SB

239

Alaska State Legislature

SENATOR ARLISS STURGULEWSKI, Chairman
SENATOR PAUL FISCHER, Vice Chairman
SENATOR SAM COTTEN
SENATOR LYMAN HOFFMAN
SENATOR CURT MENARD

P.O. BOX V
ROOM 427
STATE CAPITOL
JUNEAU, ALASKA 99811
(907) 465-3762

Senate Committee on
Health, Education and Social Services

MEMORANDUM 23 April 1991

TO: Members, Senate HESS Committee

FROM: Senator Arliss Sturgulewski

Senate Bill 239 requires companies conducting utilization reviews to obtain a license from the Department of Commerce & Economic Development.

SECTION 1:

Adds regulation of private review agents to the duties of the Department of Commerce & Economic Development for centralized licensing.

SECTION 2:

This legislation adds a new chapter to Title 8 entitled Private Review agents.

Sec. 08.85.010 sets out the purposes of this chapter.

Sec 08.85.020 requires companies conducting utilization reviews to obtain a license from the Department of Commerce & Economic Development.

Sec 08.85.030 requires the applicant to submit an application with a utilization review plan includes:

-standards used in evaluating care proposed or delivered,

-circumstances under which utilization review may be delegated to a hospital utilization review program,

-provisions for appeal and a time frame for that appeal

-number, type, and qualifications of personnel employed

-procedures to ensure access by patients and providers

-assurances that a determination of medical inappropriateness will not be rendered unless an appropriately qualified physical and conferred with the patient's attending physician

-assurances that a determination of medical inappropriateness will not be rendered except in writing

-procedures to ensure confidentiality of confidential medical records

-prohibitions against patient interviews without consent

-prohibitions against incentive payments

-a copy of material furnished to patients and providers informing them of the requirements of the utilization review plan

-a list of health care insurers for which the agent performs services

-evidence of liability insurance

-prohibitions against retrospective denial of payment for treatment.

Sec 08.85.040 allows the department of renew a license after receipt of an application, a renewal fee, and a list of complaints made

to the agent and their resolution.

Sec 08.85.050 provides for additional time to prepare documentation and allows the applicant to apply for a hearing if an application is denied. The hearing is to be held in accordance with the Administrative Procedures Act.

Sec. 08.85.060 allows the department to revoke a license if the holder of the license fails to comply with the plan required under 08.85.030.

Sec. 08.85.070 provides that a patient or provider may file a complaint against a private review agent and may request that the department revoke the license of the agent or require that the agent demonstrate proof of compliance.

Sec 08.85.080 directs the department of adopt regulations to implement this chapter.

Sec 08.85.090 exempts private review agents that operate under federal law or under contract to the fede al government.

Sec 08.85.100 requires the department to furnish a list of private review agents and their license expiration dates to hospital utilization review programs and others who may request the list.

Sec 08.85.110 prohibits a private review agent from disclosure or publication of individual medical records.

This section prohibits a person seeking payment of a reimbursement for hospital or medical ser ices from invoking the privilege of confidentiality arising from a physician-patient relationship.

This section says a patient is entitled to inspect and copy records developed or maintained by a private review agent pertaining to the health care in question.

Sec 08.85.150 defines terms used in this chapter

SECTION 3:

amends the Administrative Procedures Act to add the

Department of Commerce concerning the licensing and regulation of private review agents under 08.85.

SECTION 4:

Gives an immediate effective date to section two of this bill.

Alaska State Legislature

During Session
P.O. Box V
Juneau, Alaska 99811
(907) 465-2828

During Interim
3111 C Street, Suite 510
Anchorage, Alaska 99503
(907) 561-2040

Senator Virginia Collins

w/ SB239

MEMORANDUM

To: Senator Arliss Sturgulewski
Senate HESS Chair

From: Senator Virginia Collins

Date: April 24, 1991

Subject: SB239

I have read SB239 and have notes from my staff about the first hearing on this bill in Senate HESS today.

I would like your consideration of changing the qualifications of the nursing staff for the Utilization Review Agent. I feel a Registered Nurse with five years clinical experience in the field they are reviewing would be sufficient.

Thank you for your consideration, I will be happy to talk to you further about this bill at your convenience.

Mature Degree where Physician located

Problem - publishing criteria

7-LS1024\A

Disclosing proprietary info - criteria - lease contracts - proprietary provisions

"Dent" system -

SENATE BILL NO. 239

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Introduced: 4/5/91
Referred: HES, L&C, Finance

A BILL

FOR AN ACT ENTITLED

"An Act providing for the licensing and regulation of private health care review agents; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.01.010 is amended by adding a new paragraph to read:

(33) regulation of private review agents under AS 08.85.

*** Sec. 2.** AS 08 is amended by adding a new chapter to read:

CHAPTER 85. PRIVATE REVIEW AGENTS.

Sec. 08.85.010. PURPOSE. The purpose of this chapter is to

(1) promote the delivery of quality health care in a cost-effective and efficient manner;

(2) foster greater coordination between those paying for health care services and health care providers in the conduct of utilization review activities;

(3) assure protection for patients, state employers, and health care providers by ensuring that private health care review agents are qualified to perform utilization review

activities and to make informed decisions on the appropriateness of medical care; and

(4) ensure that private review agents maintain the confidentiality of medical records in accordance with applicable state and federal laws.

Sec. 08.85.020. LICENSE REQUIRED. (a) A person who is affiliated with, under contract to, or acting on behalf of a health care insurer or a person doing business in the state, whether or not for profit, may not perform a utilization review in this state unless a private review agent license is held by the person, the person's employer, or another for whom the person is providing those services under contract. This section does not apply to a person affiliated with a hospital.

(b) The department shall issue a license to an applicant that meets the requirements of this chapter and regulations adopted under this chapter.

(c) A license issued under this chapter is not transferable and expires biennially on a date determined by the department.

Sec. 08.85.030. APPLICATION FOR LICENSE. (a) An applicant for a private review agent license shall submit an application to the department and pay an application fee set by regulation. The application must be on a form approved by the department.

(b) An applicant is entitled to a license if the applicant submits and the department approves a utilization review plan that will be provided to patients and providers that includes

(1) the specific review standards, criteria, and procedures to be used in evaluating hospital or outpatient care that has been proposed or is being or has been delivered;

(2) those circumstances under which utilization review may be delegated to a hospital utilization review program;

(3) the provisions by which patients or providers may seek prompt reconsideration or appeal of adverse decisions by the private review agent and the time period in which the private review agent must respond to the request for reconsideration or appeal;

(4) the number, type, and qualifications of the personnel employed by or under contract with the private review agent to perform the utilization review including

(A) the requirement that a private review agent have available the services of sufficient numbers of registered nurses with masters degrees, or similarly qualified persons, supported and supervised by physicians trained in the appropriate specialty area, to carry out its utilization review activities, or to have appropriate numbers of physicians

[illegible] (DELETED TEXT BRACKETED)

trained in the appropriate specialties for which utilization review is being conducted; and

(B) a requirement that only a physician trained in a relevant specialty or subspecialty and licensed in the state be permitted to make a final determination that care rendered, being rendered, or to be rendered in that specialty or subspecialty is medically inappropriate;

(5) the procedures and policies to ensure that a representative of the private review agent is reasonably accessible to patients and providers at least five days a week during normal business hours and that payment will not be denied for treatment rendered

(A) during a period when a private review agent is not accessible; or

(B) when the appeal of an adverse decision is pending;

(6) the requirement that, except in exceptional circumstances, a determination that care rendered, being rendered, or to be rendered is medically inappropriate may not be made until an appropriately qualified review physician has conferred with the patient's attending physician and reviewed all pertinent information concerning the medical care delivered or proposed;

(7) the requirement that a determination that care rendered, being rendered, or to be rendered is medically inappropriate must include the written evaluation and findings of the reviewing physician;

(8) the procedures and policies to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(9) prohibitions against a private review agent entering a hospital to interview a patient unless the attending physician is advised of the interview with reasonable advance notice, and the attending physician or the physician's designee is allowed to attend the interview;

(10) a prohibition against an incentive payment provision or plan contained in a private review agent's contract with an entity paying for health care services under which the agent's compensation is based on controlling the amount charged for services, duration of services, or setting in which services are rendered and a prohibition against the agent receiving the incentive payment;

(11) a copy of the written material intended to be sent to patients and providers to inform them of the requirements of the utilization review plan;

(12) a list of the health care insurers for which the private review agent is performing utilization review in the state and a brief description of the services it is providing

for each client, including an affirmation that a payment incentive provision or plan designed to control the amount, duration, or setting in which services are rendered does not exist with respect to each client;

(13) evidence of liability insurance carried by the private review agent to cover potential liability from its activities under this chapter in an amount, type, nature, and carrier satisfactory to the department;

(14) provisions that, in the absence of fraud, prohibit retrospective denial of payment for treatment after it has been initially approved by the private review agent;

(15) other information the department determines to be appropriate.

Sec. 08.85.040. RENEWAL OF LICENSE. (a) The department shall renew the license of a private review agent holding a license under AS 08.85.020 if, before the license expires, the agent

(1) files an application for renewal, including the information required under AS 08.85.030(b), and submits the appropriate renewal fee; and

(2) meets the qualifications for issuance of a license under AS 08.85.020(b).

(b) An application for renewal of a private review agent license must include a list of all complaints made to the agent by patients or providers and a brief description of how the complaints were resolved, including the nature of the complaint, the review process, and the time between the filing of the complaint and its resolution.

Sec. 08.85.050. DENIAL OF LICENSE OR RENEWAL APPLICATION. (a) Before denying an application for a private review agent license or for renewal of a license, the department shall provide the applicant with reasonable time to supply additional documentation establishing that the applicant is entitled to a license or to renewal of a license.

(b) An applicant who is denied a license or renewal of a license shall be afforded the opportunity for a hearing. The hearing shall be conducted by the department. The hearing shall be held in accordance with AS 44.62.330 - 44.62.630.

Sec. 08.85.060. REVOCATION OF LICENSE. (a) The department may revoke a license if the holder fails to comply with a utilization review plan filed by the holder under AS 08.85.030(b) or otherwise violates a provision of this chapter or a regulation adopted under this chapter.

(b) Before revoking a license under this section, the department shall provide the license

holder with reasonable time to supply additional information demonstrating the holder's compliance with the requirements of this chapter.

(c) A license holder whose license is proposed for revocation by the department shall be afforded the opportunity for a hearing. The hearing shall be held in accordance with AS 44.62.330 - 44.62.630.

Sec. 08.85.070. COMPLAINTS AGAINST LICENSE HOLDER. (a) A patient or provider may file a complaint with the department alleging that a private review agent is not in compliance with this chapter or the regulations adopted under this chapter or with other applicable federal or state law. The complaint may request that the department revoke the license of the agent or require that the agent demonstrate to the department proof of compliance.

(b) Proceedings under this section shall be conducted in accordance with AS 44.62.330 - 44.62.630.

(c) If the department fails to render a decision on a complaint brought by a patient or provider within 90 days, the patient or provider shall have the right to bring suit in the superior court to compel the department to take an action specified in (a) of this section.

(d) This section may not be construed to deprive a patient, a provider, a private review agent, or a health care insurer of a right available under other provisions of law.

Sec. 08.85.080. REGULATIONS. The department shall adopt regulations to implement the provisions of this chapter, including regulations

(1) establishing license application and renewal fees in an amount sufficient to pay for the costs to the department of administering this chapter;

(2) establishing rules of procedure consistent with AS 44.62.330 - 44.62.630.

Sec. 08.85.090. EXEMPTION. A private review agent that operates solely under contract with the federal government or an agency of the federal government for utilization review of patients eligible for health related services under 42 U.S.C. 1395 - 1395ccc (Subchapter XVIII of the Social Security Act), 42 U.S.C. 1396 - 1396s (Subchapter XIX of the Social Security Act), and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is exempt from the licensing requirements of this chapter.

Sec. 08.85.100. LIST OF PRIVATE REVIEW AGENTS. The department shall periodically provide a list of licensed private review agents and the expiration date for their licenses to all hospital utilization review programs and to other individuals or organizations

requesting the list. The department may charge a reasonable fee for providing the list.

Sec. 08.85.110. PATIENT CONFIDENTIALITY AND RECORDS. (a) A private review agent may not disclose or publish individual medical records or other confidential information obtained in the performance of activities as a private review agent, except that an agent may provide patient information to a third party to which the agent is under contract or with which it is affiliated.

(b) A person seeking payment of a reimbursement for hospital or medical services may not invoke the privilege of confidentiality arising from a physician-patient relationship to withhold pertinent information from review of those services by a private review agent.

(c) Notwithstanding the provisions of this chapter or another law, a patient is entitled to inspect and copy records developed or maintained by a private review agent pertaining to the health care rendered, being rendered, or proposed to be rendered to the patient.

(d) This chapter may not be construed to allow a private review agent to take actions that violate a state or federal statute or regulation concerning confidentiality of patient records.

Sec. 08.85.150. DEFINITIONS. In this chapter,

(1) "department" means the Department of Commerce and Economic Development;

(2) "health care insurer" means a person in the business of making payments for the medical care of others, and includes an insurance company, a nonprofit health service plan, a health maintenance organization, a preferred provider organization, an employee assistance program, and a health insurance service organization;

(3) "private review agent" means a person who performs a utilization review and who is affiliated with, under contract to, or acting on behalf of a person doing business in the state, whether or not for profit, or of a health care insurer, but who is not affiliated with a hospital;

(4) "provider" means a health care provider as defined in AS 18.23.070;

(5) "utilization review" means a system for reviewing the appropriate and efficient allocation of hospital and outpatient resources and services given, being given, or proposed to be given to a patient or group of patients, including the approval or denial, or recommendation of approval or denial, of payment for hospital or medical services;

(6) "utilization review plan" means a description of the criteria, procedures, and

standards governing utilization review activities performed by a private review agent.

* Sec. 3. AS 44.62.330(a) is amended by adding a new paragraph to read:

(57) Department of Commerce and Economic Development concerning the licensing and regulation of private review agents under AS 08.85.

* Sec. 4. AS 08.85.080 and 08.85.150, enacted by sec. 2 of this Act, take effect immediately under AS 01.10.070(c).

Ito –
Masters unnecessary

David Strathon –
State plan – Sen Duncan says save $'s.
"H.R."
"pre-authorization" } feels costs down.

Rep. Brady – feels this is Insurance protection.
3rd party intervening re medical necessity.

"U" – Craig –
Cathy Cronin

TESTIMONY TO THE ALASKA SENATE
HEALTH, EDUCATION, AND SOCIAL SERVICES COMMITTEE
ON SENATE BILL 239
PRIVATE HEALTH CARE REVIEW AGENTS

SEPTEMBER 18, 1991
STEPHEN W. HO, M.D.

Good afternoon, Madam Chairwoman Sturgulewski and members of the Health Education and Social Service Committee. My name is Stephen Ho, I am the Associate Regional Medical Director for the Western Region of AETNA Health Plan. With me are:

Lynn Withrow, Senior Account Executive
Beverly Hodge, UM Manager
Judy Ketterling, our On Site Concurrent Review Nurse in Anchorage
Lyn Gale, Manager of the Anchorage office

I am a board certified physician and have practiced in different parts of the country for over 13 years. My experience with utilization management and managed care includes practicing in a managed care environment for over eight years and managing utilization review programs for over ten years as medical director for managed indemnity plans, commercial and MediCare health maintenance organizations. I joined AETNA earlier this year to oversee the medical management programs, both utilization review and quality assurance, for their HMO's and managed indemnity plans in the western region and the on site concurrent review program in Alaska.

I would like to make a few points concerning utilization review programs and the bill that is in front of this committee.

First, the goal of utilization review program is to make sure that optimal medical care is being provided in a cost effective and cost efficient manner. Second, the utilization review program needs to be as flexible as the medical care that it is reviewing. Third, the full impact of a utilization review program can only be realized when there is cooperation between the payer and the provider of the medical care.

As I have mentioned, the goal of utilization review program is to make sure that optimal medical care is being provided at a cost effective and efficient manner. Various research institutions have shown that 15-35% of the procedures which they studied are clearly inappropriate. Furthermore, there is wide variation for the rate of performance and the length of hospital stay for certain procedures from region to region within a state and within the

country. Why is the length of stay of a Caesarian Section in the East Coast 5 days versus 3 days in the West Coast? Why is the length of stay for vaginal delivery in California 0.9 day versus 2 days in the East Coast? Why one facility will advocate a 14 day alcohol rehabilitation program while another one will advocate a 28 or 30 day program? As these have been studied many times, no sound reason for the variability can be found.
The aim will then be to identify whether certain practices are more efficient and provide the optimal outcome for the patient. Unnecessary and inappropriate care can not only increase the total cost of the health care system, but also increase the risks to the patients of untoward events, such as infection, bleeding, adverse reaction, whether from the medications or anesthesia, pain and occasionally death.

More health care service or a higher level of service does not necessarily mean a higher quality of medical care. In medicine, every intervention, whether it is diagnostic or therapeutic, has its risks and its benefits. Utilization review, in this instance, is asking the physicians to assess the way they treat their patient by weighing the benefit and risk of this intervention.

As I have mentioned, the utilization review program requires the same flexibility as the practice of medicine. The utilization review standards and criteria are based on professional standards collected from professional and specialty societies, written and approved by physicians with various specialty backgrounds. Many of these standards and criteria are reviewed by outside panels of experts. As the advancement of medical science and technology progresses rapidly, the utilization review program must have the latitude to quickly incorporate these new changes into their protocols and criteria for certification. Requiring that these protocols be published prior to implementation and requiring the review agency to strictly adhere to these protocols, will result in the inability to incorporate changes which maybe beneficial to the patient, in a timely fashion.

Some may think that the practice of medicine is an exact science, but in reality it is more art than science. Every patient, no matter how similar the presentation of the signs and symptoms, is different. The application of diagnostic and therapeutic modalities must be tailored to the individual need of each patient. Similarly in utilization review, the application of clinical criteria must be tailored to each patient's distinct condition. Furthermore, just as a physician must alter his/her daily treatment plan in response to the changing need of the patient, the utilization review agent needs the same type of accessibility to current clinical information in order to determine the appropriateness for certification. On site review allows for daily, firsthand review of a patient's condition by looking at the medical record. This reduces the frequency of phone calls and telephone tags that are a common occurrence between the UR company

and the attending physicians or the hospitals. In over 90% of the review, the process is transparent to both the physician and the patient. It is only when indication for the continuous certification is missing, that the review nurse contacts the physician for additional information. The restriction in the form of advance notification and prior arrangement in order for on site review will hinder this timely process. For the State of Alaska, on site review has saved the State 11.8% of net submitted expenses.

Now, let me say a few words about the impact of timely utilization review. As can be seen in both the private and public sector, health care cost is skyrocketing. The Federation government through HCFA have contracted with HMO's to provide care to MediCare and Medicaid populations. Many private corporations have engaged utilization review programs in the form of HMO's and managed indemnity plans to decrease their health care cost.

In the case of the State of Alaska, the introduction of utilization review program has shown a one year saving of $13.8 million or 21% in health care expenses in one year. With AETNA as a administrator to CHAMPUS, The Department of Defense has saved $200 million or 20% of cost over a two year period in California and Hawaii. For every dollar AETNA spends on utilization review, claim payments are reduced by an average of $10. This translates to a lower premium and increase availability of health care insurance.

Similar kinds of savings would not be realized when restrictive regulations are imposed on the utilization review program. A recent study by The Wyatt Company, a national consulting firm, revealed that:

1. The requirement that UR decisions be made by local physicians of the same specialty or subspecialty, would increase administrative costs by 42.5% in the first year and 34% the second year.

2. The requirement that the utilization agent be continuously accessible would increase the administrative cost by 44%.

Of course, with this kind of increase in administrative cost, the health care cost saving will be greatly diminished.

Finally, I would like to address some of the other provisions of this bill which are of concern:

1. The requirement of the utilization review nurse to have a Master's Degree is unnecessary. Clinical experience is just as important, if not more important, than an advanced degree. Requirement of a Master's degree will only service to prohibit the hiring of otherwise qualified individuals. Our nurse reviewers have an

average of over five years of clinical experience. Many of them do possess advanced degrees, such as a Master's degree. As part of our quality assurance program, they received formal training on the application of clinical criteria, customer service techniques and communication skills. They are well versed in managed care operations with continuing education requirements each year. Furthermore, through our medical information system, they can keep up with the latest medical advances.

2. While the bill has put licensing regulations and strict provisions in order to alleviate some of the concern of the providers, in order to promote cost effective and efficient optimal medical care and greater coordination between the payer and the provider of health care, to achieve that end, legislation should also include some provisions to help promote the effectiveness of utilization review programs. For example:

   A. Provider must also be reasonably accessible to discuss the case with the utilization review agent and provide needed information which is not included in the medical records, within a reasonable period of time. Many times certification of the medical services were delayed because the providers did not answer or return phone calls, despite numerous attempts. And, in some situations, the representatives of the providers, for example, the office personnel, the on-call physicians or the facility's UR personnel, did not have the current information at hand.

   B. The providers must willingly discuss with the patients in a timely manner the limitations on their coverages when informed of a non-coverage by the UR decision.

   C. The act of providing false or misleading information to an UR agent should be identified as fraudulent with the appropriate penalties as with any other prosecution for fraud.

3. Finally, there is no research that has shown that the utilization review program now in effect in Alaska, is failing in any significant manner. Even if there are differences between the providers and the utilization review agents, the State should encourage the parties to resolve their differences voluntarily instead of resorting to an expensive licensing procedure. This licensing procedures will not produce any significant benefits to the patients, but will definitely increase the cost of health insurance.

In conclusion, the purpose of a flexible utilization review program is to strive for optimal medical care and at the same time to make health care service more cost effective, cost efficient and affordable.

Thank you for allowing us to testify today and we will be happy to answer your questions.

HIAA

Health Insurance Association of America

STATEMENT OF HIAA

ON

LICENSING AND REGULATION OF PRIVATE HEALTH CARE REVIEW AGENTS

SENATE BILL 239

PRESENTED BY

JAN ANDREA MEISELS

LEGISLATIVE DIRECTOR

BEFORE THE

ALASKA SENATE COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

SEPTEMBER 17, 1991

6052 Hackers Lane
Agoura, California 91301
818-991-6817

I am Jan Andrea Meisels, Legislative Director, Health Insurance Association of America (HIAA). HIAA is a national, voluntary trade association of 300 private health insurance companies which provide health insurance for 95 million Americans. HIAA is opposed to the provisions contained in SB-239.

The cost of health care has risen at a rate that is matched by no other item represented in our economy. The rate of growth consistently outstrips the other items in the Consumer Price Index and is soon going to exceed 15 percent of the value of all goods and items produced in the United States. Studies performed by the world-renowned Rand Corporation conclude that many medical services performed are not medically necessary. In fact, they list that 25-40 percent of certain procedures are medically unnecessary or equivocal. Studies conducted by Dartmouth University researchers conclude a physician's practice pattern has more to do with surgical rates than the appropriateness of care or medical necessity.

Utilization review is a method being used by both the private and public sectors to reign in the costs of inappropriate medical usage. These plans require that <u>before</u> the patient is admitted to the hospital and/or undergoes a procedure, approval must be obtained from the utilization review firm. Utilization review is a sound and reasonable approach for assuring that only medically necessary, quality care is rendered in the most appropriate and cost-effective setting. Utilization review

provides a balance to the health care provider's incentive problem by requiring the physician, hospital or other provider to justify the medical treatments/procedures they wish to perform. Traditionally, health care providers were not questioned about their services, so it is not surprising that some may be upset if they cannot medically justify their services -- resulting in the services not being approved.

During the past five to ten years, the health care delivery and financing system in this country has evolved at an impressive pace. The most visible change has been the explosion of what is becoming known as managed care delivery systems, including HMOs and PPOs, which incorporate utilization review.

Continued growth and use of managed care arrangements represent our best hope of reigning in health care costs. Moreover, managed care, as contrasted with an all payer system of rate setting, is more, not less, likely to achieve cost control results without the kind of economic disruptions associated with rate setting.

The basis of a managed care plan is not discount medicine, but quality medicine at a reasonable price. Every health care plan provider recognizes that delivering poor quality care will only drive up plan costs in the long term. A person who receives poor care will become sicker, requiring more care at additional cost. Managed care plans seek quality care providers,

recognizing their potential liability for directing people to those who fail to deliver proper treatment.

Proponents of restrictions on managed care, including restrictions on utilization review, maintain they are protecting patients to assure quality care. That is not the reason they are trying to restrict managed care plans; rather it is for their own self-interest, by attempting to thwart any controls on their rising fees and medically unnecessary utilization of services. As previously stated, managed care plans foster quality care. HIAA believes that state legislatures should not place inappropriate barriers in the way of insurers, establishing effective managed care and utilization review programs.

Recently, the HIAA commissioned the Wyatt Company, an employee benefits and compensation consulting firm, to study and estimate the costs associated with legislative provisions that would restrict managed care programs. Attached to my statement is an executive summary of the Wyatt study.

Provisions of SB-239 include some of the provisions that were studied by the Wyatt Company. The proposed requirement of local utilization review by professionals licensed in Alaska and denial reviews by physicians of the same specialty as the attending physician was one of the six areas studied by Wyatt. Many utilization review firms operate centralized units because of the cost-efficiency associated with minimizing overhead and limiting administrative expenses. They typically employ

registered nurses and physicians with years of clinical experience to perform utilization reviews. If SB-239's provisions were enacted, this provision would require utilization review to be performed by such professionals only if licensed in the state where their proposed medical service would occur, i.e., Alaska. The Wyatt study indicates that first-year administrative costs for centralized utilization review firms would increase by over 42 percent. Moving and start-up costs as well as additional personnel, would be required for a utilization review organization to move a substantial percent of its business to an in-state location and to have locally licensed specialty physicians under contract for all denial reviews. Subsequent-year utilization review costs would also increase.

Such a provision is not justified. Quality of care and competence of physicians do not change when crossing state lines. Any physician licensed to practice medicine by any of the 50 United States should be allowed to perform the review. Alaska has less than 1,000 licensed physicians. According to the American Medical Association, there are over 50 recognized specialties. Requiring only Alaskan-licensed physicians to perform reviews when there are over 550,000 licensed physicians in the United States is not only unnecessary but also places a severe drain on the limited medical resources in Alaska.

An example of how improper this provision of SB-239 is: If someone had a heart condition and saw a cardiac surgeon, his/her proposed invasive (surgical) treatment would be required to

receive prior approval, or a second opinion. If only another like-type subspecialist, i.e., cardiac surgeon, could perform the review, only an invasive procedure would be considered. If, on the other hand, another physician, i.e., an internist or cardiologist, was permitted to perform the review, perhaps an equally effective, noninvasive less dangerous to the patient and less costly treatment regimen might be recommended.

Another provision of SB-239 with which HIAA takes exception is that nurses perfcrming the review must have M.A.'s. Nurses are basically reviewing the medical indications of treatment against criteria used by the review firm. That criteria was developed with physician input. A qualified professional is what is important, not the number of degrees after the particular nurse's name.

Another objectionable provision of SB-239 is the requirement of disclosing all proprietary specific criteria, review standards and procedures. Not only is this provision impractical; in many cases it is impossible. Many of the criteria that are being used by a variety of utilization review firms and insurance companies have contracted with private organizations to use under a purchase-lease option contract, criteria developed by these other organizations. Included in those contracts is the prohibition to release or share the criteria due to the proprietary nature of the material. Another issue is the major concern that some providers game the system, i.e., if they know what will be accepted, regardless of what is medically indicated or needed,

they will advise the utilizaton review organization they are following those procedures in order to get approval, even if that is not what is planned or best for the patient.

The provision prohibiting denial of claims once an initial review has been approved does not recognize the various components required to determine that all provisions of the insurance contract are in compliance. For example, in obtaining the initial approval, all pertinent information may not have been disclosed, i.e., the patient may have had a preexisting condition; the diagnosis could change to one that is not covered under the policy, or covered only under a limited manner or in a different setting. Other claims may arrive after the initial approval, and before the claim in question was received, which may have consumed the remaining benefits allowed under the policy; or the initial approval occurred during a grace period and the policyholder did not subsequently pay the premium which negates the policy. Insurers always reserve the right to deny payment based on fraudulent information provided by the claimant, provider, agent, policyholder, etc.

The provision that requires payment not be denied for treatment during the period when a private review agent is not accessible or when the appeal of an adverse decision is pending also raises many concerns. Private review agents are available during normal working hours five days a week. It is generally recognized that when an emergency occurs, that the utilization review firm be notified within 24 to 48 hours after the patient

has been stabilized. Therefore, it is not necessary to have 24 hour, seven day a week coverage by the utilization review firm, nor is it appropriate to legislate that payment will be made when a private review agent is not accessible, i.e., what if it is an elective admission and not an emergency admission.

Under the Employee Retirement Income Security Act (ERISA), the insured always has the right of appeal. This ERISA provision addresses both self-funded and fully insured insurance contracts. If the appeal finds that the care is not medically appropriate, why, then, would the Alaska State Legislature want to mandate reimbursement for medically unnecessary care, by stating that reimbursement shall not be denied during an appeal of an adverse decision? Utilization review and all of its parameters are there for two reasons: to assure quality health care and to provide that care in the most cost-effective manner. By legislating reimbursement for care that may be found to be medically inappropriate, health insurance costs will continue to escalate unnecessarily.

We recognize that the majority of providers are ethical. However, the provision requiring payment to continue if the provider is unable to reach the utilization review agent or while the case is under appeal allows the unethical provider to "game" the system and appeal all denials, declinations, modifications to treatment proposals, while continuing to generate revenues. This is not in the best interest of the patient, policyholder or the overall health care system of Alaska.

The provision requiring the attending physician to be in attendance when a review agent is meeting with the patient is another tactic which can be used to deter the utilization review representative in meeting with the patient -- due to the physician's schedule not permitting the visit until an inconvenient time or date. When a decision to discontinue approval of treatment is made, the physician is always notified first. This helps to preserve the patient-physician relationship and allow the physician to offer any additional information not yet rendered which may affect the final decision.

We are also concerned with the legislation attempting to prohibit contract provisions between the utilization review entity and the insurance company or policyholder under which they are contracting for such services. The state should not be in the business of determining what kind of provisions between two contracting entities are permissible when one is paying for a service performed by the other.

A recent study by Foster Higgins (see attached) of over 1,900 employers whose benefit plans cover more than 12.5 million employees and whose data represented responses from all 50 states indicated that utilization review programs have had a positive effect on the behavior patterns of medical practitioners and on medical care plan use. Today, utilization review is the rule rather than the exception. Given the high rate of health plan cost increases, few employers dare go without utilization review programs -- typically preadmission certification, concurrent

review and catastrophic case management. Those employers that could estimate their savings reported an average savings of 5.1 percent of total plan costs. In another study, recently reported in Spencer's Research Reports (see attached), the Blue Cross Blue Shield Association did a year-long pilot study which found that 11.2 percent of the cases that were examined called for inappropriate use of certain procedures. Over 9,000 cases were reviewed evaluating the appropriateness of procedures. While the inappropriateness level varied by procedure, i.e., tonsillectomies, 27.1 percent; hysterectomies, 21.5 percent; and tonsillectomies combined with adenoidectomies, by 17.6 percent; the issue was determined that utilization review is important to the quality of care provided the patient as well as cost savings to the policyholder, the insured and the insurance company.

Many things are happening on the national scene which preclude the need for such onerous legislation as SB-239. The Utilization Review Accreditation Commission (URAC) has developed accreditation standards for utilization review firms. A copy of the final standards endorsed in June is attached. Currently, URAC is reviewing utilization review firms against their criteria in order to accredit these firms. The marketplace will encourage utilization review firms to receive this accreditation as policyholders will only want to use such firms that have met such standards. The purpose of these URAC standards is to encourage consistency in the procedures for interaction between utilization review organizations, providers, etc., and establish processes that cause minimal disruption to the health care delivery system

while providing consistent standards and an accreditation mechanism that can be applied efficiently nationwide for credentialing and accrediting utilization review organizations.

Utilization review is a critical component to providing quality health care, that is medically appropriate and medically necessary in the most cost-effective setting. This committee is also reviewing access to health care. No one single step can achieve on its own the results we all seek. Just as we must take those steps necessary to improve and reform access to care, so, too, must we come to grips with perhaps one of the most significant components of the problem -- cost. Placing barriers to appropriate utilization of services such as those presented in SB-239, go far astray from the desires of providing access and affordable health care to all Alaskans. HIAA encourages the Senate Health, Education and Social Services Committee to determine that SB-239 is not necessary, and therefore reject SB-239. HIAA is most willing to work with the committee in looking at access to and affordability of health care in Alaska. I will be most happy to try and answer any of your questions.

Utilization Review Accreditation Commission

Fact Sheet

In December 1989, the American Managed Care and Review Association (AMCRA) sponsored a meeting, in Washington DC, of utilization review (UR) industry representatives seeking to address a growing movement among state legislatures to regulate the UR industry. At the December meeting, and at a subsequent meeting in March 1990, there was general agreement that the relatively new and growing UR industry needed to formulate a comprehensive response to this movement. Strong support was given to the development of minimum national standards for the industry and for the formation of an independent accreditation organization.

The Utilization Review Accreditation Commission (URAC) was created in response to this need and has been incorporated as a not for profit corporation in the District of Columbia. URAC currently has an Interim Board, officers and four standing committees: Accreditation, Finance, Community Interface, and the Steering Committee.

URAC has received nationwide press for its efforts and has broad industry backing for its goals. After the National Utilization Review Standards receive final approval, URAC will began using them to survey and accredit UR firms. In preparation for this, the URAC Interim Board will be replaced with permanent members who represent a broad spectrum of interests including providers, insurers, employers and regulators.

The National Utilization Review Standards are currently being refined by the URAC Standards Subcommittee. The Standards were first published in January 1990, and are designed to:

- Encourage consistency in the procedures for interacting with UR programs;
- Establish UR processes that cause minimal disruption to the health care delivery system;
- Establish standards for the procedures used to certify medical services and to process appeals of certification determination;
- Provide the basis for an efficient process of credentialing and accrediting UR Organization;
- Provide consistent standards and an accreditation mechanism that can be applied efficiently nationwide for those states which choose to regulate UR.

Provided by Reed Stoops

UTILIZATION REVIEW

BACKGROUND

Rationale for Utilization Review

Health care costs in this country have escalated steadily to the extent that they pose a very serious and imminent threat to both our health care system and the strength of the national economy. Those costs have put health insurance beyond the means of many tens of millions of Americans. Uninsured people receive poorer quality, more expensive care because they usually defer seeking treatment until later in an illness.

A great deal of the cost explosion in health care has been attributed to an overuse of health care services. Burgeoning malpractice liability and cost-plus third-party reimbursement have led providers to order more tests, procedures and hospital admissions than necessary. Recent independent studies indicate that, despite inroads by managed care programs, key decisions that affect the use, cost and quality of health care are still made by providers. At the same time, there is ample and persuasive evidence of inappropriate variations in practice patterns, of unnecessary testing, and of self-serving decision-making by providers that call into question the necessity, appropriateness or quality of health care that was once presumed.

- A recent study by the Public Citizen Health Research Group found that use of Cesarean sections in birth deliveries varies enormously from city to city, topping 50% in some (the national rate for C-sections was 24.4% in 1987). C-sections increase the risk of maternal death 2-4 times and (in 1987 alone) cost about $1 billion more than vaginal deliveries would have cost.

- A 1988 Rand Corporation study found that 32% of carotid endarterectomies (removal of fatty deposits from neck veins) were unnecessary and that 10% of those patients undergoing the procedure died or suffered a stroke as a direct result.

- About 15% of physicians have a financial interest in medical testing laboratories. A recent study of Medicare physicians showed that those having an interest in labs order 45% more tests than those that do not.

An important national strategy for the reduction of these costs is a form of managed care known as utilization review, which has been described as:

> The assessment of treatment in accordance with guidelines and standards established and accepted by health care professionals before and during the delivery of health care with the purpose of enhancing the quality, appropriateness, medical necessity and cost-effectiveness of such health care.

Utilization review may include prior approval for certain services and concurrent review during hospitalization. It involves the use of comprehensive guidelines developed by specialist in the appropriate fields regarding appropriateness and effectiveness of treatments and services for the entire range of medical conditions. Although today some form of utilization review service is offered by most health insurers, self-insurers, health maintenance organizations and preferred provider organizations, the advent of such programs is very recent. For example, surveys conducted by benefits consulting firms show that in 1984 as few as 5% of large employers included utilization review provisions in their health benefit programs. Today, one-half or more of these employers have implemented utilization review programs.

Who Does Utilization Review/How Does It Operate

A wide variety of organizations are involved in conducting prospective and concurrent utilization review in the United States. They include insurers who may conduct review internally or through a subsidiary or subcontractor, independent utilization review organizations, third party administrators (TPAs), hospital or other provider-sponsored organizations, utilization review components of PPOs, HMOs or other network provider structures, an employers' own internal utilization review staff and others.

A utilization review organization conducts a review of the clinical information about the patient's condition, the proposed site of service, the length of stay, the health care resources required and the proposed procedure or treatment. Based on the information provided at the time of the review, the utilization review organization certifies that the proposed site, service or treatment appears to meet the applicable health benefit plan's requirement that covered services be medically necessary and appropriate.

Utilization review determinations are not directions to the provider to offer or refuse to offer any course of treatment; they are rather assessments of the medical necessity or appropriateness of proposed care for the purpose of offering an advance indication concerning benefits (is the proposed service medically necessary? appropriate?). Utilization reviewers have no authority (and seek no such authority) to direct the provider of care or patient to do or omit anything, and the provider and patient are always the final arbiters of any treatment plan. Utilization review denials simply indicate that the proposed treatment does not meet the medical necessity or appropriateness requirement in the absence of new information or changed circumstances; this is subject to rights of appeal at the certification and claim stages.

In short, by creating a managed care system characterized by (1) consumer and provider knowledge and purchaser oversight of provider services and (2) consumer involvement in utilization decisions, utilization review establishes appropriate incentives that support health care quality consistent with sound public policy.

Employer Demand for Utilization Review

Utilization review is critical to the health benefits business in general. It is demanded by the majority of employers as a feature of their insurance and self-funded benefits programs. Enrollment in managed care programs, most of which involve utilization review, is roughly as follows:

HMOs	(HIAA)
PPOs	(HIAA)
MULTIPLE OPTION PRODUCTS	(HIAA)

BARRIERS TO UTILIZATION REVIEW

Anti-Utilization Review Legislative Proposals

The utilization review industry is a new and emerging one and the variety of organizational structures and approaches that constitute utilization review should be given an opportunity to evolve without the constraints of premature regulatory oversight. Legislative and regulatory initiatives in many states threaten the ability of utilization review programs to effectively reduce unnecessary care. Further, the imposition of regulatory restrictions on utilization review organizations will result in increased overhead costs for such organizations. These costs will be passed along to payer groups, resulting in an overall increase in the cost of health care for the public. The state will also be fiscally impacted by utilization review regulation as a payer of health care for state employees and through the cost of administering regulatory programs. These additional costs are not justified in the absence of proven demonstrable harm to the public.

Institute of Medicine Endorses Non-Regulation

In response to the question, "Is public regulation of utilization management desirable and feasible now?" the Institute of Medicine's Committee on Utilization by Third Parties ("Committee") answered "No" and recommended that the state regulation of utilization review programs was premature.

In particular, the Committee concluded:

> Proposals to regulate utilization management involve uncertainties and risks that should be understood. This rapidly evolving activity could become a major pathway to disseminate and apply standards for appropriate care that are being developed through research and consensus mechanisms. To the extent that regulation raises the cost or diminishes the effectiveness of utilization management, it becomes less attractive than other approaches that

do not consider individual patient conditions. The cross-pressures in utilization management provide opportunities for dialogue between payer and physician that may educate both parties and permit more sensitivity to patients' needs than do alternatives that provide incentives to reduce services across the board.

The conduct of utilization management merits continued oversight. However, a strong argument can be made now for allowing the field to continue its rapid evolution, for increasing purchasers' scrutiny over utilization management services and for disclosing the clinical bases for utilization management decisions. State regulation, however, remains an option if abuse becomes apparent involving either harm to patients or unreasonable burdens on physicians and institutional providers. Federal action may be warranted if highly discrepant state regulations develop.

Existing Regulatory Requirements are Currently Sufficient

Utilization review organizations do not operate in isolation, but must work in conjunction with other regulated entities such as health insurers, health maintenance organizations, preferred provider organizations and self-insurers whose claims payment practices are already regulated by the state or federal government (e.g., bad faith insurance laws, ERISA rules, etc.). Thus, existing state and federal laws provide an adequate remedy for members of the public who are aggrieved by the decisions of a utilization review organization.

Opposition from Providers

But provider interest groups have nonetheless been very successful at using anecdotal information in an inflammatory way to convince state regulators that inflexible and burdensome regulation is necessary. This legislation has taken a number of forms but is primarily focused on state certification of utilization review firms, the application of general standards and criteria and the qualifications for utilization review personnel. While seemingly well-intended, these laws often make it much more difficult for managed care firms to perform the important task of overseeing the delivery of care in accordance with guidelines and standards designed to ensure quality care in a cost effective setting. Additionally, the many differences among state laws make it difficult and costly for national firms to undertake their utilization review processes.

Unfortunately, many of these laws and regulations greatly inhibit the effectiveness of managed care options in reducing rising health care costs. The following discussion will highlight the regulatory provisions which should be considered particularly harmful to utilization review.

MEDICAL STANDARDS

Limitations on use of medical protocols as an acceptable standard.

We strongly oppose the imposition of limitations on the use of medical protocols as an allowable standard for utilization review. This sometimes appears in the form of legislation to impose the use of local or community standards as a regulatory requirement for utilization review. A utilization review program is both most well founded and most effective if it is able to draw on all available medical knowledge, rather than the knowledge and practice patterns of one location only. Good utilization review standards necessarily incorporate all available accepted medical literature on the procedure or dysfunction in question. Such standards are thus by their nature national and even international. Thus, for state-by-state licensure of reviewers as local practitioners to make sense from a public policy standpoint, strong evidence would have to exist that local standards are clinically superior.

Vast differences in the frequency with which particular procedures are performed and other variations in practice patterns from location to location more clearly arise from the distribution of specialist practitioners than from the needs of local enrollees. Utilization review standards must be based on all knowledge available nationally about the effectiveness of procedures.

PERSONNEL RESTRICTIONS-RESIDENCY

Requirement that physician reviewer be licensed in the same state in which the care is being given.

We strongly oppose such a requirement. Such a requirement confuses utilization review with medical care. While it is important to have local licensure for the attending physician to provide state oversight of such local practitioners, the same requirement for utilization review physicians threatens the very existence of national review firms and utilization review in general (which, of course, is the goal of such a requirement). Variations in local practice represent an obstacle to effective and consistent utilization review, which is only exacerbated by a local licensure requirement. Such a requirement would probably require arrangements with local clinicians, which arrangements would subject the reviewer to unnecessary peer pressure and would significantly reduce reviewer consistency and individual effectiveness. Training and general oversight of review and day-to-day management would be problematic and costly. Furthermore, there is the added problem of objectivity when one local clinician reviews another; the more similar the locality the more likely objectivity will be compromised.

PERSONNEL RESTRICTIONS-CREDENTIALS

Requirement that physicians performing utilization review must be practicing or board certified in the same speciality as the attending physician of the patient.

We oppose the requirement that physician reviewers must possess the same specialty as the attending physician. (However, it should be noted that "same speciality" physicians sometimes are used affirmatively by review firms, where appropriate). Utilization review firms typically review medical requests for resource use first by registered nurses (or other appropriately qualified personnel) using protocols developed by physicians for this purpose. If agreement on hospitalization or other resource use can be accommodated with the attending physician at the time, no involvement of a physician reviewer is necessary. If agreement is not reached, a physician reviewer is generally involved. The second level of review is generally by a board certified physician generalist (internist, pediatrician, family practitioner, general surgeon). These highly trained physicians have been patient case managers in their own clinical practices and are thoroughly familiar with the indications for most types of diagnostic and therapeutic procedures, without the bias that can ensue when one has been trained only in a subspecialty area.

Additionally, it can be advantageous for patients to have their clinical case reviewed by a non-procedure-oriented physician to get a more objective assessment of the need for a potentially expensive and invasive procedure.

Requiring specialist review will significantly increase the administrative and claim costs (passed through to employers and patients) of performing appropriate utilization management in several ways:

1. Specialists are frequently paid more than generalists for doing reviews. One company has estimated the additional cost to be approximately 2.5% to 3% of program costs.

2. Specialists may be more sympathetic (less objective) to their colleagues' pleas than generalists, resulting in higher costs.

3. The higher use of specialists will necessitate larger networks of non-employed reviewers, resulting in less rigorous control of utilization review decisions.

We also oppose requirements that denials be made only by specialists in the same field as the attending provider. Our review protocols are developed or reviewed by specialists. Involving specialists in all denials is not necessary, although there are some circumstances when review by a specialist is warranted, in which case a specialist is indeed involved.

DISCLOSURE OF PROTOCOLS

Requirement that protocols be disclosed to the state or to providers.

We oppose any requirement of such disclosure, although disclosure of a summary of the utilization review system might be appropriate.

- Utilization review protocols are proprietary; in many cases they are not the property of the reviewer but rather the property of third party vendors who require confidentiality.

- Medical protocols are often lengthy, technical and subject to frequent modification or alteration. The Institute of Medicine concluded in 1989 that utilization review needs to be allowed to continue its rapid evolution; disclosure of protocols would thwart this development.

- Disclosure of protocols increases liability to employers and managed care programs.

- Protocols are not arbitrary rules that are applied without discretion; they are always subject to clinical judgment in any certification denial. A requirement of disclosure thus reflects a misunderstanding of the proper use of protocols.

INCENTIVE PAYMENT PROVISIONS

Prohibitions against tying payment (to a utilization review agent) to a reduction in utilization.

We do not oppose prohibitions on compensating individual reviewers on the basis of numbers of denials, but we do oppose prohibiting the utilization review firm from putting its fees partially (or wholly) at risk based on overall achievement of target cost savings. Many employers demand such arrangements, asking us to "put our money where our mouth is." In enacting the HMO Act of 1973, Congress accepted the view that prospective financial risk in health care serves cost-effective treatment and preventive care.

PHYSICIAN INVOLVEMENT IN DENIAL OF CERTIFICATION.

Requirement that all denials of certification be made by a physician.

We oppose requirements that all denials of certification be made by a physician. To require physician involvement in certain denials (e.g., those with which the attending physician agrees) would be burdensome and unnecessary. The concern here is adequately addressed by review procedures which include physician review at some point in the process. Certification is a complex process involving discussion, suggestion and negotiation. Regulatory requirements simply governing "denials" are ill-suited to such a complex process.

Such a requirement would be hard for the state to administer given the complexity of the utilization review process. If treated as a "bright-line" rule, it would add significantly to costs.

UTILIZATION REVIEW AS THE PRACTICE OF MEDICINE

Requirement that utilization review be defined as the practice of medicine.

We strongly oppose such a definition. Utilization review determinations do not direct a provider of care to offer or refuse to offer any specific course of treatment. They are rather an assessment of the medical necessity of proposed care in the appropriate setting for the purpose of offering an advance indication concerning benefits. Utilization reviewers have no authority to direct the provider of care or patient to do or omit anything; this is not the practice of medicine. This requirement is not justified and would add substantially to costs and interfere with effectiveness.

Initiatives defining chiropractic utilization review as the practice of medicine are particularly regrettable. Many seek to re-define the practice of chiropractic to include the review of chiropractic services so that chiropractic reviewers must be licensed to practice in the relevant state. This exhibits a fundamental misunderstanding of the nature and intent of utilization review, which does not seek to replace the practitioner or seek to dictate that certain services be offered or not offered or be performed a certain way. Further, to define the practice of an art to include a paper review of appropriateness could lead to unintended and illogical results. Such an approach, if applied consistently in other practice areas, would require that medical claims review be considered the practice of medicine, and that all reviewers by physicians. Such a position is insupportable.

In Connecticut, the Board of Chiropractic Examiners itself recently (and correctly) ruled that the review of chiropractic services was not the practice of chiropractic services.

RETROSPECTIVE REVIEW AS UTILIZATION REVIEW

Requirement that the definition of utilization review includes "retrospective review."

We oppose including "retrospective review" in any statutory or regulatory definition of utilization review and support its specific exclusion from such definitions in the event of ambiguity. Retrospective review is by and large already regulated (e.g., through state regulation of insurance claims processing and unfair claims practice laws, through ERISA etc.); consequently, standards applicable to prospective or concurrent review are inappropriate.

In states requiring physician review in utilization review denials, the inclusion of retrospective review as utilization review would add substantial additional cost to claim processing.

SPECIALIZED CONCERN IN UTILIZATION REVIEW

Psychiatric and Chemical Dependency

In some states, legislative initiatives regarding utilization review have focused on psychiatric, chemical dependency and chiropractic services, due to the efforts of certain discrete groups of providers. Utilization review in these areas, however, carries no unique problems or risks, and it is equally (if not more) important in efforts to control health care costs. For example, psychiatric and chemical dependency is an area of health care which has seen a particularly rapid rise in costs: five years ago employers spent approximately 6% of their health care costs in the psychiatric and chemical dependency area; presently the share is 15% to 30%.

Many legislative proposals nonetheless seek to restrict utilization review in the psychiatric and chemical dependency area so as to either render such programs too expensive to be provided by benefit programs or so as to drastically diminish their effectiveness. This is particularly unfortunate because psychiatric and chemical dependency not only constitute a rapidly growing segment of health care costs, but because these services are especially appropriate to utilization management. For example, the cost difference between inpatient and outpatient psychiatric or chemical dependency programs is significant. However, the effectiveness of outpatient programs is comparable to or better than, the inpatient programs. Utilization management could encourage the use of these less expensive, equally appropriate outpatient programs.

Psychiatric and chemical dependency services are also fields in which there are an increasing number of treatment options. Psychiatric review specialists can assist practitioners in assessing the appropriateness of these various options. For these reasons, efforts to restrict psychiatric and chemical dependency utilization review are particularly unfortunate.

CONCLUSION

Utilization review is an important and significant health care cost containment tool to ensure the appropriate utilization of health care services in our country without jeopardizing the delivery of quality care to the patient. Its development should be nurtured and encouraged rather than proscribed by needless regulation.

In evaluating and combating state legislative initiatives, it should be recognized that utilization review has grown rapidly from almost non-existence before the late 1970s to its current status of pre-eminence over the traditional fee-for-service arrangements without such utilization review, especially in employee benefit plans. Because it has proven to be an effective cost-containment tool, providers of late have organized to attack utilization review by proposing deathknell legislation designed to negate its effectiveness.

Organized provider groups are often politically active and powerful; they are supported by a base of members who are both geographically dispersed throughout all legislative districts and influential leaders in their communities. Rational arguments and independent studies are, by themselves too often no match for carefully chosen and well-presented anecdotes that appear to represent the "tip of the iceberg" of consumer abuse, particularly in the sensitive area of health care. Often lost in the debate is the not so surprising realization that providers critical of utilization review have an appreciable financial interest to protect in seeking anti-utilization review legislation.

An environment favorable to managed care can and should be protected. The principal danger is that state anti-utilization review legislation will be forced through legislative committees on the basis of anecdotes and alleged harm to the patient without an appropriate consideration of the value of utilization review and an understanding that much of the complaint can be traced to reductions in payments to providers. Once objections are raised, however, the process slows down and allows an opportunity for more measured advocacy, debate and compromise. Identifying the proposals at an early stage of the political process, understanding the impact of the bills on utilization review and coordinating opposition to the measures are early steps that require attention and effort. Protection of utilization review, however, is worth the price.

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

March 20, 1991

Senator Arlis Sturgulewski, Chair
Committee on Health & Social
Services
Alaska State Senate
Legislative Building
Juneau, AK 99801

Re: Utilization Review Legislation

Dear Senator Sturgulewski:

The Association would like to see legislation introduced to license and regulate utilization review organizations.

As you know, the major reason for this legislation is to protect patients by making sure the "quality" of care is not jeopardized because of cost containment efforts by insurers and utilization review organizations.

Alaska hospitals do not feel the legislation need be cumbersome, or punitive, rather that it should assure physicians and hospitals that the individuals doing the review are qualified, that all private UR organizations reviewing patient care in Alaska are registered with the state, that the hours of availability and the response to inquiries are timely, that there is an appeals mechanism and that specialty physician review is available under appropriate circumstances.

Ideally this would be done on a volunteer basis, but that appears doubtful.

Enclosed is a summary of state "private utilization review" statutes as of October, 1990.

We appreciate the opportunity to work with you on this issue.

Sincerely

Harlan R. Knudson
President/CEO

cc: ASHNHA Executive/Legislative Committees
Mr. Ray Gillespie
Mr. Rick Urion

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

SUMMARY OF STATE PUR STATUTES

OCTOBER 1990

State	AR	FL	GA	KY	ME	MD	MS	NJ***	NC*	PA**	SC	VA
Implement Date	1/1/90	10/1/90	1/1/91	1/1/91	9/30/89	11/1/90	7/1/90		1/1/91	4/15/90	5/1/90	7/1/90
Application & Renewal Fees	X 2 years	X 1 year	X 2 years	X 2 years	X	X 2 years	X 2 years		X 1 year		X 2 years	X 2 years
UR Plans-description of review stds & procedures	X	X	X	X	X	X	X		X		X	X
Mechanism for Appeals & Reconsideration	X	X	X	X	X	X	X		X		X	X
Specialty Physician Review		X	X	X			X		X			
Type & Qualifications of Personnel	X	X	X	X		X	X		X		X	X
Hours of Availability	X	X		X	X	X	X		X		X	X
Provide List of Payers	X			X		X	X					
Complaint Mechanism			X	X	X						X	

* Much more specific than other laws being drafted or having been passed.
** Auto insurance law allows insurers to use UR companies, including PROS, to review medical claims; separate PUR bill failed to pass.
*** Health department interprets part of its current statutory to cover UR companies.

RESPONSIBLE AGENCY

Arkansas	Board of Health	Mississippi	Department of Health
Florida	Dept. of Health & Rehab. Services	New Jersey	Department of Health
Georgia	Commissioner of Insurance	North Carolina	Department of Insurance
Kentucky	Cabinet for Human Resources/Health Dept.	Pennsylvania	Department of Insurance
Maine	Bureau of Insurance	South Carolina	Department of Insurance
Maryland	Dept. of Health & Metal Hygiene	Virginia	State Corporation Commission

STATUS

Arkansas	Draft Regulations Complete	Mississippi	Final Regulations Pending
Florida	Implementation Delayed	New Jersey	Proposed
Georgia	Not Implemented/Lack of Financing	North Carolina	Final Regulations Pending
Kentucky	Drafting Regulations	Pennsylvania	Drafting Regulations
Maine	Proposed Regulations	South Carolina	Regulations Proposed
Maryland	Final Regulations Published	Virginia	Drafting Regulations

BARTLETT MEMORIAL HOSPITAL

3260 HOSPITAL DRIVE • JUNEAU, ALASKA 99801 • TELEPHONE (907) 586-2611

October 11, 1990

Senator Jim Duncan, Chair
Health Care Cost Containment Task Force
Alaska State Senate
Box V
Juneau, AK 99811

Subject: Utilization Review Legislation

Dear Senator Duncan:

As the task force continues its work to understand and impact some of the factors that influence the cost of health care in Alaska, we would urge that you continue to consider the issue of utilization review standards. In the last legislative session a bill (SB 550) was introduced to try and address at least some of the important issues. We are supportive of the concepts in this legislation and feel that establishing utilization review standards will:

1) Improve communication and cooperation between providers and utilization review agents.

2) Assure that reasonable standards are adhered to in conducting utilization reviews.

3) Promote the delivery of quality, cost effective health care.

We thank you for your consideration of this along with other important matters. Please contact us if you have questions or need additional information.

Sincerely,

Garth Hamblin

Garth M. Hamblin
Controller

GMH/mem

cc: Task Force Members
Ray Gillespie

Alyeska pipeline
SERVICE COMPANY

1835 SOUTH BRAGAW STREET, ANCHORAGE, ALASKA 99512 TELEPHONE (907) 278-8611 TELEX 090-25-627

March 25, 1992

Senator Arlis Sturgulewski
Alaska State Legislative
State Capitol
Juneau, AK 99301-1182

Dear Senator Sturgulewski:

Reference: Senate Bill 239

In the 1991 legislative session, I was aware of similar proposed legislation which failed for lack of a sponsor. I understand this item is now before your committee.

Alyeska adopted a Managed Care program in January 1989. Along with the State of Alaska and other employers we were facing continually increasing cost of providing health benefits. Since our employees contribute torward their coverage, they were also experiencing increased premium costs.

Our Managed Care program has at its core a responsible utilization review and concurrent review procedure for medical in-patient/surgical care as well as chemical dependency and mental health. We use the services of Intracorp and Human Affairs Alaska . The programs have worked, providing cost effective care by reviewing the need for hospital, surgical and chemical/mental health treatment without diminishing care quality. Through the use of U.R. Programs, in conjunction with a hospital Preferred Provider Arrangement, we have been able to hold our premiums at 1990 levels.

The proposed Senate Bill 239 sounds laudable on the surface but has the following problems:

- It establishes another level of bureaucracy where none is needed. This at a time when the state is trying to bring under control a short fall in the state budget. I doubt seriously the state will collect enough fees under Sec. 08.85.080 "in an amount sufficient to pay for the costs to the department for administering this chapter",

- It is a bill that unduly benefits hospitals (Sec. 08.85.020 and 08.85.030).
  - It considers all UR activities as being hospital related ignoring Employee Assistance Programs (EAP) and related UR activities which are frequently not hospital directed nor do they use nurses.
  - requires a license for anyone not affiliated with a hospital (exempting hospitals).
  - "...have available... sufficient numbers of registered nurses"... supervised by physicians trained in the appropriate specialty area, ..."
  - "prohibitions against a review agent entering a hospital to interview a patient unless the attending physician is advised... with reasonable advanced notice".

These requirements totally favor hospitals such as Charter North and one would suspect were written by them. A hospital "UR" facility would be similar to the old saying: " the Fox guarding the Hen house".

Costs to employers and employees will increase as a result of restraining reasonable "UR" programs which evaluate the appropriateness of care, the length of confinement, and the selection of the appropriate provider. Add the cost of qualifying for a license, providing an extra layer of communication to patients and providers duplicating employer efforts (Sec 08.85.030,(b)(11), and other compliance efforts. Frankly, many small employers may not be able to continue to provide medical and EAP programs if costs increase. Most of us have worked for years to remove unnecessary controls of our own insurance carriers to lessen overhead and the need for expensive practitioners and specialists to "oversee" every case when only the most severe required such management.

I would appreciate your reconsideration of Senate Bill 239 based upon my comments.

Regards,

Gordon A. Anderson, CEBS
Manager, Benefits and Annuitant Affairs

CHARTER
NORTH HOSPITAL

2530 DeBarr Road
Anchorage, Alaska 99508
(907) 258-7575 • 800-478-7575

TOA

File # SB 239

January 31, 1992

Senator Arliss Strugulewski
Alaska State Legislature
P. O. Box V (MS 3100)
Juneau, AK 99811

Dear Senator Sturgulewski:

I wanted to write and express my sincere thanks for meeting with us to discuss Senate Bill 239. It was very helpful for the physicians to hear first hand your concerns about the bill. It is my understanding that the meeting you suggested is being arranged. I appreciate your willingness to assist in this endeavor. It has always been our goal to work with the utilization review firms to create a win-win situation.

I believe the dinner held in Juneau was a success. Individuals left with a greater understanding of the utilization review process and the objectives of the legislation.

Best wishes for a productive and successful session.

Sincerely,

Kathleen M. Cronen

Kathleen M. Cronen
Administrator

Association of
Alcoholism/Addictions
Programs

P.O. Box 1172 Ellensburg, WA 98926 (509) 962-6202

"The Statewide Association of Quality Chemical Dependency Treatment and Prevention Programs."

THE NEED TO REGULATE UTILIZATION REVIEW

Perspective from Chemical Dependency Treatment

Many people in need of alcohol and drug treatment are now being denied access to the proper level of care--and sometimes any treatment at all--because of inappropriate decisions by utilization review programs.

While we recognize the value of managed care when it is properly conducted, we strongly oppose arbitrary or discriminatory practices that endanger the lives of youth or adults who are ill and in need of treatment.

In 1987 the Washington State Legislature expanded mandatory coverage for alcoholism to encompass all chemical dependency. Since that time health insurance companies have increasingly used utilization review to circumvent the laws and regulations standardizing coverage for chemical dependency.

There currently are no statutes or regulations that govern the operation of utilization review programs by insurance companies, health care companies, and health care maintenance organizations. As a result, there are as many as 150 national and regional corporations conducting private reviews, most applying differing criteria for coverage. Most criteria do not reflect the professional norms for delivery of care.

Among the growing list of problems for patients and providers generated by private utilization review entities are the following:

- Most companies call their standards of care "proprietary" and will not share them with either the patient or provider until after the patient has commenced treatment and is denied coverage.
- Review entities invent continuums of care that exclude customary and statutorily defnied modalities, such as requiring patients fail at one modality before receiving the medically prescribed treatment.
- The reviewing agent often utilizes personnel without training or qualifications in the illnesses about which they make critical decisions on access to care, level of care and length of stay.
- The review agent may be inaccessible for days yet will deny care retroactively.

Washington State should enact legislation to regulate utilization review by requiring each review agent to develop a plan to be filed by the insurance entity that discloses standards, criteria and procedures to be used in managing health care plans. Such legislation will assure full disclosure to consumers of what they have purchased and what they can expect from their health care coverage.

LAKESIDE
RECOVERY CENTERS, INC.
JUNEAU

April 18, 1991

Representative Pat Carney
Co-Chair House H.E.S.S.
Pouch V
Juneau, AK. 99811

Dear Pat,

It is with regrets that I will be unable to testify at your committee's hearing on House Bill 269. By way of background, I administrate the local Lakeside Recovery Outpatient Drug and Alcohol Clinic here in Juneau. Lakeside is a private for profit regional based corporation which has its' corporate offices in Bothell, Washington. We have four outpatient clinics in the state of Alaska and have provided services to the chemically dependent population in this state for eight years. The locations of these four centers are Fairbanks, Anchorage, Juneau, and Ketchikan. The regulation of utilization review has been and continues to be an important issue for treatment providers, such as Lakeside, to be concerned about.

Many people in need of alcohol and drug treatment are now being denied access to the proper level of care and sometimes any treatment at all because of inappropriate decisions by utilization review programs. There are currently no statutes or regulations that govern the operations of utilization review programs by insurance companies and health care companies. As a result, there are many national and regional corporations conducting private reviews, most applying different criteria for coverage. Most criteria do not reflect the professional norms for delivery of care. Among the growing list of problems for patients and providers generated by private utilization review entities are the follcwing;

1. Most companies call their standards of care proprietary and will not share them with either the patient or provider until after the patient has commenced treatment and is denied coverage.

2. Review entities invent continuums of care that exclude customary and statutorily defined modalities, such as requiring patients fail at one modality before receiving the medically prescribed treatment.

3. The reviewing agent often utilizes personnel without training or qualifications in the illnesses about which they make critical decisions on access to care, level of care and length of stay.

3412 Glacier Highway • Juneau, Alaska 99801 • (907) 780-4948

4. The review agent may be inaccessible for days yet will deny care retroactively.

The corporation feels strongly about the enactment of legislation to regulate utilization review by requiring review agents to develop a plan to be filed in this state that discloses standards, criteria, and procedures to be used in managing health care plans. The legislation in House Bill 269 seems the responsible thing to do to protect the consumer in letting them know what they have purchased. It also would go on to ensure that the quality of chemical dependency treatment continues in this state.

Once again, it is with regrets that I will not be able to be at the committee hearings over the next couple of weeks. I will be out of town until May 5, 1991. At that time, I will call to see if I can be of any assistance in regards to clarifying any of the above issues.

Respectfully submitted,

/S/

Judi Bixby, Administrator
Lakeside Recovery Center, Juneau

JB:ym

cc: Senator Arliss Sturgulewski
Senate H.E.S.S. Chair

Melissa

PROVIDENCE HOSPITAL
3200 PROVIDENCE DRIVE
PO BOX 196604
ANCHORAGE, ALASKA 99519-6604
PHONE (907) 562-2211

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

February 20, 1992

TO WHOM IT MAY CONCERN:

I, Geneva Craig, R.N., want it to be known that I support the reason for development of Senate Bill No. 239. As Assistant Director of Utilization Management at Providence Hospital, (a provider,) I can attest to the many difficulties and challenges providers face when dealing with review agencies. The provider's reimbursements for services are frequently jeopardized. The standards and criteria utilized by review agencies are not consistent. The information requested/required is more than what is needed to certify the admission and length of stay. I find this very unreasonable and am highly suspicious that such information may be used to deny their client eligibility at a future date. Often times request for the medical chart is inappropriate. We have had instances where the chart has been requested after the hospital U.R. Coordinator had spoken with the Review agent and extension of stay had been granted. The copying charges were at the hospital's expense.

Arbitrary denial of patient care days occur without clarifying reason, even when the reason for the denial has been requested. Physicians are often the last to know of a denial, therefore they have not had any input into that decision making process. Review companies tell us they could not reach the doctor after one attempt, if any. We have had them say to us they will not call the physician, and yes the patient stay is denied. In order to appeal the hospital must write an appeal letter, (hopefully the disgruntled physician will write it), copy the medical records and mail it to the review company. We then wait several weeks for notification of payment or non-payment. The appeal process could have been prevented, if the review agent had interacted with the physician at the time of the proposed denial. We wonder why the cost of health care continue to rise and why hospitals have been forced to close their doors, shifting the direction of expenses is part of the problem.

Often the denial is issued by a nurse, or a physician outside the medical specialty with which they are dealing. It is only reasonable to expect that the person issuing the denial is in the same specialty or a specialty that is similar. Criteria utilized by the review company is considered privileged information. They seem to have a fear that the physicians will alter their practice along those guidelines to obtain payment and possibly not use their medical judgement.

I am very much aware of the reason for the evolution of Review firms. I am convinced that we need someone to regulate private-health care review agents. The bare minimum for approval of payment for the delivery of health care service is that the care is medically necessary. The need for that care is determined through evaluation of the symptoms exemplified by the patient.

Thank you for this opportunity to express my support in the development of SB 239. If needed, I am willing to help those who do not fully understand the process gain.

Sincerely,

Geneva Craig

Geneva Craig, R.N., M.A.
AD Utilization Management
& Discharge Planning

February 14, 1992

SENATOR ARLISS STURGULEWSKI
ALASKA STATE LEGISLATURE
ROOM 427-C
PO BOX V
JUNEAU AK 99811

LETTER OF SUPPORT FOR NEW UTILIZATION REVIEW LEGISLATION
SENATE BILL 239

Dr. Patrick Brady asked me to write a letter in support of Senate Bill 239, which is an act providing for licensing of private care review agents.

In my capacity as a specialist in general internal medicine in Anchorage since 1978, I have been well aware of the gradually changing health care environment and increasing review of many of my hospital patients as well as outpatients. It has been my impression and consternation that a number of times reviewers would be incapable of understanding a medical case, in the hospital especially, and would be so confused as to challenge normally accepted medical therapy. To that end, most physicians have learned to write hospital notes which sometimes are quite didactic and explain things in much greater detail than would normally be required so that reviewers that don't understand the medical problem would be more likely to accept treatment.

Two pertinent examples include:

1. About 2 years ago I had a serious question about admitting a patient to withdraw from a drug called Quinidine. Quinidine was used by this gentleman to treat a ventricular cardiac rhythm disturbance, and he was ill from the drug. Stopping the drug required admission to the hospital for cardiac monitoring. This is a normally and well accepted type of observation, and in fact, had I not admitted the gentleman for monitoring, I would have been severely criticized by Cardiology. The reviewer in this setting did not understand this kind of treatment and actually challenged admission for Quinidine withdrawal. The reviewer eventually approved this gentleman, but it was only after several letters and telephone conversations that approval was given.

2. The second incident occurred when I treated a patient with pneumonia with intravenous antibiotics. The reviewer felt that intravenous antibiotics only needed to be given for four (4) days, and I felt they needed to be given for seven (7) days. Considering that there is no accepted, written guideline for intravenous antibiotic therapy and that physicians need to individualize this treatment for any patient, I was quite surprised at the results of this review. This reviewer was finally reversed only after extensive letter writing campaigns, and a Providence Hospital sponsored meeting with the reviewer in person in Anchorage as well as the reviewer's supervisors.

In the setting of extensive medical review especially, the extra effort that goes into writing letters and defending what is normal, common and appropriate medical practice amounts to a serious disincentive for physicians to take care of patients in this category, Medicare. As these reviews are expanded to private pay patients, it only adds to the burden of paper work and physician anger which makes it much more difficult to practice medicine.

Most of these problems could be avoided if the reviewers had equal training to the diseases treated. The kinds of questions that I have had serious problems with have all been relatively simple for both myself and my colleagues to understand, and it was very unclear as to why the reviewers thought what they did. I can only assume that the reviewers were incompetent or undertrained or possibly both. For a review organization to produce any kind of effective results, it must have some sort of credibility and accuracy. Without some sort of oversight of review organizations, I am sure that they will only cause medicine to become a much more difficult place to practice and even perhaps a battle ground for physicians. In that setting you can only expect to see a gradual and progressive deterioration of medical practice. This has been occurring in this country related to the various and numerous new regulations and activities presented by insurance company reviewers, the Federal Government, etc., and can only lead to lower quality of medical care.

Please take these considerations seriously. Physicians, especially primary care physicians, are near the end of their rope nationwide in being able to cope with the numerous problems created by our ever expanding bureaucracies. These will not do any of us any good and in fact may seriously jeopardize the medical care that you and I will receive when we become ill.

John Mues.

JOHN MUES, M.D.

:cc

xc: Patrick Brady, MD

3260a/19-20

Mr. Glenn Olds, Insurance Commissioner
Division of Insurance
State of Alaska
800 E. Dimond Blvd., Suite 560
Anchorage, Alaska 99515

Patient agreed to release information to Justin Sturgulewski 3/19/92 per Dr. Brady

March 3, 1992

Dear Mr. Olds:

On January 10, 1991 I was stricken with a brain aneurysm. I was rushed to Providence Hospital and was admitted in serious condition in a live and death situation. My test at that time showed my brain was hemorrhaging and they had to stabilize me before they could operate. I really don't remember very much of those days because of my condition. I was under the care of a number of doctors. Dr. Marjorie Smith was my physician who had the final say as to my release. Dr. Smith discussed my release date with Aetna priorier to my release and Aetna agreed that was acceptable to them. She came in to my room on the 25th of January and said that she was going to release me tomorrow. I was so happy to be able to go home and continue my recovery.

When I was in the hospital I realized I could not read or write. Each day I had to order my meals for the next day and I was not able to because I could not read the menu, and then the first time I wrote my name correctly, I cried. My daughter wrote down everyone phone numbers for me and put it by my phone. When I wanted to call someone, I had to look at each number individually and then on the phone try to find a number that looked like the ones on the list. It was very flustering, and even to this day I still have problems reading and I still transpose number or read them wrong.

In the letter from Aetna refusing the pay the last night in the hospital they said that I was "showering and ambulating independently." Even something as simple a taking a shower was an ordeal because I would forget to wash something or I would wash the same arm two or three times and not wash the other one. Then I would forget what I just washed.

When I was released I was afraid to write a check because every time I did I would spell everything wrong and it was embarrassing. When I go out with my son or daughter and had to write a check, they would stand there and spell the words for me. I would forget where I was or forget what I was there for.

A couple of weeks after my release was the Fur Rondy activities and Glenn, (my boyfriend), and I thought that I would enjoy getting out of the house for a while. We went over to the Sullivan Arena to see the exhibits. As soon as we got down on the lower level I became so terrified because of all the people moving all around me. If I would have become separated from Glenn, I would have become hysterical. We had to leave. I am leery of large crowds even now.

At home I wanted to work on an afghan I was making but I could not count to ten to count the stitches that were needed. Can you imagine no being able to count to ten. When I was finally able to drive, I went shopping one evening for our dinner and I wanted to pickup some seafood cocktail, I was so proud of myself for being able to do one more thing for myself. Well, I got chili sauce instead. This may sound like a normal mistake but to me it was really traumatic because I wanted to do it so perfect and I failed.

I know that when I was released I was totally dependent on Glenn to take care of me. If I did not have him, I know I could not have been able to take care of myself. He did all the cooking and cleaning and he had to call me throughout the day to tell me what color pills I had to take and when to take them. We would play scrabble for therapy. It made me think and try to use my brain. I still have troubles reading, I do not think I will ever read like I used to and that is sad because I love to read.

The object of this letter is to appeal Aetna's decision not to pay for my last night in the hospital. Aetna has reviewed my files, and any and all phone calls from me have been totally ignored. I spoke a number of times with Judy Ketterling, our representative in Anchorage for Aetna, on the phone. She never came to my hospital room and explained to me or my family that I was being considered as and out-patience and I should go home, against my Dr's orders. I spoke with Barb Sandors, of Aetna, on February 26, 1992 to ask if Ms. Ketterling was to advise me that Aetna was responsible for explaining to me the decision to classify me as an out-patience. Since the decision was made, why didn't anyone let me or my family know this decision was made. Ms. Sandors said that when I was preauthorized to stay in the hospital a certain time limit was established for the length of my stay. I had to tell her I had a brain aneurysm and was admitted in a life and death situation and so no preauthorization was made.

I feel that under the circumstances of my illness and the care that I need that this decision is unfair and unethical. I cannot understand how people is Seattle can second guess my doctors orders and blatantly ask me why I did not go home earlier. I was under no condition to question my doctors orders, nor would I want to. They are trained professionals and I am sure they knew what was best for me. Enclosed you will find several letters from co-workers, friends, and family explaining their thoughts of my condition, before and after my aneurysm, and the progress of my recovery. These people have helped me tremendously in my recovery with patience and encouragement to keep trying and reach a little harder to accomplish the task at hand. Over the months I could see my improvements. Something I could not do 2 months ago, I can do now. I feel very fortunate to have these wonderful people near me.

Therefore Commissioner Olds, I am asking you to read my letters and review my case. Any assistance you can provide me in resolving this $495 debt to Providence Hospital will be greatly appreciated.

Sincerely,

Margaret J. (Peggy) Frazier

Margaret J. (Peggy) Frazier
403 W. 22nd, Apt 211
Anchorage, Alaska 99503
(907) 272-5996 Home
(907) 349-7755 Work
SS# 531-52-7652

ATTACHMENTS

cc: Aetna Insurance Company
Mr. Gary Bader, Director of Retirement & Benefits
Providence Hospital
Dr. Marjorie Smith, M.D.

TO AETNA INSURANCE COMPANY:

Margaret "Peg" Frazier had an aneurysm explode in her head about a year ago and subsequently had life saving surgery. While she was hospitalized I visited her frequently and called her frequently between visits. I am both a co-worker and a friend.

During these numerous visits and phone calls it was obvious that she was unable to retain memory and would easily be confused. For example, another frequent visitor and caller was S. Kaye Fergert, also a co-worker and friend. Because we both worked with Peg, I had the feeling that Peg, in her condition, was often confused about which one of us had actually visited or called her. While on the phone I often felt that, even though I had identified myself, Peg was thinking I was Kaye. Kaye reported to me similar incidents. Another thing that was obvious is that Peg didn't seem to be able to judge time spans. For example, I could have talked to her or seen her the day before, but in our next contact it was to her like it had been many days.

After her release from the hospital it was many months before she was able to perform as her old self. She went through many frustrating months were she had to relearn the basic skills of reading, writing, and numbers. These functions would confuse her and frustrate her.

She had a very competent doctor who knew her case and used her best judgement on when to release Peg from the hospital. Peg was not capable of making these judgements for herself. Nor did Aetna advise her to go against doctor's orders and release herself early. In my observation, Peg needed her medical care the entire time she was hospitalized. When I visited her shortly before her release she was in bed and still on medications. Upon her release she needed the constant care of her family. It was obvious to those around her that without constant care she would have been unable to function. It was several weeks before she could return to work and then several more months before she could perform to her old standards.

I feel it is cruel of Aetna to now tell her that she should have released herself, against her doctor's orders, any earlier than medically recommended. In the first place, she was incapable of making that kind of decision; and secondly, the doctor was monitoring her case all along and no one from Aetna advised her any differently. If Aetna feels they are wiser than the doctor on the case, perhaps Aetna should send in their own DOCTOR (not nurse) to monitor each case involving an Aetna patient and to CONSULT with the primary physician. Until then, it is certainly unwise, and perhaps dangerous, for patients to go against their doctor's orders by releasing themselves from the hospital early in the event that Aetna may decide to not pay for their last days of medical care. As an Aetna client, I am very unhappy over the handling of this case.

Barbara A. Miller

Cheryl Flothe
State of Alaska, D.E.C.
800 E. Dimond Blvd.,
Suite 3-470
Anchorage, Alaska 99515

February 18, 1992

Aetna Life Insurance Co.
Repeals Review Board
P.O. Box 21645
Seattle, Washington 98111

SUBJECT: Margaret Frazier, SS #531-52-7652

Dear Sirs:

I would like to protest a claim denial for Margaret (Peggy) Frazier, SS #531-52-7652, for her last day in the hospital, January 26, 1991. I work in the same office as Peggy Frazier. She and I are both employed by the State of Alaska, Department of Environmental Conservation. Peggy was stricken by a cerebral hemorrhage on January 10, 1991 and was immediately hospitalized and had brain surgery right away. She was incoherent for days, did not know people, couldn't speak or think clearly and so on. She was released from the hospital on January 26, 1991, just 16 days after her stroke. At the time of her release from the hospital, Peggy was still in a confused state, barely, if able to bathe herself, certainly not in any condition to deal with paperwork or able to think logically. If Peggy did not have friends and family at home with her to take care of her, she probably would have to have had paid nursing.

Peggy was on sick leave until February 25, 1991 and worked part-time for two weeks following her return to work. She used up all her sick leave and even used donated sick leave before her ordeal was through. At the time Peggy returned to work she was still a little confused, couldn't get her words straight and couldn't remember how to spell as well as she used to. She still has a problem with spelling and a little confusion, and this is a year later.

Again, I would like to protest the denial of her claim for the last day she was in the hospital. She was told by Aetna when her claim was denied that she should have just gone home the last day, that it wasn't necessary for her to be there, and she could have come in as an outpatient rather than staying overnight another night. Peggy was confused and ill--it wasn't even known at first whether she would live or die--it certainly wasn't known, even at the time she left the hospital, how much of her faculties she would retain. Her doctor, Dr. Smith, even spoke with Aetna the day before she was discharged, telling them that Peggy would remain another day, the Aetna representative acknowledged and/or agreed. All these things considered, Aetna has refused to pay for Peggy's last day in the hospital.

My complaint is that an insurance company is in the business of paying for our major medical expenses so that we will not be devastated with these major medical bills. We rely on our major medical carriers to help us through these times, especially when we are deathly ill. This is clearly a case of the big insurance company (Aetna) looking into their book of statistics, and saying, "Usually, people go home after x amount of time after having a catastrophic stroke..." [does it say 16 days in your statistics?]

I do not believe that in cases such as this we can go by a rule of thumb. When someone is under the doctor's care for a catastrophic illness, the insurance company just has to believe the opinions of the doctors who are caring for the patient, and not rely on opinions of those who are thousands of miles away in the insurance office. Neither you nor your consultants saw the person who was ill--you just looked into your book of statistics to make a ruling.

Furthermore, neither I nor my family have had to put in a claim for a catastrophic illness, thank goodness. I fear for the time we, too, may be put in a position to have to fight your list of statistics after we become well enough to realize what is going on.

Lastly, most of us never have a catastrophic illness, we usually have everyday illnesses such as doctor's visits and minor ailments. Are the few that do have major illnesses going to bankrupt our insurance plans?

I hope you will reconsider this claim, and I hope Aetna will rethink its attitude of second guessing doctors' judgments when extreme illnesses arise. Perhaps it would be in Aetna's interest to have a doctor stationed at each hospital to give a "second opinion" in each of these cases; this would be more legitimate.

Sincerely,

Cheryl Flothe

cc: Margaret Frazier

THE FOLLOWING PAGES MAY
NOT FILM LEGIBLY BECAUSE OF
THE POOR QUALITY OF THE ORIGINAL

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each of these cases; this would be more legitimate.

Sincerely,

Cheryl Flothe

cc: Margaret Frazier

409 Atlantis Ave.
Anchorage, Alaska 99518
907/563-5616

February 24, 1992

Aetna Insurance Company
P.O. Box 21645
Seattle, Washington 98111

Dear Madame/Sir:

I am writing to you on behalf of my mother, Margaret J. Frazier. She has brought to my attention the fact that you refuse to provide coverage for her last night stay, January 26, 1991, in Providence Hospital. She was instructed by her physician Dr. Marjory Smith to stay that last night in the hospital and that your company had agreed to cover this expense. Now you are going back on your word - the word you gave the acting physician for my mother.

After my mother's brain surgery she could not make even the simplest decisions for herself. She relied on family, friends, and her physicians to make those decisions for her. She could not even remember her address or phone number and on many occasions could not remember how old she was or what state she was in. Though she is much better now and is able to work she often has trouble with spelling and mathematics. She transposes letters and numbers. She also has holes in her memory. The losses cannot be given back to her - not now or ever.

Our family feels that you have taken advantage of the most traumatic time in her life by not offering the coverage promised. Ms. Frazier has always paid her premiums and has relied on the coverage your company, by contract, has been paid to provide. We greatly appreciate the coverage your company offered, it was life saving, but to go back on your word to a woman who could not make even the simplest decision is highly unprofessional and even deplorable.

My mother is requesting that you make good on your promise to cover her last night stay in the hospital and that you have whatever damage you have caused to her credit rating taken care of. If these requests are not fulfilled she will be forced to seek legal counsel and Union support.

Very Truly yours,

Kimber Laney

February 20, 1992

Aetna Insurance company
Seattle, Washington

Re: Margaret Frazier/Hospitalization 1/91-2/91

To Whom it may Concern:

I am adding my voice to the many others requesting a review of your decision not to allow full coverage for Ms. Frazier during her illness last year.

Ms. Frazier could have died from the brain hemorrhage she experienced. I firmly believe that it is only due to the excellent care she received from her physician and Providence Hospital that she is now a vital and productive member of our society. Her healing will continue to improve with time and her last physical gave her a clean bill of health. It amazes me that you would ignore the statements made by her physician to the necessity of her hospilization for however long. Perhaps its common practice in your area for people to leave the hospital before being formally released by their physician, but it's not the norm in Alaska.

I have known Ms. Frazier since July, 1987, she and I are friends of long standing. We went through six months of schooling together. I am quite aware of what Ms. Frazier was capable of before her illness. I also saw the effects her illness had on her. She couldn't read a newspaper article let alone a novel after the illness. Her eyes wouldn't state focused long enough. She couldn't remember the content of conversations that had taken place a few days before. She avoided writing checks for fear of making major errors. She was embarrassed by how long it took her to write a note or a check. Her handwriting was different. Its' taken her a year to feel comfortable doing these mundane things of life. After her release from the hospital it was four to six weeks before she was finally considered capable of returning back to work and then only on a part-time basis.

I strongly suggest you review her appeal with the utmost speed. I also suggest that you rely on the opinions of her physician in this matter, after all no one knows better all the aspects of Ms. Fraziers' case.

Sincerely,

Denise A. Linz

Denise A. Linz
3100 Ward Place, Unit 21
Anchorage, AK 99517

Mr. Glenn Hirst

March 1, 1992

Aetna Life Insurance
P.O. Box 21645
Seattle, WA 98111

To Whom it May Concern:

I am writing this letter in regards to Margaret (Peggy) Frazier's final day of hospitalization.

The letters that have been written on Peggy's behalf are both "eye opening" for me and a painful reminder of what we endured following her release from the hospital. Peggy still suffers from the effects of her aneurysm and subsequent surgery to save her life. The denial of insurance benefits for the final day of her stay has become another hurdle she feels compelled to overcome.

I can, without any reservation what so ever say that Peggy's release from the hospital was far from premature. The assertion made by Aetna that the final day of hospitalization was for consultation purposes only is ludicrous to say the least, Peggy was totally incapable remembering any instruction for longer than few minutes.

Peggy's letter to you describes what she remembers in the days after her release from the hospital. The fact is she remembers mostly what I related to her in those first few days home. Peggy was quite dysfunctional the first weeks out of the hospital. She was unable to read or write, even dialing a phone was a task beyond her abilities. If it had not been for the after care support provided by her parents, her children, and myself, Peggy could have needed professional care in order to stay at home.

In conclusion, I would like to mention that the cost to our family has been much higher than the $495 dollars denied for the final day of Peggy's hospital care. Peggy's parents flew from California to be with her at the hospital and at home. I took time off from work to give her the support she needed while in the hospital as well as afterward. Do not let the final cost be the loss of faith and trust in another insurance carrier.

Sincerely,

Glenn D. Hirst

Glenn Hirst

Aetna Insurance

Feb. 26, 1992

Dear Aetna:

It has recently come to my attention that your company is refusing to cover expenses for Peggy Frazier's last day in the hospital following her unexpected illness last year. Peggy is a very conscientious and dedicated co-worker. Prior to her illness, she had worked with us for a short period of time and was doing an excellent job.

The sudden onset of Peggy's illness came while she was at work and was quite a shock to everyone who knows her.

Following her stay in the hospital, Peggy returned to work and initially worked reduced hours due to complications from her illness. I imagine that she would have preferred to recover at home for a longer period of time, however, due to the financial hardship of not receiving a paycheck, she returned to work. When she initially returned to work, Peggy had a very difficult time reading and writing. She had to re-learn things that we all take for granted. She appeared to be physically and emotionally drained by the medical problems that she had been through.

Based on my observations, it does not seem that Peggy's stay in the hospital was excessive by any means. Her body was put through a terrible shock. Rest and close observation were necessary to insure her recovery.

I am pleased to say that since she has been back at work Peggy has made a remarkable recovery and is once again doing an excellent job in performing her work.

It is disheartening to see a large company such as Aetna refusing to compensate policy holders for expenses incurred at the direction of professional medical providers during what was virtually a life threatening situation. This is especially upsetting when one considers the significant monthly premiums that the state of Alaska pays to Aetna for medical coverage. I sincerely hope that Aetna will reconsider this matter.

Sincerely,

John Halverson

February 18, 1992

Aetna Insurance
P.O. Box 21645
Seattle, WA 98111

RE: Peggy Frazier
Alaska State Employee Medical Expenses

To Whom it May Concern:

I am writing in behalf of Ms. Peggy Frazier. Peggy is a Clerk Typist III with the Department of Environmental Conservation, Western District Office. She was a bright, intelligent, and extremely productive staff member before having her stroke last year. Peggy has made great strides towards recovery, but this has not been easy. I have known Peggy before the stroke and after, and she continues to face hurdles as a result of her condition. She has had to relearn even the most simple of thought processes that you and I take for granted.

I understand that Aetna Insurance has elected to not pay for Peggy's last days stay in the hospital. It is my concern that this decision was based on insurance guidelines, or standards, or "averages", and not based on the decision made by her physician. Peggy was in no condition nor did she have the medical expertise to make that decision or judgement herself.

If I were in the same position I would heed my physicians advice. I feel that Aetna should reevaluate their decision in the case of Ms. Peggy Frazier and pay for her final days stay in the hospital based on her doctors judgement and his best interest for her health and recovery, rather than on textbook "averages".

Sincerely,

Lynn M. Cochrane
Employee for the State of Alaska
18948 Sarichef Loop
Eagle River, AK 99577

TO WHOM IT MAY CONCERN: March 4, 1992

I worked with Peg (Margaret) Frazier from December 17, 1990 through August 1, 1991. I was in the office with her the day she became ill. All of us here in DEC were terribly worried because of the severity of the illness and the fact that her response to visitors in the hospital was so confused. I spoke with her on a daily basis once she was able to have phone calls. She would confuse my calls with those of other people. When I visited her in the hospital she was not capable of realizing from one minute to the next which fellow workers were actually there. She knew all of us, but had the wrong names with the wrong faces. She was not capable of making decisions for herself when she was released from the hospital. Personally, I felt she should have been under care for a much longer period of time. After her release I again called her on a daily basis, and up to the time she returned to work she was still having serious problems.

I believe that AETNA Insurance should be ordered to reconsider and pay the disputed amount to the hospital. She should have actually been kept longer and put on some type of a therapy program to assist her in recovery from her brain surgery.

S. Kaye Fegert

S. Kaye Fegert
Box 2111
Palmer, AK 99645

February 18, 1992

Aetna Insurance
Seattle, WA

RE: Peggy Frazier
Alaska State Employee

To Whom it May Concern:

I am writing in behalf of Ms. Peggy Frazier. Peggy was a Clerk Typist for me while I was an environmental engineer with the Department of Environmental Conservation, Western District Office. Peggy was one of our most capable clerk typists. Immediately after returning to work from the hospital she was disoriented. She had trouble typing, writing, and coordinating movements. I was surprised that she was attempting to work as she was obviously not completely recovered from her serious injury.

It is even more surprising to see this quibbling over hospital stay. Peggy was debilitated from her injury and should have been in the hospital at least a few days longer.

Sincerely,

STEVE

Steve Eng
State of Alaska

March 3, 1992

TO WHOM IT MAY CONCERN,

I am writing in behalf of Peggy Frazier, an employee of Alaska Department of Environmental Conservation. I saw a definite change in her work when she came back from the hospital. When she submitted information to me such as weekly issues I noticed that Peggy was having problems in sentence structure. Her thoughts seemed to be scrambled as though she were confused. If I can be of more help, please don't hesitate to ask.

Sincerely,

Rose Shultz

Rose Shultz

Report
to
Health Insurance Association of America

Cost Analysis of
State Legislative Mandates on
Six Managed Health Care Practices

by

The Wyatt Company
June 7, 1991

THE Wyatt COMPANY

COST ANALYSIS OF STATE LEGISLATIVE MANDATES ON SIX MANAGED HEALTH CARE PRACTICES

Table of Contents

COST ANALYSIS OF STATE LEGISLATIVE MANDATES ON SIX MANAGED HEALTH CARE PRACTICES

Executive Summary

Background

The Wyatt Company (Wyatt) was commissioned by the Health Insurance Association of America (HIAA) to study and estimate the costs associated with six legislative provisions that would mandate state control of managed health care practices. These provisions are either under discussion by state legislatures or have been enacted by one or more states. Wyatt's study aimed to estimate the costs for each legislative provision in terms of a percentage change in administrative costs, claim costs, or both. The following legislative provisions were studied:

1. Mandating that "any willing provider" be permitted to join a managed care network.

2. Prohibiting "gatekeeper" physicians in preferred provider organizations (PPOs).

3. Requiring local utilization review of health care services by professionals licensed in that state and denial reviews by physicians of the same specialty as the attending physician.

4. Mandating extended hours of operations for utilization review organizations to 24 hours a day, 7 days a week.

5. Requiring state-specific statistical reporting on utilization review organizations' activities.

6. Mandating a maximum differential of 20 percent between in-network and out-of-network benefits.

Study Overview

For each of these mandates, Wyatt developed an approach to accomplish the following goals:

- Determine the typical or favored way each of the managed care practices addressed by these mandates are administered today in the United States.

- Determine whether the principal and documentable effect of the mandate would be on administrative costs, claims costs, or both.

- Identify and access sources of data needed to complete this study, including published data, surveys, interviews, and internal Wyatt data.

- Construct models for estimating the administrative and/or claims costs of each mandate, based on the assumptions and approaches developed.

- Calculate the baseline and projected costs associated with administering managed health care programs under current law and under each potential regulatory scenario, and report results.

Wyatt surveyed 17 health care organizations representing a cross-section of organizational types and models. We received 10 responses from organizations whose combined PPO membership exceeds 8 million lives. We incorporated PPO network data from the 29 most mature PPOs in these organizations. We also incorporated data from 7 organizations providing utilization review services to over 40 million lives. Wyatt's study included total experience data from one "point-of-service" network and from 5 employers utilizing various other point-of-service networks across the country. The total lives covered by these plans exceed 0.5 million.

Not all of the six legislative mandates lend themselves to the same quantitative approach or analysis. Furthermore, a large number of assumptions were necessary due to the diversity of managed care activities and models and to the lack of data isolating the effects of the individual managed care practices addressed in each legislative mandate. There is no experience on the impact of many of the mandates on a mature managed care market, requiring the construction of models to simulate that effect. In addition, the legislative mandates being analyzed are only an approximation of fact, since individual states may vary from the "average" mandate modeled in this study. The approaches, assumptions, and models used in this study were documented and successfully tested for reasonableness against available data and experience.

Each legislative mandate was studied as an isolated event. The financial impact associated with that mandate assumes that only the variables addressed in the models will change. The multi-year projections are made in base year dollars. This study did not attempt to analyze the financial effect of mixing these legislative mandates.

Some judgment was involved in determining which set of assumptions were to be labeled "before" and "after" for the purposes of calculating projected effects on administrative and claims costs. The sets of assumptions used for this calculation were documented and, in most cases, enough information was provided to allow the reader to model costs from other points along the continuum. Where it seemed appropriate, both "possible effect" and "worst case effect" were projected.

Summary of Findings

The following pages of the executive summary briefly review the background and Wyatt's findings for each legislative mandate. The full detailed report devotes a section to each mandate. Each section in the full report contains: background; conclusions; methodology; and detailed conclusions. The survey instrument used for this study can be found in the appendix.

Section 1: Mandating that "Any Willing Provider" Be Permitted to Join a Managed Care Network

Background

The "any willing provider" mandate requires that managed care networks accept any willing provider that meets the network's established selection criteria. Such mandates are usually intended to insure that all licensed health care practitioners in a state are allowed equal access to patients who join managed health care plans. Proponents of this legislation do not deny that network managers have the right to set criteria for network participation, but they want the criteria to be public and evenly applied to all licensed providers state-wide. Managed health care organization representatives contend that network selection must include a mixture of criteria, needs analysis, credentialing committee review, discount negotiations and market demands for optimal effect. Further, prepublished fixed state-wide standards would make it very difficult to eliminate more than a relatively small percentage of total willing providers.

This study attempts to model a wide range of possible network participation assumptions to show the trends in cost impact caused by that participation. We first separately analyzed the increase in administrative and claims costs associated with the "any willing provider" mandate. Wyatt then attempted to combine the two effects and calculate the change in the marginal value of a PPO as network participation grows. We postulated that there is a point where the value in claims reduction from enlarging the PPO network will decrease to the point where the increased administrative cost of maintaining that enlarging network will eliminate all marginal value of having a PPO. We used a PPO model for this legislative mandate because most such state mandates are targeting PPOs. If health maintenance

organizations (HMOs) or other managed care network structures were included, we would expect the same general direction in cost trends.

This legislative mandate was determined to have both administrative cost and claim cost effects. Because the assumptions and methodology differ between the two, they are separated as subsections 1.A and 1.B.

Conclusions

Subsection 1.A: Administrative Costs

Implementing an "any willing provider" legislative mandate would result in increased administrative costs, which grow as network participation increases. Wyatt established the average surveyed networks' size, staffing, and percent provider penetration as a baseline. We also established the average cost associated with managing and maintaining this "typical" PPO. Increasing penetration from the average of 25.5% to 60% of physicians, 10% to 60% of other providers and 44% to 80% of hospitals increases the costs associated with network administration costs 170% above the baseline. For the purposes of this study, a 170% increase in network administration costs is considered a valid "possible" outcome of this mandate. A less likely, but "worst case," scenario of increased penetration to 80% of physicians and other providers and 100% of hospitals would increase the cost of network administration by 259%. To project the effect on total administration, we assumed a "typical" non-PPO benefit plan has a retention rate (general and claims administration costs and profit) of 12% of premium and our total additional retention for administration of our "typical" PPO is 3% of premium. Using these assumptions, the overall retention (or non-claims costs) would increase by 34% over the baseline PPO in our "possible" scenario. Retention would increase by 52% over the baseline PPO in our "worst-case" scenario under this mandate.

Subsection 1.B: Claims Costs

Wyatt constructed a provider revenue requirement model and analyzed provider behavior in a mature market with 30% PPO market share toward a "typical" PPO network comprised of 25.5% of the available physicians and 44% of the available hospitals. On average, a physician with excess capacity, making an economically rational decision, would be willing to accept a 32.6% effective discount (including the effects of both medical management and discount off changes) from current revenue per encounter while still attaining his or her income goal. A hospital provider in this "typical" PPO exhibiting like-behavior would accept an effective 10.4% discount, which yields a composite physician and hospital effective discount of 19.5%. This "typical" PPO would experience a 17.6% reduction in baseline health care claims cost (as compared to average claims costs in current revenue experience),

assuming a mature market with 90% of care received in the network. It should be noted that these effective claim reductions are not the same as discounts off charges. These are the amounts that the provider could accept off current revenue. This qualification is particularly important for hospital fees where charges are typically much higher than average revenue.

Imposing an "any willing provider" mandate would result in a variable increase in the number of network providers. In a larger network with less channeling, the average provider must either increase utilization or accept smaller discounts if he or she is to maintain the current level of net income or operating margins. If this mandate results in the "possible scenario" of a 60% participation rate for physicians and 80% for hospitals, the maximum effective discount that a provider would accept would be 17.5% for physicians and 3.7% for hospitals, or 9.4% overall. A PPO in this "possible" scenario resulting from this mandate would loose 8.8% in claims savings compared to the "typical," or baseline, PPO discussed above. The "worst case" scenario would result in a 14.2% loss in claims savings compared to baseline.

Overall Conclusion:
The detailed conclusions in subsection 1.A document an increase in administrative costs associated with the progressively larger network participation that is anticipated as a result of this legislative mandate. A decrease in claims savings associated with progressively larger network participation is documented in subsection 1.B.

The Wyatt Company combined these two separate trends to model the overall impact on the marginal value of having a PPO associated with progressively larger network participation. It should be emphasized that this is not an analysis of specific benefit plan data, but a discussion model that mixes extracted and projected data from separate sources for the purpose of demonstrating trends.

The model demonstrates that a point exists where a PPO product or sponsor will be unable to sustain any marginal value to the community if it is forced to accept more than a certain limited percentage of available providers, assuming providers follow a rational economic model for discounting. In this discussion model of a mature PPO with 30% market penetration, that point lies at or near 60% of doctors and other providers and 80% of hospitals. This is a significant finding in that, given current technology, it would be unlikely that reasonable fixed state-wide provider selection criteria could eliminate 40% or more of all licensed professionals and 20% or more of all licensed hospitals. The model suggests that, if a large percentage of providers are willing to join a PPO, this legislative mandate would eliminate the value of that PPO to the community.

Section 2: Prohibiting "Gatekeeper" Physicians in PPOs

Background

Several states have enacted or are considering a legislative mandate prohibiting managed care organizations from using physicians as "gatekeepers" for PPOs. As used in this analysis, a gatekeeper is usually a primary care physician chosen by a health care benefit plan beneficiary to provide primary medical services and to direct referrals to other providers and facilities as medically necessary. Proponents of this legislative mandate contend that the gatekeeper role does not belong in insurance products. While these proponents acknowledge that Health Maintenance Organizations (HMOs) have successfully utilized gatekeeper physicians for years, they feel it may be more acceptable there due to the increased regulatory oversight of HMOs. Managed care organizations contend that "gatekeepers" are a critical part of their health care cost containment strategies for the 1990s. They point out the substantial efficiencies seen in the last few years in "point-of-service" PPOs, which utilize primary care gatekeepers for both cost and quality management. Opponents of this legislative mandate contend that it is not in society's interest to limit successful cost-efficient medical delivery systems at this time.

Conclusion

Wyatt's analysis of the claims experience of "point-of-service" PPOs with a primary care gatekeeper indicates that savings associated with the gatekeeper function range from 4.23% to 13.5% of total claims. The mean savings associated with a gatekeeper in a "point-of-service" PPO was 6.83% of total claims costs. This is higher than the 3.5% to 6% savings prospectively estimated by most underwriters surveyed. For the purposes of this study, we consider a 6.83% loss of claims savings to be the possible result from this mandate. We consider the loss of 13.5% in claims savings as a "worst-case" result. Wyatt's findings are corroborated by survey data, studies performed by insurance carriers on their respective blocks of PPO business, Wyatt's client experience and by interviews, articles, and shared data from employers that have converted to primary care gatekeeper model PPOs. For the purposes of this report, no change in administrative costs was projected when compared to non-gatekeeper model PPOs, although more study is needed in this area.

For gatekeeper model PPOs, retrospective analysis of the claims cost impact due to the gatekeeper is complicated by the fact that frequently this product, when compared to non-gatekeeper PPOs, is packaged with substantial benefit modifications, cost sharing provisions and network access limitations. In addition, only a few of these gatekeeper model or "point-of-service" PPOs have more than two years of claims experience available for analysis.

Section 3: Requiring Local Utilization Review of Health Care Services by Professionals Licensed in that State and Denial Reviews by Physicians of the Same Specialty as the Attending Physician

Background

This legislative mandate has been proposed in a number of states in various forms. It is intended to insure that utilization review is conducted with a sensitivity to local practice patterns. Furthermore, it is intended to insure that only a true peer to the specialist or subspecialist treating the patient be allowed to review a service that involves a denial of certification for admission or treatment. Utilization review organizations respond that the standards for medical quality should not vary by state or region. The medical literature that forms the basis for treatment guidelines is national in scope as are the standards established by the medical professional societies. Furthermore, a large percentage of denials for certification occur for reasons that are not specific to the specialty or subspecialty of the provider.

This section models the increases in cost associated with the requirement to move a branch utilization review operation into another state and to include local physician specialists and subspecialists in all reviews for denials of certification. Costs were projected for both year 1 and year 2 to show the initial impact of conversion and the "steady state" of impact of operating separate offices under this legislative mandate. It was assumed that a local license requirement would include all review nurses and physicians and that a utilization review organization would respond to that mandate by opening a local office and contracting with a panel of physicians representing all specialties and subspecialties.

Conclusion

The first year administrative costs for utilization review operations would increase by 42.5% if a utilization review organization must move 20% of its business from an out-of-state central location to a location in-state and begin using locally licensed physician specialists and subspecialists for all denial review. By year two, after initial moving and staffing change costs are incurred, the administrative cost for operations would remain approximately 34% higher than the baseline in constant dollars.

These administrative costs were based on a utilization review organization serving 1 million lives, but the findings do not vary significantly (less than 2%) when a 5-million-life organization is assumed using the same model. The effect on total cost for utilization review services is greatly dependent on the level of non-operational-unit overhead and the degree to which it changes by increasing the number of operational unit sites. Assuming that 25% of total costs are non-operational and do not vary by number of sites, then year 1 after this

mandate would increase total utilization review costs by 31.9% and year 2 and thereafter would be 25.6% higher than the baseline in constant dollars. No change in claims costs was anticipated for the purpose of this study.

Section 4: Mandating Extended Hours of Operation for Utilization Review Organizations to 24 Hours a Day, 7 Days a Week

Background

Requirements that organizations conducting utilization review operate 24 hours per day, 7 days a week have been considered by a number of states. Such a mandate is usually intended to assure that medical review services, including the certification or denial of certification for admission, are available at any time during the day or night. The reported impetus behind this legislative mandate is to insure that no health plan beneficiary would be denied medical treatment due to the unavailability of review personnel. Utilization review industry representatives respond that hospital admissions after normal business hours would typically be for emergency situations only and benefit plans generally stipulate that those can be reported as much as 48 hours after the hospital admission without penalty. Likewise, admissions due to unforseen problems on weekends and holidays can typically be reported the next business day. Opponents of this mandate contend that it creates increased administrative expense for little value that can not be gained from existing plan design provisions and appeal processes.

Conclusion

Under this legislative mandate, organizations would have to significantly expand their staff with no associated increase in volume of covered lives served. Overall administrative expense for a "typical" utilization review organization's operation, which is now open 11 hours each weekday and covers 4 time zones, would increase nearly 44% to 47%. Assuming that 25% of a utilization review organization's costs are non-operational and do not vary with this mandate, utilization review costs would increase under this mandate by 33% to 35%. The cost impact of this mandate would be higher for organizations currently opened less than 11 hours each weekday. No change in claims costs was anticipated for the purposes of this study.

Section 5: Requiring State-Specific Statistical Reporting on Utilization Review Organizations' Activities.

Background

This legislative mandate is usually intended to provide a state with information on utilization review organizations' activity within its boundaries. The information could be used for a variety of reasons, from monitoring to insure compliance with state service standards to simply establishing a database for possible future regulatory or legislative activity. Most utilization review organizations maintain their records and information by employer group. The administrative procedures and protocols are usually the same for that client, regardless of the state in which services are rendered (especially for ERISA exempt benefit plans). Utilization review industry leaders express concern about the high costs and productivity losses that could be associated with state specific modifications of data collection procedures, file lengths and formats, system programs and reporting procedures.

Conclusion

Wyatt estimated that requiring disparate state-specific statistical reporting on utilization review organization activities could cost from $10,000 to $50,000 or more in administrative costs in the first year of implementation for a single state. Assuming no additional changes were made in the data or reporting requirements by that state, the costs for year two and thereafter would be reduced to $3,000 to $5,000 per state. These estimates would vary greatly by the degree to which the data required are not currently collected and available in the utilization review organization's system, the difficulty involved in modifying the manual and computer systems to accommodate the required changes and the degree of non-standard processing, editing, analysis and reporting involved in complying with this legislative mandate. Since these costs should not vary much by organization size or operational budget, Wyatt chose not to project these costs as a percentage of overall administrative costs. No change in claims cost was projected for this mandate.

Section 6: Mandating a Maximum Differential of 20 Percent Between In-Network and Out-of-Network Benefits

Background

Some states have placed restrictions on the maximum differential between in-network and out-of-network benefits in PPOs. The most common mandate is that in-network benefits should not exceed out-of-network benefits by more than 20% for a given service. At least

one state has mandated a maximum differential of 15%. This maximum is often expressed as a co-insurance level but has been discussed as a maximum differential in total paid benefits. The intent of this mandate is to insure that an individual is not unduly disadvantaged if he or she wishes to go to a non-network provider. Managed care organizations contend that employers and individuals should be given the right to choose their delivery system without such restrictions. Further, they contend that this restriction reduces the effectiveness of a PPO and may cause even more serious difficulty for the point-of-service (or primary care gatekeeper) model PPO.

Conclusion

The ability of a PPO to effectively manage health care costs is largely a function of its ability to steer patients towards efficient quality network providers. Thus, the difference between in-network and out-of-network benefits is key in effecting optimal channeling.

There have been no studies that define the specific benefit differential that achieves optimal channeling. However, Wyatt conducted a survey of actuaries at five insurance companies that specifically engage in pricing and analyzing PPO plans. Currently, a 30% benefit differential in plan reimbursement is considered the desired balance between out-of-network coverage and optimal channeling.

Using a 30% benefit differential and the associated channeling effect as baseline, Wyatt concluded that, in the course of 1 year, limiting the in-network versus out-of-network benefit differential to 20% would reduce network patient steerage by 6.1% and would result in 1.3% higher claims costs paid by the benefit plan and plan members. Furthermore, if the benefit differential is restricted to 15%, steerage would be reduced by 9.4%, and claims costs for plan and member would be 1.9% higher. The study included PPOs only because that benefit delivery model has been the principal focus of such mandates. The analysis assumed that the differentials were mandated on a total paid benefits basis, and utilization patterns were assumed to be the same in-network as out-of-network. Further study would be needed to specifically address the cost impact in an HMO or primary care gatekeeper model PPO. It should be noted that most primary care gatekeeper model PPO managers feel a 30% differential or more is necessary to gain the full management potential for this model. If that is the case, this mandate could also threaten the 4.23% to 13.5% of claims savings seen in the study on gatekeepers in section 2 of this report. No administrative cost changes were projected for this mandate.

Utilization Review As A Cost Containment Method Has Become Rule Rather Than Exception

Most employers include some type of utilization review program in employee benefits plans. Typically, utilization review programs include preadmission certification, concurrent review, and catastrophic case management.

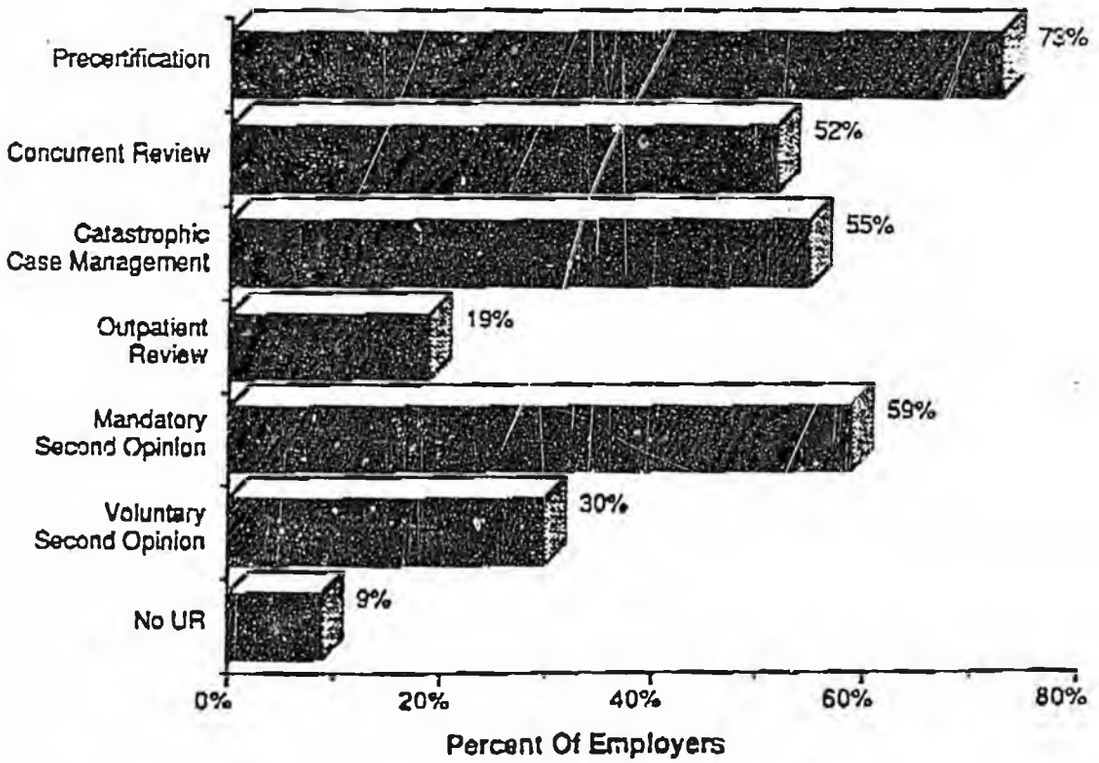
The 1989 Foster Higgins *Health Care Benefits Survey* reflects the input of 1,943 employers, whose benefit plans cover more than 12.5 million employees. The second report in the five-part Foster Higgins series focused on cost, design, and funding of insured and self-funded medical care plans.

This Research Report summarizes the information on utilization review programs offered by the surveyed employers. For additional information, contact Foster Higgins, Survey and Research Services, 212 Carnegie Center, Princeton, NJ 08543-5323, (609) 520-2441.

Utilization review is the rule rather than the exception, according to the 1989 Foster Higgins *Health Care Benefits Survey*. The second report in the five-part Foster Higgins series focused on cost, design, and funding of insured and self-funded medical care plans of 42 employer coalitions around the country. The 1989 report reflects the input of 1,943 employers, whose benefit plans cover more than 12.5 million employees. Participants include organizations of all sizes and industry types, and the survey data represents responses from all 50 states.

Although most employers are unable to determine the

Table 1:
Utilization Review Programs



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Utilization Review As A Cost Containment Method Has Become Rule Rather Than Exception

cost-effectiveness of utilization review (UR) programs, the programs have had a positive effect on the behavior patterns of medical practitioners and on medical care plan use. Given the high rate of health plan cost increases, few employers dare go without UR programs—typically preadmission certification, concurrent review, and catastrophic case management.

There appeared to be little difference in the use of precertification among insured and self-funded employers. Seventy-three percent of the 1,943 employers represented in the Foster Higgins survey require precertification of elective hospitalizations, up from 68% in 1988. Concurrent review was found in 52% of plans and catastrophic case management in 55% of plans. While 89% of employers have second surgical opinion programs, only 59% made obtaining a second opinion mandatory.

Review Responsibility

Nineteen percent of employers have outpatient UR programs—most often with retrospective review of the necessity of physician and/or diagnostic services. The survey noted that half of these employers have preferred provider organizations in which the review of physician practice patterns is the responsibility of the organization. In the absence of contractual relationships between employers and physicians, retrospective denial of payment could result in a financial burden on employees, who are ultimately responsible for paying physicians for services and supplies over and above the amount stipulated by the plan.

In most insured plans, the insurance carrier provides UR services. Self-funded employers, however, split their business between insurance carriers and independent, national, or local UR organizations. UR organizations handle precertification for 49% of self-funded employers, concurrent review for 53%, case management for 48%, and second surgical opinion for 39%.

The breakdown of UR services for all employers included in the survey is shown in Table 2.

Table 2:

	UR Program Administration		
	Commercial	Organization	
UR Program	Carrier	National	Local
Precertification	63%	25%	12%
Concurrent Review	57	27	15
Case Management	63	26	11
Second Opinion	72	18	19
Outpatient Review	53	27	20

Savings

Most survey respondents were unable to estimate how much money they saved through UR programs in 1989. Among the reasons given by employers was that most UR firms did not provide the type of reports that would allow savings to be determined. Employers that could estimate savings reported an average savings of 5.1% of total plan costs.

Table 3:

UR Program	Savings
Precertification	4.2%
Concurrent Review	3.6
Case Management	3.5
Second Opinion	1.7
Outpatient Review	4.3

AMA, BCBS Study Utilization Review Criteria To Uncover Inappropriate Medical Procedures

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Review standards are used to evaluate the appropriateness of medical care before it is provided and can strongly influence what services physicians provide to patients. Currently, there are no uniform guidelines for developing either the content or the format of review criteria. This Research Report summarizes the findings of two separate studies regarding medical care review criteria currently being used.

An increasing number of employers are making it mandatory for employees to participate in hospital preadmission programs, concurrent and retrospective reviews, and discharge planning. Failure to do so can mean the difference in the level of benefits coverage. Such programs, designed to determine the appropriateness of medical care services, can strongly influence the level and type of services physicians provide to patients.

Not all providers are pleased with having their medical care decisions challenged. The most frequent complaint providers have is that there are no uniform guidelines for developing either the content or the format of review criteria. Furthermore, physicians complain that review standards vary greatly and in many cases are not consistent with practice guidelines developed by national medical groups.

To support their recommendation of the need for standard review criteria, the American Medical Association and the Blue Cross and Blue Shield Association conducted separate studies that point out the prevalence of inappropriate medical care. The AMA studied the review criteria used by the 48 Medicare Peer Review Organizations and the BCBSA studied six of its member organizations. In each study, findings support the fact that appropriateness of medical care on a pre-service basis can be a cost-effective.

AMA Study

The AMA study examined review criteria for the three most frequently reviewed procedures by Medicare PROs: cataract removal; carotid endarterectomy, or restoring blood flow to clogged arteries; and cardiac pacemaker implants.

The study found wide variation between the PRO criteria and national practice guidelines developed by the American Academy of Ophthalmology, the American College of Physicians, and the American College of Cardiology.

For example, for cataract removal the AAO recommended that only patients with a visual acuity level of 20/50 or worse be eligible for cataract removal surgery. That level is consistent with the vision standard required to obtain a driver's license. However, the visual acuity standards used by Medicare PROs ranged from 20/30 to 20/300.

Medicare PROs' required levels of artery obstruction ranging from 50% to 90% before a carotid endarterectomy would be certified. ACP guidelines say the procedure may be appropriate for patients who have obstructions of 70% or greater.

BCBSA Study

A year-long pilot study found that 11.2% of the cases examined called for the inappropriate use of certain procedures. The study took place from July 1989 to July 1990. Five Blue Cross and Blue Shield plans and one Blue Cross and Blue Shield health maintenance organization, participated in the study, which encompassed all lines of business, including fee-for-service, as well as preferred provider organizations and both IPA and staff model HMOs. Collectively, the six plans cover a total of 1.5 million people.

The Medical Review System (MRS), developed by Value Health Sciences, Inc. of Santa Monica, California, was used as the tool to evaluate the appropriateness of the procedures in 9,125 cases. Each site chose between seven and 18 procedures to evaluate.

The rate of inappropriateness varied by procedure (see graph on next page). Procedures most often found to be inappropriate when reviewed by the MRS include tonsillectomies (27.1%), hysterectomies (21.5%), and tonsillectomies combined with adenoidectomies (17.6%).

AMA, BCBS Study Utilization Review Criteria To Uncover Inappropriate Medical Procedures

Procedures least likely to be found inappropriate by an MRS review include colonoscopy (1.5%), coronary artery bypass graft (0%), and carotid endarterectomy (0%).

Cost Effectiveness

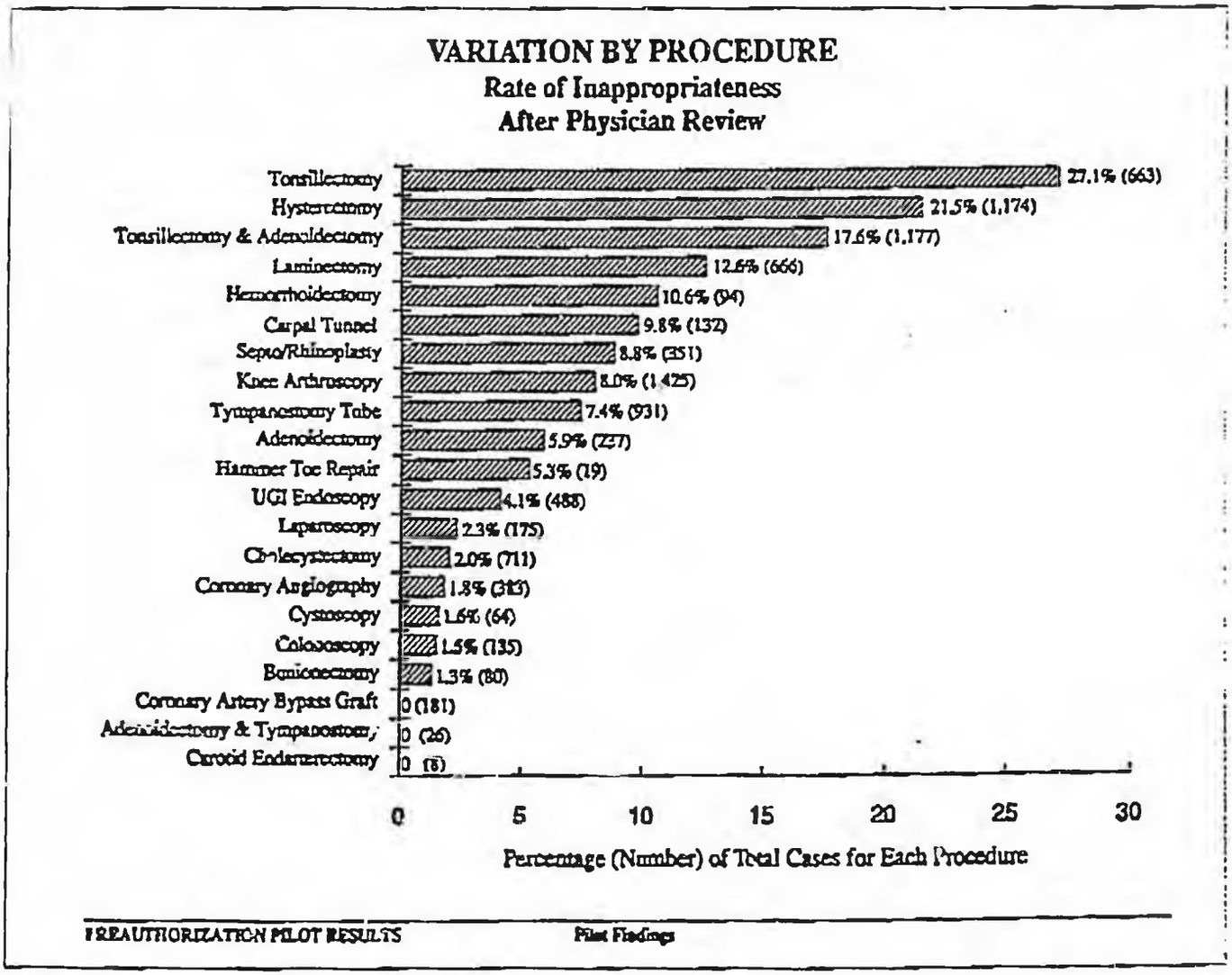
Based on the study finding, the BCBSA concludes that the appropriateness of medical care can be evaluated on a preservice basis. The Association concludes also that preauthorization can be a cost-effective method for evaluating the appropriateness of medical care.

One pilot site conducted a cost/benefit analysis and found preauthorization to be cost-effective. A total of $103,804 was spent during this plan's six-month pilot to achieve a savings of $265,280 (or $2.56 for every dollar spent on the program). For this site, the program saved $0.44 per member per month, and $433 per case.

Some procedures were clearly more cost-effective to preauthorize than others, the study notes. There was not a one-to-one correlation between specific procedures' rate of inappropriateness and their cost of review.

Conclusion

Several organizations are calling for uniform standards of review. The Utilization Review Accreditation Commission, a coalition representing the UR industry, employers, insurers, and the medical community, would like a national set of standards to be developed. The American Medical Association would like to see a sharing of review criteria, which in the Association's opinion could result in improved medical care and fewer inappropriate procedures. The Blue Cross and Blue Shield Association has published and periodically updates its medical necessity standards (see RR 333.03.-5).



UTILIZATION REVIEW ACCREDITATION COMMISSION
1227 25TH STREET, N.W.
SUITE 610
WASHINGTON, D.C. 20037

TELEPHONE (202) 296-0120

TO: CEO/President
All Utilization Review Organizations

FROM: Roger S. Taylor, M.D.
President

SUBJ: Revised National UR Standards

DATE: November 20, 1990

Enclosed is a copy of the Utilization Review Accreditation Commission's (URAC) revised National UR Standards for your information and review. These standards are the result of a great deal of work by many UR industry representatives serving on URAC's Committees and Board, as well as the Committees of the American Managed Care and Review Association's UR section.

You may recall that a representative group from the UR industry released the first set of National UR Standards on January 22, 1990. This November 1990 update incorporates the many comments and recommendations received to date from UR Organizations and other interested parties. The November Standards also focus more specifically on what UR Organizations must and should do to qualify for accreditation, leaving out much of the background information included with the January 22, 1990 version. And finally, these standards incorporate the principle elements of the "Guidelines for Concurrent Review and General Administrative Procedures" jointly developed by the American Hospital Association, American Managed Care and Review Association, American Medical Association, Blue Cross and Blue Shield Association, and the Health Insurance Association of America.

URAC is continuing with its development and with the expansion of its Board to include health care providers and consumer organizations. We would appreciate your comments and your continued support for URAC. Please contact the URAC offices at (202) 296-0120 with any comments.

UTILIZATION REVIEW ACCREDITATION COMMISSION

NATIONAL UTILIZATION REVIEW STANDARDS

NOVEMBER 1990

This document incorporates the comments and recommendations received from a broad spectrum of interested parties on the January 22, 1990 National UR Standards. Additionally, this edition of the Standards incorporates the principle elements of the "Guidelines for Concurrent Review and General Administrative Procedures," jointly developed by the American Hospital Association, American Managed Care and Review Association, American Medical Association, Blue Cross/Blue Shield Association and the Health Insurance Association of America.

Comments or recommendations regarding these Standards should be submitted to the URAC Standards Subcommittee, 1227 25th Street, N.W., Suite 610, Washington, D.C. 20037. The 1991 URAC Standards Subcommittee and Board of Directors will review these comments and recommendations and may modify or update the Standards prior to their use in URAC's accreditation process.

NATIONAL UTILIZATION REVIEW STANDARDS

Overview

A. Introduction

These standards for utilization review were developed and approved by the Utilization Review Accreditation Commission (URAC) which was established to encourage efficient and effective UR processes and provide a method of evaluation and accreditation of utilization review programs. These standards will be used by URAC to credential Utilization Review (UR) Organizations which apply for voluntary accreditation.

These standards were developed as guidelines for the evolving UR industry and are not intended to discourage the further development of effective, efficient, and innovative methods to address our nation's concern about the continuing escalation of health care costs.

B. Purpose of the Utilization Review Standards

The purpose of these standards is to provide guidelines to assure that effective and efficient utilization review programs are available to patients, health care providers and health benefit plans in the United States. These standards accomplish that purpose by:

- encouraging consistency in the procedures for interacting with UR programs;
- establishing UR processes that cause minimal disruption to the health care delivery system;
- establishing standards for the procedures used to certify health care services and to process appeals of utilization review determinations;
- providing the basis for an efficient process for credentialing and accrediting UR Organizations; and,
- providing consistent standards and an accreditation mechanism that can be applied efficiently nationwide for those states which choose to regulate UR.

These standards apply to all organizations offering UR services which apply for accreditation. Health Maintenance Organizations, Preferred Provider Organizations and other such managed care systems that contract directly with health care providers may vary from these standards to the extent that the variance is addressed in the provider contract or in the terms of the health benefit plan. UR services for health care benefits provided through certain governmental programs such as Medicare, Medicaid and through Workers' Compensation and certain Automobile Medical Payment coverages may vary from these standards to the extent that the variance is required by statute.[1]

UTILIZATION REVIEW STANDARDS

I. Scope of the Utilization Review Standards

A. These standards apply to prospective and concurrent utilization review for inpatient admissions to hospitals and other inpatient facilities as well as to outpatient admissions to surgical facilities.

B. "Inpatient admissions to hospitals" as used in these standards, includes admissions to all acute medical, surgical, obstetrical, psychiatric and chemical dependency inpatient services at a licensed hospital facility, as well as other licensed inpatient facilities such as skilled nursing facilities, residential treatment centers and free standing rehabilitation facilities.

II. Responsibility for Obtaining Certification

In the absence of any contractual agreement to the contrary, the enrollee is responsible for notifying the UR Organization in a timely manner and obtaining certification for health care services. A UR Organization shall allow any licensed hospital, physician or responsible patient representative, including a family member, to assist in fulfilling that responsibility.[2]

III. Information Upon Which Utilization Review is Conducted

A. When conducting routine prospective and concurrent utilization review, UR Organizations shall collect only the information necessary to certify the admission, procedure or treatment and length of stay.

1. UR Organizations should not routinely expect hospitals and physicians to supply numerically codified diagnoses or procedures. UR Organizations may ask for such coding, since if it is known, its inclusion in the data collected increases the effectiveness of the communication.

2. UR Organizations shall not routinely request copies of medical records on all patients reviewed. During prospective and concurrent review, copies of medical records should only be required when a

difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record should be required.

3. UR organizations may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance, evaluation of compliance with the terms of the health benefit plan or UR provisions. With the exception of the reviewing of records associated with an appeal or with an investigation of data discrepancies and unless otherwise provided for by contract or law, health care providers should be reimbursed the reasonable direct costs of duplicating requested records for retrospective review.

B. Except as otherwise provided in these standards, a UR Organization should limit its initial data requirements to the following elements:[3],[4]

Patient Information
- Name
- Address
- Date of Birth
- Sex
- SS No. or Patient ID No.
- Name of Carrier or Plan
- Plan ID No.

Enrollee Information
- Name
- Address
- SS No. or Employee ID No.
- Relation to Patient
- Employer
- Health Benefit Plan
- Group Number/Plan ID No.
- Other Coverages Available (Workers Comp., Auto, Champus, Medicare, Other)

Attending Physician/Practitioner Information
- Name
- Address
- Phone Numbers
- Degree
- Specialty/certification status
- Tax ID or other ID No.

Diagnosis/Treatment Information
- Primary Diagnosis (with associated ICD or DSM Coding, if available)

Secondary Diagnosis (with associated ICD or DSM Coding, if available)
Tertiary Diagnoses (with associated ICD or DSM Coding, if available)
Proposed Procedure(s) or Treatment(s) (with ICD9 or associated CPT Codes, if available)
Surgical Assistant Requirement
Anesthesia Requirement
Proposed Admission or Service Date(s)
Proposed Procedure Date
Proposed Length of Stay

Clinical Information (sufficient for support of appropriateness and level of service proposed)

Facility Information

Type (such as in-patient, out-patient, special unit, SNF, rehab., office/clinic)
Status (licensure/certification status and DRG exempt status, as needed)
Name
Address
Phone Number
Tax ID No. or Other ID No.

Concurrent (Continued Stay) Review Information

Clinical Contact Person
Additional Days/Services Proposed
Reasons for Extension
Diagnoses (same/changed)
Clinical Information (sufficient for support of appropriateness and level of service proposed)

For Admissions to Facilities other than Acute Medical/Surgical Hospitals, Added Information On:

History of Present Illness
Patient Treatment Plan and Goals
Prognosis
Staff Qualifications
24 Hour Availability of Staff

For Special Situations

Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second Opinion Information may also be required, when applicable, sufficient to support benefit plan requirements.

C. Information in addition to that described in this section may be requested by the UR Organization or voluntarily submitted by the provider, when there is significant lack of agreement between the UR Organization and health care provider regarding the appropriateness of certification during the review or appeal process. "Significant lack of agreement" means that the UR Organization:

1. has tentatively determined, through its professional staff, that a service cannot be certified;

2. has referred the case to a physician for review; and

3. has talked to or attempted to talk to the attending physician for further information.

D. A UR Organization should share all clinical and demographic information on individual patients among its various divisions (e.g., certification, discharge planning, case management) to avoid duplicate requests for information from enrollee or providers.

IV. Procedures for Review Determination

A. Each UR Organization shall have written procedures to assure that reviews are conducted in a timely manner.

1. Each UR Organization shall make certification determinations within two working days of receipt of the necessary information on a proposed admission or service requiring a review determination. Collection of the necessary information may necessitate a discussion with the attending physician or, based on the requirements of the health benefit plan, may involve a completed second opinion review.

2. UR Organizations may review ongoing inpatient stays, but shall not routinely conduct daily review on all such stays. The frequency of the review for extension of the initial determination should vary based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

B. Each UR Organization shall have in place written procedures for providing notification of its determinations regarding certification, recertification or extensions of previously authorized length of stay in accordance with the following:

1. When an initial determination is made to certify, notification shall be provided promptly either by telephone or in writing, to the attending physician. The notification should be transmitted in writing to the hospital and attending physician, as well as to the enrollee or patient, within two working days.[5]

2. A determination to certify resulting from concurrent review should be transmitted to the attending physician by telephone or in writing within one working day of receipt of all information necessary to complete the review process or prior to the end of the current certified period.

3. If a UR Organization transmits written confirmation of certification for continued hospitalization, that notification should include, when possible, the number of extended days, the new total number of days approved and the date of admission.

4. When a determination is made not to certify a hospital or surgery facility admission or extension of a hospital stay, or other service requiring review determination, the attending physician shall be notified by telephone within one working day and a written notification should be sent within one working day to the hospital, attending physician and the enrollee or patient. The written notification should include the principal reason(s) for the determination and the way to initiate an appeal of the determination if the enrollee, patient or their representative, so chooses. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.

C. UR Organizations shall have in place written procedures to address the failure of a health care provider, patient or their representative to provide the necessary information for review. If the patient or provider will not release the necessary information to the UR Organization, the UR Organization may deny certification in accordance with its own policy or that of the health benefit plan.

V. Appeals of Determinations Not to Certify

Each UR Organization shall have in place procedures for appeals of determinations not to certify an admission, procedure, service or extension of stay. The right to appeal shall be available to the patient or enrollee, and to the attending physician on behalf of the patient.[6] The procedures for appeals shall include at a minimum the following:

A. Expedited appeal

When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination over the telephone on an expedited basis. Each UR Organization shall provide for reasonable access to its consulting physician(s) for such appeals. Both providers of care and UR Organizations should attempt to share the maximum information by phone, FAX or otherwise to resolve the expedited appeal (sometimes called a reconsideration request) satisfactorily. Expedited appeals which do not resolve a difference of opinion may be resubmitted through the standard appeal process.

B. Standard appeal

The UR Organization shall establish procedures for appeals to be made in writing and/or by telephone.

1. Each UR Organization shall notify in writing the patient, provider and claims administrator of its determination on the appeal as soon as practical, but in no case later than 60 days after receiving the required documentation on the appeal.

2. The documentation required by the UR Organization may include copies of part or all of the medical record and/or a written statement from the attending physician.

3. Prior to upholding the original decision not to certify for clinical reasons, the UR Organization shall conduct a review of such documentation by a physician who did not make the original determination not to certify.

4. The process established by a UR Organization may include a period within which an appeal must be filed to be considered.

5. An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify should be provided the clinical basis for that determination upon request.

C. Notification to the claims administrator

Each UR Organization shall forward electronically or in writing, a notification of certification or determination not to certify to the appropriate claims administrator for the health benefit plan.[7]

VI. Confidentiality

A. Each UR Organization shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:

1. kept confidential in accordance with applicable federal and state laws;

2. used solely for the purposes of utilization review, quality assurance, discharge planning and catastrophic case management; and

3. shared with only those agencies (such as the claims administrator) who have authority to receive such information.[8]

B. Summary data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

VII. Staff and Program Qualifications

Each UR Organization shall have utilization review staff who are properly trained, qualified, supervised and supported by written clinical criteria and review procedures. Clinical criteria and review procedures shall be established with appropriate involvement from physicians.

A. Nurses, physicians and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting specialized reviews in their area of specialty shall be currently licensed or certified by an approved state licensing agency in the United States.

B. A physician shall review all cases in which the UR Organization has concluded that a determination not to certify for clinical reasons is appropriate. The physician should be reasonably available by telephone to discuss the determination with the attending physician.

C. In cases where an appeal to reverse a determination not to certify for clinical reasons is unsuccessful, the UR Organization should assure that a physician in the same or a similar general specialty as typically manages the medical condition, procedure or treatment under discussion is reasonably available, as appropriate, to review the case.

D. UR Organizations shall utilize:

1. Written clinical criteria, as needed, for the purpose of determining the appropriateness of the certification; such criteria should be periodically evaluated and updated.

2. Physician consultants, including, as needed and available, specialists who are certified by the Boards within the American Board of Medical Specialists or the American Board of Osteopathy from the major areas of clinical services.

3. A formal program for orientation and training of UR staff.

4. Written documentation of an active Quality Assessment Program.

VIII. Accessibility and On-Site Review Procedures

A. Each UR Organization shall provide access to its review staff by a toll free or collect call phone line, at a minimum, from 9:00 am to 4:00 pm of each normal business day in the local time zone in which the UR Organization routinely conducts review. Each UR Organization shall also have a mechanism to receive timely call-backs from providers and shall establish written procedures for receiving or redirecting after-hour calls, either in person or by recording.

B. Each UR Organization shall conduct its telephone and on-site information gathering reviews and hospital communications during hospitals' and physicians' reasonable and normal business hours, unless otherwise mutually agreed.

C. Each UR Organization's staff shall identify themselves by name and by the name of their organization and, for on-site reviews, should carry picture identification and the UR Organization's company identification card. On-site reviews should, whenever possible, be scheduled at least 1 business day in advance with the appropriate hospital contact. UR Organizations should agree that their on-site review staff register with the appropriate contact position prior to requesting any clinical information or assistance from hospital-staff and shall wear appropriate hospital supplied identification tags while on the premises, if so requested.

D. UR Organizations shall agree, if so requested, that the medical records remain available in designated areas during the on-site review and that reasonable hospital administrative procedures shall be followed by on-site review staff so as to not disrupt hospital operations or patient care. Such procedures, however, should not limit the ability of the UR Organizations to efficiently conduct the necessary review on behalf of the patient's health benefit plan.

E. UR Organizations should verbally inform, upon request, designated hospital personnel and/or the attending physician of the utilization review requirements of the specific health benefit plan and the general type of criteria used by the review agent. UR Organizations should also verbally inform, upon request, hospitals, physicians and other health care professionals of the operational procedures in order to facilitate the review process.[9]

IX. Accreditation Process

A. URAC will establish policies and procedures for credentialling and accrediting UR Organizations to assess compliance with these standards. Once established, an Application Form and a copy of these procedures will be made available to any UR Organization upon request.

B. URAC will establish policies and procedures for providing written confirmation of accreditation status and standard data on currently accredited UR Organizations, upon request, to health care providers, state regulatory agencies and other appropriate parties.

C. Only those UR Organizations which have formally applied for and have received a current accreditation from URAC may make any claim to be credentialed or accredited pursuant to these standards.

NOTES

1. Consideration should be given in the application of these standards to UR services in certain governmental programs such as Medicare, Medicaid and in Workers' Compensation and certain Automobile Medical Payment coverages. For example, in Workers' Compensation coverage, there is technically no enrollee, only a claimant. Under these coverages, the responsibility for obtaining certification is not usually the claimant's. The notification requirements, access to the claimant and appeal procedures may be governed by statute.

2. The timeliness of notification to a UR Organization of an admission or proposed admission is determined by the terms of the applicable health benefit plan.

   a. In general, notification should be considered timely if made a minimum of three working days prior to admission for routine or elective admissions and within two working days after emergency admission, unless otherwise provided for in the health benefit plan.

   b. In cases involving a second opinion, proper notification should be considered seven working days, unless otherwise provided for in the enrollee's health benefit plan.

   c. Hospitals and physicians should notify the UR Organization prior to actual admission, whenever possible, on cases where it is uncertain whether the admission would be defined as an emergency.

3. Hospitals and licensed physicians are encouraged to assist in providing information to UR Organizations by telephone and otherwise. Review determinations by UR Organizations are based on the information provided. Health care providers and UR Organizations are encouraged to develop more efficient and cost effective means of communicating the information in a timely and confidential fashion.

4. The information release forms signed by or on behalf of a patient at the time of treatment by hospital or physician should include language, as needed, to clarify that providers have the right to release information by telephone and in writing for utilization review purposes. Hospitals and physicians may reserve the right to discuss the release of sensitive information to a UR Organization with the patient.

5. In certain health benefit plans where the enrollee or patient incurs no financial liability for failing to obtain certification, the UR Organization is not required to notify the enrollee or patient of their determination. Further, a UR Organization may eliminate certain determination notifications by mutual agreement with the health care provider.

6. In most health benefit plans, it is the responsibility of the enrollee or covered patient to appeal. UR Organizations should routinely allow the attending physician to initiate an expedited appeal on behalf of a patient. Hospitals, other health care providers or a representative may assist the enrollee or covered person in an appeal. It is important to emphasize that the decision as to what treatment to prescribe for an individual patient remains that of the physician and his or her patient or their representative. The final decision as to whether these prescribed treatments are a covered benefit is the responsibility of the claims administrator or health benefit plan.

7. Health benefit plans operating under ERISA and state law procedures are designed to give an enrollee a full and fair review after receiving an appeal on a claim denial notice. Health benefit plan enrollees (with or without the provider's assistance) who wish to appeal a claim denial, partial payment or pending claim may utilize that health benefits plan's appeal process. Likewise, claims administrators for health benefit plans have established mechanisms for provider appeals of denied or partially paid claims. In addition, health benefit plans may include specific requirements for compliance with UR rules. The application of those requirements and the charging of any penalty or disincentive is typically a function of the claims administrator and any appeal mechanism would be specified by the health benefit plan.

8. When consistent with applicable federal and state laws, patient specific data gathered by the UR Organization which raise questions of deficiencies in quality may be shared with the hospital's or outpatient surgical facility's Quality Assurance Committee. Prior to the sharing of such information, a UR Organization may require the hospital or outpatient surgical facility to assure compliance with confidentiality requirements, to assure the appropriate review and follow-up within that hospital's or outpatient facility's Quality Assurance Committee, and to indemnify the UR Organization from inappropriate use of such information.

9. Health benefit plans and employers typically develop enrollee communications that provide information regarding UR requirements, benefits, obligations, penalties and sources for further information. UR Organizations are encouraged to take an active role in assisting health benefit plans in the development of enrollee communications and information that provides effective education of enrollees regarding the review requirements of their health benefit plan.

DEFINITIONS

For the purposes of this document, the following terms will have the following definitions:

APPEAL: A formal request to reconsider a determination not to certify an admission, extension of stay or other health care service.

ATTENDING PHYSICIAN: The physician with primary responsibility for the care provided to a patient in a hospital or other health care facility.

CERTIFICATION: A determination by a utilization review organization that, an admission, extension of stay, or other health care service has been reviewed and based on the information provided, meets the medical review requirements of the applicable health benefit plan.

CLAIMS ADMINISTRATOR: Any entity that reviews and determines whether to pay claims to enrollees, physicians, hospitals or others on behalf of the health benefit plan. Such payment determinations are made on the basis of contract provisions. Claims administrators may be insurance companies, self-insured employers, third-party administrators or other private contractors.

CLAIMANT: The enrollee or covered person who files a claim for benefits.

CLINICAL CRITERIA: The written policies, decision rules, medical protocols, or guides used by the Utilization Review Organization to determine certification [e.g., Appropriateness Evaluation Protocol (AEP) and Intensity of Service, Severity of Illness, Discharge, and Appropriateness Screens (ISD-A)].

CONCURRENT REVIEW: Utilization review conducted during a patient's hospital stay or course of treatment, sometimes called Continued Stay Review.

DISCHARGE PLANNING: The process that assesses a patient's needs for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

ENROLLEE: The individual who has elected to contract for, or participate in, a health benefit plan for either him or herself and/or his or her dependents.

HEALTH BENEFIT PLAN: Any public or private organization's written plan that insures or pays for specific health care expenses on behalf of enrollees or covered persons.

PROSPECTIVE REVIEW: Utilization review conducted prior to a patient's hospital stay or course of treatment.

PROVIDER: A licensed health care facility, physician or other health care professional that delivers health care services.

QUALITY ASSESSMENT PROGRAM: A structured mechanism which, at a minimum, monitors and evaluates a UR Organization's program and provides management intervention, as needed, to support compliance with these standards.

RECONSIDERATION: An initial request by telephone for additional review of a UR organization's determination not to certify an admission, extension of stay, or other health care service. A reconsideration may be called an expedited appeal by some UR Organizations.

UTILIZATION REVIEW: Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

UTILIZATION REVIEW ORGANIZATION: An entity which conducts utilization review and determines certification of an admission, extension of stay or other health care service.

Commentary

Should We Regulate 'Utilization Management?'

by Marilyn J. Field and Bradford H. Gray

Calls for regulation are a familiar response to change. Recently, this response has been evident in proposals to regulate private organizations that provide utilization management services for employers and other sponsors of health benefit plans. Several states have passed legislation to regulate utilization management, and others are considering it. The American Medical Association's (AMA's) House of Delegates has directed AMA staff to develop model legislation, and the American Medical Peer Review Association devoted a session at its October 1989 meeting to the question. Given this upsurge in interest and activity, an analysis of the pros and cons of regulation is timely.

In October 1989, the Institute of Medicine's (IOM's) Committee on Utilization Management by Third Parties issued its report on how utilization management works, what its effects appear to be, and what role it should play in the future.[1] Although much of the activity and interest in regulating utilization management became apparent after the committee's last formal meeting in February 1989, growing pressure for regulation was becoming apparent, and most of the basic approaches were known. This Commentary summarizes the IOM committee's analysis of the question, "Is public regulation of utilization management desirable and feasible now?" and explains why its answer is "No."

The Rise Of Utilization Management

Definition. The IOM committee adopted a relatively narrow definition of utilization management as "a set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision." Although benefit design,

Marilyn Field is senior staff officer at the National Academy of Sciences' Institute of Medicine in Washington, D.C. Brad Gray is executive director of the Yale Program on Nonprofit Organizations and professor (adjunct) of research and public health at Yale School of Medicine. Field is director of the IOM study on utilization management, a position Gray held prior to moving to Yale.

financial incentives, and other strategies can influence medical decisions, the committee focused on prospective case-by-case approaches because of the significant change they entail in the way that patient care decisions are made and because they have been adopted rapidly with little systematic study. The major forms of utilization management are (1) prior review of proposed medical services through such means as preadmission or admission review for elective or emergency hospital admissions, continued stay review for hospitalized patients, and preprocedure review for selected inpatient and outpatient services; and (2) high-cost case management. To date, programs have been aimed at the site, timing, and duration of care, focusing on hospital use. Recently, the focus has begun to include case-by-case assessments of the medical need for particular procedures.

Development. Although some prior review dates back to the 1960s and before, initial efforts to avoid payment for unnecessary services emphasized review after care had been provided or even after it had been reimbursed. Such efforts have serious limitations as ways to influence medical decisions and control costs. First, most private health plans lack the power to deny payment to a physician or institution when the "unnecessary" services had already been provided—although the growth of contracting arrangements with providers has altered the situation somewhat. Absent such contracts, the burden of payment denials falls on the health plan member. Complaints by individuals faced with such unexpected expenses create employee relations problems for purchasers and public relations and marketing problems for review organizations. The risk of litigation also weakens the will to apply retrospective review vigorously. Furthermore, although one could deny payment for inappropriate care after the fact, the patient would already have undergone the service's risk and inconvenience. In theory, all parties would benefit if such care were avoided in the first place.

Virtually all insurers and third-party administrators and many health maintenance organizations (HMOs) and preferred provider organizations (PPOs) now offer some utilization management services.[2] Many statewide peer review organizations (PROs) that monitor utilization and quality of care for Medicare beneficiaries have private clients. Dozens of independent companies provide utilization management services. Surveys by benefit consulting firms show that one-half or more of large employers include utilization management provisions in their health benefit programs, up from as few as 5 percent in 1984.[3] The American Hospital Association (AHA) reports that individual hospitals may now deal with 50 to 250 different review organizations.[4] As recently as 1984, the Mayo Clinic worked with just one prior-review program administered by the Minnesota PRO for Medicare. Now it faces over 1,000 programs, many de-

veloped by review organizations to meet individual employers' demands.

Process and impact. The utilization management programs are far from uniform. However, they tend to share certain basic features. The initial contact with the organization may be made by the patient, the physician's office, or the hospital. Registered nurses generally collect information from these sources and, for prior review cases, make the initial evaluation of whether the proposed services meet medical necessity requirements for coverage under the patient's health plan.[6] If the nurse reviewer cannot certify the care as clinically necessary or appropriate based on the organization's review criteria, then the case is referred to a staff or consultant physician for final determination, often after discussion with the patient's physician. The emphasis seems to be on changing behavior through education, persuasion, and negotiation, and it appears uncommon for the process to end with refusal to certify the necessity of services that the patient's physician adamantly contends are needed. For high-cost case management, the focus is on evaluating alternative treatment approaches that could reduce costs for patients who are embarked on a very expensive course of care, and then—if the patient, family, and attending physician agree—coordinating implementation of the alternatives. Less costly services not normally covered by the health plan (such as intensive home care) may be approved if appropriate. The IOM report describes the operational elements and variations in utilization management at considerable length.

The rise of utilization management has been fueled by purchasers' frustration with ever-increasing health care costs and by the perception, backed by growing evidence, that many services may be unnecessary and inappropriate. This was fertile ground for early reports—disseminated widely by the trade press, conferences, consulting firms, and utilization management companies—that suggested that utilization management could cut hospital use and costs. As the IOM report describes, the early evidence was methodologically weak, and many expectations were overblown. Yet, utilization management quickly became a routine part of the health care system. Research evidence is still limited and flawed, but after evaluating it, the IOM committee concluded that utilization management has affected use and costs. Its effects on the quality of care and on providers' costs have not been documented, but it is clear that a significant change has taken place in the autonomy of practicing physicians.

Current Regulation And Oversight

Utilization management in the private sector has developed largely free from systematic oversight or government regulation. Today's operat-

ing environment is governed largely by market forces with backup from a scattering of judicial decisions and voluntary standards.

The market. Purchasers exercise varying degrees of control over utilization management in their decisions to select, continue, or replace particular programs or organizations. Recognizing employers' influential position, the IOM committee offered suggestions on how employers could better fulfill their roles as responsible and informed purchasers. However, not all employers have the resources or the inclination to make truly educated evaluations, and clear, evidence-based standards for distinguishing good performers from bad do not exist. A few private firms offer to evaluate review organizations for purchasers but are used by only larger and more committed employers or review firms.

Voluntary standards. For the utilization management industry, no voluntary organization analogous to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the medical specialty boards exists to set standards or certify organizational adherence to standards. A limited first step toward voluntary standards went public this past summer when the AMA, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America (HIAA) published eight broad guidelines for the conduct of utilization management programs. Several state hospital associations have also proposed guidelines for outside review organizations.

Case law. Although state and federal courts have faced few cases dealing explicitly with utilization management, these cases—combined with a much larger array of decisions relating generally to insurance and health plan administration—have created a broad, but incomplete, picture of the responsibilities and potential liability of review organizations and their clients. On the one hand, purchasers do have the right to evaluate and challenge the medical appropriateness of an attending physician's decisions about services that their health plans are expected to cover.[2] On the other hand, review organizations are then potentially liable for "defects in the design and implementation of cost containment mechanisms" that cause medically necessary services to be denied.[3] Such defects could include sloppy program design, incompetent management and monitoring, inadequate documentation, bad faith, and poor judgment about clinical or other patient circumstances.

State regulation. Maryland and Arkansas are establishing registration and certification processes that require review organizations to submit data on such matters as confidentiality policies, clinical criteria used for review, staffing, provisions for appeals of negative decisions, and accessibility (for example, business hours).[4] North Carolina authorizes the state insurance commissioner to adopt similar regulations and to require the

use of a standardized form for preadmission certification (most reviews are telephone-based). Maine limits its requirements for annual information reports to insurers operating prior review programs. Louisiana requires that review decisions be communicated within two business days unless special circumstances warrant a longer period, and Minnesota requires a decision within ten days after the review organization has received all necessary information. Louisiana also requires—without giving specifics—that decisions be based on "nationally accepted current medical criteria." Other states have considered, but not passed, legislation requiring that physician reviewers for utilization management organizations be licensed within the state, that no penalties be imposed on patients or providers for ignoring review requirements, and that all reviews, including those now performed by nurses, be defined as the practice of medicine and be done by physicians.

Federal action. PROs responsible for reviewing the appropriateness of care provided to Medicare beneficiaries are subject to extensive and frequently revised regulation, some of which—as a matter of convenience if not mandate—will affect their review programs for private clients. Although the federal government regulates PROs in great detail in many areas, it has explicitly refrained from requiring common clinical criteria for prior and retrospective review. A study commissioned by the Prospective Payment Assessment Commission (ProPAC) found great variation in the substance and specificity of criteria used by PROs.[10]

Emphases of regulation. Regulatory approaches fall into two broad categories. Some focus on information development through organizational disclosure of operating procedures, review criteria, and so forth, or through standardization of data used for evaluation and reporting. Other regulations try to protect consumers and providers by subjecting organizations to general oversight and approval, or by specifically prescribing or prohibiting certain practices (such as requiring a standard information form or forbidding use of nurse reviewers).

The Case For Regulation

The case for public regulation of utilization management rests on several points. First, neither administrative processes nor clinical criteria for review are highly standardized, and a number of shortcomings in common review mechanisms may hurt patients and overload providers. Proponents of regulation argue that only government action, rather than market or voluntary mechanisms, offers achievable and acceptable protection against inadequate or unscrupulous review organizations.

Site visits by the IOM committee to a dozen organizations that provide

utilization management services showed that they have some broad operating practices in common but differ on many specifics. These include the clinical criteria for assessing the appropriateness of specific services; the qualifications, training, and supervision of review nurses and physicians; the links to claims administration processes; the extent of computerization; and the procedures for appealing unfavorable decisions. Most organizations say their criteria are adapted from either the Appropriateness Evaluation Protocol or the Intensity Severity Discharge and Appropriateness screens—both widely known. Still, the individual adaptations may vary considerably, and no systematic inventory of criteria exists. The uncertainty about the quality of review criteria was a major concern of the IOM committee.

Physicians have complained that utilization management organizations refuse to disclose their decision-making criteria, although it is difficult to know how widespread this may be. Certainly, some organizations consider certain review criteria proprietary and will not disclose them in full. Other shortcomings identified by the committee include the lack of rigorous evaluation of utilization management techniques and variations; the absence of standard operating procedures for review organizations when they uncover quality-of-care problems; and vagueness, inconsistency, unfairness, or undue complexity in procedures for patients or providers to appeal unfavorable review decisions. Another criticism is that there are only informal mechanisms to press utilization management organizations to weigh the costs that their activities impose on providers of care, particularly those who are willing to appeal decisions with which they disagree. Some firms survey patients about their experiences with utilization management, but the committee found no parallel mechanism for physicians and hospitals.

The current conduct of utilization management may put an unfair burden on physicians to discover the basis for a review organization's decision, find out how the decision may be appealed, and then pursue the appeal. This generates costs—time, money, and stress—for practitioners and their staffs. However, if physicians do not contest ill-considered review decisions and do change their plan of treatment to conform, they may be legally liable should subsequent harm befall their patients.

Relying on the market to weed out poor vendors and procedures could be unsatisfactory because some of the parties most affected are not involved directly in decisions to purchase utilization management services. Moreover, many purchasers know little about what they are buying. Also, the varied contexts in which utilization management is carried out make it potentially subject to the hodgepodge of regulatory frameworks that cover insurance companies, HMOs, PPOs, and em-

ployee benefits. The likelihood of inconsistency, overlaps, and gaps is high. In sum, the case for regulation rests on the perception that serious problems exist and that government regulation can solve these problems.

The Case Against Regulation

Arguments against government regulation of utilization management do not deny that current approaches are variable and suffer from inadequacies. Nonetheless, it is one thing to identify a problem and another to find a satisfactory solution. Those who now oppose regulation emphasize three general points: (1) the lack of knowledge about what and how to regulate; (2) the potential for harm from ill-conceived regulation; and (3) the lack of documented evidence of harm to patients.

The utilization management industry has been called a moving target, so dynamic that it is difficult to crystallize meaningful and responsible rules to fit the activities of a variety of organizations with different objectives, structures, and incentives. The modest available evidence about the effectiveness of particular review strategies appears to some observers to be a rationale for regulation, but others contend that we do not know enough about what works and does not work (and under what conditions) to entrench our suppositions in regulation. They suggest that self-regulation by utilization management organizations is a reasonable first step, though recognizing that self-regulation often lacks public accountability and that no organizational umbrella currently covers all or even most review firms.

Poorly conceived government regulation could lead to premature rejection of utilization management, thereby encouraging further adoption of cost containment methods—such as coverage restrictions and economic incentives—that take less cognizance of the needs of individual patients and that are not designed to affect inappropriate care selectively. Moreover, little or no evidence suggests that utilization management harms patients. In fact, since utilization management aims to eliminate inappropriate services, it may benefit patients—although neither clinical benefit nor harm has been documented. Review programs do generate extra costs and aggravation for health care practitioners and institutions, and their calls for more standard operating methods and review criteria are understandable. However, some would argue that certain regulatory proposals—for example, those to restrict who can do prior review—look more like professional protectionism than efforts to save patients from harm and practitioners from unreasonable red tape.

Overall, the IOM committee concluded that the need for regulation seems not so urgent as to outweigh the need to understand well how to

act. The sophistication with which utilization management is carried out is increasing, and voluntary standards are being developed. Regulations might freeze certain methods in place before better approaches can be substituted. Or they might render ineffective and infeasible one of the few cost containment strategies designed to be sensitive to individual patients' circumstances.

Nonregulatory Directions For Utilization Management

Although the IOM committee did not endorse regulation, it did identify areas in which more standardization is desirable and should be encouraged by purchasers of review services, relevant professional associations, and consumer groups. Such areas include knowledge development, information disclosure, and procedural matters.

Knowledge base. The IOM committee saw clinically validated utilization management criteria as a public good that should be developed through rigorous processes that take into account the scientific literature and reflect a credible professional consensus. No utilization management organization can surmount the limits of medical knowledge and the lack of national consensus that now exists regarding many medical services. In addition, systematic empirical evaluation of different utilization management strategies probably requires some public investment, since broad-based and rigorous research may be beyond the capability and objectives of most individual organizations. Unfortunately, the building of broader clinical and management knowledge bases will not be a quick or comprehensive process. Research takes time, faces ethical constraints in some areas, applies imperfectly to varied real-world settings, and provokes disagreements over interpretation.

Disclosure of review criteria. Whereas the call for more research was easy for the IOM committee to reach, the conclusion that review criteria should be publicly accessible rather than secret or proprietary was less readily achieved. The arguments in favor of disclosure were several. Certainly, it seems only fair that practitioners and patients should know the basis for decisions about whether expensive health services are deemed appropriate for payment. Moreover, disclosing review criteria will expose them to more critical scrutiny. It may also increase the educational impact of review on providers and patients, perhaps improving quality of care. In general, more disclosure should help broaden the path from clinical research to applications.

In the committee's view, utilization management organizations should compete on the basis of data systems, efficiency, and performance, not on the basis of "secret" criteria. It may be argued that disclosure is unfair to

firms that have invested in criteria development and that it will discourage such efforts because firms will not be able to capture fully the benefits of their investment but will have to share them with free riders. This point has some merit, although the most noteworthy investments by review organizations appear to be less in developing criteria than in devising software to make their use practical and efficient.

Disclosure of criteria may also facilitate gaming by practitioners and reduce the cost-effectiveness of utilization management by making it easier for physicians to gain approvals and by adding more costs for monitoring. The committee believes that the appropriate response to this concern is not secret criteria but rather the development of greater consensus about appropriate care and better means for verifying information provided during the review process.

Other issues. Since overly burdensome or obscure appeal processes could discourage physicians from challenging questionable decisions by review organizations, there is much to commend more standard appeals mechanisms and better materials to explain them. With respect to procedures for organizations to follow when they identify serious quality-of-care problems, the immediate need is not for uniformity but rather for organizations to adopt explicit policies in the first place. Finally, more standardization in data collection and reporting is needed in both utilization management and other aspects of the health care system.

Conclusion

Proposals to regulate utilization management involve uncertainties and risks that should be understood. This rapidly evolving activity could become a major pathway to disseminate and apply standards for appropriate care that are being developed through research and consensus mechanisms. To the extent that regulation raises the cost or diminishes the effectiveness of utilization management, it becomes less attractive than other approaches that do not consider individual patient conditions. The cross-pressures in utilization management provide opportunities for dialogue between payer and physician that may educate both parties and permit more sensitivity to patients' needs than do alternatives that provide incentives to reduce services across the board.

The conduct of utilization management merits continued oversight. However, a strong argument can be made now for allowing the field to continue its rapid evolution, for increasing purchasers' scrutiny over utilization management services, and for disclosing the clinical bases for utilization management decisions. State regulation, however, remains an option if abuse becomes apparent involving either harm to patients or

unreasonable burdens on physicians and institutional providers. Federal action may be warranted if highly discrepant state regulations develop.

The authors wish to acknowledge their equal contribution to this Commentary and note that their names are in alphabetical order. Members of the Institute of Medicine Committee on Utilization Management by Third Parties are: Jerome H. Grossman (chairman), Howard L. Bailit, Robert A. Berenson, John M. Burns, Richard H. Egdahl, John M. Eisenberg, Deborah Anne Freund, Paul M. Gertman, Alice G. Gosfield, Michael E. Herbert, Nathan Hershey, Neil Hollander, Karen Ignani, Carol Ann Lockhart, Arnold Milstein, Alan R. Nelson, Robert Patricelli, Cynthia L. Polich, Donald M. Steinwachs, and Bruce S. Wolff.

NOTES

1. Institute of Medicine Committee on Utilization Management by Third Parties, *Controlling Costs and Changing Patient Care? The Role of Utilization Management*, ed. B.H. Gray and M.J. Field (Washington, D.C.: National Academy Press, 1989).
2. Various trade sources list different numbers of utilization management organizations. The 1987 directory published by McGraw-Hill listed 158 utilization management companies, including many PROs. *Business Insurance* listed approximately 125 organizations in 1989, including only a few PROs.
3. Corporate Health Strategies, *The Health Poll*, Fall 1988, 1; J. Gabel et al., "Employee-Sponsored Health Insurance in America," Research Bulletin of the Health Insurance Association of America (Washington, D.C.: HIAA, January 1989); and Health Care Benefits Survey, 1987 and 1988 ed. (New York: Foster & Higgins, 1987 and 1989).
4. American Hospital Association, *Private Utilization Review*, State Issues Forum Monograph Series (Chicago: AHA, August 1989).
5. Mayo Clinic, "The Cost of Effective Utilization Review Programs," statement for the IOM Committee on Utilization Management by Third Parties, 19 May 1988.
6. Although terms such as prior review and prior authorization are often used interchangeably, the approval of benefits in advance of service provision may be contingent rather than final. Retrospective claims review will verify patient eligibility under the health plan, coverage for the category of service provided, and, to a lesser extent, accuracy of information supplied during prior review.
7. *Sarchett v. Blue Shield of California*, 43 Cal. 3d 1, 233 Cal. Rptr. 76, 729 P. 2d 267 (1987), which involved a retrospective judgment of the medical necessity of hospital care, is a key case involving the right of payers to review physician judgments. *Varol v. Blue Cross and Blue Shield of Michigan* reached a similar conclusion in a case involving prior review. See also W.A. Helvestine, "Legal Implications of Utilization Review," in *Controlling Costs and Changing Patient Care*, ed. Gray and Field, Appendix A.
8. *Wickline v. California*, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986). For discussion, see Helvestine, "Legal Implications of Utilization Review."
9. H. Meyer, "Two States Lead Move to Regulate Utilization Review," *American Medical News*, 21 April 1989, 1, 45. See also AHA, *Private Utilization Review*; and Helvestine, "Legal Implications of Utilization Review."
10. Project HOPE, Center for Health Affairs, *A Study of the Preadmission Review Process*, prepared for the Prospective Payment Assessment Commission (Washington, D.C.: ProPAC, November 1987).

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best's review

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Life/Health Insurance Edition

Does Mr. Jones Need Bypass Surgery?

BY IRENE SCHEIBNER AND CONSTANCE M. WINSLOW

Computerization of claim processing, billing and many previously manual processes has become an accepted way to enhance customer service and cut the costs of doing business. On the leading edge of trends in automation, however, are applications of technology that go beyond streamlining standard processes to make possible new products, services and programs that were inconceivable in a manual environment.

Today, Aetna Life and Casualty is applying knowledge-based systems technology to manage health care delivery more efficiently and effectively. The company's new protocol-based programs use special software to represent the decision logic used in determining the medical necessity of specific health care services.

IRENE SCHEIBNER is assistant director of Medical Management Program Development at Aetna Life & Casualty, Hartford, Conn. CONSTANCE M. WINSLOW, M.D., is medical director of Medical Management Research & Program Development at the insurer.

There is mounting evidence that suggests patients may be getting health services they do not need. A study by the RAND Corp. showed that between 17% and 32% of three frequently used procedures—coronary angiography, carotid endarterectomy, upper GI endoscopy—were performed for inappropriate reasons (*Journal of the American Medical Association*, November 13, 1987). The researchers defined "appropriate" as when the benefit to the patient clearly outweighs the risk. In a subsequent study of three hospitals in a western state, 14% of the coronary artery bypass surgeries reviewed were deemed inappropriate (*JAMA*, July 22/29, 1988).

Prompted by the results of these and other studies, we undertook the development of specific utilization management programs that could avert the unnecessary use of health services in both inpatient and outpatient settings. The programs are designed to prospectively review for the medical necessity (clinical appropriateness) of selected procedures using scientifically based clinical protocols, or practice guidelines. The company's Employee Benefits Division has been operating these programs since 1987 with more than 500,000 lives. Program results are promising and indicate that we effectively can reduce the use of unnecessary, and sometimes harmful, medical procedures.

Clinical decision making is complex, but researchers are developing methodologies to simplify our understanding of the process. Nationally recognized medical research groups developed the clinical decision logic used to screen for unnecessary or clinically inappropriate treatments or surgeries. The protocol logic is based on an extensive review of the medical literature, recommendations of medical specialty societies, and final review by an expert panel of physicians.

The resultant protocol consists of clinical decision logic and the expert panel's ratings of appropriateness. The protocols vary in complexity, depending on the underlying medical decision logic for each procedure. Outpatient procedures such as bunionectomy or tympanostomy tube insertion are not as complex as hysterectomy, for example, which has more than 2,000 indications for use. Other procedures included in the review process include cataract removal, knee arthroscopy, septoplasty/rhinoplasty, tonsillectomy,

carpal tunnel release, prostatectomy and laminectomy, among others.

The procedures are carefully selected for inclusion in the review program. The basic criteria for selection are as follows:

- Information about the effectiveness of the procedure needs to be available in the medical literature.
- The frequency and cost of the procedure must be high enough to make prospective review cost effective.
- Inappropriate use must be suspected.

The clinical protocols developed for selected procedures can then be incorporated into utilization management and quality assurance programs. Both the Outpatient Precertification program and the Managed Second Opinion program, which targets inpatient procedures, are prospective and require that patients precertify selected procedures by calling the company's utilization review nurse, who collects the pertinent clinical information from the patient and the attending physician. Through the use of the protocols, the nurse identifies cases in which a procedure may not be medically necessary and refers such cases to the company's review physician.

To minimize operational costs and to make efficient use of the patient and attending physician's time, we used knowledge-based systems software to represent the clinical logic. The knowledge-based system assists the nurse in reaching a decision to certify or refer the case, based on the clinical logic of the protocol.

Using the computerized system, the nurse is required to collect only the pertinent clinical information and can proceed through the certification interview without having to remember the logic of the protocol—the sequence of questions is built into the system. In addition, the system enables the nurse to keep the interview with the attending physician within a desired five to seven minutes.

The outpatient system is based on a new technology, hypertext technology, and is written in Apple's HyperCard software running on a Macintosh computer. The hypertext software models the human reasoning process and supports automated representation of the clinical protocol logic by linking successive questions and logic paths.

COMPLEX PROTOCOL LOGIC

The managed second opinion program operates in much the same way as the outpatient program by addressing review of selected inpatient surgical procedures. The Healthline nurse uses protocol logic to certify medical necessity and screen selected cases for the physicians' review. The program eliminates second opinions for patients whose procedure or admission is completely appropriate and focuses review efforts on cases in which the procedure or treatment may not be medically necessary. The review physician determines when a second examination is required and finalizes determination of the medical necessity of a procedure.

The difference between the outpatient precertification and managed second opinion programs lies in the complexity of the protocol logic for inpatient cases, such as hysterectomy, cardiac bypass and prostatectomy. An inpatient protocol can consider more than 1,000 clinical indications and is much more complex than the clinical logic in an outpatient protocol.

A more sophisticated knowledge-based technology was necessary to implement the managed second opinion protocols. To help streamline the extensive clinical questioning logic, newly available artificial intelligence technology, called induction technology, was used. To speed up system support for the questioning process, screen windows and button-choice features assist the nurse by clarifying definitions of the medical indications and tracking the clinical logic to facilitate the task. Further technical programming enhancements bring system performance speed to the level necessary to implement the program.

The nurse uses protocol logic to certify medical necessity and screen selected cases for the physicians' review.

Future development of these review programs will focus on further reducing administrative costs through the continued application of new technologies and by expanding the use of these programs to other areas, such as hospital ancillary services. As the cost of delivering health services continues to rise, employers will continue to demand programs that can reduce health care costs. Reducing costs, however, does not necessarily mean sacrificing needed patient care. The protocol-based programs selectively reduce the use of unnecessary procedures with consequent cost savings.

Knowledge-based technologies make it possible for us to implement utilization management programs that would not be possible with conventional technologies or in manual environments. The future of health care utilization management depends on a close, collaborative effort between informations systems technology development and the application of health services research.

UTILIZATION REVIEW ACCREDITATION COMMISSION
NATIONAL UTILIZATION REVIEW STANDARDS
JUNE 1991

Comments or recommendations regarding these Standards should be submitted to the Utilization Review Accreditation Commission, Inc., 1227 25th Street, NW, Suite 610, Washington, DC 20037

NATIONAL UTILIZATION REVIEW STANDARDS

Overview

A. Introduction

These standards for utilization review were developed and approved by the Utilization Review Accreditation Commission (URAC) which was established to encourage efficient and effective UR processes and provide a method of evaluation and accreditation of utilization review programs. These standards will be used by URAC to credential Utilization Review (UR) Organizations which apply for voluntary accreditation.

These standards were developed as guidelines for the evolving UR industry and are not intended to discourage the further development of effective, efficient, and innovative methods to promote quality care and decrease the rate of growth in health care expenditures.

B. Purpose of the Utilization Review Standards

The purpose of these standards is to encourage the availability of effective, efficient, and consistent utilization review of health care services throughout the United States. These standards accomplish that purpose through the following objectives:

- encouraging consistency in the procedures for interaction between UR Organizations and providers, payors, and consumers of health care;
- establishing UR processes that cause minimal disruption to the health care delivery system;
- establishing standards for the procedures used to certify health care services and to process appeals of utilization review determinations;
- providing the basis for an efficient process for credentialling and accrediting UR Organizations; and,
- providing consistent standards and an accreditation mechanism that can be applied efficiently nationwide for those states which choose to regulate UR Organizations.

These standards apply to all organizations offering UR services which apply for accreditation. Health Maintenance Organizations, Preferred Provider Organizations and other such managed care systems that contract directly with health care providers may vary from these standards to the extent that the variance is addressed in the provider contract or in the terms of the health benefit plan and is consistent with the objectives of these standards. UR services for health care benefits provided through certain governmental programs such as Medicare, Medicaid and through Workers' Compensation and certain Automobile Medical Payment coverages may vary from these standards to the extent that the variance is required by statute.[1]

UTILIZATION REVIEW STANDARDS

I. Scope of the Utilization Review Standards

A. These standards apply to prospective and concurrent utilization review for inpatient admissions to hospitals and other inpatient facilities as well as to outpatient admissions to surgical facilities.[2]

B. "Inpatient admissions to hospitals" as used in these standards, includes admissions to all acute medical, surgical, obstetrical, psychiatric and chemical dependency inpatient services at a licensed hospital facility, as well as other licensed inpatient facilities such as skilled nursing facilities, residential treatment centers and free standing rehabilitation facilities.

II. Responsibility for Obtaining Certification

Health benefit plans which include utilization review requirements typically specify the individual(s) responsible for notifying the UR organization in a timely manner and obtaining certification for health care services. A UR Organization shall allow any licensed hospital, physician or responsible patient representative, including a family member, to assist in fulfilling that responsibility.[3]

III. Information Upon Which Utilization Review is Conducted

A. When conducting routine prospective and concurrent utilization review, UR Organizations shall collect only the information necessary to certify the admission, procedure or treatment and length of stay.

1. UR Organizations shall not routinely require hospitals and physicians to supply numerically codified diagnoses or procedures to be considered for certification. UR Organizations may ask for such coding, since if it is known, its inclusion in the data collected increases the effectiveness of the communication.

2. UR Organizations shall not routinely request copies of medical records on all patients reviewed. During prospective and concurrent review, copies

of medical records should only be required when a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record should be required.

3. UR organizations may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance, evaluation of compliance with the terms of the health benefit plan or UR provisions. With the exception of the reviewing of records associated with an appeal or with an investigation of data discrepancies and unless otherwise provided for by contract or law, health care providers should be reimbursed the reasonable direct costs of duplicating requested records for retrospective review.

B. Except as otherwise provided in these standards, a UR Organization should limit its data requirements to the following elements:[4],[5]

Patient Information

Name
Address
Date of Birth
Sex
SS No. or Patient ID No.
Name of Carrier or Plan, including Plan Type
Plan ID No.

Enrollee Information

Name
Address
SS No. or Employee ID No.
Relation to Patient
Employer
Health Benefit Plan
Group Number/Plan ID No.
Other Coverages Available (Workers Comp., Auto, CHAMPUS, Medicare, Other)

Attending Physician/Practitioner Information

Name
Address
Phone Numbers
Degree
Specialty/certification status
Tax ID or other ID No.

Diagnosis/Treatment Information

Primary Diagnosis (with associated ICD or DSM Coding, if available)
Secondary Diagnosis (with associated ICD or DSM Coding, if available)
Tertiary Diagnoses (with associated ICD or DSM Coding, if available)
Proposed Procedure(s) or Treatment(s) (with ICD9 or associated CPT Codes, if available)
Surgical Assistant Requirement
Anesthesia Requirement
Proposed Admission or Service Date(s)
Proposed Procedure Date
Proposed Length of Stay

Clinical Information

Sufficient for support of appropriateness and level of service proposed
Contact Person for detailed clinical information

Facility Information

Type (such as in-patient, out-patient, special unit, SNF, rehab., office/clinic)
Status (licensure/certification status and DRG exempt status, as needed)
Name
Address
Phone Number
Tax ID No. or Other ID No.

Concurrent (Continued Stay) Review Information

Additional Days/Services/Procedures Proposed
Reasons for Extension, including clinical information sufficient for support of appropriateness and level of service proposed
Diagnoses (same/changed)

For Admissions to Facilities other than Acute Medical/Surgical Hospitals, Added Information On:

History of Present Illness
Patient Treatment Plan and Goals
Prognosis
Staff Qualifications
24 Hour Availability of Staff

For Special Situations

Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second Opinion Information may also be required, when applicable, sufficient to support benefit plan requirements.

C. Information in addition to that described in this section may be requested by the UR Organization or voluntarily submitted by the provider, when there is significant lack of agreement between the UR Organization and health care provider regarding the appropriateness of certification during the review or appeal process. "Significant lack of agreement" means that the UR Organization:

1. has tentatively determined, through its professional staff, that a service cannot be certified;

2. has referred the case to a physician for review; and

3. has talked to or attempted to talk to the attending physician for further information.

D. A UR Organization should share all clinical and demographic information on individual patients among its various divisions (e.g., certification, discharge planning, case management) to avoid duplicate requests for information from enrollee or providers.

IV. Procedures for Review Determination

A. Each UR Organization shall have written procedures to assure that reviews are conducted in a timely manner.

1. Each UR Organization shall make certification determinations within two working days of receipt of the necessary information on a proposed admission or service requiring a review determination. Collection of the necessary information may necessitate a discussion with the attending physician or, based on the requirements of the health benefit plan, may involve a completed second opinion review.

2. UR Organizations may review ongoing inpatient stays, but shall not routinely conduct daily review on all such stays. The frequency of the review for extension of the initial determination should vary based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

B. Each UR Organization shall have in place written procedures for providing notification of its determinations regarding all forms of certification in accordance with the following:

1. When an initial determination is made to certify, notification shall be provided promptly either by telephone or in writing, to the attending physician. The notification should be transmitted in writing to the hospital and attending physician, as well as to the enrollee or patient, within two working days of the determination.[6],[7]

2. A determination to certify an extended stay or additional services resulting from concurrent review should be transmitted to the attending physician by telephone or in writing within one working day of receipt of all information necessary to complete the review process or prior to the end of the current certified period.

3. If a UR Organization transmits written confirmation of certification for continued hospitalization, that notification should include, when possible, the number of extended days or next review date, the new total number of days approved and the date of admission.

4. When a determination is made not to certify a hospital or surgery facility admission or extension of a hospital stay, or other service requiring review determination, within one working day the attending physician shall be notified by telephone and a written notification shall be sent to the hospital, attending physician and the enrollee or patient.[6] The written notification should include the principal reason(s) for the determination and the way to initiate an appeal of the determination. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.

C. UR Organizations shall have in place written procedures to address the failure of a health care provider, patient or their representative to provide the necessary information for review. If the patient or provider will not release the necessary information to the UR Organization, the UR Organization may deny certification in accordance with its own policy or that of the health benefit plan.

V. Appeals of Determinations Not to Certify

Each UR Organization shall have in place procedures for appeals of determinations not to certify an admission, procedure, service or extension of stay. The right to appeal shall be available to the patient or enrollee, and to the attending physician.[8] The procedures for appeals shall include at a minimum the following:

A. Expedited appeal

When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination over the telephone on an expedited basis. Each UR Organization shall provide for reasonable access to its consulting physician(s) for such appeals. Both providers of care and UR Organizations should attempt to share the maximum information by phone, FAX or otherwise to resolve the expedited appeal (sometimes called a reconsideration request) satisfactorily. Expedited appeals which do not resolve a difference of opinion may be resubmitted through the standard appeal process.

B. Standard appeal

The UR Organization shall establish procedures for appeals to be made in writing and/or by telephone.

1. Each UR Organization shall notify in writing the enrollee or patient, attending physician and claims administrator of its determination on the appeal as soon as practical, but in no case later than 60 days after receiving the required documentation on the appeal.

2. The documentation required by the UR Organization may include copies of part or all of the medical record and/or a written statement from the health care provider.

3. Prior to upholding the original decision not to certify for clinical reasons, the UR Organization shall conduct a review of such documentation by a physician who did not make the original determination not to certify.

4. The process established by a UR Organization may include a period within which an appeal must be filed to be considered.

5. An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify shall be provided the clinical basis for that determination upon request.

6. In cases where an appeal to reverse a determination not to certify for clinical reasons is unsuccessful, the UR Organization should assure that a physician in the same or a similar general specialty as typically manages the medical condition, procedure or treatment under discussion is reasonably available to review the case as mutually deemed appropriate.

C. Notification to the claims administrator

Each UR Organization shall forward electronically or in writing, a notification of certification or determination not to certify to the appropriate claims administrator for the health benefit plan.[9]

VI. Confidentiality

A. Each UR Organization shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:

1. kept confidential in accordance with applicable federal and state laws;

2. used solely for the purposes of utilization review, quality assurance, discharge planning and catastrophic case management; and

3. shared with only those agencies (such as the claims administrator) who have authority to receive such information.[10]

B. Summary data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

VII. Staff and Program Qualifications

Each UR Organization shall have utilization review staff who are properly trained, qualified, supervised and supported by written clinical criteria and review procedures. Clinical criteria and review procedures shall be established with appropriate involvement from physicians.

A. Nurses, physicians and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting specialized reviews in their area of specialty shall be currently licensed or certified by an approved state licensing agency in the United States.

B. A physician shall review all cases in which the UR Organization has concluded that a determination not to certify for clinical reasons is appropriate. The physician should be reasonably available by telephone to discuss the determination with the attending physician.

C. UR Organizations shall utilize:

1. Written clinical criteria, as needed, for the purpose of determining the appropriateness of the certification; such criteria shall be periodically evaluated and updated.

2. Physician consultants, including, as needed and available, specialists who are board certified or board eligible and working towards certification in a specialty board approved by the American Board of Medical Specialists or the American Board of Osteopathy from the major areas of clinical services.

3. A formal program for orientation and training of UR staff.

4. Written documentation of an active Quality Assessment Program.

VIII. Accessibility and On-Site Review Procedures

A. Each UR Organization shall provide access to its review staff by a toll free or collect call phone line, at a minimum, from 9:00 am to 4:00 pm of each normal business day in the provider's local time zone in which the UR Organization routinely conducts review. Each UR Organization shall also have a mechanism to receive timely call-backs from providers and shall establish written procedures for receiving or redirecting after-hour calls, either in person or by recording.

B. Each UR Organization shall conduct its telephone reviews, on-site information gathering reviews, and hospital communications during hospitals' and physicians' reasonable and normal business hours, unless otherwise mutually agreed.

C. Each UR Organization's staff shall identify themselves by name and by the name of their organization and, for on-site reviews, shall carry picture identification and the UR Organization's company identification card. On-site reviews should, whenever possible, be scheduled at least 1 business day in advance with the appropriate hospital contact. If requested by a hospital or in-patient facility, UR Organizations should assure that their on-site review staff register with the appropriate contact person, if available, prior to requesting any clinical information or assistance from hospital-staff and shall wear appropriate hospital supplied identification tags while on the premises.

D. UR Organizations shall agree, if so requested, that the medical records remain available in designated areas during the on-site review and that reasonable hospital administrative procedures shall be followed by on-site review staff so as to not disrupt hospital operations or patient care. Such procedures, however, should not limit the ability of the UR Organizations to efficiently conduct the necessary review on behalf of the patient's health benefit plan.

E. UR Organizations should verbally inform, upon request, designated hospital personnel and/or the attending physician of the utilization review requirements of the specific health benefit plan and the general type of criteria used by the review agent. UR Organizations should also verbally inform, upon request, hospitals, physicians and other health care professionals of the operational procedures in order to facilitate the review process.[11]

IX. Accreditation Process

A. URAC will update policies and procedures for accrediting UR Organizations to assess compliance with these standards on an ongoing basis. An Application Form and a copy of these procedures will be made available to any UR Organization upon request.[12]

B. URAC has established policies and procedures for providing confirmation of accreditation status, upon request, to health care providers, state regulatory agencies and other appropriate parties.

C. Only those UR Organizations which have formally applied for and have received a current accreditation from URAC may make any claim to be accredited pursuant to these standards.

NOTES

1. Consideration should be given in the application of these standards to UR services in certain governmental programs such as Medicare, Medicaid and in Workers' Compensation and certain Automobile Medical Payment coverages. For example, in Workers' Compensation coverage, there is technically no enrollee, only a claimant. Under these coverages, the responsibility for obtaining certification is not usually the claimant's. The notification requirements, access to the claimant and appeal procedures may be governed by statute.

2. Retrospective review usually refers to a review of services provided or medical claims review performed after the discharge of the patient and/or after receiving the bill for payment.

   In situations where the enrollee or patient is unconscious or otherwise unable to provide notification, or where there was inadequate provider notification or response, review which should have been prospective might be conducted concurrently during treatment or retrospectively soon after treatment is completed. This delayed review usually follows the same general process as described for prospective and concurrent review in these Standards.

3. The timeliness of notification to a UR Organization of an admission or proposed admission is determined by the terms of the applicable health benefit plan.

   a. In general and in the absence of contractual agreements to the contrary, notification should be considered timely if made a minimum of three working days prior to admission for routine or elective admissions and within two working days after emergency admissions.

   b. In cases involving a second opinion, proper notification should be considered seven working days, unless otherwise provided for in the enrollee's health benefit plan.

   c. Hospitals and physicians should notify the UR Organization prior to actual admission, whenever possible, on cases where it is uncertain whether the admission would be defined as an emergency.

4. Hospitals and physicians are encouraged to assist in providing information to UR Organizations by telephone and otherwise. Health benefit plans and claim administrators are also encouraged to make information available to UR Organizations to facilitate enrollee identification. Review determinations by UR Organizations are based on the information provided. Health care providers and UR Organizations are encouraged to develop more efficient and cost effective forms of communicating the information in a timely and confidential fashion.

5. The information release forms signed by or on behalf of a patient at the time of treatment by hospital or physician should include language, as needed, to clarify that providers have the right to release information by telephone and in writing for utilization review purposes. Hospitals and physicians may reserve the right to discuss the release of sensitive information to a UR Organization with the patient.

6. In those health benefit plans where the enrollee or patient incurs no financial liability for failing to obtain certification, the UR Organization is not required to notify the enrollee or patient of their determination. Further, a UR Organization may eliminate certain determination notifications by mutual agreement.

7. Mail-in and telephonic certification programs for services which may be provided 30 or more days following the request for authorization (such as anticipated normal childbirth or certain elective surgeries) may be allowed reasonable latitude from the times for notification of certification otherwise required by the Standards.

8. In those health benefit plans where it is the responsibility of the enrollee or covered patient to appeal, UR Organizations should allow the attending physician to initiate an expedited appeal on behalf of a patient. In those health benefit plans which place responsibility for notification and appeal on the attending physician, UR Organizations should allow the attending physician to appeal directly on his or her own behalf. Hospitals, other health care providers or a representative of the enrollee or covered patient may assist in an appeal.

   It is important to emphasize that the decision as to what treatment to prescribe for an individual patient remains that of the physician and his or her patient or their representative. The final decision as to whether these prescribed treatments are a covered benefit is the responsibility of the claims administrator or health benefit plan.

9. Health benefit plans operating under ERISA and state law procedures are designed to give an enrollee a full and fair review after receiving an appeal on a claim denial notice. Health benefit plan enrollees (with or without the provider's assistance) who wish to appeal a claim denial, partial payment or pending claim may utilize that health benefit plan's appeal process. Likewise, claim administrators for health benefit plans have established mechanisms for provider appeals of denied or partially paid claims. In addition, health benefit plans may include specific requirements for compliance with UR rules. The application of those requirements and the charging of any penalty or disincentive is typically a function of the claims administrator and any appeal mechanism would be specified by the health benefit plan.

10. When consistent with applicable federal and state laws, patient specific data gathered by the UR Organization which raise questions of deficiencies in quality may be shared with the hospital's or outpatient surgical facility's Quality Assurance Committee. Prior to the sharing of such information, a UR Organization may require the hospital or outpatient surgical facility to assure due care in complying with confidentiality requirements, to assure the review and follow-up within that hospital's or outpatient facility's Quality Assurance Committee, and to indemnify the UR Organization from any inappropriate use of such information by the hospital or outpatient facility.

11. Health benefit plans and employers are encouraged to develop enrollee communications that provide information regarding UR requirements, benefits, obligations, penalties and sources for further information. UR Organizations are encouraged to take an active role in assisting health benefit plans in the development of enrollee communications and information that provides effective education of enrollees regarding the review requirements of their health benefit plan.

12. These standards are intended to encourage efficient and effective UR processes as well as to provide a basis for an accreditation process for UR Organizations. The terms "shall" and "should," as used in this document and as used as a measure of compliance within the accreditation process, have the following definitions:

"Shall" means that the UR Organization is required to carry out the action of the direction as stated.

"Should" means that while the UR Organization can be expected to carry out the action as stated, there may be reasons, based on the individual organization's circumstances, where the organization will not perform the direction. In those instances where the UR Organization does not presently carry out the stated action, the organization may choose to implement the direction as a future objective.

DEFINITIONS

For the purposes of this document, the following terms have the following definitions:

APPEAL: A formal request to reconsider a determination not to certify an admission, extension of stay or other health care service.

ATTENDING PHYSICIAN: The physician with primary responsibility for the care provided to a patient in a hospital or other health care facility.

CERTIFICATION: A determination by a utilization review organization that, an admission, extension of stay, or other health care service has been reviewed and based on the information provided, meets the medical review requirements of the applicable health benefit plan.

CLAIMS ADMINISTRATOR: Any entity that reviews and determines whether to pay claims to enrollees, physicians, hospitals or others on behalf of the health benefit plan. Such payment determinations are made on the basis of contract provisions. Claims administrators may be insurance companies, self-insured employers, third-party administrators or other private contractors.

CLAIMANT: The enrollee or covered person who files a claim for benefits.

CLINICAL CRITERIA: The written policies, decision rules, medical protocols, or guides used by the Utilization Review Organization to determine certification.

CONCURRENT REVIEW: Utilization review conducted during a patient's hospital stay or course of treatment, sometimes called Continued Stay Review.

DISCHARGE PLANNING: The process that assesses a patient's needs for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

ENROLLEE: The individual who has elected to contract for, or participate in, a health benefit plan for either him or herself and/or his or her dependents.

HEALTH BENEFIT PLAN: Any public or private organization's written plan that insures or pays for specific health care expenses on behalf of enrollees or covered persons.

PROSPECTIVE REVIEW: Utilization review conducted prior to a patient's hospital stay or course of treatment.

PROVIDER: A licensed health care facility, physician or other health care professional that delivers health care services.

QUALITY ASSESSMENT PROGRAM: A structured mechanism which, at a minimum, monitors and evaluates a UR Organization's program and provides management intervention, as needed, to support compliance with these standards.

RECONSIDERATION: An initial request by telephone for additional review of a UR organization's determination not to certify an admission, extension of stay, or other health care service. A reconsideration may be called an expedited appeal by some UR Organizations.

UTILIZATION REVIEW: Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

UTILIZATION REVIEW ORGANIZATION: An entity which conducts utilization review and determines certification of an admission, extension of stay or other health care service.

SB 239, relating to private health care review agents, was next to come before the committee members. CHAIRMAN STURGULEWSKI explained that what is being dealt with is a process that is being utilized more and more by insurance companies called utilization review. What that means is that the insurance companies get pre-approval of medical treatment for the insured. The legislation would require a utilization review board to obtain a license from the Department of Commerce and Economic Development. Under Title 8, it would require an applicant to submit an application with the utilization review plan that includes a number standards it sets out in the policies and procedures, qualifications of personnel employees, assurances that a determination of medical inappropriateness won't be rendered except in writing, and procedures to ensure confidentiality of confidential medical records. She explained that the committee was asked to introduce the legislation by those facilities that offer drug and alcohol treatment, and psychiatric and psychological counselling. Chairman Sturgulewski noted that there is also interest on the part of the medical community.

Number 189

The first person to speak on the measure was DR. HOWARD FAGIN, Health Care Consultant, Atlanta, Georgia. He informed committee members of his qualifications. Mr. Fagin said he supports SB 239 as it encourages greater coordination between payers and providers, protects the rights of patients, ensures private agents are qualified to perform utilization review, and ensures confidentiality of patient medical records. He explained that there have been some isolated instances where there were some unnecessary admissions, services preformed, and the length of stays have been longer than desired in hospitals. In some cases services were delivered in less than the most efficient setting. He noted these problems do not mean that all providers are unable or are unwilling to provide appropriate services. Providers do have an ultimate legal responsibility for patient care, Dr. Fagin noted. Reviewers of patient care may cause problems for patients since the primary motive for most utilization review firms is cost containment rather than patient care. Just as the IRS should not assume that all tax payers are criminals, utilization review firms should not assume all providers attempt to provide unnecessary services.

Dr. Fagin referred to the development of utilization review firms and said frustration has occurred by many U.S. corporations with respect to the cost of health care and their desire to have an active involvement. They are not concerned about just paying health insurance premiums, but are trying to reduce costs for their corporations. Private insurance companies are beginning to relax to this corporate pressure and the corporations are hiring the new utilization review firms to develop programs that review claims for payments. Dr. Fagin said there have been several positive results of the new firms such as health care cost reduction

in excess of the costs expended, decreases in hospital admissions for procedures that normally can be done on an outpatient basis, reduced lengths of stays for hospitalized cases, increased attention by providers to outcome analysis justifying inpatient care for certain types of patients where they are necessary, increased hospital cooperation with managed care firms, and desire to develop designated hospital staff contacts to facilitate the review process. Dr. Fagin said there have been many negative results from the implementation of utilization review: (A) There have been cases where reviewers demand hospital discharge of patients too early in the treatment process; (B) There have been cases where patients leave the hospital against medical advice, when a reviewer indicates treatment is not covered; (C) There have been cases where the reviewer, not the physician, makes the decision to admit the patients by pre-admission criteria; (D) There has been denial by reviewers of recommended ancillary health services or diagnostic evaluations for patients; (E) Cases when reviewers refuse to communicate with hospital utilization managers and page physicians to answer routine inquires; (F) Cases where reviewers (including nurses clerks, social workers or sometime computer answering devices) are evaluating medical cases without physicians involvement; (G) Cases where clinical reviewers lack experience in the field where reviewers are necessary; and (H) Cases where utilization management firms do not explain their criteria or apply criteria consistently.

Dr. Fagin said denial by physicians is essential if the utilization review firm is not going to approve a particular claim. Since the utilization firm is, in fact, setting itself up in the practice of medicine, it is only reasonable that the practice of medicine is left to physicians. Mr. Fagin continued discussing negative results regarding implementation of utilization review.

Number 302

Dr. Fagin explained that there are at least ten states that have enacted legislation relating to the practice of private utilization review agents. Prior to 1990, Maryland, Arkansas, Maine, and New Jersey had enacted legislation, and in 1990, Georgia, Florida, Mississippi, South Carolina, Virginia and Kentucky enacted legislation. He noted that legislation has been introduced in Missouri Kansas, Pennsylvania, Illinois, Texas Massachusetts and Alaska. Dr. Fagin referred to information in the committee member's packets and continue to discuss the characteristics of the legislation:

A. Companies conducting utilization review must obtain certification from either the State Department of Health or the Commissioner of Insurance.

B. Utilization review firms must submit information describing:

1. review criteria and procedures to be used in evaluating hospital and medical care;

2. the type and qualifications of personnel performing utilization review;

3. procedures and policies ensuring that a private review agent is "reasonably accessible" to patients and providers during normal business hours;

4. policies and procedures ensuring that applicable state and federal laws protecting confidentiality of individual medical records are followed; and

5. procedures by which insurers, patients or providers may seek reconsideration of adverse decisions.

C. Statements affirming availability of appropriate medical care providers when utilization review agent questions the medical necessity or appropriateness of care. The patient's attending physician or health care provider must be able to discuss the case with an identified health care provider trained in a related specialty.

Dr. Fagin explained that he has discussed SB 239 with Kathy Cronen, Administrator of Charter North Hospital. In response to a previous presentation by representative of AETNA, Ms. Cronen contacted representative at Human Affairs in Anchorage. Charter North hospital is concerned about the cost of health care, cost containment, and not unnecessarily increasing the costs to the patient. As a strong advocate of the bill, they are willing to discuss specific concerns about the legislation, versus general observations that may objectional to the organization. Dr. Fagin said Charter North is concerned that all involved understand the specific situations in Alaska including limited availability of resources as well as alternative delivery systems, and the great distances that many patients must travel to reach appropriate health providers.

CHAIRMAN STURGULEWSKI thanked Dr. Fagin for his testimony. She asked Ann Boudreaux to comment on the legislation.

ANN BOUDREAUX, Director, Division of Occupational Licensing, Department of Commerce and Economic Development, said the department agrees that there is probably a need to make sure that health care providers are not doing unnecessary procedures or are requiring a longer than necessary stay. She said a concern to her, as an individual, is if a patient is given more treatment than necessary. The department wants to make sure that the utilization review is acting in an appropriate manner. There have been complaints from state employees about delays in getting procedures approved and some rudeness when inquiring about care.

Ms. Boudreaux referred to the legislation and said a concern is that what is proposed seems to be more of a registration than a licensing. They are required to file a plan, but there are not enough specifics of following the details of that plan. It would appear that a lot of discretion is being given to the department to try and set some regulations. She said that is more than what the department wants to take on as they are not professional medical personnel.

Ms. Boudreaux referred to the legislation mentioning using a physician licensed in the state, and said she presumes that means the State of Alaska. She said the department agrees that licensed medical personnel should be used and said it may be too restrictive on the utilization review firm if it would have to be someone licensed in Alaska. Ms. Boudreaux said the language says "physician or nurse," and the department thinks that it may be more appropriate to say, "the appropriate health care practitioner" since often it could be chiropractor, naturalpath, physical therapist, etc. She referred to page 4, lines 27 through 30, which speaks to revocation of licenses, that after the word "revoke" add "," and add wording for either suspension or placing on probation of the license. She referred to page 5, lines 13 through 15, which says "the department fails to render a

decision on a complaint brought by a patient or provider within ninety days, the patient or provider shall have the right to bring suit in Superior Court to compel the department to take an action specified in this section," and said the department would have to hire an investigator that did nothing but utilization care review. Presently, there are seven investigators for all the license categories. She noted that investigations are not always complete within ninety days. Currently, there would be difficulty in meeting that requirement. Ms. Boudreaux said the department supports the intention to have some measure of control over the utilization review firms, but would request that they be compelled to be more specific in their plan.

CHAIRMAN STURGULEWSKI asked Ms. Boudreaux to submit her concerns in writing.

Number 427

HAWLEY FOUSE, Vice President, AETNA Life Insurance Company, discussed his qualifications as a board certified physician who practices actively in different parts of the country. He said he has been a consultant in cost containment and utilization management for about thirteen years. Mr. Fouse said he joined AETNA in 1987, to direct the activity of the company's physician and dental staff, to oversee the training of nurse reviewers, and to set general clinical policy regarding utilization review programs. He spoke to the goals of clinical utilization review. Utilization review required as much flexibility in its administrative and clinical applications as does the provisions of medical services. Mr. Fouse referred to the utilization review

legislation, if it is necessary at all, requires a balanced cooperation between providers and utilization review companies. That balance is missing in SB 239. The performance of certain types of procedures can vary from region to region within a single state. He asked if practices which are more scientifically sound, efficient, and provides optable outcomes for patients could be identified. There are considerable risks to unnecessary and inappropriate care. There are risks of health care systems causing infections, hemorrhage, adverse medication reactions, etc. More services does not mean quality care. Utilization review asks physicians to carefully examine their practices and to break out of the mold of practicing medicine as to what it does solely to their training and other aspects of their experiences that may have occurred, for example, twenty years prior.

Mr. Fouse said utilization review asks doctors to perform a careful analysis of the standard way they treat patients and it encourages them to consider alternatives which they may not be familiar with, but it may be just as effective in allowing a patient to achieve an optable outcome. He continued to discuss his views and the benefits regarding utilization review. Mr. Fouse said while the legislation requires utilization review licensure, the legislation should also include some protections for utilization review activities performed by licensed utilization review companies such as providers must be available to discuss cases with utilization review agents and provide needed information within reasonable periods of time upon initial contact by the utilization agent. He said he believes SB 239 moves in the opposite direction. Providers should ensure that whenever they go on vacation or off duty, they have other knowledgeable physicians who will cooperate with the utilization review process.

Mr. Fouse said hospitals and other inpatient facilities need to allow on-site concurrent review by qualified utilization review personnel. For the State of Alaska, on-site review has saved 11.8 percent of medical submitted expenses from December, 1988, through November, 1990.

Another concern, Mr. Fouse continued, is that providing false or misleading information to a utilization review agent should be defined as fraudulent, in appropriate Alaska statutes, with the same penalties as any other prosecution for fraud. He indicated he would submit a written statement to elaborate on his testimony.

CHAIRMAN STURGULEWSKI announced the legislation would be scheduled again at a later date.