Dynamic Chiropractic

"A Person's True Character Is Revealed by What He Does When No One Is Watching"

Sigmund Miller

Opinions as expressed in this article regarding the utilization review (UR) process are directed to those serving the health care marketplace; whether you are managing care or overseeing a managed care organization; whether providing medical services or paying medical benefits; whether you are serving in commercial, workers' compensation or liability arenas; or, a clinician providing services inside or outside any managed care model. Whichever side of the fence you sit or whatever agenda you serve, what is most important is the individual who is sitting on the fence and that, of course, is the patient.

The concept of utilization review is not unique. When reviewing opinions expressed in articles submitted by treating clinicians who are involved in the UR process, feelings often times run high with emotion due to various types of requests made by the UR entity or when it is appears decisions to deny treatment were arbitrary.

As president and founder of a national UR firm, I oversee this process daily. As a result, I thought there might be some interest in how I view the UR landscape. As an aside, at conclusion of this article do not look for footnotes or references being cited. Opinions expressed result from many years of observing the UR arena. My ultimate objective in expressing these opinions is to promote critical thought and to create meaningful dialogue amongst peers as well as those serving the healthcare marketplace. My intent is not to have you agree with some, or even most, of opinions expressed. In fact, I believe being too much in agreement suggests that only one of us is thinking. Given that most of the individuals reading this article represent multiple arenas within the healthcare marketplace, from the outset we should simply be able to agree to disagree.

Performing utilization review for more than 10 years has been both challenging and controversial but, like most things considered difficult, there is no elevator to success; one must take the stairs.

The Economics of It All

Some payers may suggest the primary objective in performing UR is to protect patients from inappropriate or harmful treatment. Although this might certainly be one item to consider, in contrast I believe the primary concern is the payer's need to contain costs. Simply put, the UR process assists in determining what types of services are to be considered medically appropriate and therefore eligible for reimbursement.

To support this premise to control expenditures, for a workers' compensation carrier to be competitive in an open rating system, they must improve loss ratios, close cases in order to free-up reserves, reduce loss adjustment expenditures, and control medical expenditures. For the commercial claims or general health carrier, in addition to priding themselves on providing excellent service to their clients, they too must aggressively contain the cost of medical services. In order to secure contracts with

specific clients, managed care organizations must agree to significant reductions in reimbursement rates. All examples cited above attempt to integrate the utilization review process in order to improve the bottom line.

Finally, even the treating clinician must consider how profit margins are affected when evaluating the difference between a fee for service vs. capitated arrangement. In a fee for service arrangement, overutilization is more likely to occur since "the more treatment prescribed, the more revenues generated." In contrast, when capitation is in place within a managed care environment, the trend is toward underutilization where prescribing fewer medical services increases profit margins. Suffice it to say, the payment arrangement, whether inside or outside a managed care model, greatly impacts the treating clinician's mind set when prescribing treatment. Given these contrasting economic scenarios, treatment guidelines unfortunately appear to carry less weight.

Statistical Trends

For many years, as a result of completing needs assessments for national clients, I have been provided numerous opportunities to analyze extensive physical medicine data. This has provided me insight into emerging trends. I have summarized data taken from four large national insurance companies representing 750,000 covered lives. There were approximately 109,000 separate and distinct cases where chiropractic and physical therapy related services were prescribed. This represents approximately 15% utilization. Costs totalled $59 million.

Of greatest interest, it should be noted that of these 109,000 claims approximately 86.5 percent concluded within ten visits at an average cost of $250 per case. Certainly, the payer sees no problem here.

In contrast, the remaining 13.5% of claims averaged approximately $2,400 per case and accounted for up to 52% of total expenditures. It is evident that a small percentage of claims accounts for a disproportionate amount of expenditures. As a result, the payer might consider initiating the utilization process on these type cases only. That is not to say the primary objective of UR is to deny services beyond this initial phase of treatment, but rather to implement a fair and reasonable methodology which allows the payer to control costs on those cases which might potentially be more expensive. In this regard, on behalf of the payer, a reviewing clinician of same discipline then concurrently monitors treatment in order to determine whether services provided are to be considered medically eligible for reimbursement on a case-by-case basis.

The UR Arena -- A General Understanding

I have been in private practice as a chiropractor since 1977. Knowing the intricacies of this profession has taught me to keep the review process simple and personal. Implementing effective case management methodologies requires early intervention, including a well-coordinated collaborative effort with direct communication between reviewing and treating clinicians. Developing effective and fair UR methodologies is an ongoing process, which has evolved over many years. In the attempt to improve this process, every piece of the puzzle that does not fit brings me closer to the one that does. Years ago when first implementing physical medicine UR, there was little to go on, no well-established or effective methodology to be found. National UR firms over recent years have shifted focus from a hospital to outpatient setting. Their in-patient UR model has been quite successful, but in contrast, has been ineffective when applied to outpatient physical medicine. I noted many medical-type personnel, who perform utilization review, attempting to learn the tricks of the trade rather than to learn the trade. Performing UR within the physical medicine arena requires full time commitment and constant

scrutiny. One must be open to change so that the process continues to improve resulting in all parties being best served.

I would like to briefly summarize the UR climate as it exists nationally. For the most part, two types of utilization review companies exist, one considered full menu and the other a carve-out. The former provides in-hospital and outpatient UR services for all medical specialties. A carve-out typically limits UR to one specific discipline or area of medical services (i.e. physical medicine). Due to limited focus, carve-outs can very well provide more efficient and effective UR services specific to their area of expertise, but in many instances they have difficulty competing for business against larger full menu firms since the latter can earmark substantial revenues to establish name recognition on a national basis.

Reviewing claims since 1984, I head our supervisory panel of medical, physical therapy, and chiropractic directors. I have trained many clinicians, who represent multiple physical medicine disciplines and who participate presently in this review process. Our nationally-based clients are comprised of insurance companies, third party administrators, self-insured self-administered employers, managed care organizations, and medical management and bill auditing companies who market software programs to the general health, workers' compensation, and third party liability arenas. The reviewing panel of clinicians include chiropractors, medical physicians, and physical therapists, who after completing an extensive training and credentialing program, are then capable on a case-by-case basis of monitoring physical medicine services as prescribed by treating clinicians. All reviews are discipline matched. For example, chiropractors only review chiropractic-related claims and physical therapists only review physical therapy claims. This physician adviser/UR process specializes in direct communication with treating clinicians balancing quality of care with cost savings. To enhance quality control and to assure consistency in clinical decisions, directors and senior reviewing clinicians assist and oversee other reviewing clinicians. In addition, these UR methodologies place additional focus on being capable of directly handling all appeals related to more complicated cases.

Most, if not all, full menu UR firms have obtained state certification. In contrast, this is far more challenging for carve-outs to obtain.

In outlining several responsibilities specific to performing utilization review, one key objective is to manage costs while at the same time improving patient care. On a case-by-case basis, UR assesses frequency, duration, level, and appropriateness of medical care and services being prescribed. Factors obviously affecting decisions in part relate to diagnoses submitted, patient's response to treatment, complicating factors, and findings noted specific to diagnostic tests completed.

When designing and implementing UR methodologies, one must be committed 1) to promoting the delivery of quality health care in cost-effective manner; 2) to adhering to reasonable standards for conducting utilization review; 3) to implementing a coordinated approach when interfacing with healthcare providers; 4) to improving communication and knowledge of benefits among all parties concerned before expenses are incurred; and 5) to insuring and maintaining the confidentiality of medical records in accordance with applicable laws.

Most importantly, when reviewing clinicians render clinical decisions, the amount of monies generated by that UR firm or clinician can never be based upon negative outcomes or denial of services. In other words, denying services cannot be tied to the UR company making more money. Oftentimes, I explain to clients when performing utilization review, "Our responsibility is not to tell you what you want to

hear, but rather what you need to hear". Oftentimes, I observe payers of benefits believing it inappropriate to prescribe physical medicine services. It is our responsibility when serving in UR capacity to inform all parties as to when physical medicine services are medically appropriate.

The UR Process

The UR procedure contains several key elements:

1. Clinicians -- individuals well skilled and trained in UR methodologies, rules, and regulations, working under the guide of directors and senior reviewing clinicians to enhance quality control and to assure consistency in clinical decision-making. Reviews must be discipline-specific as required by states certifying UR companies.

2. Records -- documents made available to substantiate medical appropriateness of services provided. Records include daily chart notes, which follow SOAP format or similar, examination forms completed in timely fashion, initial and interim narrative reports, and outcome assessment tools. Early on in the treatment process, one of the more useful documents include daily chart notes which allow the reviewing clinician to assess on a visit-by-visit basis patient response to treatment prescribed. Unfortunately, in many instances, the chart notes are substandard and this reason alone does not allow one to recommend treatment as medically eligible for reimbursement.

3. Criteria -- The reviewing clinician's primary responsibility in assessing records provided is to determine whether select clinical criteria are being satisfied. Only then can treatment be recommended as medically appropriate and therefore reimbursable. Although outlining criteria is not the purpose of this article, several of many include that the patient 1) reports long-term benefit to treatment prescribed; 2) demonstrates an ability to return to activities of daily living, including employment; 3) demonstrates playing an active role in the recovery process; 4) demonstrates being compliant in following through with treatment as recommended by treating clinician; 5) that the chart confirms gradual transfer of passive-dependent to more active independent treatment; and 6) that the chart confirms a tapering of visits as patient improves.

As a special note regarding patient compliancy, oftentimes treating clinicians recommend that conservative management will need to continue over an extended period since the patient is unable to follow through with recommendations. Noncompliancy is justification for discharge and not reason for prescribing continued care. Remember serving patients' needs are of primary concern. The UR process should be designed to discontinue inappropriate or ineffective treatment with the focus being shifted to investigating more effective treatment alternatives.

As an aside, although literature reviews along with more recently authored treatment guidelines assist in developing select criteria specific to physical medicine, they often lack an element of common sense in detailing criteria which are most appropriate in supporting ongoing treatment.

The treating clinician who participates in the UR process should expect the reviewing clinician to be courteous, straightforward, and professional. Clinical decisions made by reviewing clinicians should be prompt and should also accompany a clearly stated procedure for appeal. For example, after ChiroView receives the requested clinical documentation, typically via fax, response is provided in most cases within 24 hours to all parties, including the treating clinician.

One of the most crucial elements in the UR process is the ability to implement a fair and timely appeal

procedure. In this regard, the treating clinician should be provided every opportunity to state his/her case as to why treatment should be considered medically appropriate and therefore reimbursable. The appeal process must be initiated in writing and, if appropriate in some cases, followed by telephone conversation. As part of this appeal procedure, after the reviewing clinician receives additional medical documentation, in most cases follow-up decisions should again be delivered within a 24-hour period. Most state regulations allow for a period of up to four weeks to respond to any appeal. I believe this to be unacceptable. Certainly, appeals can be handled in more timely fashion.

The Managed Care Arena

I am greatly concerned about the many types of contractual agreements treating clinicians have entered into with various managed care organizations. Specific to chiropractors, I am already observing a strong backlash. In listening to many treating clinicians, several issues of concern include a continuing poor access to patients, grossly reduced reimbursement schedules, a lengthy process required to obtain treatment authorization, and difficulty in receiving authorization in timely fashion.

The general population is accessing chiropractic services in greater numbers due to the efficacy of spinal manipulation, yet unfortunately chiropractors still are underutilized given the number of people experiencing musculoskeletal-related problems. As a result, the chiropractor looks to the managed care firm to enhance their access to potentially larger groups of patients. Even with this arrangement, many clinicians still do not see increased patient volume. In addition, the process to obtain treatment authorization is cumbersome, at the very least, and in addition reimbursement rates are reduced to unprofitable levels. Given this present situation, it appears that the treating clinician oftentimes reaches a point where they ask themselves, "Is it worth it?" Nevertheless, these same clinicians are reluctant to approach the managed care company to voice their disapproval for fear of being dropped or to terminate this type arrangement for fear of being left out.

Regarding this managed care model, I believe several changes would better serve the treating clinician. Firstly, substantial savings will be appreciated not by dramatic reduction of fee schedules, but rather by implementing effective utilization review methods directed only toward the 15% of cases which account for more than 50% of expenditures. Secondly, within any managed care model, there is no reason not to immediately authorize a fair and reasonable initial phase of treatment since, as previously described, more than 85% of claims conclude within ten office visits.

Consider a scenario where the treating clinician is provided access to patients along with authorization of this initial phase of treatment with near full reimbursement. I believe strongly, given these set of circumstances, that this same clinician will then be more likely to cooperate when requested to participate in a simple, yet effective, UR methodology which is focused on those remaining cases having the potential to be more costly.

In closing, debating as to whether utilization review is appropriate is irrelevant. It is important to spend less time worrying who's right and more time deciding what's right.

The health care marketplace has identified a strong need to cost contain so the question is, "What is the most appropriate way to go about it?"

"Short cuts aren't always ..." and I believe over these many years I have done my very best in developing effective methodologies that attempt to best serve all parties.

I have always taught my children that no matter what, "keep your promise." In that regard, my

commitment is focused on the patient and what might best serve their needs.

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