

Getting the Most from an Independent Review Organization

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Providing high-quality care while keeping health care costs under control is not the responsibility of just one group. It is a collaborative effort involving interorganizational cooperation. In the arena of case management (CM), that effort is shared by the insurance provider, the patient's physician, the case manager, and often by an independent review organization (IRO).

Because baby boomers are aging and medical advances are diagnosing health conditions earlier, CM processing is growing. At Insurance Management Services (IMS) Managed Care, a staff of five serves 50,000 individuals across 15 states and handles more than 3000 preauthorizations for more than 140 groups annually. Educators Mutual Life Insurance Co. reviews between 100 and 150 disability claims per month. HealthGuard of Lancaster, Inc., serves 95,000 members and sees nearly 100 appeals every month.

Based on our own internal studies, health care providers send out between 5% and 20% of their cases for independent review, depending on the type of company—from preauthorization to fraud investigation. These organizations use IROs for several reasons: they need special medical expertise not found within their organization; they are confronted with a difficult case that requires an objective, third-party review based on medical fact; they are under pressure to reduce appeals by providing objective responses based on accepted medical

Justifications for Using an IRO

Increasingly, health care providers, insurers, and case managers are turning to IROs as a collaborative extension of their decision-making process for claims. Some of the reasons for this alliance include:

Access to deep medical knowledge. Case managers may need access to a breadth of medical expertise or to an outside source of medical expertise beyond what they have available among their staff or extended network.

Reduced concerns of partiality. Case managers may need a buffer for their clinicians from any real or perceived conflict of interest. In claims that have potential high appeal rates or some other risk factor, health plan providers and insurers may want an external, independent, and objective perspective regarding the claim so that the results are not tainted by the potential bias of a physician on their payroll.

Validation of a decision. Case managers need to ensure that the denial or the approval is based on the accepted science of medicine. An IRO provides access to a physician with the same credentials as the one making the recommendation.

Improved responsiveness. When mandated state and federal deadlines must be met, payers can use an IRO to expedite the review of a given case to ensure these deadlines are met each and every time.

Decreased cost. Case managers' organizations are under constant pressure to reduce costs. Outsourcing medical claims decision making to an IRO allows providers to reduce expensive physician overheads by paying only for what they need, when they need it.

practice; or they have mandated review deadlines to meet.

Why Turn to an IRO?

Today there is increasing pressure on health organizations and claims managers to make the right decisions, not only for the patient but also to keep health care insurance costs, premiums, and copayments under control. Using an external organization such as an IRO can be a low-cost way of making sure that a health plan is administered properly for both the insurer and the patient. Because the IRO serves as an unbiased advocate and a source of informed opinion, it can ensure that each claim is properly evaluated every time.

To ensure the best possible evidence-based outcome for the health plan provider and for the patient, the simple process of sorting out any cases that have characteristics that tend to require closer examination is a good means for determining reviews and for gathering the factual medical review data that either support the medical procedure or deny it.

Obviously, easy calls can be made on many claims. However, for some small percentage of claims, an IRO can bring greater scrutiny and detail needed to make the proper decision. Some medical procedures may need to be questioned either for medical necessity or investigational purposes, such as total abdominal hysterectomies, some spinal surgeries, bariatric surgery, intracardiac defibrillators, mastectomy, abdominoplasty, breast reductions, and even continued stays in hospitals. This cost reduction benefits a health care provider's entire subscriber base by efficiently allocating dollars only to those patients who truly need them.

Basing Decisions on Medical Fact

Basing decisions on medical fact is increasingly important because of the evolving nature of medical technique, the rising cost and complexity of medical treatments, and the widespread availability of medical information,

including experimental techniques, now available to consumers. This accessibility creates an atmosphere in which medical and case decisions are more likely to be questioned. Basing a review on factual medical evidence also makes it defensible, should that be required.

Creating a defensible review is not the sole domain of the IRO. According to Cathy Raushcer, utilization review nurse for IMS Managed Care, the more clinical information that a case manager can provide for a medical review, the better the outcome returned. Raushcer also notes that it is more efficient for the physician reviewing the case because he or she can get a complete picture of what is going on with the patient and can make a fair determination about the situation.

As the cost and complexity of medical treatments continue to increase, claims managers may be forced by circumstance to err on the side of paying unnecessary or questionable claims because they lack access to the medical expertise needed to make informed decisions within an acceptable time frame. In such cases, outsourcing medical decision making to an IRO can have

a dramatic impact on lowering health care claims costs by eliminating unnecessary treatments. Raushcer also points out that, as well as improving patient care, an IRO reduces the frustration that physicians often feel about urgent cases, because of the fast response and evidence-based results.

The explosion of medical data linked with patients' rights makes people generally more knowledgeable about potential medical solutions and new drugs, so case managers are being asked more questions by patients. Deciding whether or not a patient really needs the new drug that costs \$85 a week when the \$4-a-week drug does the same job can be objectively analyzed by an IRO. The company can consider what the accepted medical practice is regarding both drugs and the efficacy based on medical facts, instead of relying on pharmaceutical representatives' interpretation of the facts.

An IRO helps to serve as an intermediary to determine whether a recommended procedure is medically required or meets agreed upon medical standards. This objectivity provides the treating doctors with information for

their patients that helps maintain their doctor/patient relationships, regardless of whether the claim is approved or not.

And what if there are questions about a review? Whenever a recommending doctor or a case manager finds that the information in the independent review is unclear, either of them should be able to pick up the phone and have a one-on-one discussion to resolve any issues.

Handling Appeals

Insurers and health plan providers want the people in their plan to get the care they need and are entitled to. Some claims clearly fit into what is prescribed by the plan and can be approved quickly. The more problematic claims that are subject to denial require closer scrutiny and must be reviewed by a physician. In the case of a denial, patients have the right to have their cases reviewed by a physician with a similar specialty who understands their specific medical needs. A full-service IRO provides a panel of specialist physicians to meet this requirement and to ensure an impartial evaluation of the claim in question.

If an appeal is generated, it is a good idea for the case manager to have the case reviewed by a specialist at an external review organization to determine the medical necessity based on fact. An IRO also can help ensure that appeals governed by rigorous regulation, including state and federal guidelines such as Employee Retirement Income Security Act requirements and other Department of Labor regulations, are followed by meeting required deadlines and by providing reviews based on accepted medical practice, which can reduce the number of appeals. According to Ken Wasnock, manager of life and disability claims at Educator's Mutual Life Co., an IRO has helped the company instill a process for managing questionable claims, ensure these decisions are based on medical fact versus opinion, and guarantee the best possible outcome for their customers and employees. He added that, through this process,

appeals for overall denied claims have been virtually nonexistent.

How to Choose an IRO

Selecting an IRO means finding a trusted partner because, as a case manager, you work closely with physicians in that organization on a regular, even daily basis. You want an organization that can meet your expectations in three areas—relationship, business, and medical.

Relationship

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

Business

- What is the cost of the review service?
- How well does the IRO staff understand the CM process?
- How do they manage their review process internally?
- What is their knowledge of state and federal requirements?
- What type of relationships do they have with other health care providers and insurers?

Medical

- Does the organization have deep medical knowledge or access to it?
- What range of medical specialists does the review organization offer?
- Do they base all their reviews on accepted and up-to-date medical practice?
- Are they willing to get on the phone with another physician (or even with the patient) and explain or defend their review?
- Do they serve as an advocate for all parties (provider and patient)?
- What is their process when their review is challenged?

Conclusion

Information and scientific advancements in the medical field are increasing at unprecedented rates and are resulting in new specialties every year. There is simply too much medical information for one doctor to know it all. Our health care system is only as strong as the sum of its parts, and this equation includes the case managers who work under the umbrella of a health plan and the IROs they are linked to through collaborative relationships. Because of the volume and the breadth of claims it reviews on a daily basis and the depth of its specialist panels, an IRO provides a mechanism for quickly and consistently applying specialist knowledge to claims decision making.

All case managers should expect their review organization to respond quickly, to meet normal and expedited deadlines as needed, to have a depth and a breadth of medical knowledge, to provide reviews based on medical evidence, and to help preserve the long-term physician/patient relationship. Through this cooperative effort, CM can objectively balance both health care provider and patient satisfaction based on accepted medical practice. □

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