

How IROs Keep Healthcare Costs Down—and Patients Get the Right Care

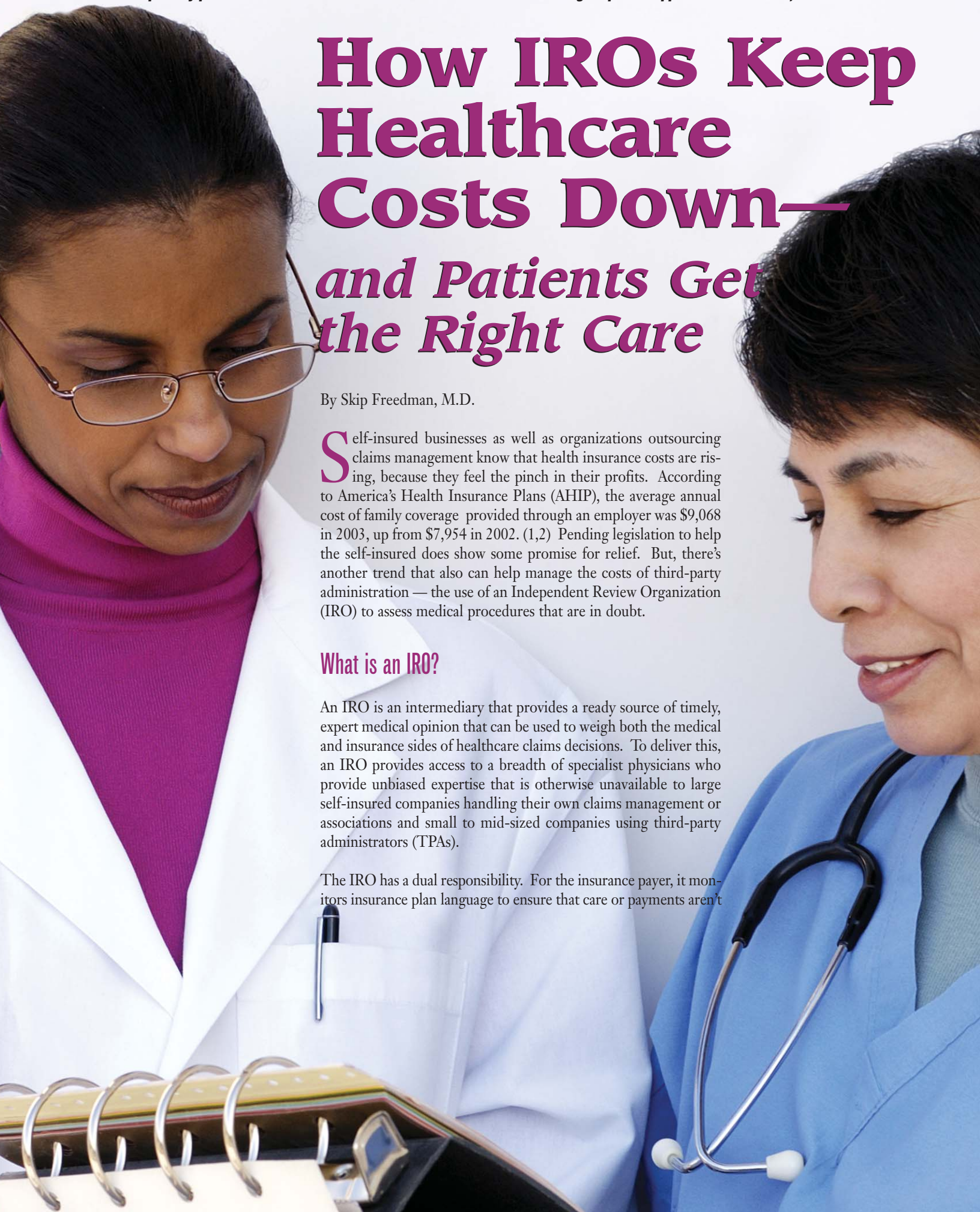
By Skip Freedman, M.D.

Self-insured businesses as well as organizations outsourcing claims management know that health insurance costs are rising, because they feel the pinch in their profits. According to America's Health Insurance Plans (AHIP), the average annual cost of family coverage provided through an employer was \$9,068 in 2003, up from \$7,954 in 2002. (1,2) Pending legislation to help the self-insured does show some promise for relief. But, there's another trend that also can help manage the costs of third-party administration — the use of an Independent Review Organization (IRO) to assess medical procedures that are in doubt.

What is an IRO?

An IRO is an intermediary that provides a ready source of timely, expert medical opinion that can be used to weigh both the medical and insurance sides of healthcare claims decisions. To deliver this, an IRO provides access to a breadth of specialist physicians who provide unbiased expertise that is otherwise unavailable to large self-insured companies handling their own claims management or associations and small to mid-sized companies using third-party administrators (TPAs).

The IRO has a dual responsibility. For the insurance payer, it monitors insurance plan language to ensure that care or payments aren't



being approved for treatments that are uncovered, unnecessary or medically unproven. For patients, it ensures that questionable cases and appeals receive objective reviews as mandated by state and federal regulations and that they receive the medical care directed by their health-care insurance.

As a mediator between patients and health insurance plan administrators, the IRO has access to a wide variety of specialized physicians on the frontlines of healthcare who have experience with the toughest cases. These experts can often better determine the medical necessity of a procedure than the patient's physician or the case administrator. Frequently, IROs help expand health coverage for procedures that were once not even considered medically necessary and, therefore, were not being covered by health insurance claims. For example, surgery for obesity (bariatric surgery) was once considered solely cosmetic. Today, physicians and insurers both acknowledge that obesity does threaten patients' health, shorten their lifespan and carry severe health consequences, such as high blood pressure and heart problems. So, under certain conditions, the surgery represents an appropriate treatment.

IROs Decide Based on Medical Fact

Medicine is a fast changing field. New medical techniques evolve. Costs rise. Treatments are increasingly complex. And patients are tuned into this. The widespread availability of medical information available to healthcare consumers makes basing decisions on medical fact increasingly important. Patients' growing awareness of emerging treatments and procedures creates an atmosphere where medical decisions are more likely to be questioned. Basing a review on medical evidence makes it understandable to the patient and legally defensible, should that ever be required. Making sound decisions that are good for business and good for the patient remains the primary goal. Creating the definitive

review isn't just the goal of an IRO. The TPA can assist in achieving this goal by making sure the IRO has all the medical information required to make a sound decision. To product a better outcome for all parties, the TPA can provide the reviewing physician with as much clinical information as possible for a medical review. This comprehensive information increases the efficiency of the physician reviewing a case because he can get a complete picture of the patient's condition to make a fair evaluation.

When to Use an IRO

Companies that want to do what is best for their employees, whether they are large self-insurer or small to mid-sized companies using third-party administrators can turn to IROs whenever they need to tap into deeper medical expertise for an objective approval or denial of a claim based on medical fact, not anecdotal evidence. Information and scientific advancements in the medical field are increasing at unprecedented rates. Medical disciplines fragment into new specialties every year. Then those spe-

How to Select an IRO

When monitoring cases, claims managers must work closely with physicians on a regular, even daily, basis. Selecting an Independent Review Organization (IRO) means finding a trusted partner that can expand and streamline your business.

To assure the right fit, it's important to select an IRO that can meet your expectations in three areas — medical, business and relationship. If you are considering working with an IRO, here are a few of things you should find out:

Medical

- Does the organization have deep medical knowledge or access to it?
- What range of medical specialist does the review organization offer?
- Do they base all their reviews on accepted and up-to-date medical practice?
- Is the IRO, or its ruling physician, willing to get on the phone with another physician (or even the patient) and explain or even defend their review?
- Does the IRO serve as an advocate for all parties — healthcare provider as well as patient?

Business

- What's the cost of the review service?
- How well does the IRO understand the third party administration process?
- How does the IRO manage their review process internally?
- What's the IRO's knowledge of state and federal government requirements?
- What type of relationships do they have with other healthcare providers and insurers?
- What's the IRO's process when a review is challenged?

Relationship

- Is the IRO easy to work with?
- Is the IRO friendly and responsive?
- Are the reviewing physicians available to you for questions?
- What sort of normal case turnaround times can you expect?
- What sort of expedited turnaround times can you expect?
- Can the organization meet mandated deadlines, and what sort of proof can they offer?
- How do its current customers feel about working with them?

cializations fragment again. There is simply too much medical information for one physician to keep up on. This means medical directors and claims managers need access to outside medical knowledge beyond their expertise. Because of the depth of expertise in its specialist network, and the volume and breadth of claims it reviews on a daily basis, an IRO provides a mechanism for quickly and consistently applying expert knowledge to claims decisions.

Patients today are more demanding. They are more aware of their rights. The Internet provides them useful information about medical practices, as well as sometimes misleading information. As a result, patients may not understand the difference between “accepted medical practice” and “experimental medical practice.” Yet even when armed with this knowledge, they may not fully comprehend what’s covered and not covered by their insurance plans or how their new information fits with their health plan.

Unfortunately, knowing about new medical procedures doesn’t make them accepted practice. This means the self-insurer or TPA claims managers need to be prepared for appeals by laymen armed with information about new drugs, treatments, procedures and equipment. Using an IRO can help provide a timely and clear understanding of how patients’ claims fit or don’t fit into the healthcare insurance plan.

There is increasing pressure on payers and plan administrators to not only make the right decision for the patient but also reduce healthcare insurance costs, premiums and co-payments. Using an IRO is a low-cost way of making sure that a health plan is administered properly for both the company and the patient. An IRO acts as an unbiased advocate for managing healthcare costs, while ensuring that each claimant is properly served, every time.

Growing Case Loads

Today claims managers must handle higher case volumes, deal with more

diverse cases, meet tight, mandated deadlines and keep pace with the evolving nature of accepted medical treatments. An aging baby boomer population only assures the volume and diversity of cases will continue to grow.

The types of cases typically sent out by claims managers for external review cover a wide range — surgeries that appear to be cosmetic; continuous or over use of intravenous therapy for Lyme disease; orthognathic surgery (misaligned jaw); bariatric surgery; eyelid surgery (blepharoplasty); plantar fasciitis; experimental cancer treatments and even organ transplants. These types of treatments increasingly put administrators in situations that make claims management more complex.

Let’s take one example. Last year almost 250,000 people in the United States underwent blepharoplasty (eyelid surgery). Aging causes the thin skin around the eyes to lose its elasticity and the eyelids begin to sag. Because of its impact on personal appearance, blepharoplasty is fast becoming one of the most sought-after plastic surgery procedures for patients over the age of 35. (It’s also largely a hereditary condition — if your siblings and parents have saggy eyelids, you probably will too.) Because of its increased demand, when reviewing a case calling for eyelid surgery, an administrator normally assumes that the procedure is being performed for cosmetic reasons. Unless cosmetic surgery is covered in the plan, the administrator correctly rejects the treatment.

However, what might be missed by the claims administrator is the fact that given specific vision conditions, blepharoplasty is medically necessary. Upper eye lid surgery might be a solution when the excess skin covers the eyelid margin or deflects the eyelashes downward impairing a patient’s eyesight. If there’s a doubt whether the surgery is cosmetic or medically necessary, the administrator should consider working with an IRO to secure a ruling based on medical fact.

To determine medical need, the claims administrator could request that the

patient take good, high-resolution photographs of the eye region. If the upper eyelid margin of the eye crosses the plain of pupil in the photo, then further testing should be done. The administrator might then suggest that an ophthalmologist run a visual field mapping test on the patient. When tested, if the patient’s visual interference with upper case letters is at 20 percent above horizon, and if taping the patient’s eyelids back improves the vision 20 degrees above the horizon, this strongly indicates that upper eyelid surgery is a medical necessity to reduce impaired vision.

How IROs Reduce Healthcare Costs

Today the types of medical tests, equipment and diagnostic tools available are increasing rapidly and are easier to access and conduct. There are always more innovative medicines, devices, procedures and treatments. Medical specialties once in contiguous fields are now adjacent specialties separated by a chasm of knowledge. As medical information grows more rapidly, there’s an ever-widening rift between specialties and narrower and narrower specialties result. As treatment costs, complexity and medical specialization increase, these factors may force claims managers to error on the side of paying unnecessary or questionable claims because they lack access to right medical expertise for making informed decisions within an acceptable timeframe. In such cases, outsourcing medical decision to an IRO can eliminate unnecessary treatments and have a dramatic impact on lowering healthcare claims costs. For example, rather than relying on a pharmaceutical representative’s interpretation of the drug facts, an IRO can consider what’s the accepted medical practice regarding both drugs, as well as the efficacy based upon medical facts. By evaluating the data, an IRO can objectively decide whether or not a patient really needs the new drug costing \$85 a week, when the \$4 a week drug will produce the same results. This level of analysis can result in healthcare cost sav-

ings and can benefit an insurer's entire subscriber base by efficiently allocating healthcare dollars only to those patients who truly need and deserve them.

Benefits of Using IROs

There are several reasons for self-insurer and TPA case managers to consider working with an IRO. IROs reduce unnecessary claims payouts. In 2000, the most recent data available, 51 percent of the cases decided by independent medical review upheld the health plan decision. (3) Anecdotal comments suggest slightly levels of upholding health plan decisions in the 60 percent range and above. Given either, companies that are processing and automatically paying all of their medical claims are missing a key opportunity to control the escalation of their healthcare costs.

In many cases, outsourcing selected medical decision making to an IRO can have a dramatic impact on lowering healthcare claims costs by eliminating unnecessary treatments: One TPA saved \$17 for every one dollar it spent on reviews and saved in excess of one million dollars in less than two years. Reasons like this that make using an IRO is not only cost justifiable, but also a best practice.

Claims managers may also want to meet or exceed organizationally mandated healthcare standards or to improve the turn-around times for claims reviews for improving internal quality goals for auditing purposes. Not only does an IRO provide timely review of all cases that meet federal and state statutory guidelines, it provides documentation that it can become included in the patient's record.

The adaptability and flexibility of an IRO enables claims managers to improve their review process, gain access to specialists and make it easier to meet required state and federal response times, weed out bogus claims and get reduced healthcare costs in the long run, by basing decisions on medical fact.



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References

(1) Rising Health Care Costs
<http://www.ahip.org/content/default.aspx?bc=3913411327>

The average annual cost of family coverage, when provided through an employer, was \$9,068 in 2003.

(2) Health Insurance Association of America Issue Brief: Why Do Health Insurance Premiums Rise, September 2002

<http://www.ahip.org/content/default.aspx?bc=391341132716170>

The average annual cost of family coverage, when provided through an employer, was \$7,954 in 2002.

(3) Independent Medical Review of Health Plan Coverage Decisions: Empowering Consumers with Solutions

<http://www.ahip.org/content/default.aspx?bc=3818212246>

In 2000, 51% of cases decided by independent medical review upheld the health plan decision...