Dynamic Chiropractic

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Demand and Reward: Incentives to Provider/Payer Partnerships in Spine Care

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Health care reform efforts have been associated with a perceived increase in suspicion between and miscommunication among constituent groups who make up the health care system. Barriers to cooperation between the strata of the system arise from identifiable sources that can be remedied. This project sought to clarify relationships and address the objectives of both payer and provider groups. Two specific areas were targeted:

1. The mystery often surrounding the criteria to evaluate performance of each group was eliminated by full disclosure of their details.

2. Cumbersome administrative processes that, depending on perspective, were believed to interfere in continuity of care or enhance quality/cost control efforts were modified. Our hypothesis was that measurable changes in performance by both providers and payers would result from reducing these barriers.

Methods

A system of patient management was developed for a network of chiropractic providers that held the following features:

1. evidence-based, consensus modified treatment protocols disclosed to payers and providers;

2. network membership representation in protocol development;

3. published pre-certification and utilization review criteria derived from the protocols;

4. rapid pre-certification using ICD-9 driven codes to access computerized algorithms;

5. provider payment on a FFS basis;

6. patient access limited to physician panel membership;

7. negotiated FFS network contracts.

A spine care network representing 255 providers developed an evidence-based set of management guidelines, user-friendly system for pre-certification, provider in-service training, published pre-certification and utilization review criteria and provider QI counseling. Patient access was restricted to panel membership under negotiated FFS and capitation contracts. Payment to providers was on a FFS basis. Quality of care was monitored as a function of typical administrative data on service utilization contrasted with payer and patient demand for services from 1992-95. This report addresses the parameters of average number of patient visits per episode; use of diagnostic imaging and the ratio of patient covered lives seeking care per network provider. Network providers and leadership and implemented a computerized algorithm of case

management, telephonic pre-certification and utilization review guidelines. Treatment protocol and guideline development used the Delphi process with content experts and end-user participation. The pre-certification process required approval within 3.5 minutes by telephone or a return call within 1.5 hours if the phone was busy.

Initial patient assessment held guaranteed approval unless retrospective review yielded evidence of unsubstantiated services. Extended treatment plans required pre-certification in the same manner.

Recommended guidelines for imaging were disclosed by in-service training to providers and payers. The number of new patients and percent use of imaging were normalized to the index year (1992) and monitored from 1992 to 1995. The number of new patients referred through the closed panel to members of the network were expressed on a provider per capita basis normalized to the index year.

Results

This system of management resulted in advantages to both the network and the payers. Over the four-year interval, two providers were decertified for inability to comply or inadequately justifying services beyond protocols in specific cases. At the same time, the network grew to include 255 providers in a statewide area.

Payer cost predictability was demonstrated by stabilizing the mean number of visits per episode to 6. Utilization of imaging declined approximately 50 percent. Providers were given the incentive of payment on a fee-for-service basis and a progressive increase in payer and patient demand for services per network provider by a factor of two over the four-year interval. By the end of the monitoring interval, gatekeeping oversight was removed on renegotiation of contracts and direct access to chiropractic spine specialists permitted.

Conclusion

Partnerships between payers and providers that focus on patient needs through evidence-based protocols and user-friendly systems can be beneficial to all groups. Accountable groups of providers can achieve delegated authority for all matters of quality in these relationships. The reward for focus on quality of care is evidenced by increases in market share.

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