as inappropriate were only changed in 4% of cases," Goehler and colleagues wrote.

Why was adherence so low? The authors suggested that it may have been because trainees and mid-level providers work under the supervision of an attending physician.
"Since the case has been reviewed with the attending, and trainees or midlevel providers are instructed to order the test, it is less likely to change at this point," the authors wrote. "There are likely also instances in which the study is requested even though the ordering provider expects a negative result but pursued in order to facilitate another aspect of the encounter. For instance, this may be done to expedite discharge when beds are scarce or to assess multiple potential differential diagnoses with a single imaging study, as may be the case in a patient with hypoxia and a known lung neoplasm or metastasis."

CDS Is Here, Where Is Your Practice?

Coding & Compliance Tips by Lori Shore, Industry & MBMS Expert, CPC, RCC

Clinical Decision Support officially introduced its voluntary reporting period in June of this year. While the penalty phase does not begin until January 1, 2021 the time to begin this initiative was yesterday. Providers will need to begin to report CDS on January 1, 2020 as an educational year, much like the transition year we had with the implementation of ICD-10-CM. As with any number of the CMS initiatives of late, this is not a simple implementation and requires radiologists to be involved to protect their income. An Appropriate Use Criteria (AUC) vendor must be selected, along with your health system, and plans implemented for both employed and independent referring physicians. Policies and procedures must be developed. Will your group deny service to those who do not consult clinical decision support? The biggest challenge is educating your referring physicians on use of the CDS/AUC and focusing them on quality rather than their perception that they need to jump through another hoop so you can get paid. CDS/AUC can improve overall processes for everyone. If used properly, the need to change orders should decrease as well as medical necessity denials. Referring physicians are the ones responsible to consult an appropriate use criteria (AUC) product for all "high end" imaging studies. This includes CT, MR, and PET. Currently, it is the responsibility of the radiologist to report a G code to indicate what type of AUC was consulted and modifiers to indicate whether or not the referring physician followed the suggestion made by the AUC. Ultimately, it is the radiologists' income that will be at risk beginning in 2021.