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Participating in the Webinar

All attendees will be muted and will remain in "Listen Only Mode"

Type your questions here so that the moderator can see them.
Not all questions will be answered but we will get to as many as possible.

A handout with the slides and room to take notes can be downloaded from your control panel.

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ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!



Week 23 – Thursday, June 8, 2023
Leadership, Diversity, Ethical Care, and Equity
Faculty: Sonali Paul, MD, MS; Cassandra D. Fritz, MD; and Lauren D. Nephew, MD
Moderator: Sophie M. Balzora, MD, FACG
At Noon and 8pm Eastern



Week 24 – Thursday, June 15, 2023
Fatty Liver Disease
Faculty: Robert J. Wong, MD, MS, FACG; Mary E. Rinella, MD, FACG; Joseph K. Lim, MD, FAC
At Noon and 8pm Eastern

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Disclosures

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Stephen T. Amann, MD, FACG

Dayna S. Early, MD, FACG

Eric D. Shah, MD, MBA, FACG

All speakers have no financial relationships with ineligible companies.

**All of the relevant financial relationships listed for these individuals have been mitigated*

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"Significant Prior Authorization Changes Looming in GI: Tips from the ACG Prior Authorization Task Force"

Stephen T Amann, MD FACG

Vice Chair ACG Prior Authorization Task Force

Dayna S. Early, MD, FACG (Chair)
Stephen T. Amann, MD, FACG (Vice Chair)
Joseph Cappa, MD, FACG
David Hass, MD, FACG
Whitfield Knapple, MD, FACG
Baharak Moshiree, MD, MSc, FACG
Shireen Pais, MD, FACG
Shabana Pasha, MD, FACG

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PA Burden and Facts

- PA has evolved
  - Experimental therapy
  - Reduce costs of healthcare
  - Protect patient safety
  - Evidence based care
- Now a cumbersome and redundant
  - Nearly all services involved
  - STEP care
  - Labs, medications, therapy, procedures

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PA Burden and Facts

- Many studies have shown increased burden and harm in care
- AMA, MGMA, HHS OIG reports
- No standard process
  - Proprietary with providers
  - Antiquated FAX systems
  - No link to EHRs
- Complex and burdensome

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PA Burden and Facts

- Practice issues
  - Interrupt workflow
  - Different process per insurer
  - Peer to peer on THEIR schedule and not generally same specialty
- Patient Harm!

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Getting It Right: "TIPS" from ACG PA TF

- Know requirements and submit correctly
- Document in EMR in preparation
- Train your PA team and share best practices in office
- Can you automate
  - Portals, eRx
- Prepare for Peer to peer

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Getting It Right: "TIPS"

Info for EMR documentation
Dates, method of diagnosis
Disease severity, use accepted descriptors and guidelines
Treatment failures, side effect of therapy, contraindications– in brief summary
Document good outcomes with current therapy (for renewals)

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Getting It Right: "TIPS"

- Peer to Peer
  - Know the case
  - Reference guidelines or literature (ACG PA documents)
  - ASK for specialty review by a gastroenterologist
    - Likely to cause further delay , so plan for this
  - Document reviewers name and all conversations in chart or notes
  - If they deny ask for guidelines used for denial
  - Be firm but cordial, ask for timeline to get decision

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Conclusion and Success

- Persevere and multiple appeals
- Get patient involved as well
- Go to your www.gi.org and the Practice Management section for terrific tools
- ACG will continue to work on this issue

- Guidelines:
- www.gi.org/guidelines
- AGA, ASGE, AASLD WGO and NID guidelines

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Conclusion and Success from ACG

- https://gi.org/practice-management/ and get the toolbox on PA
- Template letters

Biofeedback Therapy for Pelvic Floor Disorders
Eluxadoline for IBS-D
Linaclotide for Chronic Idiopathic Constipation (CIC) or IBS-C
Lubiprostone for Chronic Idiopathic Constipation (CIC)
Pancreatic cancer screening testing with CT, MRCP, and EUS
Plecanatide for Chronic Idiopathic Constipation (CIC) or IBS-C
Prucalopride for Chronic Idiopathic Constipation (CIC)
Rifaximin for Hepatic Encephalopathy
Rifaximin for IBS-D
Tenapanor for IBS-C

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Clinical Scenario: Using the Task Force's Practical Guidance into Practice

Eric Shah, MD, MBA, FACG

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What is the United guidance?

New requirements for gastroenterology services

March 01, 2023

New requirements for gastroenterology services

Last modified: May 22, 2023

Beginning June 1, 2023, you'll be required to obtain prior authorization for gastroenterology endoscopy services for UnitedHealthcare commercial plan members, in accordance with the terms of their benefit plan. Please note that screening colonoscopy procedures are not included in this new medical necessity review requirement. Please review the **Preventive Care Services – Commercial and Individual Exchange Medical Policy** for details regarding screening colonoscopies.

Affected procedures

The following procedures will now require prior authorizations:

- Esophagogastroduodenoscopies (EGD)
- Capsule endoscopies
- Diagnostic colonoscopies
- Surveillance colonoscopies

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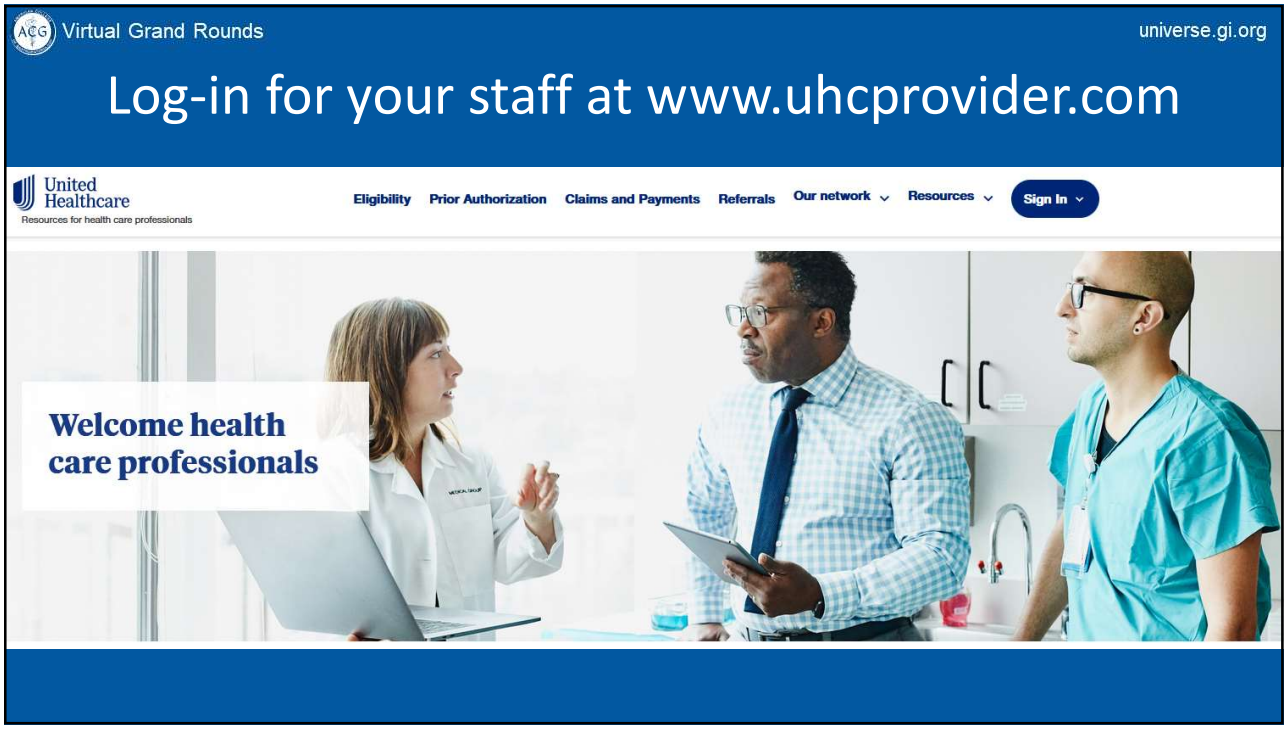
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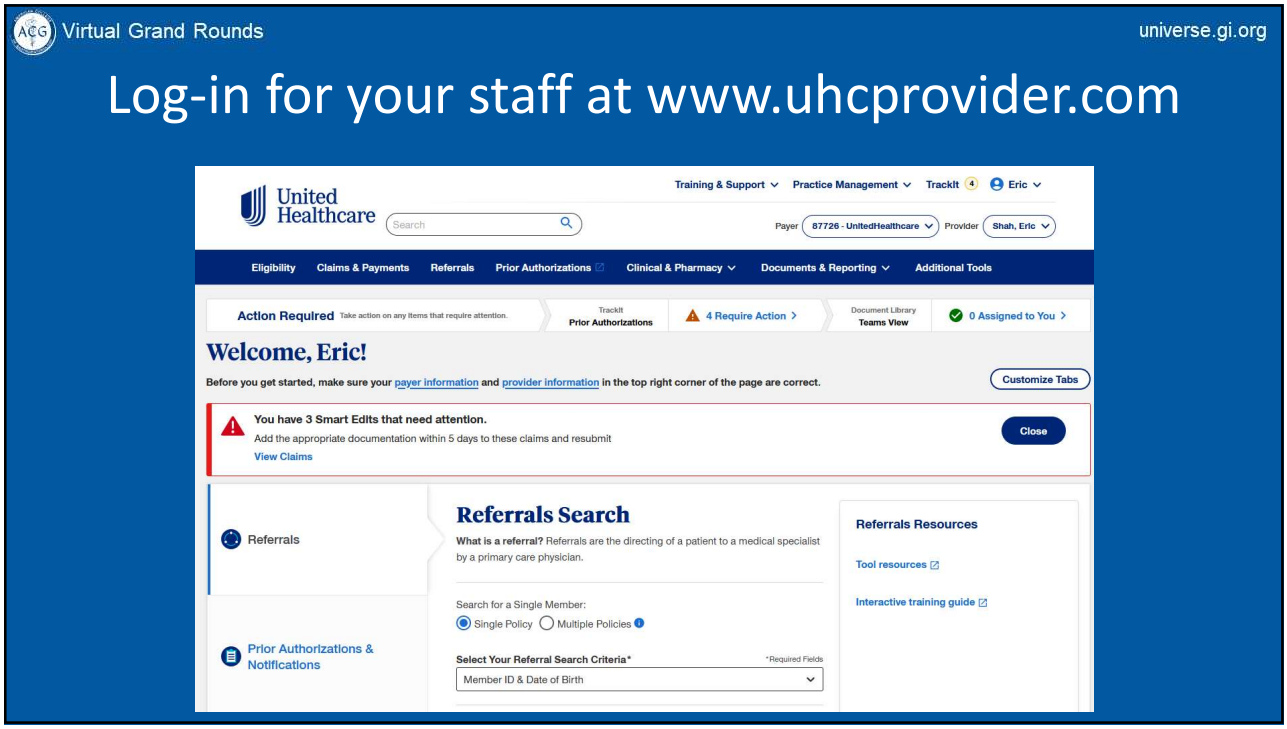
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What is a referral? Referrals are the directing of a patient to a medical specialist by a primary care physician.
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Referrals Resources
Tool resources
Interactive training guide

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What needs to be in the template letters?

Per UHC documents:

- Pertinent clinical evaluation (within 60 days; telehealth OK)
- Covered indications align precisely with guidelines

EGD-1.1: Dyspepsia/Upper Abdominal Symptoms

The following are indications for EGD in individuals with dyspepsia or upper abdominal symptoms. Dyspepsia is defined by the American College of Gastroenterology (ACG) and Canadian Association of Gastroenterology (CAG) as predominant epigastric pain lasting at least one month and can be associated with any upper gastrointestinal symptoms such as epigastric fullness, nausea, vomiting, or heartburn.

- New-onset symptoms in individuals ≥ 60 years of age.
- Individuals < 60 years of age without red flag symptoms
  - EGD if failure of an initial "test and treat" approach for H. pylori or a trial of empiric therapy for 4 weeks with a proton pump inhibitor (PPI)*
    - See Background and Supporting Information: Dyspepsia
- Any age with presence of ANY of the following red flag symptoms associated with dyspeptic or upper abdominal symptoms:
  - Family history of any of the following upper gastrointestinal (UGI) malignancies in a first-degree relative:
    - Esophageal

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What is a guideline?

1. We suggest dyspepsia patients aged 60 or over have an endoscopy to exclude upper gastrointestinal neoplasia. Conditional recommendation, very low quality evidence.
2. We do not suggest endoscopy to investigate alarm features for dyspepsia patients under the age of 60 to exclude upper GI neoplasia. Conditional recommendation, moderate quality evidence.
3. We recommend dyspepsia patients under the age of 60 should have a non-invasive test for *H. pylori*, and therapy for *H. pylori* infection if positive. Strong recommendation, high quality evidence.
4. We recommend dyspepsia patients under the age of 60 should have empirical PPI therapy if they are *H. pylori*-negative or who remain symptomatic after *H. pylori* eradication therapy. Strong recommendation, high quality evidence.
5. We suggest dyspepsia patients under the age of 60 not responding to PPI or *H. pylori* eradication therapy should be offered prokinetic therapy. Conditional recommendation very low quality evidence.

References: ACG guideline for dyspepsia
https://bestpractice.bmj.com/info/us/toolkit/learn-ebm/what-is-grade/

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Certainty	What it means
Very low	The true effect is probably markedly different from the estimated effect
Low	The true effect might be markedly different from the estimated effect
Moderate	The authors believe that the true effect is probably close to the estimated effect
High	The authors have a lot of confidence that the true effect is similar to the estimated effect

Strength of recommendation	What that means
Strong	most patients should receive the recommended course of action
Conditional	many patients will have this recommended course of action but different choices may be appropriate for some patients and a greater discussion is warranted so each patient can arrive at a decision based on their values and preferences

References: ACG guideline for dyspepsia
https://bestpractice.bmj.com/info/us/toolkit/learn-ebm/what-is-grade/

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Direct from GRADE…

- "GRADE is subjective: GRADE cannot be implemented mechanically; there is by necessity a considerable amount of subjectivity in each decision. Two persons evaluating the same body of evidence might reasonably come to different conclusions about its certainty. What GRADE does provide is a reproducible and transparent framework for grading certainty in evidence."

References: ACG guideline for dyspepsia
https://bestpractice.bmj.com/info/us/toolkit/learn-ebm/what-is-grade/

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Guideline development methods are not designed to be cost-effective: So why are they used by insurers?

Test-and-treat is recommended by guidelines, but many patients receive early endoscopy in practice

Patient with uninvestigated **dyspepsia** without alarm features

How to investigate?

Strategies

- Test-and-treat*
- Test-and-scope*
- Prompt endoscopy
- Empiric acid suppression

Factors to consider

Commonly
- Efficacy
- Safety
- Tolerability

Proposed
- Healthcare costs
- Patient satisfaction
- Health gains
- Work-productivity losses
- Others?

Factors beyond efficacy, such as **cost** and **patient satisfaction**, may explain the divergence between guidelines and clinical practice

In our model, which considers proposed factors, prompt endoscopy maximizes cost-effectiveness; test-and-scope maximizes cost-patient satisfaction

* Test for *H. pylori*

Clinical Gastroenterology and Hepatology

References: Clin Gastroenterol Hepatol. 2023 Jan 13;S1542-3565(23)00030-7.

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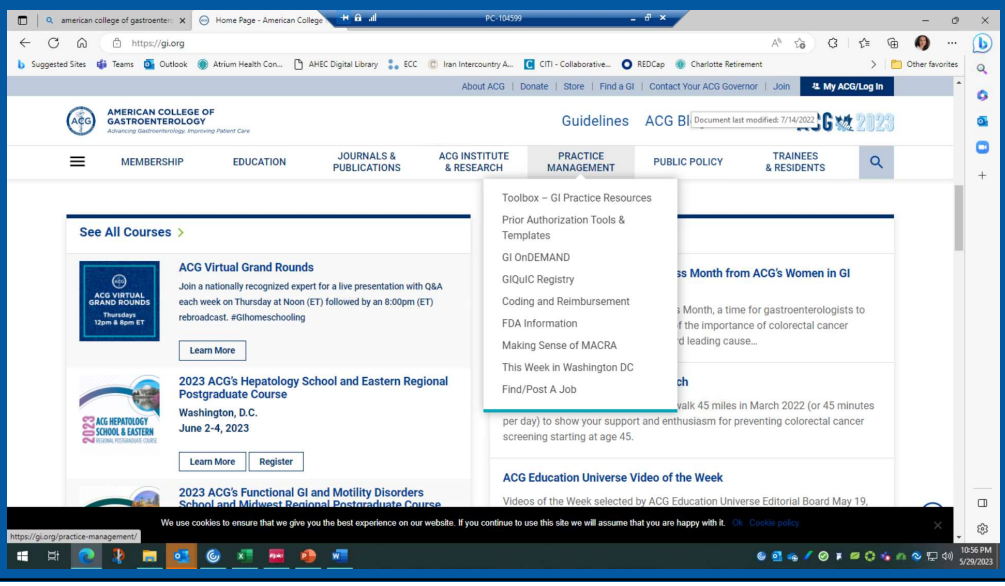
ACG Taskforce ToolBox



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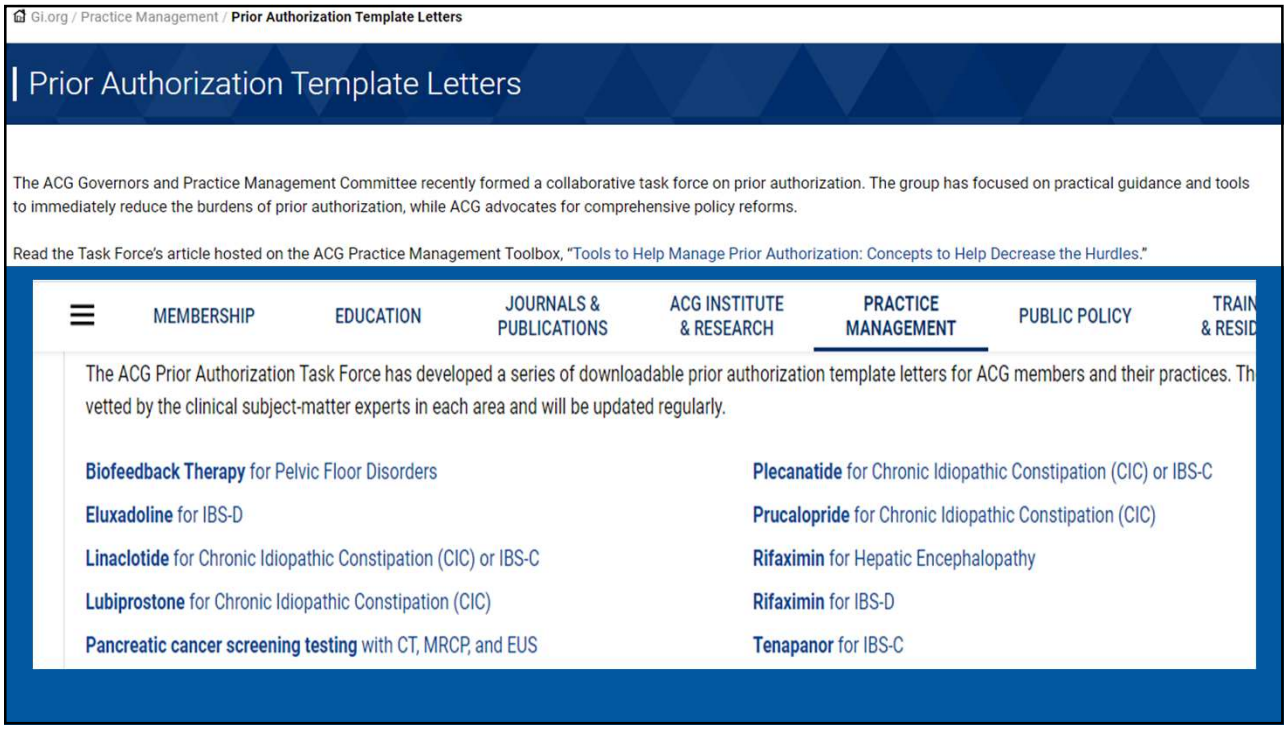
Gi.org / Practice Management / Prior Authorization Template Letters
Prior Authorization Template Letters
The ACG Governors and Practice Management Committee recently formed a collaborative task force on prior authorization. The group has focused on practical guidance and tools to immediately reduce the burdens of prior authorization, while ACG advocates for comprehensive policy reforms.
Read the Task Force's article hosted on the ACG Practice Management Toolbox, "Tools to Help Manage Prior Authorization: Concepts to Help Decrease the Hurdles."
MEMBERSHIP
EDUCATION
JOURNALS & PUBLICATIONS
ACG INSTITUTE & RESEARCH
PRACTICE MANAGEMENT
PUBLIC POLICY
TRAIN & RESID
The ACG Prior Authorization Task Force has developed a series of downloadable prior authorization template letters for ACG members and their practices. Th
vetted by the clinical subject-matter experts in each area and will be updated regularly.
Biofeedback Therapy for Pelvic Floor Disorders
Eluxadoline for IBS-D
Linaclotide for Chronic Idiopathic Constipation (CIC) or IBS-C
Lubiprostone for Chronic Idiopathic Constipation (CIC)
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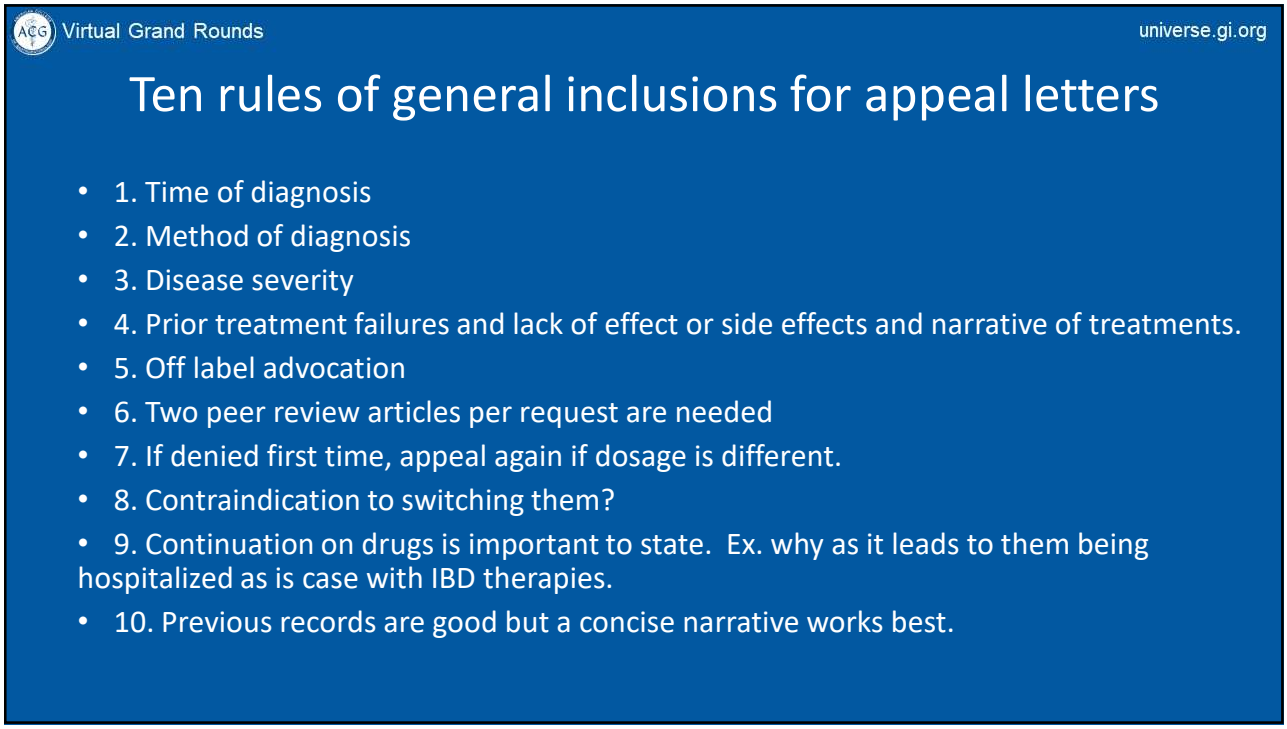
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Ten rules of general inclusions for appeal letters
1. Time of diagnosis
2. Method of diagnosis
3. Disease severity
4. Prior treatment failures and lack of effect or side effects and narrative of treatments.
5. Off label advocation
6. Two peer review articles per request are needed
7. If denied first time, appeal again if dosage is different.
8. Contraindication to switching them?
9. Continuation on drugs is important to state. Ex. why as it leads to them being hospitalized as is case with IBD therapies.
10. Previous records are good but a concise narrative works best.

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Sample appeals for procedures on ACG website

Sample Letter

SAMPLE APPEAL LETTER: Biofeedback therapy for pelvic floor disorders

Patient:

Date of Birth:

ID #

Pat Acct #

Insurance Company

RE: PATIENT

DATE

ICD-10-code: Dyssynergic defecation (K83.8), Fecal incontinence (R15.9), Rectocele (N81.6), Rectal prolapse (K62.3)

Requesting Physician:

NPI #:

Dear Medical Reviewer:

I am writing to formally appeal your denial for our patient ---------- for her/his treatment with biofeedback therapy for _____. This therapy has proven effective for treatment of constipation and fecal incontinence. Please see ICD-10 codes above.

Several recent publications and recommendations by the Gastroenterology societies have recommended biofeedback therapy for treating pelvic floor disorders such as dyssynergic defecation, constipation and incontinence. These are standard therapies and can help patients avoid the high morbidity caused by alternatively having to have surgery. Biofeedback therapy is a method where through a computer device, patients can learn to control some of the muscles in the pelvic floor and wear electrical sensors placed in the anorectal region to control those muscles and either relax them or learn to strengthen them. This sensory and motor input retrains the pelvic floor and the brain to help with getting many patients off laxatives. Both the American and British Societies now advocate anorectal physiology testing followed by biofeedback therapy in especially women with irritable bowel syndrome with constipation not responding to standard therapies or with suspected pelvic floor disorders based on history or exam findings as response rates to biofeedback therapy are so favorable.

This treatment is usually done either by a physical therapist trained in performance of pelvic floor therapy or a certified nurse in motility supervised by a physician.

References provided

Please see recent publications below that advocate these recommendations below:

1. Jelovsek JE, Markland AD, Whitehead WE, Barber MD, Newman DK, Rogers RG, Dyer K, Visco AG, Sutkin G, Zyczynski HM, Carper B, Meikle SF, Sung VW, Gantz MG; National Institute of Child Health and Human Development Pelvic Floor Disorders Network. Controlling faecal incontinence in women by performing anal exercises with biofeedback or loperamide: a randomised clinical trial. Lancet Gastroenterol Hepatol. 2019 Sep;4(9):698-710.
2. Lacy BE, Pimentel M, Brenner DM, Chey WD, Keefer LA, Long MD, Moshiree B. ACG Clinical Guideline: Management of Irritable Bowel Syndrome. Am J Gastroenterol. 2021 Jan 1;116(1):17-44.
3. Vasant DH, Paine PA, Black CJ, Houghton LA, Everitt HA, Corsetti M, Agrawal A, Aziz I, Farmer AD, Eugenicos MP, Moss-Morris R, Yiannakou Y, Ford AC. British Society of Gastroenterology guidelines on the management of irritable bowel syndrome. Gut. 2021 Jul;70(7):1214-1240.
4. Rao SSC, Valestin JA, Xiang X, Hamdy S, Bradley CS, Zimmerman MB. Home-based versus office-based biofeedback therapy for constipation with dyssynergic defecation: a randomised controlled trial. Lancet Gastroenterol Hepatol. 2018 Nov;3(11):768-777.

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Medication appeal letter instructions

- Narrative summary with “buzzwords” are helpful
- Prior medication failures should be listed
- Practice guidelines should be incorporated in
- For new labeling of drugs add 2 peer-reviewed articles especially FDA labeling if available.
- State adverse reactions to or contraindications of other choices in medications
- Could ask for gastroenterologist or content expert if available
- IMPORTANT: Ask for the turnaround time if urgent – can ask for 48 hour or 72 hour turnaround as priority

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Medication appeal sample letter

Dear Sir/Madam,

I am writing on behalf of my patient, Mr./Ms._____, to request prior authorization for eluxadoline 75mg or 100 mg twice daily for the treatment of irritable bowel syndrome with diarrhea (IBS-D, ICD-10- K58.0). Eluxadoline is a peripherally acting mixed mu and kappa opioid receptor agonist/delta opioid receptor antagonist approved for the treatment of men and women with irritable bowel syndrome with diarrhea. The most recent American College of Gastroenterology guidelines give a conditional recommendation with moderate quality of evidence for using eluxadoline in IBS-D.[1] In 2 large randomized, double-blind, placebo controlled trials, eluxadoline improved global IBS-D symptoms in men and women.[2] Two studies demonstrated eluxadoline improved symptoms in patients with IBS-D who failed previous therapy with loperamide. [3-4]

Mr./ Ms. _____ was diagnosed with IBS-D on _____. He/She has tried other therapies including low FODMAP diet, soluble fiber, dicyclomine, hyoscyamine, loperamide, tricyclic antidepressants and rifaximin without success or has experienced side effects. There is no history of pancreatitis, alcoholism, alcohol abuse or addiction, and no history of cholecystectomy. I am requesting they receive eluxadoline for IBS-D based on the previously failed therapies and the supporting literature.

1. Lacy B, Pimental M, Brenner D, Chey W, Keefer L, Long M, Moshiree B. ACG Clinical Guideline: management of irritable bowel syndrome. American J Gastroenterology 2021; 116(1): 17-44.
2. Lembo A, Lacy B, Zuckerman M, Schey R, et al. Eluxadoline benefits patients with irritable bowel syndrome with diarrhea. New England J Medicine 2016; 374: 242-53.
3. Lacy B, Chey W, Cash B, et al. Eluxadoline efficacy in patients with irritable bowel syndrome with diarrhea who experience inadequate symptom control with loperamide. American J Gastroenterology 2017; 112: 924-32.

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Questions

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