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REGIONAL POSTGRADUATE COURSE
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ACG Institute
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Application Deadline: Friday, July 14, 2023
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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.

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, FACG
At Noon and 8pm Eastern

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All speakers have no financial relationships with ineligible companies.
*All of the relevant financial relationships listed for these individuals have been mitigated.

“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, FACP (Chair)
Stephen T. Amann, MD, FACP (Vice Chair)
Joseph Cappa, MD, FACP
David Hass, MD, FACP
Whitfield Knapple, MD, FACP
Baharak Moshiree, MD, MSc, FACP
Shireen Pais, MD, FACP
Shabana Pasha, MD, FACP
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

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
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!

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
Getting It Right: “TIPS”

Info for EMR documentation

<table>
<thead>
<tr>
<th>Dates, method of diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease severity, use accepted descriptors and guidelines</td>
</tr>
<tr>
<td>Treatment failures, side effect of therapy, contraindications— in brief summary</td>
</tr>
<tr>
<td>Document good outcomes with current therapy (for renewals)</td>
</tr>
</tbody>
</table>

• 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
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

Conclusion and Success from ACG

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

<table>
<thead>
<tr>
<th>Biofeedback Therapy</th>
<th>Plecanatide for Chronic Idiopathic Constipation (CIC) or IBS-C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eluxadoline for IBS-D</td>
<td>Prucalopride for Chronic Idiopathic Constipation (CIC)</td>
</tr>
<tr>
<td>Linaclootide for Chronic Idiopathic Constipation (CIC) or IBS-C</td>
<td>Rifaximin for Hepatic Encephalopathy</td>
</tr>
<tr>
<td>Lubiprostone for Chronic Idiopathic Constipation (CIC)</td>
<td>Rifaximin for IBS-D</td>
</tr>
<tr>
<td>Pancreatic cancer screening testing with CT, MRCP, and EUS</td>
<td>Tenapanor for IBS-C</td>
</tr>
</tbody>
</table>
Clinical Scenario: Using the Task Force’s Practical Guidance into Practice

Eric Shah, MD, MBA, FACG

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:

- Esophageal gastroduodenoscopies (EGD)
- Capsule endoscopies
- Diagnostic colonoscopies
- Surveillance colonoscopies
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

What is a guideline?

1. We suggest dyspepsia patients aged 60 or over have an endoscopy to exclude upper gastrointestinal neoplasm. 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 neoplasm. 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 proton pump therapy. Conditional recommendation very low quality evidence.

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

- **Strength of recommendation**
  - **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.

<table>
<thead>
<tr>
<th>Certainty</th>
<th>What it means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very low</td>
<td>The true effect is probably markedly different from the estimated effect.</td>
</tr>
<tr>
<td>Low</td>
<td>The true effect might be markedly different from the estimated effect.</td>
</tr>
<tr>
<td>Moderate</td>
<td>The authors believe that the true effect is probably close to the estimated effect.</td>
</tr>
<tr>
<td>High</td>
<td>The authors have a lot of confidence that the true effect is similar to the estimated effect.</td>
</tr>
</tbody>
</table>

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 eradication therapy. **Conditional recommendation** very low quality evidence.

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

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/
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

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?

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

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

References: Clin Gastroenterol Hepatol. 2023 Jan 13;S1542-3565(23)00030-7.
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.
Sample appeals for procedures on ACG website

Sample Letter

Patient:
Age:
Sex:
Insurance Company:
Date:

References provided

Please see recent publications below to advocate these recommendations below:


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
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/δ 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.1 Two studies demonstrated eluxadoline improved symptoms in patients with IBS-D who failed previous therapy with loperamide.1, 4

Mr./Ms. __________ was diagnosed with IBS-D on __________. He/She has tried other therapies including low FODMAP diet, soluble fiber, diclofenac, hyoscine, 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.


Questions

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GI

ACG Hepatology Circle

ACG Functional GI Health and Nutrition Circle

ACG GI Circle
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ACG Women in GI Circle

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