

Sorting Out the Patient Care Puzzle

The Role of IROs and Medical Management Companies

■ Why Independent Medical Reviews?

Most private or public health insurers paying for patient care require some form of independent medical review to decide the need and appropriateness of a proposed medical treatment. To protect consumers, most states and many federal regulatory agencies require it. How these reviews are administered affects nearly every person enrolled in a private or government funded healthcare plan. Typically, payers and doctors call them utilization reviews or utilization management reviews.

Although the two terms are often used interchangeably by administrators and doctors, utilization review is the older term and has broader meaning than utilization management. It's a more generic phrase that encompasses utilization management. Government and state insurance commissions use the phrase utilization review to create consumer healthcare protection. Legal decisions on patient care cite utilization review and not utilization management.

To sort out the confusion, let's clearly define the two ideas and then apply them to medical management and utilization management firms, as well as independent review organizations (IROs).



■ Defining the Terms

Utilization review. This term has two uses, one abstract and the other backward looking. Its abstract meaning appears in consumer protection language crafted by legislators or regulatory organizations. This offers generic and broad guidelines and allows wiggle room for future interpretation. For example, a regulation may state that utilization review is required for consumer protection and offer case review deadlines, but not state what the process is, leaving health insurance carriers to decide. One carrier may use an internal process to decide whether the health care services and procedures being sought are suitable and call this utilization review. Another may call it a pre-authorization review, which technically falls under utilization management.

The second meaning is backward looking and clearer, because it describes a retrospective review of medical cases. The Utilization Review Accreditation Commission (URAC), a nonprofit organization promoting healthcare quality by accrediting healthcare organizations and promoting best practices, says utilization review portrays the appraisal of cases after healthcare services are conducted. Peer review and case audits are other examples of this. Also, some Medicare work is after the fact and may be called utilization review.

Utilization management. The need to pre-authorize and concurrently review cases shifted the notion of utilization review toward utilization management. Today utilization management is a specific phrase used within the healthcare industry. It refers to some form of medical review performed to validate the appropriateness of proposed medical care. Used this way, it has a narrower meaning than utilization review. Utilization management stresses forward-looking, concurrent case review, such as pre-authorization for treatment. URAC defines utilization management as: "the evaluation of the medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures and facilities under the provisions of the applicable health benefits plan."

Utilization management describes proactive processes — discharge planning, concurrent planning, pre-certification and clinical case appeals. It can also cover proactive procedures, such as peer reviews and concurrent clinical reviews, even reactive appeals introduced by the health insurer or patient.

While their meanings overlap, the two terms are not synonyms. In short, utilization management has a narrower meaning having to do with pre-authorization of a treatment and it falls conceptually under the broader concept of utilization review.

■ **Medical Management Firms**

According to URAC, medical management refers to a broad array of practices, such as utilization management, case management and disease management, used to provide oversight for medical practice. It describes the services that a medical management company may offer. But these companies can also offer medical practices and hospitals an array of administrative services from recruiting, records management, billing, case management as well as other process-oriented functions including business process, financial analysis and risk management. Like IROs, medical management firms may also help health insurers navigate the labyrinth of federal and state regulations while applying the insurer's policy requirements. In addition, they may offer pre-authorization reviews of patient treatment or peer reviews to assure patient safety.

The fact that some insurance companies own medical management companies and provide both utilization review and management services, only increases the confusion of the terms. Often the mix of services falls under the banner of offering customers full service or increasing the internal efficiency of the company's business processes. But in these organizations, efficiency and ethics can conflict.

While an internal case management review group may be efficient for approving patient treatments, refuting patient claims becomes thorny. Denying a claim can be seen as supporting the profit motive of the company rather than a patient's treatment, which raises a conflict of interest question. This puts the health insurer and medical management company in the position where they might be limiting access to treatment and opening ethical and moral issues that may lead to litigation.

While it's legal for an insurer to own a utilization management company and to run a utilization review arm, the firm must not place itself in a sticky ethical situation about patient care. To be independent, its personnel pre-authorizing treatment should look at no cases coming out of the parent company, for to do so poses a conflict of interest. This is especially true of rejected cases.

■ **IROs, Intermediaries for Patients and Payers**

The grassroots patients' rights movement suggests patients have the right to a doctor's review of their case before a denial of care. And not just any doctor. It has empowered patients with the right to have care reviewed by a doctor holding the same specialty as the doctor who has given the care. Also, it has provided the right to a review by a doctor who is not in the employ of the healthcare provider, insurer or payer. Only separate third-party utilization reviewers, like independent review organizations (IROs), provide that unbiased evaluation of medical need.

IROs are an intermediary for patients to exercise their right of appeal. Doctors employed by an IRO are independent of the patient, the payer, the insurer as well as the treatment, drug or process and anything else that could represent a conflict of interest for either the insurance payer or the patient.

As an intermediary, using an IRO assures that a patient's treatment claim is fairly reviewed. Most IROs work with a vast array of board certified, specialist doctors who review the case based on the current standard of care and medical science. As part of the checks and balances of the healthcare business, doctors working with an IRO are detached from anything that might cloud their objective review of a case which reduces conflict of interest questions.

State and federal regulators set up differing responsibilities for healthcare organizations to meet, such as timing, formats for reporting, who needs to be notified and what needs to be reported. All meet the declared standard, yet each has different requirements. This creates a jumble of differing utilization review requirements that health organizations working in several states must understand and meet.

Because each state and federal agency defines the utilization review "rules" differently, an IRO can help insurers and payers meet these sometimes confusing requirements, including differing regulatory review deadlines. The IRO also

reviews each patient's case in terms of the health insurer's policy coverage and the regulatory requirements set forth by federal and state agencies.

Utilization management, utilization review, medical management and IRO businesses all play overlapping roles in today's healthcare review puzzle. They offer different forms of case review to help health insurers provide appropriate care to patients enrolled in their programs. In cases where there are questions of conflict of interest or special medical knowledge arise, a disinterested third party, like an IRO, is detached from the economic, contractual and personal entanglements that can taint a patient's rejected treatment. Because of this, IROs are free to provide objective, medically justifiable reasons for accepting or rejecting patient treatment without raising conflict of interest issues.

■ A Few Commonly Asked Questions

The following questions have come up during discussions with doctors, health insurers and medical management organizations over the years. They can help clarify the overlapping roles among IROs and medical management and utilization management companies.

What's the difference between an IRO and a medical management firm such as a utilization management or utilization review company?

- Denials are usually the result of these companies applying their internal guidelines and plan language to the patient's case. As a disinterested third party, the IRO applies specific, objective medical expertise to the decision by a utilization management or review firm before denying a patient treatment.

When does a payer or self-insured company need utilization review, and when do they need an IRO?

- Think of utilization management companies as the spokes of a bicycle wheel. These companies apply rigid guidelines to case management to direct and manage patient care. Questions arise because often the utilization management or review firms do not have access to the specialist expertise needed to provide a medically defensible answer for the patient. Or the utilization management or review firm has a potential conflict of interest and their decisions appear to be limiting patient care. By using independent doctors to provide the medical answers that are specific to cases, an IRO fills in the spaces between the spokes.

When should a utilization management company use an IRO, as opposed to its own medical director or internally formed panel?

- Unfortunately no individual can cover the gamut of growing medical knowledge and emerging specialties today. Even the best medical director can know only a portion of it. An IRO provides access to this breadth of medical knowledge and can tap into emerging specialties.
- A utilization management company needs to decide what business it is in. It needs to ensure that its enrollees get access to the medical care they need based on assessments by same specialty doctors who are actively treating similar patients. Conversely, it needs to ensure that enrollees don't get treatments they don't need. To do this, it must understand how "independent" or "objective" its reviewers are—or not—on any particular case. As a disinterested participant, the IRO provides objective and medically defensible reasons for rejecting cases.
- Internally formed panels are not set up to perform as efficiently as an IRO. Typically internal panels suffer from three potential deficiencies:
 - Potential conflicts of interest because of economic, competitive and contractual issues or because of relationships with the patient or referring doctor.
 - Lack of sufficient specialists to offer a defensible medical necessity response.
 - Cases often pile up, hampering the internal panel's ability to meet strict, mandated deadlines, because panel members view their primary job as patient care, not case review.
 - Without an ongoing recruiting and credentialing effort, internal panels often are not kept up to date with changing standards of care, and with emerging specialties and subspecialties.
 - Because of the volumes of cases they review, IROs have highly optimized workflows that deliver medical decisions at a lower cost than most internal panels can provide.

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How do UM firms and IROs overlap?

- Often times, insurers have cases that are handled by a utilization management firm who in turn consults with an IRO. The payer may also have cases that go directly to the IRO. Today, most utilization management firms have an ongoing relationship with an IRO, and regularly send cases out for review by the IRO where specialist knowledge is required.

What are the criteria for selecting an IRO?

- The most important consideration is easy access to the doctors, depth and breadth of the IROs peer specialists, including multiple doctors in all specialties. Second is looking beyond the doctor's declared credentials. Third is the IROs quality management system and turnaround time. Look for comparable experience in community tertiary hospital and academic environments that match the practice where the patient's care is being given. An IRO should be able to provide both.

About AllMed Healthcare Management, Inc.

Founded in 1995, AllMed is a URAC-accredited Independent Review Organization (IRO) serving insurance payers, medical management firms, TPAs and claims managers nationwide. Reviews are conducted by board-certified physicians in active practice. AllMed's growing client base includes premier organizations, such as American Health Holding, IMS Managed Care, HealthNet, Tenet Healthcare, HCA, several Blue Cross Blue Shield organizations, TriWest Healthcare Alliance, Allianz and many other leading healthcare payers.

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