Utilization Review

In General

These firms provide utilization review and control programs for employers, plans, TPAs and insurers. Their existence reflects the great concern with rising health care costs. Because of the increasing significance of these firms, they should be analyzed as to functions, impact on medical care, resultant practical and legal difficulties as well as the likely future role of such firms. These are the services usually offered by these firms.

- Precertification of care
- Ongoing monitoring (recertification of care) including large case management
- Retrospective review including hospital audits.

The utilization review firm is compensated usually on a contractual basis ($2 per month per plan participant, e.g.); on a per assignment basis; or on a per savings basis.

The scope of the firm's review includes the following factors:

- Appropriateness of care (including medical necessity and large case management)
- Accuracy of charges and fees (hospital bill audit, reasonable and customary charges, e.g.).

There is the theory that the utilization review firm will be objective and so removed from any conflict of interest that its recommendations should be relied upon comfortably by all parties involved. However, their very existence is based solely on their reducing provider costs, and they may not reasonably be deemed to be independent or objectively unbiased.

The Contracts

The problems arise when these various contractual relationships are considered.

1. *Employer-Patient (Employee)*
   There is the employment contract and the plan document contract.
2. *Employer-Plan Supervisor*
   There is the administrative agreement.
3. *Provider-Patient (Employee)*
   The hospital-patient relationship is governed by a contract.
4. *Plan Supervisor-Utilization Firm*
   The utilization provides a contract on agreement prior to its performing its services

There are other possible contracts in these circumstances:

1. HMO is involved.

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2. PPO is used.

For simplicity of discussion, these additional contracts are ignored. The point of the contract discussion is this: with so many contracts in place, many of which are neither known nor understood, the likelihood of difficulties and misunderstandings is great.

Characteristics of Utilization Review Firms

- Physicians are usually employed by utilization review firms on a part-time basis or as consultant advisors.
- Registered nurses are heavily involved in first-level review decisions, but physicians become more involved during the second level review and appeals process.
- The firms generally use commercially-developed review criteria when making their recommendations.
- Most firms have established appeal procedures. Of the few utilization review decisions that are appealed, many are successful.
- The firms usually have implemented quality assurance procedures to ensure adherence to company directives.

Standards for Utilization Review

These are national standards promulgated by the Utilization Review Accreditation Commission:

- Collect only the information necessary to certify the admission, procedure or treatment and length of stay for routine reviews. For example, a reviewer shall not routinely request copies of medical records on all patient reviews, or routinely require hospitals and physicians to supply numerically codified diagnosis or procedures to be considered for certification. Firms must limit their data requirements for information on the patient, attending physician, diagnosis, treatment and facility to elements listed by the Utilization Review Accreditation Commission.
- Establish written procedures to assure timely review and provide notification of certification decisions. For example, the review firm must make certification determinations within two working days of receipt of necessary information on a proposed admission or service.
- Meet minimum requirements on procedures for expedited and standard appeals of determinations not to certify an admission, procedure, service or extension of stay. For example, a review firm must notify in writing the enrollee or patient, attending physician and claims administrator of its determination on a standard appeal as soon as practical, but in no case later than 60 days after receiving the required documentation.
- Adopt written procedures on confidentiality of specific patient information.

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- Ensure staff is properly trained, qualified, supervised and supported by written clinical criteria and review procedures, which must be established with appropriate involvement from physicians.

Problems Arising with Utilization Review

From a practical standpoint, certain problems arise for these reasons:

1. *Providers don't understand the plan.*
   Plan rules are intrusive; not followed; treated as abrasive or inconsequential.
2. *Utilization review firm communicates poorly.*
   Direct physician-to-physician contact is many times desperately needed but sadly lacking.
3. *Penalties for noncompliance.*
   These penalties are usually received negatively and create plan difficulties.
4. *Medical criteria*.
   Too often the utilization review firm *wings* it. Their medical criteria are jealously guarded for *proprietary* reasons. At best, the reviewer *second guesses* the *hands-on* physician with the reviewer usually being a nurse with partial records and no *hands-on* information.

Utilization Review Firms Need Regulating

Background

While utilization review is deemed by many health care plan sponsors to be a most effective managed care technique for controlling costs, it is alleged that not only has utilization review failed to reduce (and may have actually increased) costs, it has also compromised the quality of care that is available to health care plan participants.

What is UR?

Utilization review places another level of review between the provider of health care (e.g., a doctor or hospital) and the payer (e.g., the health care plan insurer). Providers must consult with the utilization review service either before a course of treatment is instituted (a precertification review), or on an ongoing basis as the treatment is being conducted (a concurrent review).

The utilization review service reviews the program of treatment to make sure it does not include procedures that are either unnecessary or of questionable effect. In addition, utilization review sees to it that when care is necessary, it is provided in the most cost-effective way. If the program falls within the standards that guide the utilization review reviewer in making his determination, the treatment will be approved.

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However, if the treatment is not approved, either on initial review or on appeal, it does not mean the patient will be denied the care, it simply means the payer will not foot the bill. The patient is always free to pay for the care without being reimbursed by the plan.

Is UR Effective?

Utilization review is perceived to be an effective method of controlling costs, even by those paying the bills. In one survey, benefits managers and insurance brokers were asked to rank the effectiveness of various managed-care options. Most practitioners accept utilization review as effective in producing cost savings.

In spite of the perceptions of health care purchasers, however, utilization review may have had the unintended effects of:

- Shifting costs elsewhere, either to the patient, the provider or other payers, in the form of higher costs down the road as a result of deferred care.
- Adding another step in the health care chain of events by increasing the volume of paper and phone calls, with a corresponding increase in the number of persons involved to manage the utilization reviews and appeals, and thus raising administrative costs.

What About Quality?

Utilization review aims for standardized treatments that fail to accommodate the differences that exist among patients, caregivers and circumstances. The process of utilization review, the critics say, brings third party payers in conflict with the attending physicians, the ones who are most intimately familiar with the patients' conditions and medical needs.

It is also alleged that utilization review is biased in favor of certain types of treatment and biased against others. Prescriptions for chiropractic and mental health care, for example, are more likely to be carefully scrutinized.

It may also be reasoned that utilization review does not reduce the level of treatment, but merely postpones it. By refusing the more intensive treatment, however, utilization review may have the effect of allowing the illness to intensify. This would necessitate more expensive, and arguably less effective, inpatient treatment later on.

State Regulation

State laws that are crafted to regulate utilization review firms tend to be concerned with these areas:

- UR liability (primarily aimed at limiting)
- Ownership and interest conflicts
- Response time and service

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- Telephone discipline
- Protocols
- Confidentiality
- Consulting physician must not be *phantom*
- Appeals process in place.

Accrediting the Utilization Review Firm

There is a trade association called the American Managed Care and Review Association made up of utilization review firms. This trade association has promoted and continues to promote standards to be followed by such firms. Earlier attempts to define and maintain standards were disappointing. These involved the AMA, National Blue Cross, HIAA, AHA and Council of Medical Specialty Societies. The Association in 1990 established a Utilization Review Accreditation Commission to set and maintain standards; the management of the Commission is broad-based (AMA, BC, AHA, HIAA, NALC, NAM, nurses, unions, third party payers, etc.).

Standards

The accreditation is voluntary with the utilization review firm. The standards are designed to:

- Encourage consistency
- Result in minimal disruption (low hassle factor, e.g.)
- Standardize procedures
- Accredit and credential firms.
- Give regulators a standard that may be built into statutes and/or regulations.

Current utilization standards require the following:

- Inpatient reviews within two days of receipt of required/sufficient information
- All clinical reviews conducted by licensed health professionals.
- Noncertification reviews by a physician.
- All appeals by a physician who did not render the original decision; reviewing physician must be board-certified to the condition under review.

Accreditation Program

There are two types of standards:

- Mandatory
- Optional.

To gain accreditation, all of the mandatory and 60% of the optional standards must be met. The standards deal with a wide variety of items:

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- Demographic data
- Availability and accessibility of reviewers
- Data collection
- Utilization review procedures
- Appeals procedures
- Protection of privacy rights
- Staffing and staff qualifications
- Program qualifications.

Utilization Review Firm Due Diligence

Here are the tough, but needed questions:

Is the UR Company Accredited by the National Utilization Review Accreditation Commission? Although accreditation is voluntary, it indicates a certain level of quality assurance in an area in which the employer may have limited experience. More and more states are requiring the Commission accreditation as a benchmark for quality assurance standards.

Do the Employees Understand Their Benefits Clearly? Is someone in the company assigned to educate employees and their dependents? Employers are finding it pays to educate employees before they access the system.

How Does the UR Company Arrive at its Decisions on Health Care Requests? Who has final say if the physician disagrees with the UR assessment? Can he review information on the procedures used to make such decisions? Can one see a procedure manual? What criteria are used for those decisions? Who has approved the criteria? Is protection of patient confidentiality a priority?

What Are the Qualifications of the People on the Other End of the Phone? If the physician is a specialist, does the reviewer have equivalent credentials? What level of experience and training does the UR department require of its nurse reviewers?

Who is the UR Company's Medical Director? What are his or her credentials? Is he or she full-time on site? If not, who supervises daily decisions? The credentials of the staff director are a significant quality indicator.

If There is a Denial of Coverage, What is the Appeal Procedure for the Physician? Who will decide the appeal? Are there any other rights? How long does an appeal take to be decided? Such questions can be vital if time is a critical factor. An appeal that takes months can render some entire procedures useless. Even if the patient is right, the only option may be to pay for the services out of pocket.

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Does the Monthly UR Report - An Important Resource in Analyzing the Health Care Costs and Budget - Contain the Right Information? This report should evaluate the service's cost-benefit ratio. Does it cost more than it saves? Since UR reports are based on a compilation of data, the employer should verify what safeguards are in place to prevent data entry mistakes, demand to know what kind of daily quality-assurance program is in place, and find out what formulas are used to justify cost savings. Do they indicate real savings? Many times the employer will not actually save money after paying for UR because little hospitalization was involved. But many employers still use the UR report to help assess and manage overall costs. The goal should be to get information that helps employers contain costs - but certainly not at the expense of patient care or safety.

What Training Procedure Does the UR Company Use as Part of Its Quality Assurance Scheme? The physicians and other providers spend valuable time calling and interacting with UR departments and companies. When the doctor calls the UR company, the reviewer on the other end of the line must be a professional, not just a notetaker. The nurse-reviewer must be able to do more than go through a list of routine questions.

Is This Plan Governed by the Federal Employee Retirement Income Security Act of 1974? Under ERISA, UR companies are immune from malpractice liability. Although a doctor is liable under malpractice law for the decisions he makes, the UR company may not be legally liable for its similar decisions.

Can the Employer Demand an On-Site Audit? Employers should insist on the right of access to the information necessary to evaluate UR procedures and policies. If one cannot obtain this information, demand a full audit.

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