Reducing the Managed Care Hassle Factor

Recommendations of the American Society of Internal Medicine

June 1998
Reinventing Managed Care
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Executive Summary and Recommendations

The immense growth of the managed care industry has introduced unprecedented hassles to the daily operations of the physician's office. The American Society of Internal Medicine (ASIM) defined the "hassle factor" in its landmark policy paper, America's Health Care System Strangling in Red Tape (1990), as:

The increasingly intrusive and often irrational administrative, regulatory review and paperwork burdens being placed on patients and physicians by the Medicare program and other insurers.

Today the hassle factor is worse than ever before. A recent survey of 200 primary care physicians in the greater New York metropolitan area provides practical evidence of the hassle factor's effect on the practice of medicine. The survey yields the following observations:

- Physicians are spending more time on managed care paperwork and less time seeing patients.
- Physicians believe that their managed care organizations (MCOs) question their professional judgment too often.
- Physicians have to hire additional personnel to keep up with the abundant paperwork that managed care creates.

Patients also are experiencing many difficulties caused by the economics-based philosophy of managed health care. Health care consumers have become more concerned about managed care coverage policies and the restrictions on access to care that some MCOs impose. Interestingly, the growing suspicion among consumers may not be the result of firsthand experiences with MCOs. Many patients who are reluctant to switch to an MCO from a traditional fee-for-service arrangement are more likely to base their decisions on concerns expressed by an acquaintance or a relative.

While many physicians acknowledge that managed care is here to stay, few are complacent about plans' burdensome bureaucratic policies and procedures. The most problematic of MCO practices hassling physicians today include:

- Physician credentialing;
- Facility and medical records reviews; and
- Utilization review/utilization management (UR/UM).

MCOs may have sound reasons for these policies and procedures but often implement them in a manner that wastes physicians' time, creates discontinuities in patient care, and forces inappropriate levels of care for some patients. Physicians are concerned about how these policies fundamentally alter the traditional physician-patient relationship. This paper explores these policies and offers practical recommendations for streamlining and reducing the hassles they create.

As part of its continuing campaign to reinvent managed care, ASIM recommends that MCOs adopt the following policies and procedures for physician credentialing, facility and medical records reviews, and utilization review:

Credentialing Recommendations

1. In consultation with practicing physicians, MCOs should develop a uniform, standardized credentialing process for collecting and verifying documents—including applications and credentialing questionnaires—for managed care products. Managed care and other entities should adopt these standardized credentialing materials and a uniform credentialing process.

2. Each MCO should evaluate the professional competence of physician applicants and panel members in a manner that is comprehensive, but not cumbersome or inordinately time-consuming.

3. MCOs should assess physicians on the basis of education, training, experience and demonstrated competence.

4. MCOs should use nationally recognized guidelines for procedural competence in assessing physicians.

5. MCOs should provide a fair hearing and an appeals process for applicants or panel
members who have been denied participation or retention for reasons related to professional competency.

6 Each physician should have to complete the credentialing document collection process only once; other MCOs or contractors can share the results, with the physician's consent. Similarly, physicians should complete recredentialing documents only once every two years; other MCOs or contractors can share the results, with the physician's consent.

7 Physicians should have to fill out the uniform credentialing application only once. Recredentialing applications should contain a summary of the information in the credentialing file for the physician to review, verify and change as necessary.

8 Physicians who change practice location or affiliation should not have to undergo automatic recredentialing.

9 MCOs should recognize the services provided by any qualified locum tenens physician covering for physicians already on the health plan's panel, for a specified, reasonable maximum number of days per year (determined on a case-specific basis). The health plan should base payment to the covering physician on its accepted schedules or arrangements.

Facility and Medical Records Review Recommendations

1 In consultation with practicing physicians, the managed care industry should develop and adopt standardized guidelines for in office safety audits of facilities, office administrative procedures and record-keeping. These guidelines should be relevant to the type of facility and practice under review, incorporating appropriate elements of consistency, frequency, prior notice, patient confidentiality, and due process.

2 Physicians should receive a written description of the review process and criteria at least 30 days before the review.

3 There should be only one initial facility and medical records review; other MCOs or contractors can share the results, with the physician's consent.

4 Re-review should occur no more than once a year; other MCOs or contractors can share the results, with the physician's consent. However, quality concerns or an immediate threat to patient care can dictate more frequent reviews.

5 Single-source credentialing and facility review organizations are preferable to multiple credentialing and facility reviews by several different organizations.

Applicable to facility review only:

6 Reviews should give physicians appropriate time to improve their physical practice facility, if necessary, using feedback from the previous review before a re-review, unless quality concerns or an immediate threat to patient care emerge, dictating immediate improvements.

Applicable to medical records review only:

7 A medical records review should maintain patient confidentiality.

8 There should be an established process to assure that patients have authorized any review of their medical records.

9 Medical records review should use patient medical information solely to review the practice and not to determine patient insurance coverage or eligibility.

Utilization Review/Utilization Management (UR/UM) Recommendations

1 MCOs should reveal UR/UM criteria—such as computer algorithms, screening criteria, and weighting elements—to physicians and their patients, on request.

2 MCOs should require preauthorization only for services for a specified procedure if there is clear evidence that: (1) Routine use of preauthorization substantially reduces the
number of medically unnecessary services; and (2) The costs of conducting the preauthorization—including costs incurred by the physician's office in complying with the preauthorization requirements—do not exceed the potential savings.

3 MCOs should require that UR/UM personnel and processes focus on medical procedures that have a consistent pattern of overutilization, pose significant medical or financial risk to the patient, or for which there are no clear medical indications for use.

4 MCOs should apply uniformly the UR/UM criteria established or endorsed by a UR/UM organization or the medical community, based on sound scientific principles and the most recent medical evidence.

5 MCOs should ensure that the UR/UM process is educational. Instead of punishing physicians or preventing appropriate care, the process should alert physicians to practices that may not be cost-effective and efficient. UR/UM should encourage physicians to examine methods for altering practices and procedures while viewing high quality patient care as their priority.

6 Physicians' adherence to evidence-based, scientifically-supported practice guidelines should result in payment without excessive demands for documentation and without filing appeals. If the patient care does not comply with these guidelines, the physician should provide information to justify the claim.

7 No contract between an MCO and a physician should contain any provision restricting the physician's ability to communicate information to a patient regarding the medical care or treatment options that the physician deems are in the patient's best interest.

8 MCOs should not exclude physicians who have served as patient advocates in appealing UR/UM decisions.

9 UR/UM policies must never place physician financial incentives in conflict with patient welfare.

10 MCOs must not initiate UR/UM contracts intended to deny medically necessary services.

11 MCOs must not base the compensation of individuals who conduct UR/UM on the number or monetary value of care denials.

12 UR/UM appeals should provide physicians with due process, including the right to review the material used to make the claims denial with the actual personnel responsible for the review.

13 For review determinations, MCOs should use only licensed, certified or otherwise credentialed health professionals who are free from financial bias, and should make the reviewers' credentials available on request.

14 MCOs should provide timely access to review personnel; if review personnel are unavailable, MCOs should waive any preauthorization requirements.

15 MCOs should accept a prudent layperson's assessment of an emergency condition in determining when to pay for initial screening and stabilization in the emergency room. MCOs should base the determination on what the patient knows at the time of seeking the emergency care, rather than on what the emergency department visit reveals.

16 With input from practicing physicians, the MCO industry should standardize utilization review authorization processes.
Introduction

Managed Care Credentialing

The first encounter between a physician and an MCO usually occurs during the credentialing process, which can be redundant and time-consuming. Physicians typically face a rigorous credentialing process each time they apply to join a new MCO's panel. In addition, most MCOs recredential participating physicians every two years, repeating the burdensome process. The applications require extensive paperwork and detailed explanations, taking a physician's time and resources away from patients and adding to the hassles and frustrations of medical practice under managed care. Standardized credentialing is one of the best ways to reduce the administrative burden on physicians, allowing them to devote more time to quality patient care. The health care industry and the physician community should pursue and develop a standardized credentialing process.

This policy paper highlights the efforts of several organizations to streamline and standardize the credentialing process and offers ASIM's recommendations to ease credentialing hassles.

Medical Records and Facility Reviews

Internists also must prepare for frequent visits by various MCO representatives armed with checklists and standards manuals for evaluating facilities, office procedures and record-keeping. Like other aspects of managed care, medical office reviews contribute to the inordinate amount of administrative work required of physicians and their staffs. ASIM believes that with more efficient organization these reviews could create fewer interruptions in an office's daily routine.

An Oregon initiative to standardize the managed care facility and medical records review processes has reduced substantially the amount of time needed to prepare for—and successfully complete—these audits (see page 14). The implementation of similar programs across the country would ease the heavy administrative burden on physicians and their staffs, affording more time for patient care.

Utilization Review

Utilization management (UM) programs evaluate the necessity, appropriateness and efficiency of the use of medical services, procedures and facilities to control the cost of health care.

The evaluation and determination process—known as utilization review (UR)—can affect the quality of patient care directly, by unduly limiting the resources required by the physician to meet a patient's needs. Ambiguous, vague and time-consuming UR/UM policies and procedures can detract from the time that physicians spend with patients and can create unnecessary administrative obstacles to quality patient care.

Standardized UR/UM processes could alleviate much of this burden, streamlining UR/UM with shorter turnaround times for decisions (particularly in emergency cases) and clear, accessible appeals processes. Physicians and health plan enrollees also should participate on the committees that develop UR/UM procedures and policies. This policy paper discusses some of the problems related to UR/UM and recommends ways to make the process more effective while preserving quality care and patient access to care.
Physician Credentialing

Scope of Physician Credentialing

The ever-increasing numbers of MCOs and other organizations requiring profiles of physicians have spurred the growth of credentialing organizations that gather and disseminate physician information within the managed care industry. MCOs typically require the physicians with whom they contract to undergo credentialing. More and more, physicians also are undergoing a review process voluntarily through professional organizations.

The Credentialing Process

Generally, physicians who want to be credentialed must fill out lengthy applications containing questions that delve into their educational, professional and personal backgrounds; they must do this for each MCO they wish to join. Often these applications are duplicative; they require physicians to answer similar—although not always identical—questions repeatedly and in different formats. It is illogical and wasteful for physicians to provide the same information over and over again to different MCOs. Similarly, it doesn’t make sense that many MCOs independently collect the same information from the same providers again and again. Standardizing and streamlining the credentialing process should reduce this waste of time and money.

Once a physician submits a completed application, the MCO or a hired credentials verification organization (CVO) cross-checks the information with one of several, national databases compiled from primary sources or directly contacts such primary sources as the applicant’s medical residency program. Many MCOs use the minimum credentialing requirements—established by the National Committee for Quality Assurance (NCQA)—to determine a prospective physician’s eligibility.

One national database, the American Medical Association (AMA) Physician Masterfile, maintains profiles of more than 700,000 physicians, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has approved it for credentials verification since January 1996. The Masterfile contains information on physicians’ personal backgrounds, medical school attendance records, hospital internship and residency data, medical board certifications, state licensures, and state and federal disciplinary sanctions. Like similar services, this database not only can streamline the credentialing process but also can reduce the amount of money and time MCOs and consumers spend in verifying physician credentials.

Recent Efforts To Standardize the Credentialing Process

Many agencies and accrediting bodies have sought to develop an industry standard for physician credentialing. Efforts are under way in some states and organizations to design and implement a standardized credentialing process. Frustrated by the amount of time and energy that physicians must devote to credentialing, the California Medical Association (CMA) created a standard credentialing application for use by MCOs and hospitals. Also contributing to the design of the California Participating Physician Application (CPPA) were the Independent Physician Association of California, the Unified Medical Group Association, the California Association of Health Maintenance Organizations, and the California Healthcare Association. CPPA allows individual organizations that are interested in more extensive information to attach specific questions about billing services, foreign languages spoken and other information not related to clinical competence. Several California health care organizations now are using CPPA.

Another move toward standardization is AMA’s American Medical Accreditation Program (AMAP). AMAP streamlines several facets of the accreditation process, including physician credentialing. Using Masterfile, AMAP collects and disseminates physician information for MCOs, hospitals and other programs that need extensive information for evaluating applicants. Besides collecting physician credentials and personal qualifications, AMA plans to collect data on the environment of care, clinical performance and patient care.
In June 1997, the American Association of Health Plans (AAHP) introduced a standardized credentialing form for physicians planning to participate with an AAHP-affiliated MCO. Designed in keeping with recent AAHP initiatives to enhance the quality of care by including physician input in critical areas of decision-making and program review, the form reflects suggestions and advice from several physician groups, including ASIM. The standardized form is a welcome innovation as managed care begins to address physician concerns about the current managed care credentialing burden. Alan R. Nelson, MD, ASIM's executive vice president, commented that AAHP’s credentialing form “will ease hassles for physicians and lead to a fairer process for evaluating physician credentials.”

The development of AAHP’s standardized credentialing form and its adoption by AAHP-member MCOs should alleviate much of the hassles of physician credentialing. However, it remains to be seen how uniformly the AAHP membership will implement the new process and what changes may be needed to make the form a practical success. Other MCOs should follow the AMA, CMA and AAHP initiatives and adopt a uniform credentialing process. Specifically, ASIM recommends that:

1. In consultation with practicing physicians, MCOs should develop a uniform, standardized credentialing process for collecting and verifying documents—including applications and credentialing questionnaires—for managed care products. Managed care and other entities should adopt these standardized credentialing materials and a uniform credentialing process.

A uniform, standardized application would ensure that MCOs are making informed selections; it also is more sensible economically. Patients too would benefit from a uniform, standardized credentialing process, assured that the physicians managing their care have met all the generally accepted criteria set by the marketplace, regardless of the MCO they choose. Physicians and their staff would save time under a uniform, standard process and be able to spend more time taking care of patients.

### Commonly Accepted Credentialing Criteria

NCQA has served as a major national accreditation organization for MCOs since 1991. Its standards, adopted by the industry, furnish minimum physician credentialing requirements for MCOs that contract with physicians to provide care to patients. Although these standards require MCOs to carry out a “rigorous” credentialing of participating physicians, they are the only criteria that a plan must use to gain NCQA accreditation. MCOs often adopt additional credentialing requirements.

Physicians must submit or document the following items during their initial application to participate in a plan:

- A valid license to practice;
- Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;
- A valid Drug Enforcement Agency or Controlled Dangerous Substances certificate, as applicable;
- Graduation from medical school and completion of a residency or board certification, as applicable;
- Work history;
- Current, adequate medical liability insurance according to the MCO’s policy; and
- History of professional liability claims that result in settlements or judgments paid by or on behalf of the practitioner.

The MCO’s application for membership must include statements by the physician supplying the following information:

- Reasons for any inability to perform the essential functions of the position, with or without accommodation;
- History of illegal drug use;
- History of loss of license and felony convictions; and
History of loss or limitation of privileges or disciplinary activity.

Finally, the MCO must request information about prospective physicians from the following sources to verify malpractice claims, loss of licensure and Medicare or Medicaid sanctions:

- National Practitioner Data Bank (NPDB);
- Health Care Financing Administration; and
- State board of medical examiners or state department of professional regulations.

As managed care spreads, consumers are acquainting themselves more thoroughly with the MCOs they join, and they are demanding higher levels of service. In response, many MCOs have gone beyond the basic NCQA credentialing requirements and are measuring applicants against more subjective criteria. For example, while one plan might find minimal malpractice settlements acceptable, another may shy away from practitioners who have even a single entry on record in the NPDB, which maintains data on malpractice suits and other litigation. Other MCOs may refuse physicians who have chosen to keep their practices small, and consequently do not have admitting privileges at several of the plans' in-network hospitals.

One of the many topics of contention between physicians and MCOs is the use of board certification as a minimum requirement for physician accreditation. ASIM believes that board certification should not be the sole standard for evaluating physician competence. In its 1995 policy paper, The Use of Board Certification To Credential Internists, ASIM noted that even though more than 60 percent of all physicians are certified by one of the American Board of Medical Specialties organizations, certification is not the only indicator of quality patient care. Other indicators include faculty appointment in a medical school or participation in teaching residents and medical students; evidence of extensive continuing medical education; appointments to peer review or quality assurance committees; evidence of a large, busy practice of satisfied patients; and others. Moreover, the use of board certification as a credentialing requirement potentially eliminates physicians who began practicing medicine before their particular specialty adopted certification. It also may exclude physicians who recently completed their residencies in a specialty that requires several years in practice to gain eligibility for the board examinations.

Because physician credentialing appears to be a necessity in managed care, the process should employ sound methods to aid an MCO in selecting competent providers, and should ensure providers a fair application of the selection criteria. ASIM recommends that:

1. Each MCO should evaluate the professional competence of physician applicants and panel members in a manner that is comprehensive, but not cumbersome or inordinately time-consuming.

2. MCOs should assess physicians on the basis of education, training, experience, and demonstrated competence.

3. MCOs should use nationally recognized guidelines for procedural competence in assessing physicians.

4. MCOs should provide a fair hearing and an appeals process for applicants or panel members denied participation or retention for reasons related to professional competency.

5. Each physician should have to complete the credentialing document collection process only once; other MCOs or contractors can share the results, with the physician's consent. Similarly, physicians should complete recredentialing documents only once every two years; other MCOs or con-
Physicians should have to fill out the uniform credentialing application only once. Recredentialing applications should contain a summary of the information in the credentialing file for the physician to review, verify and change as necessary.

Physicians who change practice location or affiliation should not have to undergo automatic recredentialing.

Recredentialing, which MCOs usually require for all participating physicians every other year, is particularly troublesome. Often, MCOs ask a physician to fill out an entirely new credentialing application to determine if anything in the physician's practice has changed since the initial or most recent credentialing. This forces the physician and the office staff to spend time providing information that the plan already has on file.

Another unnecessary hassle occurs when an MCO requires an entirely new credentialing each time a physician changes practice location or affiliation. A full recredentialing is for the most part unnecessary. Instead, the MCO should give the physician a summary of information contained in the credentialing file to note any changes and to verify that all other information is current.

Temporary Credentials

Temporary credentialing is another area the managed care industry should simplify. MCOs often deny or delay participating provider status to locum tenens physicians—physicians who work for a physician group for a short period of time—despite the minor credentialing expenses. MCOs should recognize that some physician groups will hire a locum tenens physician to fill in for the practice while a member is recovering from an illness or on temporary leave of absence. MCOs often refuse to grant temporary provider status to locum tenens physicians in physician groups, creating serious disruptions in physician practices, and serious problems for continuity of care in cross-coverage situations. Similarly, MCOs should not deny privileges to physicians just out of residency and newly in private practice who do not yet have all their credentials verified; in these cases, the health plan should offer temporary privileges while it proceeds with verification. ASIM recommends that:

MCOs should recognize the services provided by any qualified locum tenens physician covering for physicians already on the health plan's panel, for a specified, reasonable maximum number of days per year (determined on a case-specific basis). The health plan should base payment to the covering physician on its accepted schedules or arrangements.

MCOs' Perspective on Credentialing

In today's cost-driven, competitive business environment, the quality of the physicians who participate in an MCO is a major focus in marketing efforts. Because of the large supply of well-qualified physicians, MCO credentialing committees can choose their panels carefully, setting whatever standards they deem necessary for recruiting high-quality applicants. Furthermore, employers evaluate the size, scope and quality of the various MCO physician networks when determining which MCO should provide health care benefits to their employees. Credentialing is part of the process that MCOs must employ to maintain their own accreditation through NCQA and other similar groups. Therefore, MCOs have a major stake in ensuring that they recruit physicians who meet high standards.

MCOs clearly benefit from the credentialing process. It can lower the risk of malpractice lawsuits by providing detailed background on a provider's previous performance. NCQA-accredited MCOs also have access to the National Practitioner Data Bank (NPDB), which collects such information.

Finally, MCOs that credential physicians in their networks enjoy a marketing advantage. Consumers, employers and other purchasers look positively on MCOs that conduct rigorous credentialing and consider these efforts to maintain a high standard of quality. As health care markets emphasize quality assurance, physician credentialing will become even more important to MCOs and more attractive to consumers.
Facility and Medical Records Reviews

The Medical Office Review

MCO reviews of medical practice sites present the busy internist’s office with a variety of challenges. During these visits, reviewers try to verify that a physician’s practice meets generally accepted managed care marketplace standards, as well as more subjective standards set by many individual plans. Consequently, each plan that maintains a contract with the physician will visit the practice at least once every two years.

During these visits, reviewers examine every aspect of a practice, ranging from patient relations to accreditation and maintenance of laboratory equipment. They quiz office staff about proper safety procedures and patient confidentiality measures. Finally, reviewers often perform a comprehensive audit on a sample of the practice’s medical records to assess the thoroughness and appropriateness of the patient care.

Facility reviews influence MCOs’ decisions about physician deselectation, so physicians and their staff must become familiar with the criteria used to evaluate practice settings.

Review Criteria

MCOs glean their review standards for facilities and medical records from several sources. JCAHO publishes its standards annually in its Comprehensive Accreditation Manual for Ambulatory Health Care, while NCQA publishes standards for medical records reviews annually in its manual, NCQA Standards for the Accreditation of Managed Care Organizations.

Internists can expect reviewers to examine the following areas in a typical facility review:

- The physical appearance and condition of the office. Reviewers will examine the accessibility of the facility and will be interested in ensuring that accommodations for handicapped and elderly patients meet the Americans with Disabilities Act standards. They will evaluate the adequacy of parking lots and visibility of signs directing patients to the correct office. They will note the physical condition and cleanliness of the building, as well as the need for repairs. They will look at examining rooms, rest rooms and the reception area to determine if there are ample facilities to accommodate the number of patients normally seen in the practice. Finally, reviewers will look for children’s accommodations, and will notice any safety hazards to either child or adult patients.

- The physical plant characteristics, particularly the use of the proper technology in safe, working condition. The types of technology of interest to reviewers include: X-ray equipment, Doppler, electrocardiogram (EKG), microscope, incubator, colonoscope and other diagnostic equipment. They also will note the presence, location and condition—or absence of—emergency equipment including the crash cart, emergency kit, defibrillator and oxygen supply, as well as documentation for emergency and evacuation plans.

- The use and control of pharmaceuticals and pharmaceutical equipment. Reviewers will evaluate whether the staff has a system for monitoring drug expiration dates and for discarding unused products. They will determine whether the staff identifies and secures controlled substances and keeps records of use. They will verify that prescription pads, needles, syringes and other pharmaceutical equipment are inaccessible to patients. Finally, reviewers will ask the staff about policies for handling refill requests over the phone.

- Infection and exposure control policies and procedures. Reviewers will evaluate the office’s sterilization and disinfection methods and its procedures for discarding needles, syringes and other hazardous waste.
They will ask if staff has training in universal/HIV precautions and if the facilities and procedures comply with the Occupational Safety and Health Administration’s bloodborne pathogen standards.

**The facility’s safety features.** An MCO will want to confirm that the proper safety equipment and procedures are in place throughout the facility. Reviewers will check that smoke alarms and fire extinguishers are present, visible and in proper working condition. They will make sure that exit signs are visible, that multiple exits are readily accessible in case of emergency, and that the facility meets local fire and safety standards. Finally, they will check to see if the office enforces a no-smoking policy.

**The practice’s patient relations.** MCO subscribers want to know that their physicians will treat them with respect and will see them promptly. Reviewers will ask about the practice’s office hours, the number of patients scheduled per day, the average waiting time for appointments, and the provisions made for after-hours coverage. Reviewers also will look at how staff answer the telephone, the typical phone-waiting times, and who responds to patients’ medical questions on the phone.

**Benefits of—and Problems with—the Facility Review Process**

MCOs’ facility reviews give physicians the opportunity to have their practice sites reviewed using criteria that promote quality health care. Used as an educational tool, periodic reviews can provide insight into current facility standards and “best practice” models that other physicians employ. These reviews can serve as a quality check, benefiting physicians and their patients.

ASIM advocates the standardization of the steps in facility reviews, which now are cumbersome and arbitrary. In some cases, a physician can risk termination or deselection from a plan for not measuring up to often unannounced or arbitrary standards. Additionally, some physicians maintain more than a dozen different health plan contracts and face a facility review from each plan on a regular basis. Although these reviews are similar, they are not uniform or standardized. The amount of time that each practice must devote to facility reviews increases whenever a physician joins a new plan.

ASIM also has heard complaints from internists that some MCO safety guidelines extend beyond the scope of care customarily required in the physician’s medical office and differ from what might be expected and reasonable for a similar public facility. For example, one MCO required an exit sign on the back of an exam room door even though that was the only way in or out. Complying with such unreasonable guidelines creates additional expense and unnecessary bureaucratic hassles for physicians, with the threat that noncompliance could result in deselection from the MCO.

**Programs Developed To Address the Hassles of Facility and Medical Records Reviews**

Frustrated by the arbitrary and seemingly never-ending facility review process, members of the Oregon Medical Association (OMA) developed a streamlined facility review program, which requires physicians to undergo a single major audit every two years. To date, 12 of the state’s major MCOs have endorsed and are participating in OMA’s Ambulatory Records Certification (ARC) program.

Launched in February 1995, ARC is a computerized site survey and medical records audit system incorporating in its detailed review process many of the standards already described. Equipped with laptop computers, reviewers conduct a thorough assessment of the office of each physician who belongs to the MCO. A program manager, registered nurse or contracted physician can conduct ARC reviews. The individual MCOs taking part in the program—specifically their quality assurance departments—work together to develop and monitor ARC policies.

The ARC review divides into two parts, beginning with an examination of office policies using NCQA criteria and ending with a review of six MCO patient charts. Each of the items is weighted according to importance: to pass the review,
the physician must score at least 70 percent overall. Those who do not pass the original review must implement a plan to improve their score and must complete a second review in six months. Some fail the initial review because of deficient preventive services. Because they are relatively new to practicing in a managed care environment, some physicians are not aware of what is expected during a site review.

AMA's program, AMAP, also addresses the overwhelming and duplicative accreditation process. AMAP encompasses several components, including physician credentials, personal qualifications, clinical performance, patient care results and the environment of care. The environment of care component will cover essentially the same criteria as the ARC program, using JCAHO and NCQA standards to conduct a periodic, comprehensive review of practice sites.

Finally, COLA—a physician-directed national accrediting organization, which has led the way in the field of clinical laboratory accreditation—also has expressed interest in reducing the hassle of facility and medical records reviews. COLA has developed the Medical Practice Achievement (MPA) program to promote excellence in medical record-keeping, facility safety, access and convenience. MPA focuses on quality improvement through education and through the medical practice's participation in an onsite COLA survey. When they enroll in the program, medical practices receive educational materials, including a presurvey checklist and "OfficeGuides," to assist them in meeting MPA standards.

### Easing the Hassles of Facility and Medical Records Reviews

ARC, AMAP and MPA—as outlined in the previous section—offer facility and medical records reviews once every two years, using nationally recognized and professionally approved criteria. All have minimum requirements for passing the review and require implementation of improvement plans and subsequent review for practices that do not pass. The benefits of these streamlined—but thorough—programs to patients, physicians and MCOs are significant. Physicians undergo only one audit every two years after meeting acceptable practice standards; plans save a significant amount of money on facility review personnel; and consumers are assured that their physicians are meeting professionally-recognized standards.

ASIM believes that these programs are significant steps toward the goal of reducing the hassles associated with each review. ASIM advocates universal adoption of these programs by the managed care industry. Specifically, ASIM recommends that:

1. **In consultation with practicing physicians,** the managed care industry should develop and adopt standardized guidelines for in-office safety audits of facilities, office administrative procedures and record-keeping. These guidelines should be relevant to the type of facility and practice under review, incorporating appropriate elements of consistency, frequency, prior notice, patient confidentiality, and due process.

2. **Physicians should receive a written description of the review process and criteria at least 30 days before the review.**

3. **There should be only one initial facility and medical records review; other MCOs or contractors can share the results, with the physician's consent.**

4. **Re-review should occur no more than once a year; other MCOs or contractors can share the results, with the physician's consent. However, quality concerns or an immediate threat to patient care can necessitate more frequent reviews.**

5. **Single-source credentialing and facility review organizations are preferable to multiple credentialing and facility reviews by several different organizations.**

   **Applicable to facility review only:**

6. **Reviews should give physicians appropriate time to improve their physical practice facility, if necessary, using feedback from the previous review before a re-review, unless quality concerns or an immediate threat to patient care emerge, dictating immediate improvements.**
ASIM strongly supports the development of nationwide programs to ease the burden of facility reviews and medical records audits on physicians and their office staff. Clearly, the benefits of such facility and medical records review programs should encourage the development of similar programs throughout the industry. Here, as in other areas of compliance, a standardized, nationally integrated data-gathering and processing system would reduce the hassles created by the current review process.

A nationwide system could reduce the frequency, complexity and length of facility and medical records review visits. Other MCOs with which the physician contracts would be allowed to access the data, with the physician’s permission. This would reduce the time physicians and their staff spend duplicating review responses for several MCOs and increase the time available for patient care; it also would reduce costs for participating MCOs by eliminating multiple, overlapping inspections.

**Commonly Accepted Guidelines for Medical Records Review**

Although federal law does not require MCOs to gain NCQA accreditation, more health care consumers are demanding that an experienced and nationally recognized accreditation body examine and credential the plans they join.

NCQA has developed guidelines for the minimum criteria that accredited MCOs can accept during medical records audits. As many of the standards imply, the review is not simply an evaluation of the clerical aspects of a physician’s record-keeping practices; it also serves as an evaluation of the quality and appropriateness of patient care. When analyzing a physician’s medical records, reviewers are looking to see that the following criteria are in place:

- Each page in the record contains the patient’s name or ID number.
- Personal or biographical data include the patient’s address, home and work telephone numbers, marital status and employer’s name.
- All entries in the medical record contain author identification.
- All entries are dated.
- The record is legible by someone other than the writer.
- The problem list indicates significant illnesses and medical conditions.
- The record prominently notes medication allergies and adverse reactions. (If the patient has no known allergies, the record notes that appropriately.)
- Past medical history is easily identifiable and includes serious accidents, operations and illnesses. For children and adolescents, past medical history relates to prenatal care, birth, operations and childhood illnesses.
- For patients 14 years of age and older, there are appropriate notations concerning the use of cigarettes, alcohol and other harmful substances.
- The history and physical records have appropriate, subjective and objective information pertinent to the patient’s complaints.
- Laboratory and other studies are ordered, as appropriate.
- Working diagnoses are consistent with findings.
- Treatment plans are consistent with diagnoses.
- Encounter forms note follow-up care, calls or visits, and record the specific time of return in weeks, months or “as needed.”
- Subsequent visits address problems unresolved in previous office visits.
- Consultants are not under- or over-utilized.
- If a consultation is requested, the consultant’s notes appear in the record.
- The primary care physician initials consultation, lab and imaging reports filed in the chart, signifying review. If the reports are in electronic format, there should be an indication that the physician has reviewed them. Consultations and abnormal lab and imaging results should have explicit notations for follow-up plans in the record.
There is no evidence to suggest that a diagnostic or therapeutic problem has placed the patient at inappropriate risk.

There is evidence that the physician or clinical staff offered preventive screening and services in accordance with the MCO's practice guidelines.

Nurses or other MCO reviewers who have clinical health care backgrounds usually handle medical records reviews. Because medical records often contain sensitive personal information, ASIM recommends that:

7 A medical records review should maintain patient confidentiality.

8 There should be an established process to assure that patients have authorized any review of their medical records.

9 Medical records review should use patient medical information solely to review the practice and not to determine patient insurance coverage or eligibility.

Some physicians have expressed concern about the risk of compromising patient confidentiality during the course of medical chart evaluations. Reviews conducted by managed care representatives may reveal a member's health problems and could lead the MCO to cancel the patient's insurance.
Utilization Review/Utilization Management

Among the most burdensome and challenging hassles physicians face in today’s managed care environment is the management of health care resources through utilization review (UR). Whether done prospectively, concurrently or retrospectively, UR and utilization management (UM) directly affect the quality of the care physicians supply to their patients. UR/UM can educate physicians positively about best-practice methods, by using peer-reviewed clinical guidelines and including physician input. However, UR/UM also can emphasize cost controls and come into conflict with the physician’s interest in the patient’s welfare.

In AMA’s 1990 Socioeconomic Monitoring Survey, internists indicated that UR/UM was the most intrusive factor in their practice. Given a choice of UR/UM, professional liability, capitation and fee schedules, practice guidelines, prevailing practice patterns, other factors, or none at all, 29.9 percent of all internists rated UR/UM as the factor that most interfered with their clinical decision-making, followed closely by professional liability (23.9 percent). Internists found retrospective review of surgical opinions the form of UR/UM that most interfered with clinical decision-making (31.2 percent), followed closely by preadmission or preprocedure certification (30.8 percent) and concurrent review (25.3 percent). Only 6.2 percent of the survey respondents did not report interference in clinical decision-making due to UR/UM. Internists specifically identified three forms of UR/UM as most time consuming: 34.3 percent cited preadmission or preprocedure certification; 34.2 percent, retrospective review; and 18 percent, concurrent review.14

Originally, UR/UM aimed to reduce the number of inpatient admissions and unnecessary hospital days. The process included precertification and concurrent review. Precertification analyzes medical necessity and the concurrent review analyzes the need for ongoing care. These decisions generally used tables indicating the average length of hospital stay, projecting hospitalization based on the principal diagnosis and comorbidities.15 MCO administrators then could apply this process retrospectively, even when there was no initial review.

Programs to manage health care utilization emerged more than 25 years ago. Currently, UR/UM programs affect more than 90 percent of the approximately 180 million people with private medical insurance. UR/UM has moved well beyond hospital care to other medical services (e.g., laboratory medicine, pharmacy) and to other care settings (e.g., physician offices). UR/UM has become a major cost-containment strategy for MCOs. The review of drug, psychiatric and substance abuse, and of dental services also is widespread.16

Almost every provider- or payer-sponsored utilization management program includes precertification and concurrent review. Typical characteristics of these two components are:

- The collection of data about diagnosis, required services, diagnostic test results, and symptoms;
- The review of criteria that describe the conditions or services to support the care request;
- The comparison of medical information to medical necessity criteria;
- Referral of the case for physician review, if it does not meet the criteria;
- Physician determination of medical necessity;
- The communication of the review’s outcome; and
- The right of the physician to appeal the decision.

UR/UM practices quickly became part of federal and state health care programs as well as MCOs. The federal government established professional standards review organizations (PSROs) in 1972 to provide UR/UM services to Medicare patients. The program terminated in 1982 for lack of effectiveness, and in 1983, peer review organizations (PROs) replaced PSROs. PROs are federally financed and regulated regional entities responsible for assuring the quality of Medicare services and eliminating unnecessary care.
Improving the Disclosure of UR/UM Criteria

Many states now have established legislation requiring that MCOs make UR/UM criteria available to physicians and patients. In some instances, this has reduced the number of cases referred for review by about two-thirds. The effectiveness of this requirement in avoiding disputes should increase as MCOs and physicians become more familiar with UR/UM. Therefore ASIM recommends that:

1. MCOs should reveal UR/UM criteria—such as computer algorithms, screening criteria, and weighting elements—to physicians and their patients, on request.

ASIM believes that participating MCO physicians must be involved in examining the UR/UM guidelines and policies of their MCOs to make certain that medical necessity determinations are appropriate. By keeping the criteria for coverage decisions secret, MCOs increase the potential for denying legitimate medical care arbitrarily and incorrectly.

Improving the Scope of UR/UM Processes

Although precertification and concurrent review are the oldest and most developed methods for controlling utilization, their impact remains unclear. Supporters of UR/UM suggest that these processes have assisted the development of outpatient technology, fostered the shift from inpatient to outpatient care, reduced the number of unnecessary inpatient days, and provided a mechanism for timely identification of patients who require discharge planning and case management.

UR/UM opponents contend that these processes contribute to administrative overhead, offer an uncertain cost benefit, delay care, and are not physician-friendly. Critics also maintain that precertification and concurrent review already have reached their potential to reduce utilization, and that any further reductions in unnecessary utilization will require new techniques.

ASIM believes that there are elements of truth in both the pro and con viewpoints and that the scope of UR/UM processes needs improvement. ASIM recommends that:

2. MCOs should require preauthorization only for services for a specified procedure if there is clear evidence that: (1) Routine use of preauthorization substantially reduces the number of medically unnecessary services; and (2) The costs of conducting the preauthorization—including costs incurred by the physician's office in complying with the preauthorization requirements—do not exceed the potential savings.

3. MCOs should require that UR/UM personnel and processes focus on medical procedures that have a consistent pattern of overutilization, pose significant medical or financial risk to the patient, or for which there are no clear medical indications for use.

Well-run precertification programs may result in a more optimal management of utilization, as measured by appropriate admissions and length-of-stay data for inpatient services. However, developing and administering these programs requires a substantial investment of resources, including nurses, information systems, medical review criteria and administrative support. The potential cost savings of preauthorization should not compromise patient care or inhibit physician compliance.

Applying a uniform set of UR/UM criteria developed in conjunction with the medical community would alleviate some—if not all—of the discomfort patients feel about the purpose and effect of UR/UM. If physicians have confidence in the system that has produced the UR/UM policies, they can assuage their patients' uneasiness. Physician confidence relates directly to the peer-reviewed information available and to sound scientific principles. Therefore ASIM recommends that:

4. MCOs should apply uniformly the UR/UM criteria established or endorsed by a UR/UM organization and the medical community, based on sound scientific principles and the most recent medical evidence.
UR/UM programs will be more effective if they encourage physician efficiency and high quality patient care based on the latest, peer-reviewed clinical evidence. The development and operation of review criteria and policies should be subject to peer review and open to public scrutiny. Furthermore, beneficiaries have a right to expect that the determination of their care has its basis in sound medicine, not in cost considerations.

**Increasing the Educational Role of UR/UM**

One of the most positive aspects of UR/UM is its potential as an educational tool to enhance the practice of medicine. UR/UM can produce evidence-based, best-practice guidelines, protocols and other informational tools, using data derived from clinical practices. Such peer-reviewed, standardized information should be a major goal of UR/UM, providing physicians and patients guidance in deciding the best possible course of treatment. Therefore, ASIM recommends that:

1. MCOs should ensure that the UR/UM process is educational. Instead of punishing physicians or preventing appropriate care, the process should alert physicians to practices that may not be cost-effective and efficient. UR/UM should encourage physicians to examine methods for altering practices and procedures while viewing high quality patient care as their priority.

2. Physicians’ adherence to evidence-based, scientifically-supported practice guidelines should result in payment without excessive demands for documentation and without filing appeals. If the patient care does not comply with these guidelines, the physician should provide information to justify the claim.

Physicians and most accrediting bodies agree that evidence-based guidelines or protocols should be the foundation for UR/UM determinations. Efforts are under way to move the industry toward a more educational approach to UR/UM. NCQA has set standards for HMO accreditation that call for medical appropriateness protocols based on reasonable medical evidence. In addition, MCOs must document the criteria clearly, as well as review and update them periodically.

One practical outcome of this approach would be the ability to identify physicians who have practiced and continue to practice in efficient ways. This would allow MCOs to concentrate on practitioners who consistently fall outside the parameters of efficiency, with the possibility of exempting from unwarranted UR/UM those who consistently comply. Indeed, some physician practices may fall within these parameters with such consistency that it makes more sense for the MCO to exempt them from UR/UM protocols than to burden the MCO, physicians and patients further.

For the most part, physicians consistently have held the view that no single set of practice guidelines is sufficient to meet the needs of their patient mix. While ASIM recognizes the difficulties in establishing and maintaining practice guidelines for the purpose of UR/UM, such standards, when completed, will be much stronger if they are evidence-based, scientifically supported, and developed in consultation with practicing physicians.

Insurers and MCOs, when faced with a lack of scientific information, alternatively revert to evaluations based on economics and on whatever clinical data is easily obtainable. As a result, studies have associated inappropriately applied UR/UM with increased expenditures for long-term care and hospital readmissions. A 1996 study of four-year longitudinal change in health status showed that four HMOs examined in the late 1980s were less effective than fee-for-service care in maintaining the physical health status of older, sicker patients. Other studies found a significant relationship between limiting length of stay through utilization review and an increased risk of readmission. These studies show that UR/UM should be more educational and outcomes-focused.

**Impact of UR/UM on Physician-Patient Relationships**

Historically, MCOs have used UR/UM to exercise cost controls on the health plans they offer. In
establishing UR/UM programs, MCOs attempt to standardize care, thus providing a way to predict costs for certain populations on the basis of resource utilization. However, physicians, patients and health care advocates have raised serious concerns about UR/UM processes that inadvertently threaten physician autonomy, prevent patient access to appropriate care, create conflict between physician reimbursement and patient care, and ultimately damage the physician-patient relationship.

UR/UM can threaten physician autonomy in the following ways:

- External utilization review challenges the authority of the medical profession and raises issues of control.
- Paperwork and other bureaucratic requirements of external review distract physicians from their fundamental mission of patient care. Some physicians must contend with a variety of differing and often inconsistent UR/UM requirements.
- UR/UM of clinical decisions—along with protocols that managed care uses to standardize treatment—fosters a style of medical care that disregards the needs and conditions of individual patients, forcing physicians to practice what some call "cookbook" medicine.

These elements combine to erode professional standards. There are other factors associated with UR/UM that also influence the physician-patient relationship: gag rules and the incentive plans that many MCOs use to garner physician compliance with utilization goals.

MCOs can enhance their relationships with physicians and bolster patient confidence by respecting physician autonomy as much as possible. Patient advocacy is the physician's pre-eminent social and medical role. Physicians who have served effectively as patient advocates must not face exclusion from managed care plans.

**Gag Rules**

Gag rules hinder the physician's autonomy and role as patient advocate by limiting the physician's freedom to discuss therapy options with patients. Even if the patient never finds out that UR/UM has altered the treatment options, that only tempers the consequences of the policies in the short run. Historically, some MCOs have tried to discourage physicians from addressing UR/UM with their patients. At the heart of the physician-patient relationship is honest, open communication by both parties. Any attempt to limit physician communication with patients is intolerable because it restricts the independence of both physicians and patients, and subverts physicians' obligations to their patients. ASIM recommends that:

7 No contract between an MCO and a physician should contain any provision restricting the physician's ability to communicate information to a patient regarding the medical care or treatment options that the physician deems are in the patient's best interest.

8 MCOs should not exclude physicians who have served as patient advocates in appealing UR/UM decisions.

Gag rules also can create considerable costs—e.g., for second and third opinions—as patients and health care purchasers seek to protect themselves from negative outcomes. An increasing share of the health care dollar is shifting from therapy to self-protection, regulatory enforcement, and physician compliance. A 1992 study estimated that these activities cost about $2.3 billion.

**Physician Incentives**

Managed care entities implement and administer UR/UM programs in several ways. MCOs often specifically link physician bonuses and incentives to utilization. MCOs enforce utilization compliance using withholds and other risk-management arrangements. Such policies emphasize withholding services from patients. Financial incentives to limit care options available to the physician can create a significant conflict of interest. ASIM is particularly concerned about these issues and recommends that:

9 UR/UM policies must never place physician financial incentives in conflict with patient welfare.
10 MCOs must not initiate UR/UM contracts intended to deny medically necessary services.

11 MCOs must not base the compensation of individuals who conduct UR/UM on the number or monetary value of care denials.

Most practicing physicians do not oppose efforts to provide quality patient care while containing costs. However, the potentially coercive nature of UR/UM, when tied to incentives, can give physicians little encouragement to maintain a balance between quality and cost. This is particularly true when UR/UM systems have no objective, uniform standards for evaluation.25

Any incentives to limit care raise profound issues of trust. UR/UM incentives have the potential to disrupt the most important link in the health care chain—the physician-patient relationship. There must be limits on incentives that put physicians in financial conflict with their patients' interests. Ascertaining the appropriate limits depends on how the MCO couples financial incentives with quality assurance mechanisms. This issue demands careful consideration by MCOs and their contracted physicians.

Denials and Appeals

After the precertification and concurrent review requirements, the areas physicians most often cite as confusing and frustrating are the denial and appeals process and the qualifications of the personnel who make UR/UM decisions.

In some cases, MCOs do not inform physicians about the process for appeals when UR/UM protocols deny care to their patients. MCOs should make the criteria for appeals available to all participating providers. ASIM recommends that:

12 UR/UM appeals should provide physicians with due process, including the right to review the material used to make the claims denial with the actual personnel responsible for the review.

As previously stated, the procedures for appealing a denial can be numerous and confusing. Multi-layered UR/UM appeals processes can create difficulty for physicians—whose time already is limited due to the administrative constraints of managed care—to obtain the care they believe their patients need. At the least, physicians should have the opportunity to review the information with the UR/UM personnel responsible for the claims denial. This would ensure that there is communication between the physician and the reviewer and that the patient's case receives proper consideration.

UR/UM Personnel Qualifications

UR/UM decision-making should require a high degree of clinical expertise. However, physicians and patients often do not know who is making the decisions, leaving little recourse for review and appeal of a determination. ASIM recommends that:

13 For review determinations, MCOs should use only licensed, certified or otherwise credentialed health professionals who are free from financial bias, and should make the reviewers' credentials available on request.

14 MCOs should provide timely access to review personnel; if review personnel are unavailable, MCOs should waive any preauthorization requirements.

There should be uniform personnel standards for UR/UM organizations. In addition, physicians and patients should have access to qualified administrative personnel when inquiring about, or appealing, UR/UM decisions. Furthermore, access to UR/UM personnel must be timely.

Emergency Care

While UR/UM rarely is used prospectively in emergency care, it nonetheless has an impact on a patient's access to appropriate care when a retrospective review denies payment. MCOs often make only broad promises that appropriate emergency care is available to enrollees. However, MCOs do not explain clearly enough to patients how requests for emergency services are handled. In its 1996 report to Congress, the Physician Payment Review Commission recommended use of a "prudent layperson" standard as one factor in determining coverage of initial
screening and stabilization in the emergency room for Medicare MCOs. The prudent layperson standard considers what the patient knows when seeking the emergency care, rather than what is learned as a result of the emergency department visit. ASIM recommends that:

15 MCOs should accept a prudent layperson's assessment of an emergency condition in determining when to pay for initial screening and stabilization in the emergency room. MCOs should base the determination on what the patient knows at the time of seeking the emergency care, rather than on what the emergency department visit reveals.

ASIM urges all MCOs to adopt this standard. In this way, for example, an MCO could not penalize a beneficiary who experiences sudden shortness of breath, thinks it means a possible cardiac event, and reports to the emergency department only to find there was no risk of heart attack.

Lack of Standardized UR/UM Processes

While MCOs must broaden the educational focus of UR/UM and develop protocols based on outcomes, they should concentrate their initial efforts on standardizing the review process itself. Without a standardized UR/UM process, physicians must flounder in the many different and sometimes conflicting policies and procedures of the various MCOs with which they contract. The amount of time involved in any given UR/UM episode can be substantial because physicians and their staff have to maneuver through a myriad of different MCO requirements. A mistake means repeating the process or potentially facing an inappropriate denial of care. Therefore, ASIM recommends that:

16 With input from practicing physicians, the MCO industry should standardize utilization review authorization processes.

The UR/UM process should be effective for the purpose of the review but not require more than a minimal amount of time and effort on the part of the physician and the physician's staff. Without a national standard, MCOs establish their own UR/UM criteria, making it more difficult than necessary for physicians to obtain authorizations or to appeal denials. To reduce the hassles associated with often confusing authorization requirements, MCOs should develop consistent standards for:

- Specifying limits on information requirements;
- Timeliness of reviews;
- Appeal procedures;
- Staff and program qualifications; and
- Accessibility of reviewers to providers.

Developing a UR/UM Standard

Initially, insurance companies or contracted organizations conducted UR/UM activities. Physician-sponsored organizations that participate in risk contracts also have developed mechanisms to conduct precertification and concurrent review. Standards for this decision-making process have become more explicit as the American Accreditation HealthCare Commission (AAHCC)/Utilization Review Accreditation Commission (URAC) and NCQA have developed standards that apply to different components of utilization management.

AAHCC/URAC's Health Utilization Management Standards exemplify an approach to standardizing the UR/UM process. The standards require UR/UM entities to establish a three-step procedure to determine the medical necessity of a proposed treatment or service:

1 Initial clinical review. Licensed health professionals, such as nurses, must perform the initial clinical review. The reviewer must have training in UR/UM principles and AAHCC/URAC standards and must have access to a licensed physician for support and guidance in the review process. If the reviewer finds that the proposed medical service is medically necessary, it is approved; the approval concludes the UR/UM process at this step.

2 Peer clinical review. If the reviewer cannot approve the proposed service during initial
clinical review, the case goes to a physician qualified to render a clinical opinion concerning the proposed medical service. If the treating provider is a nonphysician, then a comparable provider may perform the peer clinical review (e.g., a chiropractor may conduct chiropractor UR/UM). The person who performs peer clinical review must be available to discuss the determination with the provider within one business day after the decision. As with initial clinical review, if peer clinical review results in certification, the UR/UM process ends at this step.

3 Appeals consideration. If the peer clinical review does not result in certification, the treating provider and the patient have the right to an appeals consideration. The clinical peers who consider these appeals are board certified and in active practice in the profession and specialty that typically manages the medical condition under review.

AAHCC/URAC also recommends criteria for the timeliness of communicating UR/UM decisions to the patient and the treating physician:

- Two business days for prospective and retrospective UR/UM certifications;
- One business day for concurrent review certifications, by telephone or in writing; and
- One business day for all noncertifications. It further specifies that noncertification notifications must include the principal reasons as well as instructions for appeal.

The AAHCC/URAC utilization review denial and appeals process requires:

- Either the patient or the physician must initiate appeals. For appeals involving ongoing or imminent medical care, the UR/UM entity must expedite consideration. The entity must complete and transmit determinations for these expedited appeals to the treating physician and patient within two business days. It must complete standard appeals—which do not involve ongoing or imminent care—within 30 days. Expedited appeals that do not result in a reversal may enter standard appeal.

- Throughout the process, the UR/UM entity must use explicit clinical review criteria based on sound clinical principles and processes, and reviewed and revised on a periodic basis. The UR/UM entity must disclose the criteria for a noncertification decision to the patient or the treating physician on request.

- UR/UM entities also must have a medical director who is a licensed physician and is responsible for the clinical oversight of the UR/UM process. UR/UM entities that focus solely on reviews for care provided by certain nonphysician practitioners may have a nonphysician clinical director who is certified in a health care profession appropriate to the types of reviews conducted.27

These standards represent a practical approach that should alleviate many of the hassles associated with UR/UM. MCOs also should include physicians in the development and administration of UR/UM, and obtain clinical data for best-practice guidelines in concert with the adoption of AAHCC/URAC standards.
Conclusion

The managed care industry has evolved in response to concerns about the rising costs of health care delivery. With its evolution have come concerns about the quality of patient care and about managed care's impact on the integrity of the traditional physician-patient relationship. Some policies MCOs have enacted to ensure financial well-being have had a detrimental affect on the practice of medicine. Among the managed care policies most burdensome to internists are physician credentialing, facility and medical records reviews, and utilization review/utilization management.

AAHP and certain states have suggested methods to streamline physician credentialing. A uniform, standardized credentialing process will alleviate some of the time-consuming burden that physicians in managed care shoulder. A less cumbersome credentialing process will leave physicians more time for patients and the practice of medicine.

The Oregon Medical Association's ARC program has suggested ways to streamline facilities and medical records reviews. National standards—such as NCQA's—could help standardize these processes, making them less arbitrary. Preparing for and conducting different facility and records reviews for different MCOs is labor- and cost-intensive. An information-sharing system could reduce these costs.

UR/UM can create inappropriate delays, reductions or denials of patient care. UR/UM programs must guard against these potential problems. MCOs should emulate standardized UR/UM processes such as those developed by AAHCC/URAC.

The series of recommendations described in this paper serve as a template to improve MCO credentialing, facility and medical records reviews, and UR/UM programs.
References


8. Ibid., p. 67.

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12. NCQA, op. cit.


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