cid management

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You Can't Manage What You Can't Measure

Getting a return on your Utilization Review dollars by knowing what's important

by Steven Cardinale

The Price of Medical Cost Containment

For years industry pundits have complained about the price of medical cost containment (MCC) services, including utilization review (UR). According to a CWCI study, MCC costs in California rose 277.8% between accident years 2002 and 2011 (Ireland and Swedlow, 2012). Recent discussions surrounding workers' compensation reform in the state have raised the question of whether UR reduces unnecessary costs or simply adds another fee to the system.

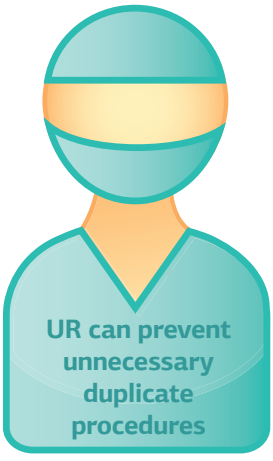
Does UR reduce unnecessary costs or simply adds another fee to the system ?

First of all, for measurements to be useful, any data point that will be used in future reports needs to be captured in a single-system database. Essentially the database organizes and structures the UR process to ensure that appropriate types of data are captured. This allows for accurate future reporting. This does not mean simply cutting-and-pasting from an Excel document or having to review a Word attachment. Instead, all of the data needs to be consolidated into sortable fields for reports to be valuable. That is where the technology comes in.

UR is supposed to ensure that the treatment plan set forth by the provider is appropriate for the patient. It should be a tool that determines appropriate care without delaying treatment or increasing costs.

Is UR working for your company? If not, how do you make it work?

We know that UR works in extreme cases. For example, when an orthopedic surgeon operates on the same shoulder four times. Used earlier in the case, UR could have prevented the second, third, and fourth repetition of procedures that obviously were not necessary. Another example is seen in the case of an injured firefighter who required spinal surgery. The treating physician wanted to operate immediately despite an infection that could have put the patient's life at risk. Once assured the surgery would occur once the infection cleared up, the treating physician agreed to wait. In this instance, UR may have saved a life.



Of course, most cases aren't extreme. Consequently, some argue that it is less expensive to provide the treatment than to send the request to UR. Obviously, it doesn't make sense to send a request for a $10 shoe insert through a $100 UR. On the other hand, a $30-per-month prescription that the injured worker will take for five years should go to UR.

The Challenge is Determining Which Cases Should Go to UR

Payers need to standardize their UR referral processes so they can consistently send only the cases that really require UR. This necessitates measuring existing UR efforts, but many payers do not know what really needs to be measured or how to measure the program. They do not even know how many cases went to UR last year, much less how many requests involved chiropractic care or surgical procedures.

If you don't measure it, you can't manage it. So what are the metrics?

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What metrics need to be measured?

Ultimately, payers should be able to capture 100 percent of inappropriate treatment.

- The cost of UR versus the cost of the procedure
- How many times a UR decision was appealed
- Of these appeals, how many challenges went to a work comp board ? Were the challenges successful
- Treatment requests by medical specialty and UR results by medical specialty.

The most important metric is the overall return on investment.

At the end of each month, review the UR program. How many services were approved, modified, and denied? Compare your UR costs to the savings UR produced to determine the program's effectiveness.

What metrics need not be measured?

Denial rates – these are extremely unreliable because different payers use different processes. As an example, Payer A sends everything to UR while Payer B conducts internal reviews, approves a lot of services and only sends UR the claims that are expected to be denied. Payer A will have denial rates of 20-30 percent, while Payer B, with fewer requests, will have a higher denial rate of 70-80 percent.

Appeal rates – these are equally meaningless. Aggressive applicant attorneys, stubborn clinicians, and a lack of consequences for excessive appeals dictate appeal rates.

With the right data, you can eliminate unnecessary UR requests. Don't send everything to UR; you're supposed to be providing good care AND saving money.

About Steven Cardinale

Steven Cardinale brought 15 years of business and technology experience to co-creating CID Management in 2002. Just prior to CID, Mr. Cardinale served as Chief Technology Officer for iBidCo, an on-line real estate sales site that sold more real estate "sight unseen" than any other, where he crafted a partnership with eBay. An accomplished business, management and technology strategist, he has consulted with Eli Lily, Janus Funds, IBM, PricewaterhouseCoopers, and the J. Paul Getty Museum.

Cardinale holds a degree in Economics from the University of California, Los Angeles (UCLA) and is a graduate of the prestigious Wharton School of the University of Pennsylvania. Email him at scardinale@cidmcorp.com

About CID Management

Based in Westlake Village, California and serving workers' compensation payers nationally, CID Management is a workers' compensation utilization management company that offers a unique range of services collectively known as The Clinical Experience. Under The Clinical Experience umbrella, CID provides URAC-accredited utilization review (UR), peer review and peer-to-peer physician case management to provide decisions that support evidence-based care, control medical costs and mitigate risks. CID offers three additional Clinical Experience services; Clinical Help Desk, MD On-Call, and Physician Conversations that help clients get fast and instructive answers to clinical, regulatory and administrative questions to keep claims from stalling.

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