EDITORIAL

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Just What the Doctor *Didn't* Order: More Regs

In this issue of *Emergency Medicine*, Drs. Hentel, Sharma, Wladyka, and Min tackle the difficult subject of trying to describe the appropriate use of (head) CT in the emergency department. They do so a few months after CMS announced plans to reduce the number of "inefficient" emergency department imaging studies by using the final diagnoses to retrospectively determine the appropriateness of head CTs ordered for patients with nontraumatic headaches.

There are two important reasons why all physicians should have been more concerned about overuse of CT imaging before we reached this point: (1) exposing patients to excessive radiation and (2) cost. Even though the government may be more concerned about the latter, reducing unnecessary studies for either reason is not a bad idea. But such measures need to be based on solid scientific evidence and not just cost-cutting rationalizations or bad science. It should be noted that CMS is still determined to proceed with its "dry run" despite rejection of the proposed measure by the National Quality Forum (NQF).

Dr. Hentel and colleagues expertly take *EM* readers through the salient findings of the important published studies on this subject to date, and end up demonstrating that there is neither a consensus on appropriateness nor a single safe and convincing study on which EPs can rely. They also point out the dangers of trying to apply the results of a study that had been conducted on one segment of the population to patients from another segment and quote ACEP's admonition that CMS is using recommendations from studies that excluded older adults to inappropriately create a performance measure for a population that is largely 65 and older. The authors note other reasons to be concerned about the CMS approach, including not taking into account different practice settings where alternatives to CT, such as MRI, are not available, and the difficulties created when the written recommendations of consultants are not consistent with official recommendations or guidelines.

Added to all of these confounding factors is the erroneous premise that a negative study is inefficient, unnecessary, or wasteful. Emergency physicians have long been accustomed to the idea that "rule-out" diagnoses, such as "rule-out MI," are not acceptable to third-party payers. But when a patient is experiencing a nontraumatic headache and has a fever and stiff neck, is it safe to forgo a CT scan (if available) to "rule out" or exclude a space-occupying lesion such as an abscess before performing a lumbar puncture?

If all of this sounds vaguely familiar, it should. In recent years there have been many previous attempts by third-party payers to cut health care costs by restricting access to care (including ED visits)—or reducing or eliminating diagnostic testing. In the early days of managed care, a notice from one insurer advised all EDs in our area that radiologic studies for acute orthopedic conditions would be covered only if they revealed fractures and not if they led to a diagnosis of sprain or strain. Most cost-cutting initiatives aimed at providers are based on either incentives to stay within the guidelines or penalties for those who don't. And of course, many that start with the former quickly evolve into the latter.

But CMS is not just *any* third-party payer, and its penalties are far more significant than those meted out by managed care companies. To the extent that this CMS proposal sensitizes us to the needs of reducing radiation exposure and costs, everyone will benefit. But whatever form the final regulations take must be based on solid science and, most importantly, patient safety. **EM**