Utilization Review

The utilization review process

Utilization review (UR) is a key element of the screening process Pennsylvania Blue Shield uses to assure that its members receive health care services that are medically necessary and that the claims for these services are submitted properly.

There are three phases in UR:

During initial **claims review**, Blue Shield staff reviews each claim. In this editing process, we single out easily identifiable errors and spot services claimed for payment that are not covered in a customer's benefit package. Frequently, Blue Shield pays for eligible services, even though a more extensive review of practice patterns may take place at a later time.

Pre-payment UR takes place before we pay the claim. Here, the staff looks closely at selected claims to determine the medical necessity of the services reported. As in the initial claims review process, Blue Shield may conduct further review after the provider is paid.

Retrospective or **post-payment UR** takes place after we pay the claim. Frequently, post-payment UR cases involve long-term tracking and monitoring of many services rendered by providers.

UR's history and goals

Blue Shield initiated UR in 1962 in cooperation with the Pennsylvania Insurance Department. Since that time, it has increased in importance, not only at Blue Shield, but in the entire health care industry.

The goal of Blue Shield's UR program is to prevent future problems or abuses in claim reporting.

Blue Shield's Benefits Utilization Management department communicates regularly with providers about the company's policies and procedures. The staff tracks and monitors health care practice patterns and determines if a provider is reporting excessive services. Blue Shield then alerts the health care provider of his, or her, practice changes.

Frequently, the provider is unaware of the changes and corrects reporting once alerted.

In rare instances of suspected fraud, Blue Shield's Special Investigations unit tracks claim reporting, collecting information that may become evidence for law enforcement officials or the courts.

Professional consultants support and advise Blue Shield personnel in these UR activities.

Defining the issue: overutilization vs. misutilization

Overutilization is the unnecessary or the repetitive performance of an eligible service, which either is not medically necessary, or is not in accordance with the accepted practice of medicine in the community.

Misutilization is the reporting of services not performed, the reporting of an ineligible service or the upgrading of a service to obtain a higher fee. This may involve fraudulent actions by either a patient or provider.

Identifying and investigating potential utilization problems

Along with identifying them on their own, Blue Shield receives leads on potential utilization problems from several sources. Blue Shield pursues all complaints to resolution.

These sources include:

- Providers
- Members
- The Pennsylvania Insurance Department — which often asks Blue Shield to review complaints that it receives.

Blue Shield uses several different techniques to investigate potential problems. They include:

Routine surveys of paid claims. Following generally accepted auditing principles, Blue Shield routinely surveys a percentage of all claims it receives. Our staff verifies the claims' accuracy by gathering information from hospital record rooms, physicians' offices or patients.

Special surveys. Surveys are performed as a result of discrepancies uncovered during other reviews. A number of representative claims are selected from all those submitted by a particular provider. Each claim is then verified through patient interviews or record reviews.

Statistical review of cumulative claims payment data. Blue Shield has developed a state-of-the art utilization review system called ULTRA (Utilization Trends, Reporting and Analysis). ULTRA analyzes claims data and tracks the utilization of services to detect unusual patterns of utilization, charges or payments. ULTRA sorts services in many ways, such as by the number performed, the percentage of selected service, the region, the specialty, the diagnosis code and more, in many unique ways.

Pre-payment review of unusual claims. Conducted before final processing and payment of a claim, these provider-specific reviews are in addition to the usual pre-payment examination of all claims. The criteria for initiating pre-payment focused reviews vary as sophistication in processing claims increases.

Examples of the criteria used are:

- Reports of unusual combinations of multiple services;
- Multiple services by the same provider during one hospitalization;
- In-hospital medical care reported by several providers for the same case;
- Claims from providers whose practices are under review as a result of other utilization activities.

Special research studies. Benefits Utilization Management frequently conducts special studies to identify new areas for review, and to assess the adequacy of the present system to ensure cost-effective, quality health care.

One of these special studies revealed significant increases in services and payout for restorative therapy. These study results led to the establishment of a dedicated unit in Benefits Utilization Management to review restorative therapy claims on a pre-payment and post-payment basis. Professional consultants provide support in reviewing these cases and in developing clinical guidelines.

Our professional consultant program involves almost 250 independent health care professionals who provide Blue Shield their perspective on issues of medical policy, clinical guidelines and unusual claims.

UR case procedures: what happens after a case is identified

When a potential problem is identified, a UR case is initiated. Here are the basic steps that we follow. A UR case can be closed at any of these stages, if the information developed satisfactorily explains the initial problem detected.

Analysis of claims processed (UR275 letter): Blue Shield will conduct a statistical analysis of the claims processed for a particular provider. This analysis will compare the provider's utilization to his peers.

If irregularities are found (for example, the provider is performing more of a particular service than his or her peers), Blue Shield's first action is to inform the provider of the irregularities through a UR275 letter. In the letter, we identify possible problems and include a statistical report to demonstrate where the provider may want to alter his, or her, pattern of practice.

Field investigation: If warranted, a field investigation is conducted. This usually includes obtaining copies of clinical records.

Patients also may be interviewed by a Benefits Utilization Management representative staff member to verify that services were performed as reported. Or, if the patient's age or condition precludes an interview, the representatives may interview the patient's relatives, as appropriate. These interviews usually are necessary only when office or home services are involved.

The interview seeks answers to four basic questions:

1. For what medical problems did you visit the provider?
2. When or approximately how often did you see the provider?
3. What services do you recall that the provider performed?
4. Were there any services for which you made payment yourself?

Our representatives are trained to avoid making any improper comments about the provider or to comment on the quality or appropriateness of treatment the patient received. They always clearly identify themselves and present their contact with the patient as a routine verification of services paid by Blue Shield.

Discrepancies between information reported on the claim form and the patient's recollection of the services performed are pursued carefully during any interview. Representatives make every effort to assess the reliability of persons interviewed and the accuracy of their statements.

Utilization review specialists

UR specialists examine and summarize hospital and office records and reports of field investigations. They also review statistical information on payments made, and prepare summaries of individual treatment patterns for a random selection of patients covering a period of at least one year.

Review by professional consultants

Next, one of Blue Shield's professional consultants reviews the case and submits a written opinion on the pattern of practice, and whether it appears to indicate overutilization or other problems. Blue Shield has almost 250 professional consultants who are practicing health care professionals, representing every major professional specialty and discipline.

Provider contact

At this time, the provider is contacted by a Provider Relations representative to discuss the statistical data, the individual treatment patterns and the professional consultant's opinion. If Blue Shield has determined that it is due a refund, the representative will inform the provider of the amount of the refund request and the provider's options for repayment.

The representative also advises the provider that he or she may provide additional information for review. The representative then prepares a report of the meeting with the provider, which is added to the case summary.

The Medical Review Committee

A UR case that cannot be resolved between Benefits Utilization Management and the provider under review is referred to the Medical Review Committee (MRC). This committee is charged under the Highmark Inc. Bylaws to investigate and resolve claims disputes and conduct peer reviews. It bases its decisions on current medical practices and Blue Shield medical policy.

The method of selecting the members for the MRC has changed. Members were once appointed by the chairman of Blue Shield's Board of Directors. Now, the chairman appoints a selection committee — made up of all health care professionals, except one.

This committee then selects the members of the MRC — who may not necessarily be corporate members — but who are independent physicians, not affiliated with Blue Shield.

The MRC is empowered to take a wide range of actions to resolve disputes. A provider has the right to be present when the committee considers his or her case, and to be represented by legal counsel.

The committee may take one or more of the following actions:

- Refer the case for recommendation or action by any appropriate committee, board or division of the state professional society or local professional society of the provider involved.
- Refer the matter to the appropriate law enforcement officer or agency of the Federal, State or any local government — if the committee has probable cause to believe that the provider submitted claims to the corporation with the intention of defrauding it.
- Refer the matter to the state professional licensure board of the provider involved.
- Render a finding that the corporation is entitled to a refund or fees paid to the provider.
- Render a finding that authorizes the corporation to collect any refund by withholding future payments due from the corporation to the provider involved.
- Render such decision or take any other such action as may be necessary or appropriate to fully resolve any dispute presented to the committee.

Resolution

Following a decision by the MRC, Benefits Utilization Management contacts the provider to resolve the problem. This may involve a change in the provider's reporting practices, and may require the provider to refund overpayments.

Precertification

Some coverage programs require precertification (basically, pre-approval) for certain elective procedures and elective hospitalizations. Precertification involves three basic elements of patient care:

1. Procedures
2. Location
3. Length of patient stay

You can identify patients whose benefits include precertification by their identification cards.

When you propose one of the precertifiable procedures or an elective hospital admission, contact the appropriate Plan's precertification unit on Page 6. They will determine whether an inpatient hospital stay is necessary.

If the admission is approved, the precertification unit will assign an initial length of stay. Through concurrent review, the length of stay is monitored to facilitate discharge planning.

For requests involving one of the elective procedures, the pre-admission and/or pre-procedure certification processes are performed concurrently. If the procedure is approved, the patient need not obtain a second opinion.

However, if the procedure is not initially approved, the Plan's precertification unit may require a second opinion. Once the procedure is approved, the Plan determines the need for an inpatient stay, as previously described.

Emergency and non-elective maternity admissions reviewed post-admission

Emergency and non-elective maternity admissions of more than two days are reviewed after the member is admitted to the hospital. However, you, your hospital's UR department or your patient must obtain approval from the precertification unit by the first working day following the emergency or maternity admission. When approval is granted, the precertification staff assigns a length of stay.

Experience and medical experts indicate that certain elective procedures may not always be the most appropriate treatment for a given condition. Or they may show that less costly treatment alternatives are available.

When you propose any of the following procedures, you or your patient must submit it for review prior to performing the procedure:

- Bunionectomy
- Carotid endarterectomy
- Cataract surgery
- Cholecystectomy
- Coronary artery bypass
- Hemorrhoidectomy
- Herniorrhaphy
- Hysterectomy
- Knee surgery
- Prostate surgery
- Spinal and vertebral surgery
- Submucous resection (repair of deviated septum)
- Tonsillectomy/adenoidectomy
- Varicose vein stripping and ligation
- Cesarean section (scheduled/elective only)

Some coverage programs require precertification for additional diagnostic procedures, such as CT scans, myelograms, endoscopy or magnetic resonance imaging. Please contact the appropriate Plan to verify your patient's benefits — these additional services may need to be precertified.

Appealing denied procedures

If the precertification program denies a request for coverage of an elective procedure or hospital admission, it does not mean that you must cancel the hospitalization or procedure. You and your patient should proceed with the treatment you feel is necessary. You and your patient have 60 days to appeal the decision, supplying additional pre- or post-treatment documentation to support your position.

Some accounts impose penalties on members for failure to precertify, even when treatment is found to be medically necessary. As always, treatments or admissions found to be medically unnecessary are not covered.

Usually you, your hospital's utilization review department or your patient may secure precertification from one of the precertification units listed below. Occasionally, you will have to request precertification from an out-of-area Plan. The Pennsylvania precertification units are:

- **Pennsylvania Blue Shield**
  Capital Blue Cross
  The Precertification Center
  PO Box 898125
  Camp Hill, Pa. 17089-8125
  (800) 441-2330 (medical-surgical in Pennsylvania)
  (800) 441-2333 (medical-surgical outside Pennsylvania)
  (877) 441-6080 (physical rehabilitation)
  (800) 441-8811 (mental health or substance abuse)
  (800) 626-9090 (Fax)

- **Independence Blue Cross**
  Quality Care Admission Review Department
  PO Box 13499
  1901 Market Street
  Philadelphia, Pa. 19101
  (800) TO ADMIT
  (800) 862-3648

- **Blue Cross of Northeastern Pennsylvania**
  The Preadmission Certification Center
  70 North Main Street
  Wilkes-Barre, Pa. 18711
  (800) 638-0505

- **Highmark Blue Cross Blue Shield**
  Healthcare Management Services
  301 Fifth Avenue Place
  Fifth Floor
  Pittsburgh, Pa. 15222
  (800) 223-9647

Precertification for managed care preferred provider programs

Under our managed care preferred provider programs, network primary care physicians and specialists are required to obtain precertification for certain established procedures and for referrals to non-network specialists.

In some programs, precertification or management of mental health and substance abuse services are provided through a separate case management entity. Ask to see the patient's Blue Shield identification card for details on precertification.

Mandatory Second Surgical Opinion Program vs. precertification

The Mandatory Second Surgical Opinion Program (MSSOP) is different from precertification. Under MSSOP, whenever specified elective procedures are proposed, a second opinion is always necessary. Under precertification, second opinions are required only if the precertification unit does not approve the procedure.

Secondly, under the standard MSSOP benefit, the proposed surgery is covered by insurance, regardless of the recommendation of the MSSOP consultant(s), as long as at least one additional provider has examined the patient. Under precertification at least one other physician, in addition to the operating surgeon, must support the need for surgery. Otherwise the procedure is considered not medically necessary and will not be covered by insurance.