Private Utilization Review

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I. INTRODUCTION

To cope with rising health insurance premiums of the last decade, employers, local and national business coalitions, and private insurance carriers have undertaken serious efforts to more effectively manage the costs of providing health care coverage for their employees. A principle component of such cost management strategies is hospital utilization review (UR).

UR is a process undertaken by employers and insurers to monitor effective use of health care by requiring third-party evaluation of the need for medical treatment. The underlying belief of UR is that health care costs can be controlled, in part, by decreasing or eliminating unnecessary care.¹ Although a precise definition of unnecessary care is elusive,² such care generally includes those services that are in excess of the needs of the patient.

Some studies have shown that unnecessary care occurs frequently and absorbs excessive funds.³ In identifying the

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² See discussion infra notes 62-74.

³ A variety of studies have shown that between 10 and 20 percent of hospital admissions and 20-30 percent of hospital days are inappropriate or unnecessary. See, e.g., Milstein, Oehm & Alpert, Utilization Review Performance: Skepticism About Some Review Programs Spawns Use of Medical Audits, BUS. AND HEALTH, Feb., 1987,
sources of unnecessary care so as to prevent excessive spending, UR studies have targeted hospital use. Hospital use has been the most closely studied aspect of the health care system mainly because hospitals provide the highest cost services and hospitals are fewer in number than physicians or other health care providers. Therefore, while there are some UR programs that focus on managing the use of outpatient services, UR has typically focused on controlling the unnecessary use of hospitals.

Today, UR is the most widely used approach in controlling or eliminating overuse of hospital services. According to a 1990 survey of 776 of the largest employers in the United States, 74 percent use UR as part of a health care cost management strategy. A similar survey in 1985 showed only 47 percent had implemented UR. According to the Health Insurance Association of America, about half of all United States businesses use some form of UR.

Employers (large and small) are the primary purchasers of private UR services. They purchase services from firms which only offer UR services or from insurers which offer either their own UR services or contract for UR services from free-standing vendors. Most national insurance carriers offer UR services in conjunction with claims administration services. UR services are integrated into a variety of health plan designs, including indemnity plans, preferred provider organizations (PPOs) and health maintenance organizations.

at 10; Restuccia & Gertman, A Comparative Analysis of Appropriateness of Hospital Use, HEALTH AFFAIRS, Summer 1984, at 130; Siu & Sonnenberg, Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans, 315 NEW ENG. J. OF MED. 1259 (1986).

4. See supra note 3.

5. The highest cost services include intensive care, premature infant care, and significant surgeries such as coronary artery bypass graft.

6. Provider is used in this Article as a generic term which includes any person or institution which gives medical services. Providers typically are physicians and hospitals.

7. Programs focused on outpatient services are less common and well-developed and will not be addressed in this paper. Some UR firms perform review of selected outpatient procedures, and some national carriers evaluate patterns of care through their claims data systems. Ambulatory utilization review efforts are primarily associated with Health Maintenance Organizations (HMOs).


9. Id.

10. See Marcinko & Foster, Mixed Reviews—More Scrutiny for UR, MHCI & T 14 (Fall 1990).
Despite the tremendous increases in health care costs and the resulting growth of UR, there is disagreement about the effectiveness of UR in controlling health care costs. There are two general views on the value and effectiveness of private UR programs. The first view is that UR is a positive factor in the health care system, but it has some problems which can be resolved to improve the process. The second view is that, while theoretically UR is positive, its implementation is an unnecessary administrative burden on the health care system and an intrusion into the practice of medicine. The view taken largely depends on the specific types of programs one has experienced, and, because programs vary widely, both views are valid.

This Article describes the history of private UR and provides illustrations of successes, problems and controversies. The Article concludes with some suggestions and prescriptive advice for those who are likely to encounter UR, either through work with particular clients or directly as part of a private benefit plan.

II. BACKGROUND ON PUBLIC AND PRIVATE UR

Historically, in both the public and private sectors, third party payors (e.g., the government and employer-sponsored insurance plans) paid providers on a percentage of charges or fee-for-service basis. As long as services were "covered," the third party would pay, and the third party payor required little information from the provider beyond a diagnosis and the total charges. In typical employer plans, insurance covered 80 or 90 percent of charges and the employee paid the remainder sub-

11. There are three major generic types of health plan designs. All three have many different variations in practice. In indemnity plans, insured persons have free choice of physician and hospital, and the insurance carrier pays the provider directly. The amount of payment (e.g., 80 percent) and any deductibles are administered by the insurance carrier. In a preferred provider organization, an insurance carrier or employer contracts with a network of specific hospitals and physicians. Employees choosing a provider from this network receive a higher benefit. The network providers may be paid on a fee-for-service or per member per month (capitation) basis. In a health maintenance organization, specific physician and hospitals are paid on a capitation basis, and employees are offered incentives such as lower monthly health care payments, no deductibles, etc., for participation.

12. Covered services are generally defined in the basic health plan. Most plans, for example, exclude cosmetic and experimental treatments from coverage. Most plans cover services which are medically necessary for the treatment of illness or injury. Most plans also provide that services must be ordered by a physician.
ject to deductibles and annual out-of-pocket expense limits. Providers, primarily physicians, controlled both the volume and price of services rendered. Third party payor questions were generally limited to coverage issues, deductibles, and pre-existing conditions.

A. Public Sector Utilization Review

The earliest attempts to control escalating health care costs in the 1970s began in the public sector, and specifically in the Medicare program. With Medicare, the responsibility for performing UR was vested with hospitals and insurance carriers participating in the Medicare program. Such efforts largely failed to control costs because the hospitals and physicians had no real incentive to provide fewer services. Further, the insurance carriers monitored the hospital performance at infrequent intervals.

Drawing largely on the experience of medical care foundations, in 1972, the Professional Standards Review Program (PSRO) was implemented. PSROs were federally-funded private, non-profit corporations formed by state and local groups of practicing physicians following requirements laid out by law. PSROs were charged with assuring that the services provided under the Medicaid, Medicare, and Maternal and Child Health Programs were medically necessary, met professionally recognized standards of care, and were provided in the most appropriate setting.


14. Id. Arguably, in fact, hospitals and physicians had incentive to increase the amount of services provided to maximize their own revenues. Early private sector efforts showed greater promise for controlling costs than the previous public efforts. Medical care foundations developed various techniques, including review of planned hospital admissions in advance, which seemed to show more promise than traditional internal hospital review. Medical Care foundations are privately organized groups of physicians who perform UR and claims administration services. See also Department of Health, Education and Welfare, Social Security Administration, Office of Program Policy and Planning, Office of Research and Statistics, An Evaluation of a Medicare Concurrent Utilization Review Project: The Sacramento Certified Hospital Admission Program, Health Insurance Statistics, (March 17, 1978).

15. Id.

16. Yale University Study Group, Prepared for the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign
PSROs were fully implemented in most states by the end of the 1970s.\textsuperscript{17} Despite some successes,\textsuperscript{18} variations in local PSRO performance, continued increases in public sector costs, and the development of new Medicare payment policies, led to the replacement of the PSRO program with the current Peer Review Organization (PRO) program. The PRO program is designed to monitor quality and costs under Medicare's Prospective Payment System (PPS).\textsuperscript{19}

In contrast to PRO review, PSRO review programs were applied prior to or concurrently with the delivery of services. Under the Medicare PPS, PRO review is designed to be applied primarily after services are delivered and after payment has been made. With the change in the public sector focus of review (from prospective to retrospective), employers found PROs somewhat less attractive. This conflict in review approach coupled with the increasing private demand for UR led to the development of the many private review programs which exist today.

\textit{B. Development of Private Utilization Review}

As public UR spread, and controls were tightened on public programs such as Medicare and Medicaid, providers shifted more costs to private insurance plans which were largely uncontrolled. As a result, by the late 1980s, when the national health care bill was almost 12 percent of the Gross National Product,\textsuperscript{20} the private sector was financing nearly 60 percent of

\textit{COMMERCe, BACKGROUND REPORT ON PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS. H.R. Doc. 3, 95th Cong., 1st Sess. (1977).}

\textsuperscript{17} In fact, in the late 1970's and early 1980's, employers began to look to PSROs to provide services in the private sector. Rulifson, \textit{Deere and Company Battle Costs Through Peer Review}, 1 THE INTERNIST, 25, January, 1984, at 25.


\textsuperscript{19} The Medicare Prospective Payment System (PPS) replaced the previous cost-based hospital reimbursement with the development of an estimated cost per case. Using historical Medicare cost data from hundreds of hospitals, complex computer algorithms which categorize cases into different diagnosis-related groupings (DRGs) were developed. In general, regardless of the length of stay, the hospital would be paid the same rate for a particular type of case. Very high-cost or long-stay cases can qualify for additional reimbursement. See U.S. DEP'T OF HEALTH & HUMAN SERVICES, Hospital Prospective Payment for Medicare: Report to Congress 7-18 (Dec. 1982) (reprinted in \textit{MEDICARE AND MEDICAID GUIDE} (CCH), Ed. 374 (Jan. 5, 1983).

these enormous health care expenditures.\textsuperscript{21}

This cost shifting from public to private payers intensified the pressure on employers. Although consistent national data are not readily available, a few employers have published reports on their specific increasing health care costs. Two companies which have published such reports are Deere and Company and Chrysler Corporation.\textsuperscript{22} Between 1972 and 1977, the direct costs of providing health care benefits to Deere and Company's 200,000 employees, dependents, and retirees rose 300 percent, from $20 million to $60 million annually.\textsuperscript{23} By 1983, health care expenditures accounted for 11 percent of Deere and Company's total direct labor costs for production.\textsuperscript{24} Similarly, in 1988, Chrysler reported a 14 percent increase in health care costs, more than triple the consumer price index.\textsuperscript{25}

Because of rapidly rising health care costs, health benefit plans have become very valuable in attracting employees and in negotiating collective bargaining agreements. As such, employers faced with rising health care costs began to look for ways to reduce costs without cutting back overall benefit levels. One way to achieve these apparently contradictory goals appeared to be by eliminating unnecessary hospital use.

Estimates of unnecessary hospital use indicate that between 10 and 20 percent of hospital admissions and between 20 to 30 percent of hospital days are not medically necessary.\textsuperscript{26} Independent evaluations performed on behalf of individual employers revealed that between 10 and 47 percent of all hospital days were not medically necessary.\textsuperscript{27} Thus, elimination of unnecessary hospital use has the potential of reducing overall benefit plan costs without requiring the employer to make major alterations in the overall benefit plan design or delivery system.\textsuperscript{28}

\textsuperscript{22} See infra notes 23-25.
\textsuperscript{24} Id.
\textsuperscript{25} Califano, Billions Blown on Health, N.Y. Times, April 12, 1989, at A25, col. 3.
\textsuperscript{26} Restuccia & Getman, supra note 3, at 130, 132, 134.
\textsuperscript{27} Milstein, Oehm & Alpert, supra note 3, at 10.
\textsuperscript{28} Controlling unnecessary use is the principal focus of UR, but it is only one element in many companies' cost containment strategies. Increased deductibles and co-payments, revised benefit limits, point of service plans, and alternative delivery systems such as preferred provider organizations and health maintenance organizations are frequently used in conjunction with UR.
Some private sector efforts have been quite successful. One comprehensive study found that private UR reduced hospital admissions by 13 percent, total days by 11 percent, and total medical expenditures by 6 percent. Additionally, high yield comprehensive medical cost containment programs have resulted in 15 to 30 percent savings in medical costs. Such programs have substantial promise for achieving the elusive goals of controlling health care costs without compromising the quality of care provided to patients.

III. THE STRUCTURE OF PRIVATE UTILIZATION REVIEW

With the increasing demand for UR services, the number of firms has grown and, although there is no complete directory, there are more than 200 firms operating today. While these UR firms share generic goals and processes, actual implementation of UR programs varies.

The most typical private UR programs are telephone-based. In these programs, providers or employees (patients) call a toll-free telephone number to notify the UR firm of expected treatment. Some plans have employee penalties (e.g. an increased co-payment or flat fee) for failure to notify the review system. In nearly all programs, the penalty is waived if the patient attempted but was unable to notify the review system. In other programs, notification is voluntary.

Once the call is made, one or more specific review processes is applied. The review of hospital services generally occurs in three stages: prior to admission (preadmission review) for scheduled surgeries; at or immediately after admission for emergency admissions (admission or concurrent review); and during a hospital stay (continued stay or concurrent review). As part of or as an add-on to these three basic services, most UR firms offer surgical necessity screening (often associated with second opinions), discharge planning,

31. Id. UR firms compete heavily for lucrative private accounts which generate charges of $20 to $36 per covered employee per year.
32. For most employers, basic UR requirements and relevant toll-free numbers are contained on the employee insurance identification cards.
33. Each specific UR service is designed to control a different aspect of hospital use. Most UR firms use the same labels to market their services.
and high cost case management. Some firms offer review services after discharge.\textsuperscript{34}

\textbf{A. Preadmission Review\textsuperscript{35}}

Preadmission Review applies to planned admissions, usually surgeries. Its goal is to assure that a particular patient is not hospitalized for a specific procedure that could be performed outside the hospital for a lower cost and at a lower risk to the patient. All UR firms look at the appropriateness of site of care during the preadmission review process. Once the hospital is approved as the most appropriate site of care, many firms will establish a projected length of stay and will include an assessment of the need for any in-hospital days prior to surgery (pre-operative nights).

Most UR firms will discuss these recommendations with the attending physician and rely on the physician to communicate with the patient. However, it is not clear how regularly and clearly physicians discuss outpatient options or length of stay with patients. To the extent attending physicians (or a UR firm) talk to patients about length of stay, patients can be influenced to more willingly forego the pre-operative night and accept an ambulatory surgery or a much shorter hospital stay.\textsuperscript{36} Instead of relying solely on physicians informing patients, a few UR firms actively seek to discuss coverage options and general length of stay information with patients. Those firms that do discuss coverage options tend to have better patient response and greater savings than those that do not.

Another feature of the preadmission review process is determining the necessity of a surgical procedure. In some UR programs this review is automatic; in others, surgical necessity review is a separate program requiring separate telephone calls.

\textsuperscript{34} Review services provided after discharge are not within the typical scope of service routinely offered by UR firms. Another nontypical UR service that some firms offer is a hospital bill audit service. In bill audit programs, the UR firm obtains a copy of the hospital medical record and compares the individual services rendered with the billed services. Frequently, bill audits are applied only to cases in which prospective or concurrent review was not applied. Because bill audits and retrospective review services are not typical private review services, they are not addressed in detail in this Article.

\textsuperscript{35} Preadmission review is also known as pre-certification, prior authorization, preadmission certification, and pre-determination.

Programs reviewing the need for surgery vary widely. Some employers have lists of operative procedures which require a second opinion prior to approval of the procedure. If the patient does not obtain a second opinion, the patient cannot receive maximum benefit coverage. High cost or frequently-performed elective procedures are normally on these lists.

In other plans, a wide variety of therapeutic and diagnostic procedures are screened by the UR program to determine the need for surgery. These programs may require substantial clinical information, may engage in detailed interviews with patients, and may apply relatively sophisticated computer algorithms before requiring a second opinion.

The original goal of second-opinion programs was to reduce unnecessary surgery and thereby reduce health care costs. The most effective programs are those that use a selected panel of second-opinion consultants, do thorough patient histories, and consult the physicians. In addition, these second-opinion programs provide a means of educating the patient about the benefits and risks of surgery.

B. Admission Review

Admission review applies to urgent or emergency admissions which are essentially unplanned. The goals at this stage are to verify the medical necessity for admission and assign an initial length of stay, usually within 24 to 72 hours following

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37. See supra note 1.
38. The longest running second-opinion program in the United States is the Cornell-New York Hospital program. Findings from this program showed that 18 percent of those required to seek a second opinion were not confirmed for surgery. See McCarthy, Second Opinion Elective Surgery at 155 (1981). The reported successes from this program resulted in replication of programs around the country. Unfortunately, the replications have had less success than the Cornell program.
39. Admission Review is also known as concurrent admission review, emergency admission certification, or with continued stay review as concurrent review.
hospital admission. Some programs verify the actual urgent or emergent nature of admission to determine if the case should have been subject to preadmission review. If preadmission review was in order, a late notification penalty may be applied. Finally, the admitting offices of most hospitals understand third party review and, thus, hospital admitting office personnel will often notify UR firms of urgent and emergency admissions.

C. Continued Stay Review

The goal of Continued Stay Review is to assure the patient is hospitalized only as long as necessary. To accomplish this, following a preadmission or admission review, most UR firms will contact the hospital and/or physician at specific checkpoints during a hospital stay.

D. Discharge Planning

The goal Discharge Planning is to actively facilitate discharge by identifying and arranging any needed alternatives to hospital care which could shorten the length of stay. Although most firms "advertise" this service, in many cases the planning function consists of a referral to a hospital social service or discharge planning department. Some UR firms actively assist patients and physicians with short term arrangements (e.g. home care, durable medical equipment) to facilitate early discharge.

E. Case Management

An increasing number of UR firms are offering specialized management services for patients with various high-cost problems of a catastrophic or chronic nature. These patients include individuals with AIDS, spinal cord or brain injuries, stroke, and premature infants.

In typical programs, UR firms employ case managers, usually nurses, many with specialized experience and expertise in the clinical management of high-cost cases. The goal of high-cost case management is essentially to coordinate and organize

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40. Continued Stay Review is also known as length of stay review and concurrent review.

41. Using diagnosis-specific and length of stay screens or by direct referral from general review staff, case managers evaluate each case for potential management based on an overall assessment of the patient's medical and social requirements. In many
health care resources to most efficiently address the medical and psychosocial needs of patients and families. For such high-cost cases, the UR firm may authorize benefits for services which are not normally covered or may help extend the use of lifetime benefits by developing unique plans such as modifying a patient’s home to accommodate a wheelchair.

In most firms, each stage of review is carried out by nurses making calls to hospitals or physician’s offices to collect clinical data. After clinical data are obtained, nurses screen the need for hospital care using screening criteria adopted or established by the firm. Cases failing to meet the criteria parameters are generally referred to a physician for evaluation. These physician evaluations may result in a contact with the patient’s treating physician.

Some plans have penalties which are imposed on patients or hospitals for failure to follow the UR recommendations. In some plans, there is no coverage after a negative UR determination. In others, there may be a benefit reduction (e.g. 70 percent coverage instead of 90 percent). All programs have appeal provisions for persons dissatisfied with a review decision.

Overall, there is some degree of uniformity between UR programs. Nonetheless, there are substantial differences as well. Because private UR is regulated in only a few states, and, until late in 1990, there were no voluntary guidelines, there is little consistency in UR program implementation.

IV. Formal Solutions to Utilization Review Problems

Because the number of UR firms has markedly increased over the last 5 years, there are more UR firms requesting more information concerning the care of patients. As a result, physicians’ offices and hospitals are becoming increasingly resistant to the volume of requests and vastly different information requirements of various UR programs. The resistance and con-

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43. Two criteria sets have the most widespread use in the United States today. The first is the ISD Review System criteria, revised to become the ISD-A Review System criteria published by InterQual. The second criteria set is the Appropriateness Evaluation Protocol (AEP), developed by Paul Gertman and Joseph Restuccia. Many UR firms have developed their own criteria, incorporating decision-tree logic into computerized programs which nurses can apply.
cerns of providers and employees have been formally and informally transmitted to various national health organizations and to federal and state governments.

In response to these increasing concerns, the National Academy of Science's Institute of Medicine (IOM) formed a committee to study third party payers' utilization strategies in 1987 and 1988. The committee was charged with providing an overall picture of private UR, an analysis of the effects on various participants in the process, a framework for questions raised by UR in its current applications, and recommendations for future action. The IOM report concluded that, while national regulation of the UR industry was not warranted at the time, greater accountability on the part of UR firms was needed. Specifically, the committee recommended that UR firms provide (and purchasers demand and provide to employees) information in the following areas: 1) Source of screening criteria; 2) Availability criteria to providers; 3) Source of physician reviewers; 4) Qualifications of nurse reviewers; 5) Appeals/grievance mechanisms.

In response to the IOM recommendations, five national healthcare trade associations the American Hospital Association (AHA), the American Medical Association (AMA), the Health Insurance Association of America (HIAA), Blue Cross and Blue Shield Association (BCA) and the American Managed Care Review Association (AMCRA), issued voluntary guidelines in September 1990 to promote the consistency and uniformity of UR procedures. At the same time, the AMCRA formed the Utilization Review Accreditation Com-

45. Id.
46. Id.
47. AMCRA is the trade association supported and paid for by UR firms. AHA is the national trade association for hospitals; AMA is the national trade association for physicians; HIAA is the national trade association for private insurance companies; BCA is the national trade association for Blue Cross and Blue Shield plans. These trade associations have no authority over members. Compliance with professional standards as defined by the organization is voluntary. The trade associations came together largely because of concerns raised by their respective members about private UR and the wide variability of UR implementation.
mission (URAC). URAC is a separate, free-standing organization created to form common national standards and a voluntary accreditation process for UR organizations.

The voluntary guidelines issued by the five national healthcare organizations are intended to form the basis for URAC’s work in establishing accreditation standards and, in part, are based on the IOM’s recommendations. As of now, no formal accreditation surveys have been completed. However, most UR firms are apparently aware of the voluntary guidelines and indicate they plan to follow them.

The voluntary guidelines address the following areas:

1. **Physician involvement and access to physician reviewers.** The guidelines specifically recommend physician involvement in establishing medical protocols, review processes, and physician reviewer availability to discuss medical rationales for review decisions.

2. **Medical criteria.** Professionally accepted criteria should be used for review, and criteria should be updated regularly. Review organizations should inform physicians and hospitals, upon request, about their program requirements and the general type of criteria used.

3. **Frequency of concurrent review and provider contacts.** The guidelines recommend focused reviews, discourage daily reviews on all patients, and encourage notification of the provider if medical treatment is not supported.

4. **General contact procedures.** Review organizations should make available general contact procedures for questions and specific appeals procedures.

5. **Patient confidentiality.** Review organizations should

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49. URAC was incorporated in 1990 in the District of Columbia as a non-profit organization. Articles of incorporation and bylaws were adopted and an interim board and four standing committees were established. URAC was formed by AMCRA and is intended to be a voluntary accreditation body. At this writing, no accreditation surveys have yet been undertaken.

AMCRA has provided the financial and staff support for URAC’s first year. Support in subsequent years is intended to come from payments from organizations who pay for voluntary accreditation surveys. Memo from Roger Taylor, M.D., President, Utilization Review Accreditation Commission to Utilization Review Organizations (Sept. 27, 1990) (copy on file with the University of Puget Sound Law Review).

50. The IOM study was federally funded by the National Academy of Sciences in Washington D.C., and the committee was comprised of invited “volunteers” who are experienced in UR or related fields. The report was issued for information only; IOM has no authority over any UR firm.
have procedures in place to protect patient confidentiality.\textsuperscript{51}

In addition to recommendations concerning the actual conduct of review, the guidelines include recommendations concerning administrative procedures. These administrative procedures encourage UR firms to be sensitive to operational demands on hospital and physician time, recommending that firms accept call-backs, collect only the information required to make a review decision, and attempt to consolidate calls to the same providers.\textsuperscript{52} Likewise, the guidelines also encourage hospitals and physicians to cooperate with UR efforts. They recommend that employees be fully informed of plan requirements governing UR and that information release forms be available to permit the exchange of information with UR firms.\textsuperscript{53}

For at least seven states these voluntary efforts have come too late. Largely in response to pressure from state medical and hospital associations,\textsuperscript{54} the members of which are resistant to UR, seven states have enacted laws governing private UR.\textsuperscript{55} In general, these state regulatory efforts generally parallel the recommendations in the IOM report.\textsuperscript{56}

The principal problem with most of the state laws is that the states do not enforce implementation. Although those states that have passed specific implementation regulations do have application materials and fees, UR firms report they send

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\textsuperscript{51} See IOM Report, \textit{supra} note 44.
\textsuperscript{52} Id.
\textsuperscript{53} Id.
\textsuperscript{54} All states have trade associations of physicians and hospitals. These associations have varying amounts of political power and influence on state and local government. In the author's opinion, based on her experience and work with more than 100 UR offices around the country, physicians in the South are particularly resistant to cooperating with UR.
\textsuperscript{56} The following summary of state laws was prepared by the law firm of Altheimer \& Gray in Chicago for use by health benefits consultants. Maryland enacted the earliest law (effective in December, 1988, and modified in July 1990) governing private UR. MD. HEALTH-GEN. CODE ANN. \textsection 19.1301-.1313 (1990). Maryland law requires certification by the Maryland Secretary of Health and Mental Hygiene
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before conducting UR. *Id.* at § 19.1303. It also requires that case involving alcoholism, drug abuse, or mental illness by reviewed by specialists. *Id.* at § 19.1305.1.

Maryland requires the following information on the application:

1. An outline of the UR plan, including a description of review standards and procedures and provisions for appeals;
2. The types and qualifications of the personnel employed or under contract to perform UR;
3. Procedures to ensure a UR representative is accessible 5 days a week during normal business hours;
4. Policies and procedures to ensure the confidentiality of medical records;
5. Copies of material informing patients and providers of the UR requirements;
6. A list of the third party payors for which the organization performs UR. *Id.* at § 19.1305.


Effective in July 1989, Maine’s law is similar but requires more detail on the types of programs offered and the timing of notices to providers and patients differs. Maine also provides that the Superintendent of Insurance may conduct periodic reviews to ensure compliance and may conduct telephone audits to ensure access. *Me. Rev. Stat. Ann.* tit. 24 § 2342-45 (1989).

In Kentucky, effective January 1, 1991, certain firms must register with the Kentucky Cabinet for Human Resources before conducting UR. Kentucky requirements are similar except that 1) toll-free telephones are required; 2) UR plans must list circumstances where UR may be delegated to a hospital; 3) UR plans must specify how the firm will notify patients and providers when payment is denied; 4) specialists must be available; and 5) UR plans must specify time requirements for notice and appeals. *Ky. Rev. Stat. Ann.* § 211.461-.466 (1990).

Although similar to Arkansas law, the Mississippi statute, which became effective July 1, 1990, contains a significant provision: written certification by a licensed physician that the patient was in immediate need of hospital care should be forwarded to the insurer within 72 hours of admission. *Miss. Code Ann.* § 41-83-21 (1990). This creates a prima facie case of the medical necessity of admission. *Id.* This provision essentially prevents any UR firm from making a binding decision on medical necessity and could provide a significant barrier to effective UR in Mississippi. The statute also provides that a patient’s physician can require the evaluation and concurrence of a relevant specialists or sub-specialist before an adverse UR decision is made. *Id.* at § 48-83-31(b). Mississippi requires certification by the State Department of Health.

Effective January 31, 1990, South Carolina requires UR agents to be registered and regulated by the South Carolina Chief Insurance Commissioner. *S.C. Code Ann.* § 38-70-20(A) Law Co-op. 1976 (Supp. 1990). The statute is similar to the Arkansas law but requires notification to the insured of an adverse UR decision within 5 business days and permits the Commissioner to conduct periodic reviews to ensure compliance and to conduct telephone audits to ensure accessibility. *Id.* § 38-70-20(c)(1).

Virginia’s statute is similar to Arkansas law. Sections 38.2-5300 through 38.2-5309 of the Code of Virginia, effective July 1, 1990.

Florida has proposed an extremely restrictive bill which is expected to be effective in October 1991. Among the more restrictive provisions are the requirements that there be procedures and policies to ensure accessibility of a UR representative 40 hours a week and that the UR firm provide proof of a sufficient amount of professional liability insurance. *Fla. Stat. Ann.* § 395.0172(5)(d) (West 1991). Other provisions include a requirement that any determination that care is medically inappropriate includes the written evaluation findings of the reviewing physician, *id.* § 395.0172(5)(b)2, and requires the UR firm to disclose any incentive compensation
in the application and fee and hear nothing more.\textsuperscript{57} Given the lack of active state efforts to implement their UR laws, it is likely that the voluntary accreditation efforts will be more effective at addressing and resolving some of the common problems with UR implementation.

V. PROBLEMS IMPLEMENTING UTILIZATION REVIEW

The voluntary guidelines and most state laws are intended to address variations in UR program implementation which create problems for employers, patients, physicians, and hospitals. Some of these problems are unique to the areas in which specific firms are located. However, there are problems and concerns which are common to many, if not most, UR firms. These problems include inaccessibility, variations in medical criteria, too few physician reviewers, unqualified staff and untimely reviews.\textsuperscript{58} Each of these problems impinges on the effectiveness of UR and prevents UR from gaining widespread cooperation by providers and acceptance by employers.

\textsuperscript{57} Based on conversations with more than 100 UR firms, it is the opinion of the author that there is a lack of strong implementation of state laws. Some UR firms are unaware of the states which have enacted such laws and therefore do not comply with the state's specific laws. Other firms have tried to apply for certification but have not received responses or have been told the certification process has not yet been implemented. Furthermore, it is not clear how any of the states actually evaluate or use what they receive.

\textsuperscript{58} The problems and issues discussed herein are based on the author's direct experience in performing on site program assessments at more than 100 UR offices across the country between 1985 and the current date. These evaluations have been conducted on behalf of employers, insurance companies, governments, and the UR firms themselves by the Medical Audit Services unit of William M. Mercer, Inc., an international employee benefits consulting firm. A team comprised of an individual experienced in the operations of UR systems and a physician experienced in the clinical application of efficient standards of care visit the UR office to evaluate the program operations. These on-site assessments are usually preceded by an off-site analysis of the UR programs operational materials. The team focuses on key aspects of the program including the clinical appropriateness of criteria and their application, qualifications and numbers of staff (including physicians), timeliness of review, telephone access, system efficiency, and responsiveness to patients and providers. These assessments are conducted under a variety of confidentiality arrangements and, therefore, specific organizations cannot be referenced.
A. Clients Lack Access to Utilization Review Firms

Lack of access is one of the major problems with UR program implementation. This problem results from three types of situations: inadequate hours, inadequate numbers of staff members, and inadequate telephone service. Often, all three are related.

Inadequate hours are caused when national UR firms staff their offices only during business hours in their own local time zone. In this situation, a firm located on the East coast may work from 7 a.m. to 5 p.m. Eastern time, leaving West Coast providers and patients with access between 4 a.m. and 2 p.m. Pacific time. This means that out-of-area providers have fewer hours to make contact with the UR firm during the business day. These providers are probably less likely to make contact.

Since physicians who are willing to return calls to UR firms generally do so at the end of their business day, UR firms which do not offer extended hours are inaccessible to these callers. Even though most firms have answering machines for after hours calls, many still request call-backs during normal business hours, and they do not provide a message service.

Even in those situations where a client attempts to call back within the UR firms’ hours, the client may be unable to get through. In some cases, a review of telephone monitoring reports has validated many complaints by clients. These reports show abandoned call rates in excess of 10 percent with an average abandonment time of over one minute. Such a showing indicates that people were at least calling and waiting on hold and not just hanging up immediately.

A client who does manage to call within the firm’s business hours and who does get his or her call answered may still be unable to speak with a reviewer. The client may be put on hold for long periods of time or told to call back because of the unavailability of staff. Since UR is labor intensive and nurses are expensive and in short supply, some firms are thinly staffed. Nurse staffing ratios vary dramatically, partially as

59. A UR firm has many “clients” who may lack access to it, including employees, patients, physicians, and hospitals in addition to the specific employer or insurer with whom the UR firm has a contract.

60. Since some employers impose penalties (e.g. a cash penalty such as $250 or a reduction in benefits such as from 90 percent to 70 percent coverage) for failure to notify, the ability to get through to register the case can be critical.
the result of technological support available in the organization and partly as the result of cost. Staffing ranges from one nurse for every 8000 covered lives to one nurse for more than 50,000 covered lives. When staffing is thin, nurses cannot respond to all the calls received. This can result in "telephone tag" which frustrates UR staff members as well as patients and providers.

Nurse staffing is particularly critical to the effective review of emergency admissions because, frequently, admitting office staff will have record of only the patient's diagnosis and possibly a patient procedure that is being done, but the staff will have no clinical information. Since many emergency admissions are for symptoms such as chest pain or abdominal pain, there is not a great deal of clinical data immediately available to the UR program. Because the attending physician may not have seen the patient yet, and key lab results may not be available, the physician will have little information. Consequently, UR firms frequently rely on hospital UR departments for clinical data.

Although practices vary, many large hospitals and many smaller hospitals have UR departments or staff people who work with external UR firms to provide clinical information. A few hospitals simply refuse to cooperate, referring the UR caller to the physician or patient. Even though most hospitals cooperate, they express concerns about the level of detail required by some UR firms. Hospital UR staff are sometimes frustrated by providing a lot of information and then not receiving any assistance from the UR firm when they want to check on review status.

Because emergency admissions are difficult to review and often require daily follow-up, many UR firms essentially do not try to review them. A few firms simply approve up to three days, no questions asked. Others try to review them ret-

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61. See supra note 57.
62. "Telephone tag" can result in substantial confusion about what, if anything, has been completed by the review firm. For example, a patient, thinking his or her admission has been approved, may go to the hospital only to be told the review decision has not been received. While there are no written industry standards for staffing or telephone access, the most sophisticated telephone systems permit a UR firm to monitor its service levels by evaluating average speed of answer, abandoned call rates, average time to abandon, average hold time, and average talk time. Most firms have target service levels and many used automated attendants to help guide callers to the proper department. Common access targets include abandoned call rates of less than 5% and average speed of answer within 30 seconds to one minute.
rospectively, requesting data from physicians' offices and hospital medical records departments.

The smaller the UR staff, the less likely these cases will be reviewed in a timely fashion, resulting in unreasonably late requests for clinical information. If these cases are not reviewed at all but just "automatically" approved, providers begin to simply ignore the system, and UR effectiveness suffers. Despite hospital and physician complaints about requests for information about current patients, most believe that influencing hospital use is a legitimate UR goal and they are more likely to cooperate for current patients. Most are not likely to cooperate with requests for clinical information about discharged patients. Providers view these requests as simply "job justification" for incompetent review firms.

Until and unless review programs operate 24 hours per day, seven days per week, medically unnecessary emergency admissions will not be totally eliminated. Although very few programs offer extended hours, more programs are offering patient help-lines, one or two of which offer extended hours for patients and providers. Thus, in most programs, the review goal is not to deny or divert the admission but rather to assure the length of stay is only as long as is needed to adequately diagnose and resolve the problem.

B. Effective Medical Criteria are Difficult to Implement

A major contributing factor to overuse of hospital services is the variation in local and regional patterns of practice that is unrelated to the health status of the local population.63 It is clear that hospital use varies widely across the United States. Although there are no complete national comparative statistics on hospital use in the private sector, in its 1989 Annual Report, Mutual of Omaha reported a national average of 461 days of care per 1,000 people. By state, the same figure varied from a low of 261 to a high of 695.64 This wide variation in clinical

63. Blumberg, Regional Differences in Hospital Use Standardized by Reported Mortality, 20 MED. CARE, 931 (Sept. 1982).

64. For example, based on clinical research during the early 1980s, patients undergoing a simple cholecystectomy (removal of gallbladder) without complications can be safely discharged on the third postoperative day, resulting in a total length of stay of 2 days. Hall, supra note 36. Yet in 1988, for patients of ages 20 to 49, the national average length of stay was 4.5 days. "Length of Stay by Diagnosis and Operation, United States, 1988," Healthcare Knowledge Systems, Ann Arbor Michigan, October, 1989.

In the western United States, the length of stay for a standard cholecystectomy is
practices may create problems for UR firms as they attempt to implement criteria that will eliminate unnecessary care.

The criteria a UR firm uses are important because the criteria in large part determine overall effectiveness in curbing unnecessary hospital use.\textsuperscript{65} Theoretically, the more comprehensive and rigorous the criteria, the more unnecessary care will be eliminated and hence the lower the costs of care.\textsuperscript{67}

Problems may arise, however, when a UR firm uses criteria that differ from the predominate practice in an area. In such an instance, physicians may be uncooperative.\textsuperscript{68} As a result, employers and employees may experience confusion approaching two days. In other parts of the country, the stay remains at four or more days. Mutual of Omaha Companies, Annual Report on \textit{Current Trends in Health Care Costs and Utilization} (1989).

\textsuperscript{65} See \textit{supra} note 42.

\textsuperscript{66} Ware, \textit{Comparison of Health Outcomes at a Health Maintenance Organization with those of Fee-For-Service Care}, \textit{THE LANCET}, May 3, 1986 at 1017.

According to Rand Corporation’s Health Insurance Experiment, the HMO reduced expenditures by about 25 percent, principally through a 40 percent reduction in hospital care without a reduction in the quality of care provided. In this study, 1,673 individuals living in Seattle, Washington in 1976 were randomly assigned to an HMO (The Group Health Cooperative of Puget Sound or to one of eleven insurance plans in the fee for service system (FFS)). These patients were studied over 3 to 5 years. This study found that

"health outcomes in the two systems of care differed for high and low income individuals who began the study with health problems. For the high income initially sick group, the HMO produced significant improvements in cholesterol levels and in general health ratings compared with free FFS care. The low income initially sick group assigned to the HMO reported significantly more bed-days per year due to poor health and more serious symptoms than those assigned free FFS care, and a greater risk of dying by comparison with pay FFS plans.

\textit{Manning, A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services}, 316 \textit{NEW ENG. J. OF MED.} 1505 (1984).

\textsuperscript{67} The more rigorous the UR firm’s criteria, the more clinical detail they require for evaluation. Some firms address only the site of care (hospital or ambulatory) during the preadmission review process and do not address the need for surgery. Weak criteria permit a patient to be hospitalized for a procedure that could be safely performed outside the hospital. For example, cataract surgery is routinely performed on an ambulatory basis in all parts of the country. However, practice patterns vary with tonsillectomy, hernia repair, myelogram and cardiac catheterization. Although these procedures are performed safely and routinely in an ambulatory setting in many areas, providers in other areas simply will not perform certain procedures on an ambulatory basis.

For procedures always requiring an inpatient stay (e.g. coronary artery bypass grafts), most UR firms will authorize a specific number of hospital days, usually until the next review date.

\textsuperscript{68} The criteria used by a UR firm create most of the major controversies and fuel much of the provider resistance to UR. The more rigorous the UR criteria, the fewer the days assigned on initial review. To influence hospital use, the most effective UR
because they are caught between their physicians' advice and the UR firms' recommendations.

In response to the dilemma of attempting to implement effective criteria in the face of varying physician practices, UR firms adopt very different criteria. Some firms deliberately sacrifice maximum effectiveness for local provider acceptance. These firms use criteria which accommodate the widest possible variation of practice. Other firms adopt rigorous criteria and apply them rigidly, engendering numerous complaints from providers, patients, and employers. The firms most successful in balancing a high level of effectiveness with high provider acceptance use rigorous criteria applied in a consultative way. That is, they work to educate the patients and providers, "bending" the criteria when locally appropriate. This way, requires setting an initial stay (or review date) at the patient's earliest possible discharge date.

Many UR firms use national averages to set initial stays. While more acceptable to providers, such programs primarily focus on long stay cases rather than on attempting to influence the overall average pattern of use. Thus, "savings" in these programs may be limited.

Physicians may or may not discuss expected lengths of stay or ambulatory surgery options with patients, and patients may not ask the questions. Many UR firms do not talk to patients at all and instead rely on physicians to communicate UR recommendations. In fact, some firms consider patient calls "junk" calls.

69. Some UR firms have developed and adopted proprietary medical criteria which are derived from the clinical literature and are modeled on effective HMO standards of hospital use. HMO standards generally are that any services that can be provided outside the hospital setting will be provided in that alternate setting. Organizations applying the HMO approach to an indemnity fee-for-service plan may apply criteria rigidly, issuing denials of coverage when criteria are not met. Other firms will screen based on HMO-type criteria but will accommodate and verify the lack of local services such as rehabilitation or nursing home care.

Many firms use national criteria sets such as the InterQual Intensity of Service, Severity of Illness, Discharge Screens Appropriateness (ISD-A) criteria or the Appropriateness Evaluation Protocol (AEP). See discussion supra note 43. In 1978, using the AMA criteria, PSRO and Medicare data, and updated clinical literature, InterQual published its "Intensification Criteria for Concurrent Review." These criteria were intended to be more specifically tailored for easy review of hospitalized patients. InterQual regularly updates its criteria based on the clinical literature and technological and organizational changes in the health care system.

In 1984, Restuccia & Gertmann, supra note 3, developed the Appropriateness Evaluation Protocol (AEP) which provided some generic (i.e., not as diagnosis specific as AMA criteria or as body-system specific as InterQual) to identify inappropriate hospital days.

More recently, some organizations have developed proprietary screening criteria which include the concept of efficiency of use—i.e., not only are the services required by the patient's condition, but are also provided in the most efficient, least costly setting consistent with high quality of patient care. These criteria essentially reflect very broad patterns of practice and accommodate a wide variety of practice styles.

UR firms using HMO-type criteria seek to change "average" practice patterns.
the UR firms are able to encourage providers to give less unnecessary care.

Eliminating unnecessary care is possible for many providers. For example, in the West, the length of stay (reflecting local practice) for an uncomplicated normal vaginal delivery is approaching one day post-delivery. In the East and South, three day post-delivery stays are not uncommon and the average length of stay over two days. Another example of local practice variation is preoperative hospital admission. For most planned surgeries, patients can be safely prepared on an outpatient basis and admitted the day of surgery. Even so, there are still areas of the country where pre-operative nights are the normal pattern of practice.

In light of these examples, it appears as though clinical criteria would be relatively straightforward and easy to enforce. However, there are a number of problems. One principal problem is physician resistance to the application of criteria that the individual physician may perceive as unacceptable. The criteria may be unacceptable to a physician because the criteria are different from the way he or she has always practiced. Also, the physician may disagree with the clinical literature on which the criteria are based.

Another problem is that patients and physicians alike may perceive more care as better care. In other words, the more time in the hospital, the better the care. In reality, however, more is not always better when it comes to hospitals. Hospitals are not necessarily conducive to speedy recoveries. They are noisy, the food is often poor, and there are risks of acquiring a hospital-based infection or receiving the wrong medication.

Despite the evidence that hospitals are not always best for the quickest recoveries, many physicians continue to recom-

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70. All of the states with UR regulations are in the East and South. These areas have had some of the highest levels of hospital use in the country. See Healthcare Knowledge Systems, supra note 64.

71. Such variations are fairly consistent across the full range of diagnoses and procedures. See supra note 66.

72. Clinical criteria are theoretically based on the biology of patients (e.g. a woman delivering a baby on the East coast is not biologically different from a woman on the West coast), clinical studies or practice consensus. However, there are legitimate clinical disagreements. One study of six medical and surgical procedures, found an 11-29 percent disagreement among physicians on the indications for the particular procedures. Park, Physician Ratings of Appropriate Indications for Six Medical and Surgical Procedures, 76 AM. J. PUB. HEALTH 766, 769 (1986).
mend hospital stays which are too long in comparison to lengths of stay common elsewhere. Since many patients continue to regard physician advice as absolute, patients may not willingly accept a shorter hospitalization. Dealing with these perceptions is perhaps UR's biggest challenge. Those firms which are most successful in attaining maximum impact with minimum provider or patient dissatisfaction engage in extended discussions with both physicians and patients, seeking to identify acceptable compromises. This approach requires good access and a high level of staffing.

The failure of a UR firm with rigorous criteria to actively engage in discussions with physicians and patients leads these same physicians and patients to perceive that benefits are being taken away. In these programs, a patient may end up in the middle of a disagreement between the UR firm and attending physician. At other times, the patient may not be aware of the problem until he or she is notified that the services have not been approved. Either way, these situations result in negative UR experiences for the patient and the provider. To address these problems, employers often request that the UR firm waive the criteria and approve the services. Then, not only is there the cost of unnecessary care but there is also the cost of "wasted" UR services.

Clearly, perceptions of patients, physicians and employers on the necessity for hospital services are important. A major function for UR firms could be to soften and change these perceptions. However, this is not seen as a high priority by many firms.


74. Some UR firms use rigorous criteria but do not engage in active discussions with providers and patients to explain the rationale and benefits of the criteria. Rigorous criteria mindlessly applied results in substantial hostility. Ironically, those firms with weaker criteria which simply collect information to support common practices are viewed as unnecessary burdens on the health care system. Thus, programs adopting common practice criteria may find lack of provider cooperation because they essentially "don't do anything."

75. Based on the author's experience, many UR firms do not view themselves as having "educational" responsibilities. They narrowly define their roles to applying a set of clinical criteria to the medical information collected on a case. Some do not talk to patients or physicians. The less effective programs approve everything and are viewed by providers as ineffective. Other ineffective programs issue many denials which are subsequently approved on appeal and these programs are viewed as harassment.

The most effective programs use rigorous criteria as discussion points with providers and patients and they issue few denials or straight approvals. Rather, they
Some have suggested that the use of second opinions would eliminate much unnecessary care by decreasing unnecessary surgeries. However, requiring a second opinion is not necessarily a solution to curbing unnecessary surgery for several reasons. Primarily, the physician providing the second opinion may practice in the same region as the primary physician, and, therefore, may act in accord with the same regional practices. Furthermore, in rural areas, there may be only one or two physicians in a particular specialty; providing second opinions for each other can be a major source of revenue. At the same time, UR becomes a joke and is viewed as a costly administrative layer in the health care system.

Some UR firm staff have no clear concept about the core intent of a second opinion program and may “sympathize” with patients about the administrative hassle of the second opinion requirement, indicating that the purpose of a second opinion is merely to fill an insurance requirement. These firms reinforce provider and patient views that UR is a “hassle” and a potential “take away.”

Another problem UR firms face in discouraging unnecessary hospital care is the lack of local alternative services in some areas. Many services that have typically been available only in a hospital setting (e.g. home intravenous antibiotics, physical therapy, traction, etc.) are now widely available on an ambulatory basis. However, some areas lack high quality alternative services. In these situations, UR firms can do little to eliminate the unnecessary hospitalization.

C. Insufficient Qualified Physician Reviewers

Another concern facing UR firms is inadequate access to physician reviewers. Attending physicians are often frustrated by their inability to talk with a UR physician about the proposed treatment plan or a pending denial. The most successful UR firms employ specific physicians who are available during business hours to take calls from attending physicians. A combination of full-time skilled professional physician reviewers supplemented by contracted specialists seems to be an optimal physician staffing pattern. Ideally, an attending physician should be able to talk “live” with a reviewing physician within two hours of a request.

are able to negotiate treatment plan modifications. Firms that take the negotiations stance tend to have longer hours and provide easier access to review staff.
Attending physicians become frustrated and suspicious if they can never reach a UR program physician. The worst example of this is the few UR programs in which the physician reviewers actively "hide" from attending physicians. They will not engage in a telephone discussion with an attending physician concerning the particulars of a case or the firm's review criteria. These physicians may refuse to give their names and are essentially anonymous. Even if physician reviewers do not hide, however, many firms do not have ready access to specialists if a physician wants a specialty review, and some firms use retired physicians who are not current in their medical knowledge.

The scope and depth of physician involvement in all aspects of UR program operations is critical to a UR firm's ability to balance effectiveness with provider acceptance. In programs without ready physician review, very few cases are disapproved. These programs tend to use relatively weak clinical criteria and are viewed by providers as essentially an administrative "hassle" layer.

Other programs, which tend to use more rigorous criteria, do offer much better access to reviewing physicians who are willing to engage in clinical discussions with attending physicians. These programs are also more likely to offer immediate specialty backup. As a result, these programs also have very low outright disapproval rates. However, review physicians will be involved in as many as 40 percent or more of the cases assessed. The principal goal of these programs is the negotiation of a mutually acceptable plan of treatment.

D. Staff Qualifications Are A Significant Concern

The vast majority of UR firms use nurses to screen the information obtained from the physician or patient against clinical criteria. Nursing experience requirements vary widely, with some programs requiring one or two years of clinical experience and others requiring a minimum of five years. Some firms provide regular continuing education, others do not.

Although the employer and provider concerns may be expressed as staff qualifications, actual qualifications may be less important than the way staff present themselves on the

76. Some programs use non-licensed support staff to collect demographic and even some basic clinical information.
telephone. Providers may not be aware they are talking to nurses because staff do not always identify themselves. In some programs, nurses talk like insurance clerks, using insurance jargon and illogical terms. For example, one provider describes a call, six months after discharge, in which the UR firm caller requested the "plan of treatment and the diagnosis to receive preauthorization approval."77

Unfortunately, such confusing calls are not uncommon.78 The situation is further complicated by the fact that the provider receiving the call thought the caller was a clerk, when the caller was probably a nurse who had fallen into the common habit of merely requesting information rather than attempting to assure the appropriateness of care. These calls contribute to local perceptions of incompetence and insensitivity, and also create substantial internal confusion.

E. Timeliness and Frequency of Review is Critical

To effectively influence use, a UR firm must review a case as quickly as possible, either before or while the services are being provided. Actual use will not change if review is routinely completed long after services have been rendered.79

Most firms establish target turnaround times for review decisions that are commonly within 24 to 72 hours after the firm becomes aware of a case. In a few programs, as many as 40 percent of the reviews are completed late, more than one working day after receipt of a timely notification. When review decisions are delayed, the patient and physician have two basic choices. They can proceed without approval and deal with any problems after the fact or they can wait for approval. In most cases, however, they will proceed without approval. Since this usually works and services are eventually approved,


78. In fact, some firms develop definitions for terms like "total and partial retrospective pre-determinations."

79. Retrospective review programs tend to focus on the accuracy of billing. These programs focus on comparing the hospital bill with the services actually documented in the medical record. They may also focus on charges relative to a particular fee schedule or prevailing usual and customary charge for a specific service. In some cases, these reviews identify medically unnecessary services. The problem with retrospective denial of services (as opposed to fee modifications) is that someone, whether it is the patient, the provider, or the public in the case of bad debts, will ultimately pay for the denied services.
providers quickly identify those firms who do not conduct timely reviews and essentially ignore them.

Review delays associated with second opinion requirements can have substantial hidden costs. For example, requiring a second opinion only one or two days before the date of the procedure disrupts physician and hospital surgical schedules and interferes with the patient's plans for time off from work. Although in the vast majority of programs the second opinion requirement is applied only to planned or elective procedures, there are rare instances in which a second opinion has been required for non-elective procedures, thereby delaying an obviously necessary surgery.

The best UR firms complete more than 90 percent of reviews within 24 hours of notification. Both telephone and written notification of recommendations are often provided. If the review is not timely, the ultimate outcome will have no effect on use but rather simply shifts the costs of the services to the patient or provider.

In a typical telephone appeal process, a call between the treating physician and reviewing physician will be scheduled at a mutually convenient time. If no agreement is reached, a call with another reviewer may be scheduled. Depending on the case, the treating physician may request the second call to be with a specialist or sub-specialist. In the vast majority of cases involving a telephone appeal, the reviewer and treating physician reach some agreement and no formal disapproval is ever issued.

Another complaint hospitals have on the review process is that UR firms use different timetables for follow-up. More frequent review intervals may put pressure on hospital UR staff to perform more frequent reviews than they would normally schedule. In a few programs, the UR firm expects the hospital or physician to call and request additional days at the end of the authorized length of stay. Under this approach to continued stay review, hospitals legitimately feel it is not their job to track external review dates. In the absence of contract arrangements with providers which require such notification, it is difficult to require provider performance or apply penalties in this type of program.
VI. THE FUTURE OF UR FUTURE—PROSPECTS AND POTENTIAL PROBLEMS

A. The Requirement of Increased Accountability

A significant future trend will be greater legal accountability for UR programs. This trend started with two important cases which raised key issues of a UR firm’s legal accountability to patients.

Both cases involved the legal responsibility a third-party payor has for harm caused to a patient when a UR program is used to allegedly affect the treating physician’s medical judgment. In each case, the defendant third party payors in each case failed to approve additional hospital days, and, as a result, the patients were discharged earlier than the patients’ physicians had originally requested, and in both cases, serious consequences resulted.

In the first case, Wickline v. State of California, the plaintiff sued the State of California for negligently discontinuing her Medi-Cal eligibility, causing her to be prematurely discharged from the hospital, leading to the amputation of her leg. The patient had been hospitalized for a graft insertion into an artery, a procedure necessary to restore full circulation to her lower leg. Prior to her hospitalization, the plaintiff’s surgery and a ten day post-operative hospital stay were approved, as required, by a Medi-Cal employee.

Following surgery, the plaintiff developed complications, inducing her physicians to request eight additional post-operative hospital days. The Medi-Cal physician reviewing the request form rejected the eight-day extension, approving instead only four additional days.

81. 192 Cal. App. 3d 1630, 228 Cal. Rptr. 661 (1986). Wickline was the first case in which a patient attempted to “tie a health care payor into the medical malpractice causation chain.” Id. at 1633, 228 Cal. Rptr. at 662.
82. The plaintiff’s medical benefits were provided by the State of California’s medical program. Medi-Cal is California’s equivalent of Medicaid. Id. at 1635, 228 Cal. Rptr. at 664.
83. Id. at 1633, 228 Cal. Rptr. at 662.
84. Id. at 1634, 228 Cal. Rptr. at 663. The patient actually suffered from Leriche’s syndrome, a condition caused by obstruction of the terminal aorta. In her situation, the occlusion was just above the point where the aorta divides into two iliac arteries, one of which descends into each leg. Id.
85. Id. at 1636, 228 Cal. Rptr. at 664.
86. Id. at 1637, 228 Cal. Rptr. at 665. The Medi-Cal reviewing physician testified
Although the patient's treating physicians were aware they could try to obtain a further extension, they instead complied with the limited extension and discharged the patient after 14 post-operative days.\textsuperscript{87} Nine days later, the patient's new vascular graft occluded, and her leg had to be amputated.\textsuperscript{88}

The plaintiff sued, naming Medi-Cal as the sole defendant, for negligent withholding of care. She claimed that had she been granted the eight additional days as her physician had requested, she would not have suffered the loss of her leg.\textsuperscript{89} Therefore, the plaintiff alleged that the State of California should be liable for negligently interfering with her physician's treatment plan.

The court found that third party payors could be legally responsible for medically inappropriate decisions resulting from defective cost containment measures.\textsuperscript{90} However, that was not the situation here. In this case, Medi-Cal's judgment met the standard of care for "medical necessity."\textsuperscript{91} Furthermore, had the treating physicians believed that the plaintiff should have remained hospitalized for an additional four days, it was their responsibility to keep her there; the discharge decision "is the responsibility of the patient's own treating doctor."\textsuperscript{92} However, instead of exhausting the administrative remedies available to them, the plaintiff's physicians chose to comply with Medi-Cal's decision without protest, and this left them, not Medi-Cal, responsible.\textsuperscript{93}

A second example of a case involving the withholding that there was nothing on the extension request form showing any patient problems and he presumed the patient was progressing satisfactorily. \textit{Id.} at 1638, 228 Cal. Rptr. at 666.

\textsuperscript{87} \textit{Id.} One of the plaintiff's treating physicians testified at trial that he felt Medi-Cal had the power to tell him when a patient must be discharged from the hospital. \textit{Id.} at 1640, 228 Cal. Rptr. at 667. He also testified, however, that the plaintiff's discharge was medically proper. \textit{Id.} at 1641, 1645, 228 Cal. Rptr. at 667, 670.

\textsuperscript{88} \textit{Id.} at 1641, 228 Cal. Rptr. at 667.

\textsuperscript{89} \textit{Id.} at 1642, 228 Cal. Rptr. at 668. The plaintiff's treating physician testified that had the plaintiff been in the hospital for the additional four days, he would have noticed the changes in the plaintiff's leg caused by a clot occluding the graft. In that case, he could have taken the plaintiff to surgery and removed the clot, thereby saving her leg. \textit{Id.}

\textsuperscript{90} \textit{Id.} at 1645, 228 Cal. Rptr. at 670.

\textsuperscript{91} \textit{Id.} Title 22 of the California Administrative Code § 5110 provided that the standard of care should be in accord with the usual standard of medical practice in the community.

\textsuperscript{92} \textit{Id.} at 1645, 228 Cal. Rptr. at 670, 671.

\textsuperscript{93} \textit{Id.} at 1646, 228 Cal. Rptr. at 671.
medical care because of prospective review came in Wilson v. Blue Cross of Southern California, a case in which the California Court of Appeals limited Wickline to its own facts. The Wilson court reversed the trial court’s grant of the summary judgment motions of four defendants, including an independent UR provider. In reversing the trial court, the appeals court found a triable issue of fact on whether the defendants’ conduct was a substantial factor in causing the death of Mr. Wilson.

The Wilson case involved the termination of Mr. Wilson’s hospitalization insurance after he had received eleven days of a planned three to four week course of in-patient treatment for “major depression, drug dependency, and anorexia.” This termination of insurance was based on the independent UR provider’s determination, under its concurrent utilization review process, “that the patient did not meet the admission criteria for his particular insurance policy and that his further stay was not justified or approved.” Although Mr. Wilson’s physician believed this UR determination incorrect, the physician nevertheless informed Mr. Wilson that he would be personally liable for the costs of his three to four week stay. Unable to pay for the services without insurance, Mr. Wilson left the hospital. Twenty days later, Mr. Wilson committed suicide.

As in Wickline, the defendants argued that they were insulated from potential liability by the physician’s failure to institute normal appeals procedures with the UR provider. However, the appeals court rejected this argument. The court distinguished Wickline on the basis that the physicians in that case failed to follow a statutorily mandated appeals procedure. By contrast, in Wilson the procedure for questioning the UR provider’s judgment was “informal” and, at any

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95. Id. at 664, 271 Cal. Rptr. at 878.
96. Id. at 660, 271 Cal. Rptr. at 877.
97. Id. at 672, 271 Cal. Rptr. at 883.
98. Id. at 660, 271 Cal. Rptr. at 877.
99. Id. at 669, 271 Cal. Rptr. at 882.
100. Id.
101. Id. at 660, 271 Cal. Rptr. at 878.
102. Id.
103. Id. at 673, 271 Cal. Rptr. at 883.
104. Id. at 674, 271 Cal. Rptr. at 884.
105. Id.
rate, was not mandated by statute.\textsuperscript{106}

Therefore, the \textit{Wilson} court limited the language in \textit{Wickline} which stated that physicians bear sole civil liability for their decisions to discharge patients based on UR determinations that further treatment is unnecessary.\textsuperscript{107} The court held the language in \textit{Wickline} dicta because it was unnecessary to the decision.\textsuperscript{108} Thus, under California law, independent UR providers may be liable for negligently determining that care is unnecessary if such determination is a substantial factor in subsequent harm to the patient and if the patient's physician was under no statutory obligation to pursue appeals procedures.

Furthermore, the \textit{Wilson} court rejected the defendants' argument that other language in \textit{Wickline}, which noted the "profound importance" of UR "to the health care community and to the general public," should lead the court to affirm the summary judgment because such important public policy issues require a departure from normal bases of tort liability.\textsuperscript{109} Refusing to extend the \textit{Wickline} dicta involving the public Medi-Cal program to private insurance and health care contracts, the appeals court found no expression of a public policy favoring protection of private UR providers from tort liability for negligent determinations of unnecessary care.\textsuperscript{110}

As a result of these decisions, under \textit{Wickline}, public third-party payors and their UR providers are protected from tort liability if they follow procedures and such procedures are "reasonable," even if physicians fail to follow statutorily mandated appeals procedures. On the other hand, under \textit{Wilson} private third-party payors and independent UR providers are not protected from liability for negligently finding health care unnecessary, even if physicians fail to follow non-statutory appeals procedures under the same conditions.

The \textit{Wickline} and \textit{Wilson} decisions indicate that as the competition in the market increases, so will UR firms' accountability for the appropriateness of their procedures. In addition to increased accountability, however, UR firms will have to support the validity of claimed savings.

\textsuperscript{106} \textit{Id.}
\textsuperscript{107} \textit{Id.} at 666, 271 Cal. Rptr. at 879.
\textsuperscript{108} \textit{Id.} at 671, 271 Cal. Rptr. at 880.
\textsuperscript{109} \textit{Id.} at 672-73, 271 Cal. Rptr. at 884, citing \textit{Wickline}, 192 Cal. App. 3d at 1633.
\textsuperscript{110} \textit{Id.}
B. The Need to Support the Validity of Claimed Savings

As described in prior sections, there are independent studies which show UR can influence utilization and thereby reduce overall medical costs. However, many firms grossly exaggerate the magnitude of savings. These exaggerated claims have made employers suspicious of the value of UR.\textsuperscript{111}

The suspicions could turn to outright hostility if a UR program claims huge savings for an employer and simultaneously that same employer's insurance premium rates were raised drastically. It is even worse if the employer's benefits management department receives complaints from employees and providers about the program.

Employers have typically relied on the UR firms themselves to report savings. Unfortunately the methodologies most widely used by UR firms are simplistic and seriously flawed because they do not tie savings to any actual changes in utilization or health care costs. One popular savings calculation method compares the number of days requested by the provider with the number of days authorized. These numbers may or may not be tied to actual use.

As an example, for a laminectomy (back surgery), the provider might "request" five to eight days. Most providers simply report either their longest length of stay or whatever their normal length of stay is. If the UR firm uses national length of stay criteria, it would probably authorize five days on initial review. Some firms would enter the eight days into the system as requested days and the five as authorized days. If the patient stayed five days, three days in savings might be claimed. If the patient stayed only four days, four days in savings might be claimed, even though the UR firm authorized five days. If the patient stayed the eight days, and UR authorized additional days, no savings would be claimed. Days saved are totaled and multiplied by some dollar value assigned to a hospital day. The result is described as UR savings.

Another firm might take the same case, enter the five as days requested and claim no savings if the patient only stayed five days. Such reports become difficult to support in the face of other data (such as claims data) which might show overall increases in actual use. The obvious problem with such a method is that providers, in the hope of reducing the number

\textsuperscript{111} BENEFITS NEWS ANALYSIS, Number 3, March, 1986
of future review interactions, might overstate what they really expect will be needed. Over time, providers may request as many as 30 percent to 50 percent more days than patients actually use. UR firms operating on the basis of community standard criteria might approve 10 percent to 20 percent fewer days than requested and still be approving 10 percent to 20 percent more days than patients actually use.

State regulations, voluntary guidelines, and greater employer scrutiny \(^{112}\) seem to be sending a clear messages to the UR industry that some changes are needed. The more innovative firms are implementing programs which apply high-cost case management techniques to broader categories of cases. For these firms, each case is evaluated for potential management, even if only a day or two are in question. Nurses are assigned to individual groups of patients and they act as resource persons to help employees access the health care system more effectively.

UR firms which attempt to do this generally have multiple advantages. They often have staff who are clinically sophisticated and have a good understanding of and sensitivity to the needs of providers. As a result, their staff generally have fewer hostile encounters with providers. These programs generally have more rigorous clinical criteria, better access to physician reviewers, and more contacts with treating physicians involving discussions of clinical issues. They also tend to have reasonable overall access and provide timely notifications and responsive formal and informal appeals procedures. In addition, these firms regularly evaluate themselves and the use by their employee groups, and they identify program modifications and new services.

VII. CONCLUSION

Employers and coalitions of employers continue to expand their roles in health care cost management as they more actively manage employee use of their health benefits.\(^{113}\) The increasing demand for health care benefits in the workplace coupled with the spiraling costs of health care premiums leads to the inevitable conclusion that, regardless of the overall cost

\(^{112}\) See Diblase, Employers Scrutinize UR Programs, Bus. Ins., February 15, 1988, at 1.

\(^{113}\) L. BERGTHOLD, PURCHASING POWER IN HEALTH, BUSINESS THE STATE AND HEALTH CARE POLITICS (1990).
management strategy UR will be involved in monitoring the effective use of health care. In general, therefore, the challenge of attaining an optimal level of effective use will be to refine effective UR processes by improving provider and patient relationships.