Coming soon: Appropriate use criteria

By Terry Stanton

Follow-ups to CPGs focus on clinical application

As they continue to develop and issue new clinical practice guidelines (CPGs), AAOS volunteers are also embarking on a major new phase in the Academy’s comprehensive quality initiative: appropriate use criteria (AUCs).

Although CPGs have been well received, one of their primary limitations is that for many topics, little, if any, top-quality evidence exists. Physicians must make daily decisions about when to use a particular procedure, even if data are not available or do not provide enough detailed or reliable evidence to apply to the full range of patients seen.

William C. Watters III, MD

The AUCs will serve as clinically relevant complements to the CPGs, providing important guidance on the appropriate use of a procedure or other therapeutic measure. As William C. Watters III, MD, chair of the Appropriate Use Criteria Committee explains, “Evidence-based CPGs tell us if a procedure or service works. AUCs specify when it is appropriate to perform that procedure or service.”

The approach used to develop AUCs was originated by the Rand Corporation and refined by the American College of Cardiology (ACC) into a method applicable to clinical medicine.

The following system will be used to develop appropriate use criteria:

- Each criterion will mirror an already developed CPG.
- A topic writing panel made up of orthopaedic surgeons will develop up to 100 clinical scenarios.
- A review panel made up of different orthopaedic surgeons will review all the scenarios to ensure that they represent realistic patients and treatment decisions that practitioners are likely to encounter.
- A third group of orthopaedic surgeons, the voting panel, will review the acceptable scenarios and rank each on a scale of 1 to 9 as to their appropriateness.
- All the scenarios and their rankings will then be discussed by the voting panel and a second, final ranking will be performed to form a consensus on what would be appropriate uses of that procedure.

The first AUC to be developed will be for distal radius fractures, which are already covered by a CPG. This will enable the committee to hone its skills and refine the AUC process. In an interview with AAOS Now, Dr. Watters addressed other considerations and issues involved in AUCs, including how they might be received and used by insurance companies and how orthopaedic surgeons can benefit from them.

AAOS Now: What need will AUCs fill?
Dr. Watters: CPGs have been well received but are not very user-friendly. AUCs describe an appropriate way of providing treatment where expected health benefits would exceed any negative consequences by a very wide margin. Although AUCs are based on evidence, they are more likely to be user-friendly.

The CPGs focus on specific topics such as the best way to diagnose or treat certain conditions. They identify what needs to be done to achieve a certain goal, such as performing a total knee replacement (TKR) in a patient with severe arthritis. But they don’t address the total spectrum of possible uses of TKR—in other words, when is it appropriate to perform a TKR? We know it works, but for whom does it work?

By creating a series of clinical scenarios in which a physician might employ TKR, we can establish a universe of ways to treat the problem that are in reasonable bounds of good medical care. We’re not talking about a TKR, we are talking about multiple situations in which a TKR is likely to be used. Is a TKR appropriate for a 12-year-old? Probably not, unless the patient has rheumatoid arthritis. Is a TKR appropriate for an 85-year-old person who is very ill and confined to a wheelchair? That may not be appropriate either. But between these extremes, a spectrum of situations exists in which TKR may be appropriate. The AUC scenarios will be used to search for these situations.

We will select topics that have a substantial amount of potential morbidity associated with them to make sure that important procedures, such as spinal fusion, are being used appropriately and not overused (or possibly underused). We will seek topics that consume resources from the standpoint of payers. We want to focus on procedures that lots of doctors do lots of times.

Topics that have variation in usage across the country, indicating less-than-hard indications for their use, may be ripe for the development of appropriate use criteria. We want to focus on the ambiguities of a particular procedure to define the boundaries of its appropriate use.

AAOS Now: Some physicians might be concerned that insurers will use AUCs to deny payment.

Dr. Watters: The intent is to clarify the use of orthopaedic technologies. That’s no guarantee, unfortunately, that insurance companies won’t misinterpret or misuse the information. Yet they are consistently asking for this type of information.

Insurers appreciate the work that the AAOS has done in developing CPGs and often prefer to use them rather than guidelines from commercial entities. But payers really want a better real-world approach to how physicians might use a technology or procedure and when physicians might use it appropriately and thus be appropriately paid for it.

Some physicians may believe that insurance companies will take this information and limit what doctors do. I think the opposite will be true; I think this will broaden the indications for much of what we do routinely without a rigid evidence base.

AAOS Now: What did you learn from the ACC?

Dr. Watters: The ACC started out, as the AAOS did, with a very rigid adherence to the Rand approach. But they found that they were not able to address many questions that their members wanted answers to—questions that didn’t have a lot of evidence. The ACC developed techniques to broaden the field of inquiry and address areas where evidence isn’t strong one way or the other. We’ll follow their method.

When the ACC began this process, some of their members saw AUCs as unrelated to their world, much the way guidelines were perceived. But now, members look forward to new AUCs and often say they wish the ACC had begun developing them earlier. That’s the kind of endorsement we hope to see at the AAOS.

AAOS Now: How do AUCs fit into the quality movement, and what is the benefit?

Dr. Watters: AUCs certainly are within the context of the Academy’s thrust toward quality. They are an extension of the use of evidence and bring the practitioner more practical information for the clinical decision making process. AUCs are relatively new and haven’t been applied in clinical medicine until recently. The AAOS intends to become the leader in applying this technology to musculoskeletal care. AUCs are an exciting new concept and should benefit our patients and our members, as well as regulators and payers.


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