Medicare Imaging Demonstration

Open Door Forum (ODF) Listening Session
October 1, 2009
Questions and Answers

Question #1: Who can serve as conveners and how will conveners be chosen?

Answer: A convener can be an entity (e.g., medical specialty organization, large group multi-specialty practice, decision support system (DSS) vendor, radiology benefit manager) which meets the defined criteria and performs the following functions described in the request for proposals (RFP). Convener will recruit and coordinate (200-1000) physicians across size, practice type, and across geographic areas; secure a DSS specific to the 11 selected demonstration procedures and guidelines; deliver data to and from practices, deliver data to and from Centers for Medicare & Medicaid Services (CMS); and distribute incentive payments and feedback to practices.

CMS will issue a RFP for participation in the demonstration. The solicitation describes the legislative mandate and defines specific requirements, including evaluation criteria. Proposals will be evaluated by a panel of reviewers as part of the competitive award process. Conveners will propose a price, exclusive of physician payments, for implementing the above tasks as part of their proposal that will be evaluated as part of the competitive selection process.

Question #2: How will CMS obtain a broad representative cross-section population of practicing physicians for the demonstration? Sampling a volunteer population of physicians could have inherent selection biases and therefore potentially represent a skewed population of physicians being sampled. Success of the demonstration relies partially upon the selection of representative physician populations in various geographic distributions to ensure that the findings of the demonstration are generalizable.

Answer: Section 135(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 provides authority to design, implement, and evaluate the Medicare Imaging Demonstration (MID). The statute does not provide authority to mandate physician participation in the demonstration. Consequently, physician participation in this demonstration is voluntary and self selection biases may occur. Conveners must recruit physician practices across practice size, type, and physician specialty. The pre-post demonstration will provide a baseline from which to measure current compliance with appropriateness criteria as well as changes during the demonstration. Using claims data, we will also compare utilization during the demonstration and baseline periods with utilization

during the same period of the previous year to determine changes in ordering practices and utilization.

Question #3: How did CMS calculate the proposed recruitment size (200 – 1000 physicians per convener) and does it incorporate various geographies and practice type and size that might otherwise be included in the demonstration?

Answer: Our design contractor looked at the number of images needed to yield a large enough sample size to generate statistically significant results. To achieve adequate sample sizes based on a total number of practices for each convener, we assumed approximately 200 – 1,000 physicians that vary in size, specialty mix, type, and geographic location.

Question #4: Please clarify what is intended in the requirement for a minimum of 5 imaging studies of the 11 selected for the project ordered in the prior year for participating sites. Does this mean that participating physicians need to have ordered tests in at least 5 of the 11 categories?

Answer: Our goal is to include both high volume and low volume ordering physicians and to encourage participation of low ordering practices. We will be looking for claims for the 11 selected procedures ordered by a practice and for a minimum of 5 claims (per practice) during the prior year. It is not 5 of the 11 procedures, rather a minimum of 5 procedures of any of those 11 procedures included in the demonstration for which there are claims during the prior year by the practice.

Question #5: What is the purpose of physician incentive tiers? Will this result in a change in reimbursement for specific imaging modalities for the future?

Answer: CMS will pay physician practices for reporting data under this demonstration based on the ordering volume for year prior to the start of the demonstration. The incentive payments for physicians are independent of their Medicare reimbursement. Because we are not interested in providing an incentive for increasing or decreasing advanced imaging utilization rates, CMS will pay participating practices based on historic ordering volume (of the 11 imaging procedures included in the demonstration).

Question #6: Will conveners select the DSS to be used in the demonstration? Are conveners required to choose one DSS for the entire demonstration area proposed? Will all conveners be required to use the identical DSS? Will the demonstration assess the impact of different DSS?

Answer: The purpose of the demonstration is to determine whether the use of decision support systems utilizing medical specialty guidelines by physicians improves the appropriateness of the use of advanced imaging services. It is not to compare different DSSs.

Each proposal must identify a DSS that meets the requirements of the demonstration described in the RFP. For example, the DSS must employ the medical specialty guidelines and 11 advanced imaging procedures used in the demonstration. It must be able to provide feedback, transmit and report data in a method that meets the specification identified in the RFP, and it must meet all quality requirements (e.g., test cases).

We anticipate each convener will propose using one DSS. In addition, the convener must ensure the DSS remains current with the medical specialty guidelines. However, each

convener must identify the DSS to be used by the physician practices. CMS will not select one DSS to be used across all conveners.

Question #7: How will CMS ensure that differences between conveners do not affect the outcome of the demonstration? Will the imaging guidelines /appropriateness criteria used in this demonstration differ across demonstration sites?

Answer: No, the medical specialty guidelines for the 11 modalities used in this demonstration will not differ across conveners. CMS will test each system prior to collecting physician practice data to validate that the DSS is consistent with the guidelines. We recognize that differences will exist in the implementation of DSSs across conveners and that physicians may be influenced in their ordering of imaging tests for Medicare patients as a result of their current use of systems for commercial and other payers. The demonstration design seeks to minimize these differences and influences from the current environment.

We will select conveners based on the ability to meet the criteria and perform core functions defined in the RFP, including the requirement to employ a DSS that meets specific requirements involving specified guidelines for given modalities, and transparency to minimize these differences.

Question #8: In addition to being consistent with Medicare coverage policies, can a DSS incorporate clinical guidelines developed by medical specialty societies based upon years of experience as augmented by application of published literature and informed experience? For those physician practices already using DSS, will they continue to use their current system or be required to implement a new system?

Answer: The MIPPA statute specifically requires that the appropriateness criteria used in the demonstration be based on those developed or endorsed by medical specialty societies. CMS worked with medical specialty societies and other stakeholders including the AQA, to get their input and information on available guidelines. Consequently, for purposes of this demonstration, DSSs must be consistent with published medical specialty society guidelines for the 11 procedures identified.

Question #9: How will disagreement between or gaps within guideline criteria be dealt with?

Answer: In general we find that where multiple medical societies have promulgated appropriateness guidelines that are relevant to the procedures we are targeting, the societies have issued guidelines collaboratively, or there is concordance across guidelines. We are aware of a limited set of areas where there may be some differences. We expect conveners to make physicians aware of differences and DSSs to be transparent related to sourcing of medical specialty guidelines.

Question #10: There may be an artificially lowered baseline level of appropriateness rates because of the potential “sentinel” effect that may occur during the baseline collection of data, as physicians are aware they are participating in the demonstration.

Answer: The pre/post research design will allow CMS to measure the impact of using a DSS on the appropriateness of advanced imaging orders in the Medicare fee for service population. The baseline collection of data allows orders to be rated by their appropriateness, which cannot be done with claims data alone and would be inordinately costly to perform

through a retrospective review of medical records. It is certainly possible that there may be an artificially lowered level of appropriateness because of a sentinel effect during the baseline collection of data. Some evidence of the extent of this effect will be obtained from advanced imaging utilization of participating physicians during the previous year, as measured from claims data. In other words, the evaluation team will compare utilization during the baseline period with utilization during the same period of the previous year. If a sentinel effect is observed, the appropriateness rate estimate will be interpreted as a "lower bound" estimate.

Question #11: What are the specific reporting requirements of the demonstration, and what constitutes "completeness of reporting?" How will CMS undertake the prior year calculation and do claims data submitted by radiologists contain information on ordering physician?

Answer: The solicitation will provide details regarding the data collection requirements. In general, the data to be collected by each DSS includes: physician and practice identifiers; patient identifiers and demographic information; diagnosis, symptoms, and/or treatment history; procedures proposed to be ordered and actually ordered; appropriateness determinations; and test result.

Completeness of reporting (COR) will be measured by matching the number of DSS records captured to the number of advanced imaging service claims for the 11 target procedures found in the Medicare FFS claims data. Completeness of reporting will be measured at both the practice level and at the convener level. The COR threshold for year 1 of the demonstration is 80 percent (i.e. no less than 80 percent of the tests ordered must have a DSS record) and the COR threshold for year 2 is 90 percent. The goal is to encourage conveners to collect complete data from the practices for the targeted 11 advanced imaging procedures.

Claims data for imaging services contain the NPI for both the ordering and rendering physicians. Thus it is possible to use the claims data along with information to be submitted in response to the solicitation on physician practices and their physicians to determine the historical ordering volume of the practices.