Ensuring that AAOS CPGs Are Used—But Not Abused

An interview with Kevin J. Bozic, MD, MBA

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Clinical Practice Guidelines (CPGs) are being developed by physicians across all disciplines to determine the evidence base and appropriateness for a particular procedure or technology. CPGs are valuable tools for multiple audiences: they can aid clinical decision making for physicians who are uncertain about the value of a specific intervention; they can empower patients by fostering shared decision-making opportunities; and they can inform payers about which procedures and technologies yield the best results.

The impact that CPGs could have on payer decisions has sparked controversy among physicians. Skeptics worry that guidelines might be too inflexible to meet the needs of specific patients, could inhibit the doctor-patient relationship, and may provide payers with the grounds to deny payment for certain procedures.

As the AAOS prepares to update previously developed CPGs and introduce new ones, Kevin J. Bozic, MD, MBA, chair of the Council on Research and Quality, sat down with AAOS Now to address concerns about the guidelines, how the process has evolved, and what the AAOS is doing to ensure that Academy guidelines are not misused by payers and other stakeholders.

AAOS Now: Can you describe the AAOS CPG process? What is different about the process now compared to when it started?
**Dr. Bozic:** The CPG process is intended to synthesize the best available evidence to inform clinical decision making. Early on, some of the clinical topics chosen for CPGs had either limited available evidence and/or were on topics of limited impact both within and outside of orthopaedics. Since then, we have begun to shift to topics of broader impact, like the treatment of hip fractures, and those that might have a broader research base.

**AAOS Now: Are other stakeholders given the opportunity to participate and/or comment?**

**Dr. Bozic:** Yes, we very much try to include all groups of stakeholders where appropriate in our CPG work groups. (See “Get Involved in the CPG Process”). In particular, we select orthopaedic surgeons from specialty societies that have a vested interest in a particular topic to participate and often lead the work group. We also involve experts outside of orthopaedics. For example, the work group that updated the VTE prophylaxis guideline included a hematologist.

Also, once the draft is written, we solicit input and feedback from a number of different stakeholders who we think would have interest in a guideline.

**AAOS Now: Do you ever include patients in CPG development?**

**Dr. Bozic:** Yes, that is another thing we are changing. We have started to include patients at the outset as we plan our guidelines and then solicit their input as we draft the guidelines. This fall, we are going to be working on a CPG for total knee arthroplasty (TKA). We are planning a pilot with AARP to gain access to panels of patients who can provide the patient perspective on the selection of topics within the TKA CPG.

**AAOS Now: Each guideline includes a level of recommendation. Can you describe the grades of recommendation for AAOS guidelines?**

**Dr. Bozic:** The strength of the recommendation, ranging from strong to inconclusive, is determined by a number of factors. One is the level of evidence that is used to support that recommendation. So if multiple Level I (randomized control trials) studies support a recommendation, it would have a stronger recommendation than one supported by multiple Level III (case control) studies.

Another factor that influences the strength of a recommendation is the consistency of the findings in the studies. For example, if multiple Level III studies all favor an intervention, then that will positively affect a recommendation despite the lower quality of evidence. On the other hand, multiple Level One studies that contradict each other may lead to an inconclusive recommendation.

**AAOS Now: Do weak or inconclusive guidelines threaten physician payments for those procedures?**
Dr. Bozic: This has been a source of controversy. A weak recommendation means that evidence exists to support the use of a diagnostic or therapeutic intervention, but the evidence comes from lesser quality studies, Level III or IV. But, less than half of all recommendations in all guidelines in the National Guidelines Clearinghouse are supported by strong evidence. So even a weak recommendation ranks in the top half of all recommendations and guidelines.

In my opinion, a weak recommendation should be considered as evidence to support the use of an intervention and should not threaten coverage determinations. An inconclusive recommendation means that either there is not enough evidence or the evidence is contradictory. So, the coverage implication is unclear, but it still should not affect payments.

When there is strong, moderate, or weak evidence against the use of a procedure or technology, it would make sense for a payer to reconsider a coverage decision. However, even though the guideline on symptomatic osteoporotic spinal compression fractures found evidence against the use of vertebroplasty, no payer changed its coverage decision for that technology.

AAOS Now: What is the AAOS doing to ensure that payments are not being denied as a result of AAOS guidelines?

Dr. Bozic: First, we are monitoring any payment decisions that reference our guidelines to make sure that the guidelines are being interpreted properly. Recently, the New York State Medicaid program decided to deny coverage of knee arthroscopy based on a misinterpretation of our knee osteoarthritis treatment guideline. Upon discovering this, the AAOS immediately responded, citing the misinterpretation, and the decision was promptly reversed. (See “New York Overturns Payment Policy on Knee Arthroscopy.”)

To prevent further misinterpretations, we will be looking this fall at alternative wording that has been accepted by the National Quality Forum and others to see if modifying the language we use can make our guidelines more understandable to payers and clinicians. We are looking into developing “plain language summaries,” which are essentially restatements of the guideline recommendations in lay terms to make them more clear and understandable by nonclinicians.

We are also looking for opportunities to influence coverage decisions that are non–evidence-based. For instance, the current Medicare Administrative Contractor and Recovery Audit Contractor audits that the Centers for Medicare & Medicaid Services (CMS) is performing for hip and knee replacement procedures use non–evidence-based, proprietary criteria. The AAOS is currently advocating that CMS and other payers use our evidence-based CPGs and appropriate use criteria and incorporate them into coverage decisions that are currently based on non–evidence-based criteria.

AAOS Now: How are CPGs distributed and disseminated?

Dr. Bozic: The process of dissemination continues to evolve. We disseminate CPGs through the various AAOS media channels like the AAOS website, AAOS Now, the Journal of the AAOS, the Journal of Bone and Joint Surgery, and at the Annual Meeting. We just applied for a grant
through the Agency for Healthcare Research and Quality to use web-based mobile technologies for disseminating guidelines so they can be available at the point of service when doctors are interacting with patients.

All AAOS guidelines are posted in full on the AAOS website (www.aaos.org/guidelines), where anyone—patients, the public, other stakeholders, legislators, and the media—can access, read, and review them. In addition, executive summaries of the guidelines are included in the online searchable databases of the Agency for Healthcare Research and Quality National Guidelines Clearinghouse (http://guideline.gov) and the Guidelines International Network (www.g-i-n.net).

The AAOS public relations department sends media press releases announcing the publication of every new guideline; announcements are also sent to specialty societies and other stakeholders.

**AAOS Now: What if a guideline’s recommendation is the wrong decision for an individual patient? Would that threaten the doctor/patient relationship?**

**Dr. Bozic:** I think the key point is that CPGs are not meant to be prescriptive. They are meant to help synthesize the available evidence as it relates to a clinical decision. They are certainly not the only point of information available to physicians. CPGs should be incorporated into a clinical decision with other factors, including a physician’s own clinical experiences, the physician’s patient population, and the particular patient scenario. Also, specific patient factors such as comorbidities, allergies, or other risk factors should be considered when determining the appropriateness of a guideline recommendation.

**AAOS Now: Is there anything else you want our members to know about AAOS CPGs?**

**Dr. Bozic:** Our evidence-based CPG process is constantly evolving based on feedback from fellows and other stakeholders. We strongly believe that the AAOS has a duty to define and synthesize the evidence base for clinical decisions related to orthopaedics. We also believe that CPGs have policy relevance; we are working to make these products user-friendly for our clinicians and their patients, as well as to meet needs of other stakeholders who, we hope, will be using these guidelines as well.

For more information on AAOS clinical practice guidelines, visit www.aaos.org/guidelines

Dr. Bozic reports no conflicts; he serves as a board member or has a committee appointment with the following: AAOS; Agency for Healthcare Research and Quality; American Association of Hip and Knee Surgeons; American Joint Replacement Registry; American Orthopaedic Association; California Joint Replacement Registry Project; California Orthopaedic Association; Orthopaedic Research and Education Foundation.

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