House
Legislative
Analysis
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REGULATE MEDICAL REVIEWERS

House Bill 5152 (Substitute H-2)
First Analysis (6-10-92)

Sponsor: Rep. Michael J. Bennane
Committee: Public Health

THE APPARENT PROBLEM:

The costs of health care continue to be one of the major problems facing both government and the private sector. One major cost factor in health care is the utilization or intensity of services, and, consequently, controlling the utilization of services has been one major way of attempting to control these costs. As a result, there has been a proliferation of medical review companies. Originally, medical review services were used primarily by self-insured employers to watch over amounts paid on claims, to determine whether the care given was necessary, to monitor the length of stays in the hospital, and to investigate the care of high-cost individuals (often referred to as "case management" or "managed care"). These services came as part of packages offered to self-insured employers by third-party administrators (TPAs) or by insurance companies in "administrative services only" (ASO) contracts, but they also were offered by separate companies (sometimes referred to as "the fourth party"). Increasingly, as employers became less and less willing to pay the costs of leaving health care decisions up to the medical profession, even employers who were not self-insured also began turning to these medical review companies in their attempts to curtail costs. (Since most insured groups are levied premiums based on their claims experience, a review system can lower costs.)

Medical review systems accomplish their task of cutting costs in various ways. They require second opinions on certain surgeries. They require that doctors obtain permission from the reviewers before admitting patients to hospitals for elective care, and they decide on the number of days this care should take. They may continue to review the necessity of care even after a patient is in the hospital (called "concurrent review"), and they may allow certain treatment only on an out-patient basis (by stating ahead of time that benefits will be reduced or eliminated if the care is given during an in-patient stay). And, finally, their personnel coordinate the care required to treat high-cost employee illnesses. In such cases, the reviewer ("case management coordinator") contacts specialists involved in the patient's care and works with home health agencies and hospital social workers to arrive at the most appropriate and least expensive way of continuing treatment. Case management coordinators can even approve treatment or items not ordinarily covered by the plan.

However, there are problems with medical review companies. As might be expected, doctors do not like having their patients' employers trying to call the shots when it comes to delivering health care. Doctors resent being put in the position of having to seek permission from a third or fourth party before admitting a patient to the hospital, and describe a number of problems they have encountered with medical reviewers: the numbers doctors are told to call before ordering procedures frequently are busy; the personnel doctors do reach are not medically qualified to consider the care in question; and the review systems are said to be too inflexible to allow proper consideration of individual cases.

Medical review systems also are criticized for causing hardships on patients. In some areas, second opinions cannot be obtained conveniently, and the patient may have to travel some distance and take time off from work to do so. Charges also have been made that in some cases reviewers have denied the necessity of surgery until a patient's condition worsened, landing him or her in the hospital anyway but under less-preferable emergency conditions.

Since utilization review companies are not currently regulated, there are no standards governing the qualifications of the reviewers, no requirements that these companies make available copies of their review plans, nor even any requirements for an appeals process in cases in which claims are denied. Legislation has been introduced to regulate utilization review companies.

THE CONTENT OF THE BILL:

The bill would create the "utilization review act" to regulate utilization review companies, to establish administrative fines for violations, and to exempt certain organizations and programs from the bill's requirements.

Regulated groups. Anyone engaged in the business of conducting utilization reviews of outpatient health services and certain inpatient services (acute medical, surgical, obstetrical, psychiatric, or chemical dependency services in an inpatient facility such as a hospital, skilled care facility, nursing facility, residential treatment center, or freestanding rehabilitation facility) would have to comply with standards established by the Utilization Review Accreditation Commission (URAC). (The bill would define "utilization review" as "the evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities".)

Beginning 180 days after the bill took effect, anyone who had applied to URAC for accreditation could conduct utilization reviews unless his or her application had been denied.

Qualified groups. A utilization review entity would be considered "qualified" if it were accredited by the Utilization Review Accreditation Commission or by any other organization the Department of Public Health (DPH) considered to have comparable or better standards.

Utilization review plans. The bill would define "utilization review plan" as "a reasonable description of the standards, criteria, policies, procedures, reasonable target review periods, employee training programs, and reconsideration and appeal mechanism" governing the person or business conducting a utilization review. Utilization review plans would have to comply with URAC's requirements.

Rules promulgation. The Department of Public Health (DPH) would be required to promulgate rules to administer and enforce the bill, as well as regarding any changes in URAC standards.

Exemptions. The bill would exempt from its provisions commercial health care insurers, Blue Cross and Blue Shield of Michigan, health maintenance organizations (HMOs), and self-insured health benefit plans. The bill also would not apply to outpatient mental health services until URAC standards were available for these services.

Violations and penalties. The bill would prohibit those employing utilization review companies from reimbursing these companies based on the amount of money saved from the denial of claims. The DPH could bring an action under the Administrative Procedures Act for violations of the bill, and violators could receive administrative fines of up to $10,000 for each violation.

BACKGROUND INFORMATION:

According to its literature, the Utilization Review Accreditation Commission (URAC) was established to encourage efficient and effective utilization review processes and to provide a way to evaluate and accredit utilization review programs. URAC developed and approved a set of "National Utilization Review Standards" (as of June 1991) in order to credential utilization review organizations applying for voluntary accreditation. URAC specifically says that these standards were developed as guidelines for the evolving utilization review industry and that the standards are not intended to discourage "the further development of effective, efficient, and innovative methods to promote quality care and decrease the rate of growth in health care expenditures." The URAC standards are intended "to encourage the availability of effective, efficient, and consistent utilization review of health care services throughout the United States."

The URAC standards detail the scope of the standards, who is responsible for getting approval of proposed treatment, the kinds of information on which utilization reviews should be done, review procedures, appeals procedures (for denied services), confidentiality, staff and program qualifications, accessibility of reviewers and on-site review procedures, and the accreditation process.

Some of the specific standards are as follows:

* Scope of the standards. The standards would apply "to prospective and concurrent utilization review for inpatient admissions to hospitals and other inpatient facilities as well as to outpatient admissions to surgical facilities." ("Inpatient admissions to hospitals" would include admissions to all acute medical, surgical, obstetrical, psychiatric and chemical dependency inpatient services" at

licensed hospital facilities, "as well as to other licensed inpatient facilities such as skilled nursing facilities, residential treatment centers and free standing rehabilitation facilities.")

* Staff training and qualifications. Utilization review staff would have to be "properly trained, qualified, supervised and supported by written clinical criteria and review procedures." Medical service reviewers (nurses, physicians, and other health care professionals) and clinical reviewers reviewing specialty areas would have to be licensed or certified by "an approved state licensing agency in the United States." If a request was denied for clinical reasons, a physician would have to review the case (and "should be reasonably available by telephone to discuss the determination with the attending physician").

* "Certification" procedures. Review organizations would have to make "certification determinations" (that is, decide whether to allow a proposed admission or procedure) within two days of receiving the necessary information. Review organizations could review ongoing inpatient stays (but could not routinely conduct daily reviews on all inpatient stays). Review organizations would have to have written procedures for notification of its decisions. These procedures would have to require "prompt" notification (by telephone or in writing) of an initial decision to certify (preferably within two working days of the decision). Extensions or additional services preferably would be conveyed within one working day of receipt of the necessary information.

* Review information. Review organizations would be allowed to collect only the information necessary to make the decision regarding the admission, procedure, or treatment and length of stay. They could not routinely require providers to supply numerically coded diagnoses or procedures in order to be considered for approval (though they could ask for such coding). They also could not routinely request copies of medical records on all patients reviewed. Only when problems arose in deciding on approving a request should medical records be requested, and then only the necessary or relevant parts should be required. Reviewers could request copies of medical records retrospectively for certain purposes (such as audits, quality assurance, etc.), but providers should be reimbursed for "reasonable costs" of duplication of such records. Finally, the standards list the elements to which reviewers should limit their data requirements. Other information could be requested (or voluntarily submitted) when there was "significant lack of agreement" between the reviewer and provider regarding the appropriateness of approval during the review or appeal process.

* Denials. Denials of requests would have to be conveyed to the attending physician within one working day and should include the principal reasons for the denial and a way to begin an appeal.

* Appeals. Review organizations would have to have written procedures for appeals (which would be available to patients or enrolles and to attending physicians). The procedures would have to include both an expedited appeals procedure and a standard appeals procedure. If an attending physician believes that a denial warrants immediate appeal, he or she would have to have the opportunity to appeal over the telephone on an expedited basis. Each review organization would have to provide for "reasonable access" to its consulting physicians for expedited appeals, and expedited appeals that were denied could be resubmitted through the standard appeals process. There would have to be procedures for appeals to be made in writing and/or by telephone, though the decision to deny a request would have to be made in writing to the patient or enrolle "as soon as practical" but no later than 60 days after receipt of the required documentation on the appeal. Before upholding an initial denial, the review organization would have to have a physician (other than the one making the decision to deny) review the documentation. Review organizations could set deadlines for appeals to be filed in order to be considered. Physicians whose appeals had been denied would have to be given the clinical basis for that denial (if they so requested), and the review organization should have a physician in the same or a similar specialty be "reasonably available" to review the case.

* Confidentiality. Review organizations would have to have written procedures to assure that patient-specific information obtained during the review process was:
(1) kept confidential in accordance with applicable state and federal laws;
(2) used only for utilization review, quality assurance, discharge planning, and catastrophic case management; and
(3) shared only with authorized agencies (such as claims administrators).

* Access to reviewers. Each review organization would have to provide access to its review staff toll-free (or by collect call), at a minimum, from 9 a.m. to 4 p.m. of each normal business day in the provider's local time zone in which the organization routinely conducts reviews. Each organization also would have to have a mechanism to receive timely call-backs from providers and would have to have written procedures for taking or redirecting after-hour calls. Each review organization would have to conduct its telephone reviews, hospital communications, and on-site ("information gathering") reviews during reasonable and normal business hours (unless otherwise mutually agreed). On-site reviews should be scheduled at least one business day in advance. On-site reviewers should identify themselves before asking for any clinical information or help from hospital staff. Upon request, review organizations should verbally inform providers of the operational procedures in order to facilitate the review process and of the utilization requirements of the specific health benefit plan and the reviewer's general criteria.

FISCAL IMPLICATIONS:

Fiscal information is not available. (6-9-92)

ARGUMENTS:

For:

While utilization reviewers may play an important role in helping reduce (or at least keep down) the high costs of providing health care, the fact that the industry is not regulated has resulted in a number of problems for providers and patients alike. Because reviewers have no regulatory oversight, they don't have to meet any requirements for appeals processes (should they deny requests for approvals), nor do they have to have reviewers who have any particular kind of medical training (resulting in situations in which non-medically trained reviewers can make -- and have made -- decisions regarding whether or not a procedure or a hospital admission was medically necessary). Review organizations need not reveal their reimbursement criteria, and can impose such patently unfair requirements as requiring 24-hour notification of hospital admissions while themselves being closed on weekends (so if someone were admitted on a Saturday, their request for approval could be denied the following Monday because admission took place outside the required 24-hour limit). Reviews have no time limitations, and can wind up taking 30 or even 60 days to complete.

By requiring medical review companies in Michigan to adopt industry-developed and -approved standards, the bill would encourage consistency in the relations between review organizations and providers, payors, and users of health care; establish review processes that were minimally disruptive to the health care system; establish standards for the procedures used to certify health care services and to process appeals of utilization review determinations; and provide the basis for an efficient process for credentialling and accrediting review organizations.

Against:

While fair and equatable standards fairly applied are much to be desired, and while the bill is a good beginning in this direction, questions remain. The bill would exempt self-insured health benefit plans, Blue Cross and Blue Shield, commercial health insurers, and health maintenance organizations. If utilization review is to be a consistent, uniform process, there are so many exemptions that one must ask, "What's left?" Furthermore, the bill would not require that utilization review companies even notify the state regulator (in this case, the Department of Public Health) that they were in operation. How can the department regulate what it doesn't even know exists? At the very least, regulated reviewers ought to be required to register with the department so the department can check to see if they are accredited.

Response:

The exemptions allowed under the bill (with the exception of the mental health services exemption) all are regulated under other state or federal laws, and the bill would "capture" those who currently are not so regulated.

Against:

The bill, by adopting URAC standards that in many places are permissive rather than mandatory, does not go far enough. Notes appended to the standards say that the terms "shall" and "should," as used in the standards "and as used as a measure of compliance within the accreditation process, have the following definitions: 'Shall' means that the URO [utilization review organization] is required to carry out the action of the direction as stated. 'Should' means that while the URO can be expected to carry out the action as stated, there may be reasons, based on the individual organization's circumstances, where the URO will not perform the

direction. In those instances where the URO does not presently (sic) carry out the stated action, the URO may choose to implement the direction as a future objective." Thus, for example, although the standards seem to limit the amount and kinds of information review organizations may require, since this standard is phrased in terms of "should" ("a UR organization should limit its data requirements to the following elements") it need not do so. And while attending physicians must be notified (by telephone and in writing) of any denials of admissions or extensions or other services, the standard does not require that the written notification include the reason for the denial (it only "should" include such information). In appeals to reverse a denial by the reviewer, the standard does not require that the physician reviewing the case be in the same or a similar specialty as typically manages the case under discussion (again, he or she only "should" be such). In these -- and many other -- places in the standards, these permissive requirements should be made mandatory.

POSITIONS:

Representatives from Blue Cross and Blue Shield of Michigan and from the Economic Alliance for Michigan testified in support of the bill. (6-4-92)