In this era of accountable healthcare, broadly defined here by me as evidence based cost effective and financially prudent care, it is imperative that medical experts assess what is necessary care, lest the bean counters and politicians do it for us. Those of us who deal with the preauthorization process of the health insurance companies know how challenging that can be. Although ostensibly purported to be in the best interest of the subscriber (AKA, the patient), healthcare providers often suspect preauthorization is more for the financial benefit of the insurance company. So the health provider community has been challenged over the years to sort out its own house by evaluating the appropriate use of tests and treatments.

Towards those goals, the American Board of Internal Medicine Foundation has accepted, and in my estimation, met that challenge. In an initiative called “Choosing Wisely”, the ABIM Foundation has set forth some guidelines on relatively costly procedures that are done perhaps more frequently than objective evidence would otherwise justify. The ABIMF asked fellow medical specialty societies to come up with five procedures in their core areas and compare them to their own appropriate use criteria and guidelines. So nine groups, representing almost 375,000 physicians, came up with their list of five procedures, for a total of 45 items. That these lists came from recognized professional societies gives this effort significant weight. Eight more groups will add their lists later this year.

The American College of Cardiology identified circumstance when it may not be necessary to perform stress-imaging studies or advanced non-invasive imaging, when to use echocardiography, and when coronary obstructions may not require stenting.

While I will not comment on the lists generated by the other specialties, I find no objection to those suggestions from the American College of Cardiology. I will be cognizant of these guidelines with my own patients. It does seem to me, however, that these advanced imaging studies, such as echocardiography, should not be performed or interpreted by those not fully qualified to do so. As I have seen the results of tests done in some of these marginal and often mobile echo labs, not only could significant cost savings be achieved by such constraint, overall quality of care would also likely improve. The payers have sought to control costs by reducing reimbursement, which may have resulted in overuse to make up the financial losses. These Choosing Wisely efforts should ideally result in increased reward for fewer procedures done under appropriate use criteria in qualified laboratories.

Although both physicians and patients should question the routine use of these 45 procedures, all of us need to accept that clinical judgment should be the final arbiter of their use. The health insurance industry would be wise to avoid misusing these recommendations as *de facto* rules to justify denial of claims for corporate financial gain. These recommendations are informational only and should not to be interpreted as a substitution for consultation with the patient’s own physician.

For more information, please see www.choosingwisely.org