

# ACCREDITWATCH

A URAC PUBLICATION

VOLUME 3, ISSUE 3 – 2005



A sneak peak at

## “Trends and Practices in Medical Management: 2005 Industry Profile”

URAC is a national leader in tracking medical management issues through its accreditation activities with hundreds of health plans and medical management organizations, educational programs, research and reports.

Elements of transformation in medical management are at the heart of a 2005 survey and research project from URAC. The resulting report, “Trends and Practices in Medical Management: 2005 Industry Profile,” will be released in its entirety at URAC’s 6th Annual Quality Summit & Exhibit, Oct. 26-28, but URAC is pleased to

highlight some of the early findings in this issue of AccreditWatch.

The survey and report are intended to identify historic and future trends in the industry and to help identify best practices and leading medical management programs.

URAC is a national leader in tracking medical management issues through its accreditation activities with hundreds of health plans and medical management organizations, educational programs, research and reports. Research such as this keeps URAC on top of industry best practice in its promotion of health care quality through URAC accreditation and other programs. URAC currently accredits 193 utilization review (UR) programs, 106 case management (CM) programs, and 18 disease management (DM) programs.

Medical management is the general term often applied to the practices of utilization management, case management, disease management, independent review (IR) and health call center/telephone triage (HCC), alone or in combination with each other. URAC offers accreditations in all five of these areas, and the study delved into medical management in all its diverse forms. The research was a follow-up to a similar 2001 URAC survey, but with more in-depth information-gathering and analysis using a national survey, focus groups, onsite visits and interviews with senior leaders in a wide array of medical management organizations.

“Through our accreditation activity with organizations across the health care spectrum, URAC leads the market by promoting best practices within the industry,” said Annette Watson, URAC vice

president. For example, this year URAC introduced the next generation of quality management standards, including a comprehensive revision to promote continuous quality improvement, consumer safety and error reduction.

“Patient Safety has historically been viewed as the exclusive responsibility of the providers of care. But in response to the Institute of Medicine’s Call to Action, URAC has taken a leadership role in the development of patient safety standards that address methods to identify, prevent, and report medical errors through medical management functions like UM, CM and DM and IR,” Watson said.

*see “Support Standards” page 7*

## URAC’s 6th Annual Quality Summit & Exhibit



Join us for URAC’s 6th Annual Quality Summit & Exhibit, Oct. 26-28 at the Westin Kierland Resort & Spa in Scottsdale, Arizona. For complete details, go to [www.urac.org](http://www.urac.org).

## Inside

Message from the Chairman of the Board	Page 2
Meet the Board Member	Page 3
Q & A with CMSA’s Jeanne Boling	Page 4
URAC Education Calendar	Page 5
URAC Conference Update	Page 5
URAC’s First Comprehensive Survey of Independent Review Organizations	Page 6





## Ask Accreditation

# CMSA Comments on URAC's

"Trends and Practices in Medical Management: 2005 Industry Profile"

As URAC celebrates its 15th anniversary this year, the Case Management Society of America (CMSA) is also marking 15 years of success in its efforts to support and develop the profession of case management through educational forums, networking opportunities and legislative involvement. URAC saluted CMSA and their parallel journeys in an issue brief earlier this year, "Converging Pathways: A Journey Towards Quality Case Management," available at [www.urac.org](http://www.urac.org).

Over the years, as URAC set quality standards for organizations using case management, CMSA developed educational tools and quality standards for individual case managers. The two organizations have welcomed considerable collaboration over the years in areas where interests in quality and research have overlapped. So AccreditedWatch asked CMSA Executive Director Jeanne Boling, MSN, CRRN, CDMS, CCM, who serves on URAC's Board of Directors, and who was a major contributor to the project, to offer her thoughts about URAC's "Trends and Practices in Medical Management: 2005 Industry Profile."

### A CASE MANAGEMENT GLOSSARY

**Case Manager**—Known traditionally as the individual who facilitates care and education toward best outcomes for the medically complex and chronically ill individual.

**Advanced Integrated Care Management**—A patient centric model which integrates medical and behavioral care coordination of services and interventions within health plan, employer or government individual programs and moves them into a single delivery model/application. Advanced Integrated Care Management provides that consumers/patients/beneficiaries make the most informed and rational use of their health care benefits/resources by reducing uncoordinated care and multiple contacts while improving communication with providers.<sup>1</sup>

<sup>1</sup> Definition courtesy of Cheri Lattimer, associate executive director of CMSA.

*Q. What are the benefits of URAC's 2005 Industry Profile to the case management industry?*

A. URAC's 2005 Industry Profile offers a global view, a reflection of current practice. It offers each individual in the case/care management industry the opportunity to determine trends, anticipate the future and to prepare educationally for successful career advancement.

*Q. From your perspective as a case management professional, what's your take on the findings regarding integration of services? How does integration affect the case manager on the ground?*

A. The strong trend toward integration of UM/CM/DM services shown by the 2005 Industry Profile is a response to market drivers. The increasing cost of care drives pressure for administrative efficiency to blend successful services. The multiple administrative, staffing, and technological support expense for siloed UM/CM/DM programs is duplicative. Integration will create efficiencies, thus cutting costs.

A second market driver is the availability of more sophisticated IT systems (incorporating health risk assessment and predictive modeling, in addition to housing practice guidelines) which are currently capable of supporting full integration.

For the new integrated care manager, the 2005 Industry Profile is a view to the future where there will be many new opportunities. To stay current and prepared to assume the integrated role, the integrated care management will need to:

- Master the availability, evaluation and best use of proliferating resources;
- Aggressively seek education and experience to remain qualified in various strategies as they come online;
- Master management and leadership skills to communicate and lead the integration process and consumer connection.

Integration will take another turn with the proliferation of electronic medical records (EMR) and pay-for-performance models. Use of EMR will expand the hospital-based case management role and will place significant emphasis on the emerging role of integrated care manager-physician collaborative practice.



## Special Feature

# URAC undertakes first comprehensive survey of Independent Review Organizations

Independent Review (IR) is an emerging segment of the medical management industry. Although health insurance providers have made some form of appeal or disputed claims review available to policyholders, consumers grew dissatisfied with a process that sometimes placed cases for review into the hands of physicians who were employed by or associated with the very insurance company that initially denied the claim. Consumer backlash against managed care and the need for unbiased, third party review of disputed claims led state legislatures to enact laws mandating certain patient rights, often including IR. Although there is no federal mandate for IR, 44 states and the District of Columbia now mandate some form of it.

URAC is the only organization in the U.S. offering accreditation for IR. URAC accreditation standards assure that organizations performing this service are free from conflicts of interest, establish qualifications for physician reviewers, address medical necessity and experimental treatment issues, have reasonable time periods for standard and expedited reviews, and appeals processes in place.

As an adjunct to its 2005 Medical Management Survey, URAC and the National Association of Independent Review Organizations (NAIRO) developed a survey report to better identify current and future industry practices. Results of the IRO study will be presented at URAC's 6th Annual Quality Summit & Exhibit, Oct. 26-28 at the Westin Kierland Resort & Spa, Scottsdale, Arizona. The program, "Independent Review in the United States: Where We've Been, Where We Are, and Where We Hope to Go," will be co-presented by John DuMoulin, MS, vice president of government relations and product development for URAC; Winifred Hayes, PhD, president and CEO, HAYES, Inc. and member of URAC's Board of Directors; and Bettina B. Kilburn, MD, M.Div., corporate medical director, senior ethics and policy consultant, Prest and Associates, Inc.

Independent review organizations (IROs) are a small industry of only 40 to 50 firms. This survey represents the first time this industry has been studied in-depth. "URAC conducted this study to learn more about the IRO industry, and to ensure our standards are relevant to that industry," DuMoulin said.

"The survey looks broadly at IR and its role in the case management process," Hayes said. "We are also trying to characterize how many reviews are done and with what impact. It should help

us to better understand the market as a whole, its size, and what kind of contribution IR is making."

Hayes said it is highly appropriate that URAC takes leadership in conducting the survey and report "because URAC is the standards-setting organization for case management in the U.S."

"In order to continue to set the bar higher, URAC needs to continually ensure that its standards are resulting in high quality services," she said. "URAC is the only organization in the world that is really focused on the process of case management from the practitioner's perspective. This survey is directly related to URAC's mission."

Most IROs responding to the survey said they are most likely to provide services for external (state regulated) third level clinical review, and this represents the lion's share of business for most firms. IROs also provide internal second level appeal clinical review, but this is a much smaller business segment (18 percent of their business). IROs also provide services such as internal second level appeal clinical review and disability review. Half of those surveyed said they provide pre-determination/precertification review, and about one in five respondents said they provide case consultation (although this accounts for only 1 percent of their total business).

As part of the survey, IR organizations were queried about review methodology, and were asked to rank their use of criteria-based review, practice guideline-based review, and evidence-based review.

In general terms, *criteria-based review* is based on the payer's own clinical criteria that are germane to the particular coverage decision, in conjunction with the reviewing physician's own training and expertise. *Practice guideline-based review* looks to professionally recognized guidelines based on medical consensus from a professional association directly related to the area of care for a particular case, as well as from universities, research organizations or groups (e.g. the US Preventative Health Services Task Force), and other consensus bodies composed of applicable practitioners and/or specialists. For example, Hayes said that guidelines from the American Association of Cardiology may be consulted by a specialist reviewing a cardiac case. The third type of review, *evidence-based*, is grounded in a scientific review of the current relevant evidence in the medical literature.

see "Independent Review Organizations" page 10

## “Sneak Peak at Trends” continued from page 1

And to offer administrative and congressional support, the Patient Safety and Quality Improvement Act signed by President Bush in July 2005 further offers a boost to the patient safety movement by providing for the development of Patient Safety Organizations.

“We think URAC is uniquely positioned to assist HHS as they move forward with certification of patient safety organizations—in whatever form—and URAC looks forward to discussing this with Health and Human Services officials,” Watson said.

### Accreditation- a Predictor of Quality Reporting

In the survey, researchers found that accredited companies reported a significantly increased level of tracking and reporting of quality and performance measures. The finding reflects a greater focus on quality functions among accredited companies.



“It was exciting for us to find that accredited companies definitely track and report more quality indicators than companies that don’t go through accreditation,” said John DuMoulin, URAC’s principal investigator for the project.

### Medical Management Integration- Staffing and Information Systems

One notable finding, predicted in the 2001 survey, is *increased integration of medical management systems*. From 2001 to 2005, many companies moved towards integration of some traditional UM techniques with CM, UM and IR. URAC researchers observed during the 2005 focus groups and onsite visits that most health care organizations are experimenting with different ways to integrate their medical management systems. Some are emphasizing the integration of staffing functions, while others are emphasizing integration through better information technology (IT).

However, URAC concluded that few if any health care organizations have yet optimized an integrated approach to medical management. Despite leaps in IT sophistication over the past several years, a lack of interoperability of IT systems is still a significant issue for most companies. Although some companies have created ways for clinical staff to view information through multiple windows on the same computer, there were significant gaps in the ability to put all medical management functions onto one interoperable platform so that information flows seamlessly between the different medical management functions. URAC researchers did not locate a truly seamless IT system integrating medical management functions among all the key stakeholders (between the health care organization, their customers, and the participating providers).

Aside from the lingering IT challenge to integration, there are still more questions about the effectiveness of cross-training staff to perform multiple functions. Among other reasons, focus group participants noted that nurse training, experience and retention issues sometime limit how aggressive a company can be when integrating medical management functions. For example, some nurses are more comfortable with supervising the UM process only, while others prefer the multi-dimensional tasks of coordinating a wide range of issues through complex case management.

“Companies have discovered that, in many cases, the clinical employees just don’t want to do more than one function,” DuMoulin said. “A utilization management nurse may not have professional interest in doing intensive case management as well—it’s a different skill.”

DuMoulin said URAC is pursuing further quantitative research into integration of services in medical management and will present the complete findings in the final report. “What we’ve found so far is that different companies have different strategies,” he said.

DuMoulin noted that there is an increase in collaboration between practitioners within companies to refer patients from one function to another, depending on patient need and which intervention will be the most cost-effective.

“There is an increased focus in that area—companies don’t want people to fall through the cracks, and they don’t want to collect the same information multiple times,” he said. “There is more interest in the handoff between one type of medical management to another. For instance, CM is referring to DM, or a patient may call a health call center and that triggers sending a case to CM. It depends on the intensity of the case and what intervention the patient needs at a given time.”

see “Sneak Preview at Trends” page 8

## “Sneak Peak at Trends” continued from page 7

“Four or five years ago, people saw these different interventions as more siloed approaches, and now companies are reporting more of a continuum of services. We’re seeing more of a consumer-centric focus. Companies are providing more types of services and they’re trying to work with the patient through all the services they provide.”

### New Emphasis on UM to Fend off Challenge of Rising Costs

Another key finding is a *reemergence of traditional UM functions* in many settings, such as the use of precertification and concurrent review for diagnostic imaging, or using UM to identify cases for case management and disease management interventions.

DuMoulin said the increase is tied to employer health care costs, which seemed to moderate in the late 1990s but have since reached an all-time high. In fact, the study found that many health care organizations use a hybrid approach depending on the preference of their customers in self-funded arrangements. In cases where the health care organization is assuming the risk, a more uniform approach is applied throughout the company. Other companies prefer a focus on more costly cases.

The application of UM is changing from its earlier role, when precertification, concurrent review and retrospective review were common for nearly every case. Over the past several years, URAC has tracked the movement from traditional utilization interventions to a more fluid care coordination approach to determining the medical necessity of care. As part of the 2005 findings, URAC found that traditional UM functions are still actively used in many different types of health care organizations—but not for every diagnosis, or for every customer.

“What we found is that UM is coming back, but with a new focus on high cost cases that will show a clearer return on investment,” DuMoulin said. “We believe one reason behind that shift is due to a cultural change within provider practice. Originally, you had to have UM approval for everything, and that trained providers to think about the medical necessity of the service they were providing. Once their mindset was oriented in that way, companies could focus in on the cases where it is necessary to do UM.”

### Medical Management Customization to Meet Client Needs

In fact, *greater reliance on the ability to customize* medical management systems, in large part based upon client needs and expectations, is another major research finding. Newer IT systems can be highly customized, depending on the type of health care insurance arrangement being offered. This flexible approach to medical management still allows companies to offer traditional

UM services such as precertification, concurrent review and retrospective review services when required by the customer.

“With this flexibility, there is no one-size-fits-all solution any more,” DuMoulin said. “Companies now negotiate with the customer about what they want to buy with regard to medical management services.” Medical management companies are now developing their software platforms to accommodate their own organizational focus and the needs of the clients they target. For instance, a company with a primary focus on DM will also need to integrate UM and CM services to the extent that individual clients demand those services as well. “

### Medical Management Companies Focus on US Market

One surprising finding is that medical management companies have made very few inroads into the international market, although this seemed to be a future trend among companies surveyed in 2001.

“It is pretty rare that medical management companies go into the international marketplace to get new clients,” DuMoulin said. “Companies that do offer services internationally do so because they have a relationship with a U.S. company with employees overseas.” While focus group participants indicated a desire to outsource clinical functions overseas, state licensure laws and customer acceptance stifle the efforts.

The completed survey report, “Trends and Practices in Medical Management: 2005 Industry Profile,” will be presented at the 6th Annual Quality Summit & Exhibit, Oct. 26-28, 2005 at the Westin Kierland Resort & Spa in Scottsdale, Arizona. The report will be available on the URAC website following the conference. ★

## Standards

Having a difficult time interpreting URAC standards? Send your questions to [interpretations@urac.org](mailto:interpretations@urac.org). Please include the program name, standard and version number in the subject line of the e-mail.

*“CMSA Comments” continued from page 4*

*Q. How has improved technology affected the pace and quality of case management?*

A. Technology enables access to best practice guidelines. Integration of services previously divided among two to three people appears to initially decrease caseload capacity for the integrated professional. The time required to manage the whole scope of health care is understandably greater than to manage/facilitate only one part. The new technology increases the potential for more consumer-involved customized care, grounded in evidence-based practice.

Technology supports, but does not replace, the critical professional skill of the integrated care manager. The integrated care manager interacts with the patient and health team to facilitate movement towards adherence to optimal health practices and to adherence to recommended treatment as benchmarked against best practice.

As to pace—yes, the pace tends to increase. Challenges for organizations employing integrated care managers are to partner with these professionals to identify optimal caseload levels which produce the best quality of care and return on investment.

*Q. How has enhanced collaboration and coordination between medical management programs improved care for the patient?*

A. It's all about delivering for the patient/consumer.

One point of contact reduces the frustration and hassle of multiple and duplicative communications for patients, their caregivers and the medical team.

One point of contact reduces the opportunity for dropping critical information due to lack of coordination among care managers. This in turn enhances patient safety, patient satisfaction and clinical outcomes significantly.

Research shows that case management intervention reduces hospital admissions, readmissions and emergency department visits, and

increases quality of life. Patients are better able to manage their symptoms, they experience decreased stress, decreased health risk factors, and decreased cost of care. Case management provides improved care for culturally diverse patient groups reduces depression and is associated with prolonged life.

*Q. Which trends do you see as having the most powerful affect on case management, and why?*

A. First, technological advances will change basic case management practice to integrated care management practice. They will shift more care management to physician office and hospital. They will significantly change the scope of practice, educational preparation for career entry and continuing education. Meanwhile, biotech and gene therapy advances and technologically scientific advances will alter the practice of medicine and thereby the need for consumer education and decision facilitation.

The second trend to watch is consumer-centric care. While costs of leading edge care will continue to escalate, consumer pressures for access to care will increase with the aging of the baby-boomer generation. Contrary to the generation preceding it, U.S. baby boomers are the sickest population, the most health care informed population, and the most demanding of care information to enable their decision making. Increasing consumer ownership of care decisions will position integrated care managers as trusted health knowledge sources. Consumer demand for effective outcomes of care will increase while integrated care managers are increasingly recognized as effective facilitators, educators and coordinators of those outcomes.

Finally, the nursing shortage will become much more profound while the number of patients with multiple, complex conditions becomes more numerous. These parallel trends will serve to increase integrated care managers' management responsibilities, scope of practice and authority, recognition and value by consumers, and ultimately their salaries. ★

*“Independent Review Organizations” continued from page 6*

“Evidence-based review is really designed to look at the evidence the medical community has to evaluate whether the proposed intervention is medically necessary, safe and effective, or of clinical benefit,” Hayes said. “These are the type of reviews that the IRO community would concede are really important to determine whether care is denied because the payer believes they are experimental or if it is really of proven benefit. In those cases, it seems that the review should not hinge on the opinion of a particular reviewer’s opinion alone—it really has to be supported by what the scientific evidence says.”

Survey respondents indicated that their leading form of review methodology was criteria-based for internal review, followed next by practice guideline-based and then evidence-based review. For external review, both criteria-based review and evidence-based review were selected by an equal proportion of respondents as the lead review methodology.

The vast majority of those surveyed said client preference was the leading determination of the primary review basis for internal review, and regulatory requirement was the leading determination of the primary review basis for external review (closely followed by client preference).

In truth, many review situations simply don’t lend themselves to questions that would require the more time-consuming, and thus more costly, evidence-based methodology, Hayes said.

“Most review situations don’t involve questions about experimental treatments or diagnostic interventions—most denials are disputes over medical necessity,” she said. Those types of review better lend themselves to referencing criteria and practice guidelines, and of course, the reviewer’s own experience in the field.

Hayes said the survey report will be valuable for the industry and for URAC to gain an informed sense of how to promote quality in IR and its impact on the health care system, particularly for patients and physicians.

“By looking at the methodology employed in the field, we’ll gain new insight into how to improve that methodology so that the outcome of the reviews promotes quality of care,” she said. “I can’t overestimate the importance of URAC’s role in IR and in care management as it continues to change and evolve.” ★

**ACCREDITWATCH**

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