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Guest Editorial: Radiologists can embrace e-Ordering as a viable alternative to third-party utilization controls

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The massive influx of federal dollars to promote healthcare information technology (HIT) has generated significant expectations by the government-as-payer. Interspersed with this unprecedented level of government funding is a drive to pay for it by "booking savings" elsewhere. For the past five years, medical imaging has been a favorite target, as technology has advanced techniques for lifesaving diagnosis and as many nonradiologists have expanded their ancillary services to include select imaging services. Imaging was in the bull's eye with the reimbursement cuts included in the Deficit Reduction Act of 2005 and it hasn't moved out of the crosshairs since. Currently, the push for savings is focused on controlling utilization, with some studies pointing to inappropriate use of imaging services.

As a neuroradiologist, I believe we must loudly and proudly show support for data-driven, evidence-based HIT tools that electronically document that we are providing appropriate care. There are patient-centered, physician-friendly solutions available to "prove" to whomever the payer is that the right test has been done at the right time.

One of the expectations of HIT is that physicians' clinical decisions will be evaluated through electronic means. These analyses are to be designed to demonstrate which physicians are providing "quality" care. The vast majority of physician-colleagues I have worked with welcome evidenced-based clinical analysis. However, I believe most practicing physicians have grown cynical about payer and government quality-data collection attempts because, in the end, it is usually about the money, not quality.

A current cause of my cynicism is radiology benefits management (RBM) vendors who are telling Congress that they should be hired to ensure "that patients have access to high-quality, safe and clinically appropriate advanced diagnostic imaging services," according to a press release from Magellan Health Services (owner of the RBM, National Imaging Associates). The RBMs charge a per-member, per-month fee, which will result in a nice windfall if all Medicare providers are required to contact an RBM before ordering an imaging study. I have concluded that the only way for RBMs to "save" money for the payer is by denying more care than they charge to administer the program. They do this by keeping their decision trees private and increasing the hassle factor to get patients and physicians to opt out and/or give up on ordering the imaging service.

In our experience at Center for Diagnostic Imaging, RBMs drive up administrative costs for providers, sometimes delay diagnosis and patient care, and erode the physician-patient relationship because a third party is determining care decisions. Additionally, the RBM appeals process for denied claims is cumbersome for the provider and a liability for the third party payer contracting with the RBM.

In Minnesota, the launch of RBMs by commercial payers caused a firestorm three years ago. CDI radiologists disagreed with the RBM concept vehemently and the ordering physicians disliked it as well. In search of alternatives, CDI became an early adopter of e-Ordering. Working collaboratively with the commercial payers, the Minnesota provider community has embedded imaging ordering decision support (e-Ordering) into hospital electronic medical record (EMR) systems. Smaller and independent providers can access the e-Ordering tool through CDI, the Minnesota Hospital Association or other entities. As a provider community, we are electronically documenting our practice patterns— offering reassurance to payers and patients that the care delivered is clinically appropriate. Although still evolving, Washington state is exploring an e-Ordering solution similar to Minnesota.

For our referring physicians, e-Ordering offers real-time access to evidence-based clinical guidance regarding appropriate imaging studies for specific presenting conditions. Unlike the RBM model, e-Ordering:

- avoids inconsistencies in performance and standards,
- significantly reduces the time and cost involved in obtaining authorization by a factor of 10 to 1,
- offers the ability to create an electronic record of the interaction,
- allows aggregated analysis of the data for credible quality measurement purposes,
- meets national HIT goals of interoperability and inter-connectivity, and
- fosters ongoing physician education rather than creating hassle and frustration.

While e-Ordering is relatively new, it is technologically robust. The clinical guidelines used will require constant upkeep yet these guidelines are expanding on a daily basis, thanks to heightened demand and response from various specialty societies.

Recently, e-Ordering got a national boost with the formation of the Imaging e-Ordering Coalition, which includes: the American College of Radiology, CDI, GE Healthcare, Merge Healthcare, Nuance Communications and Medicalis. The Coalition's goal is to help educate state and federal policy makers about e-Ordering along with benefits to the industry, patients and physicians.

I prefer facing a future which includes e-Ordering rather than an RBM, where savings are not sustainable and quality is not the end goal. As with e-prescribing, e-Ordering can grow with us as our technology and services change, all the while documenting that the care we are delivering is appropriate.