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To: Members of the Committee on Administrative Policies

From: The Acting Committee Secretary

Subject: Phase II of the Review of the Medical Benefits Plan: Details Concerning Voluntary Provisions of Utilization Review Measures

The attached paper, which has been prepared for the information of the Committee, contains a description of the voluntary provisions of the utilization review measures that were approved earlier in the year as part of Phase II of the review of the Medical Benefits Plan. The utilization review measures include pre-certification for non-emergency hospital stays, professional management of large cases, and focussed review of long-term psychiatric cases.

Miss Dove (ext. 38221) or Mrs. Shannon (ext. 37258) are available to answer technical or factual questions relating to this paper.

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INTERNATIONAL MONETARY FUND

Phase II of the Review of the Medical Benefits Plan: Details Concerning Voluntary Provisions of Utilization Review Measures

Prepared by the Administration Department

Approved by Graeme Rea

July 23, 1992

I. Introduction

On February 4, 1992, the Committee on Administrative Policies considered the staff papers relating to Phase II of the Review of the Medical Benefits Plan (MBP). The Committee's recommendations were subsequently approved by the Executive Board.

The recommendations included the following measures to contain costs:

-- pre-certification for non-emergency hospital stays;

-- professional management of large cases;

-- focussed review of long-term psychiatric cases.

However, it was agreed that before the above measures would be put into effect, the Committee would be provided with more detailed information, with regard to the voluntary aspects of these measures, and how they would affect the enrollee's choice of medical care. This paper has been prepared in accordance with that understanding. It begins with a brief description of steps taken since February; it then provides more detailed information on how each of the three measures would work; and finally it lists further steps that will be necessary before implementation.

II. Background

Since the last discussion, the staff has reviewed proposals from four "Utilization Review" (UR) companies that specialize in providing cost-containment measures. A preliminary decision has been made on the selection of one of these organizations to provide the three measures listed above for the Fund. In making this selection, particular attention was given to the following:

-- concern for the quality of health care;

-- demonstrated knowledge of medical facilities available in the Washington metropolitan area;
-- sensitivity to individual needs and concerns;
-- demonstrated experience in effectively administering voluntary programs without financial penalties;
-- ability to provide guidance to staff in obtaining information regarding medical questions; and
-- procedures that can be followed with minimal effort on the part of the staff member.

The methodology and statistics referred to in the following sections have been derived from materials provided by the preferred UR company.

While utilization review measures are usually implemented as part of a patient-support and cost-containment program that encourages their use by providing financial penalties for not using them, this will not be the case in the Fund. Staff will be encouraged to use the review procedures, but no one will be penalized for not using them or for failing to follow any resulting advice. It is hoped, however, that the benefits associated with having the help and guidance the UR company provides will lead many staff to participate, and, in the process, minimize expenses for them and the MBP.

It is planned to make a final selection of the UR company by the middle of August, with a view to implementing the program effective January 1, 1993.

III. Pre-certification for Non-Emergency Hospital Stays

The purpose of this pre-certification program is to provide advance assurance to both the enrollee and the Plan administration when non-emergency hospitalization is contemplated to ensure that it is medically necessary and that the chosen hospital is appropriate for the treatment envisaged. 1/ The review provides advice on the appropriateness of the recommended care and facility, and whether treatment should be in an inpatient or outpatient setting.

The certification process will involve the following steps:

1. A hospital stay is recommended by the patient's treating physician.

1/ A patient requiring an emergency admission would not be subject to this type of review.

2. Notification of UR company

The enrollee has the option to notify the UR company's Service Center that a hospital stay is recommended. 1/ This can be done directly by the enrollee; or by the physician, with the prior approval of the enrollee. Notification is made by means of a telephone call to a toll-free number designated exclusively for enrollees in the Fund's MBP or by the completion and mailing of a form. 2/ Forms will be available in the Staff Benefits Division and the Medical Claims Office. It is best for such notification to be made in advance of entering the hospital. However, later notification can be made with the concurrence of the enrollee, by the admissions clerk when the patient checks into the hospital. The notification will be received by one of some 75 registered nurse-reviewers on duty at the UR company's Service Center.

3. Information needed by the UR company

When the enrollee, physician, or the admissions clerk in the hospital provides the notification, the Service Center will ask for standard information such as patient's name, enrollee's name (if different), the nature of the planned hospitalization, and the name and telephone number of the treating physician. The Service Center will then ask the treating physician's office to provide information on the precise nature of the hospitalization and the expected length of stay. A treating physician is asked six questions on average; and the average time taken is less than three minutes.

4. Option not to notify

If the enrollee elects not to notify the Service Center, no delay in hospitalization will occur, nor will a financial penalty be incurred. The identity of the enrollee who elects not to notify the Service Center will be unknown to the Fund. However, actual MBP claim payment records will be matched against the Service Center records, so that the Fund can receive statistical information regarding the level of participation.

5. Certification

An initial certification of the appropriateness of the in-hospital setting, as well as a specified number of days' stay for treatment, will be made by the reviewer after consultation with the treating physician. The determination regarding length of stay is initially made using "length-of-stay" norms for a particular illness or procedure, adjusted for such factors as the severity of the illness or physical well-being of the patient. A

1/ "Enrollee" for the purposes of this paper means either the staff member or another adult covered under the MBP.

2/ This telephone number will be printed on the MBP enrollment cards.

written notification of the certification will be sent by the Service Center to all parties.

6. Physician Advisor review

If the reviewer has doubts regarding medical necessity, the appropriateness of the hospital, or the course of treatment, such concerns will be referred to a Physician Advisor who, in turn, will discuss the case with the treating physician. The Service Center employs four full-time Physician Advisors who have had long experience as General Practitioners. This review by the Physician Advisor is referred to as the "first level of Physician Advisor review". The Service Center involves its Physician Advisors in direct discussion with the patient's treating physician in approximately 25-30 percent of the reviewed cases, and it is understood that most physicians are quite willing to discuss options with the Physician Advisors.

7. Second-level Physician Advisor review

If a disagreement regarding appropriate treatment or length of stay occurs between the Physician Advisor and the treating physician, the case will be referred to a "second level of Physician Advisor review". The UR company likely to be selected maintains contractual relationships with over 400 practicing physicians nationwide who perform the second level of review. Second level Physician Advisor reviews are conducted by specialists who are of the same specialty as the treating physician. Physician Advisors on contract for second level review must have a current, active medical practice and be Board Certified. They cover all principal medical and psychiatric specialties and sub-specialties.

8. Follow-up reviews

Subsequently, during the course of the hospital stay, the nurse reviewer will telephone the patient's physician to determine the patient's progress toward the established discharge date and to examine the necessity for continued stay. If the stay is to be extended, the above steps in the certification process may be repeated. It should be emphasized that it will be the prerogative of the treating physician and/or the patient to decide whether an extension is made.

9. Patient advocacy

Calling the toll-free telephone number can also trigger a wide range of patient advocacy activities and information services. For example, the UR company's registered nurse can assist an enrollee in the purchase of necessary durable medical equipment; provide information regarding specific diseases, surgical procedures, medications and possible side effects, and medical terminology; provide information on how to best use the U.S. health care system; provide information on hospitalization, outpatient surgery, home health care, weekend admissions, and preadmission testing; provide

explanations of treatment plans, diagnostic tests, and the average length of hospital stay based on diagnosis and procedures; answer questions about the medical review process (e.g., when a second surgical opinion may be needed); and provide guidelines on specific questions a patient may want to ask a physician. Early notification of a pregnancy would trigger the mailing of informational material to the expectant parents on the various stages of pregnancy in order to encourage a healthy lifestyle for the mother and the delivery of a healthy baby. The reviewers, however, will not be able to provide a medical opinion, diagnose an illness, or provide advice regarding treatment options or the appropriateness of one type of treatment as compared to another.

IV. Professional Management of Large Cases

The primary purpose of large case management is to provide an advocacy service and encourage, if appropriate, effective alternatives to hospital confinement when there is a medical situation that is likely to lead to great expense. A "case coordinator" is designated to work closely with the treating physician and the patient to determine if less costly but equally effective treatment can be provided in an alternative setting. The case coordinator is a registered nurse who has had specific training and experience in the relevant area of medical specialty and who is familiar with local medical centers and resources. The conclusion that an alternative course is appropriate could result in payment of benefits not specifically provided by the MBP (e.g., for equipment or home modifications to facilitate the patient's care at home), if agreed to by the treating physician, the patient, and the patient's family.

The large case management process involves the following steps:

1. Identification of large cases

One way that the process may be triggered is during the pre-certification process. A claim may be identified by the UR company as having the potential to become a "large case" requiring special attention. This determination is usually made on the basis of a diagnosis (such as a head or spinal injury, stroke, cancer, or maternity complications) that usually indicates the potential for large expense and treatment options. Alternatively, large case management may be triggered by the enrollee. Thus, an enrollee becomes aware of a medical situation within the circle of his or her covered dependents that may lead to a great expense, the enrollee might bring it to the attention of the UR company through the toll-free telephone number mentioned above.

Generally, about six percent of medical cases are identified for large case management. When the UR company identifies a case, it is then assigned to a case coordinator.

2. Initial planning

An assessment and initial plan will be made by the case coordinator to determine what services and resources are necessary and to determine where, and by whom, those services might be most appropriately delivered.

3. Contact with the treating physician

Contact will first be made with the treating physician (not the enrollee or the patient) to determine the feasibility of alternative services. The case coordinator will stress the use of specialized treatment facilities and non-critical-care options. If the treating physician does not believe it is in the best interest of the patient to pursue the case management approach, the case is dropped by the UR company.

4. Contact with the family

If the treating physician agrees with the possibility of alternative services, the patient and family will be approached regarding the various options. The case coordinator may visit the patient, the family, and the treating physician to discuss these matters. If the patient and/or the family do not wish to participate in the program, the case will not be pursued.

5. Implementation of agreed arrangements

If the patient and family agree to participate in the program, the case coordinator will make the agreed arrangements, which may involve transfer to another medical facility. Treatment for the medical condition will not be interrupted. As mentioned above, in some cases, the case coordinator will arrange with the Fund for payment of benefits that are not specifically covered under the MBP but are appropriate for the given case. Throughout the program, which typically can last from several weeks to several months, the coordinator's role involves assisting the physician and the family as well as the patient. The coordinator may give the primary physician an overview of the patient's home situation and help to coordinate the activities of consulting physicians in a team approach to treatment. The coordinator may also become the family's guide throughout the course of treatment by (i) helping to explain terminology and options, (ii) intervening in relationships with providers and hospitals, and (iii) assisting family members in exploring community resources and alternative forms of treatment.

6. Continuing evaluation

The case coordinator will continue to follow the patient's progress, assure that services are delivered, and determine what else is required. The plans developed by a case coordinator typically will include medical rehabilitation, discharge planning, and vocational rehabilitation. The

coordinator may make all necessary arrangements for home care, including therapy, nursing, the purchase or rental of medical equipment and supplies, and securing assistance from family members.

V. Focussed Review of Long-Term Psychiatric Cases

The primary purpose of the focussed psychiatric review measure is to encourage, if appropriate, effective alternatives to hospital confinement or other in-patient therapies when the diagnosis indicates that psychiatric treatment will be required for an extended period of time. The procedures involved in focussed psychiatric review closely parallel those of medical case management. The cases are identified, assigned, and handled in the same manner, and the coordinator usually manages these cases with face-to-face visits with patients, psychiatric staff, and family while treatment is underway. As with the large-case management, if an enrollee is aware of a psychiatric condition or illness within the circle of his or her covered dependents that may lead to a great expense, it could be brought to the attention of the UR company through the toll-free telephone number mentioned above.

In managing and coordinating mental health cases, the factors that merit special attention by the case coordinator include:

1. Quality of care

The quality of mental health providers and institutions varies considerably because not all therapists are required to be licensed, although providers in the Washington metropolitan area are better regulated than in some jurisdictions. Mental health case coordinators ensure that therapies are being provided by appropriately trained personnel and that only qualified institutions and individuals are selected.

2. Coverage

Under the planned program, the case coordinator will check to ensure that the diagnosis matches the symptoms and that, if patients are being treated on an in-patient basis, this is indeed the most appropriate treatment setting for the condition.

3. Children

A high proportion of mental health cases involve children, and mental health case coordinators devote considerable effort to promoting family involvement with, and support for, a child's progress. In chronic cases, schooling is also an important concern, and the case coordinator may be of assistance in identifying ways to continue school while undergoing therapy.

4. Treatment

The case coordinator will review the plan for treatment with a view to establishing, in particular, how long the treatment will last, what the specific aims are, and when these are likely to be accomplished.

VI. Next Steps in Implementing these Cost-Containment Measures

Arrangements are being made to develop appropriate administrative procedures for coordinating data and reports between Metropolitan Life and the UR company, drafting the certification notifications, revising the MBP enrollment cards, and preparing informational material for staff. It is planned that brochures will be developed and distributed to all enrollees prior to the effective date of the program. These brochures will introduce the UR company to the enrollees, explain each of the programs that will become effective, and provide information on how each program can be accessed. In addition, the Staff Benefits Division, together with the UR company, will provide seminars for staff to familiarize them with the benefits and procedures relating to these new measures.