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A Physician Case Study: An Alternative Approach for Utilizing the URAC Tools

This case study describes an intervention using national standard utilization guidelines to modify an individual physician's practice patterns for workers' compensation patients. The goal of the intervention was to change individual practitioner behaviors. These changes were necessary to alter the physician's status in several workers' compensation networks relating to their concerns of operational, knowledge and performance deviations from network norms.

Background: A practitioner was identified as having aberrant practice patterns in managing worker's compensation patients in a state that was transitioning from monopolistic and state managed insurance programs to a private insurer and network care management model. The subject practitioner's historic practice patterns were reviewed along several dimensions including: lost time from work; number of services per case; average cost per case; application of guidelines for both treatment and for absence per case; and for disability and indemnity cost per case.

Results of the review of the practitioner's performance resulted in the practitioner being terminated from the dominant employer's panel and from participation in the two largest and most dominant worker's compensation networks in the practitioner's catchment area. The practitioner was effectively barred from providing worker's compensation services to injured workers, including those patients routinely being seen by this practitioner for medical benefits purposes.

Our subject practitioner had a long term history of providing services to worker's compensation patients; had a significant investment in various physical therapeutic equipment, space and staff; and was confused about how to respond to or even conceptualize changes that might be necessary to improve performance and increase the potential for becoming a participant within the rapidly evolving worker's compensation environment.

Network organizations offered little support for change, education and consultation that might have assisted the practitioner to understand the nature of managed workers' compensation programming and network operational considerations.

The practitioner was simply told that he could appeal decisions about network participation to a committee review process. The major regional employer refused to discuss its decision concerning terminating the practitioner's ability to provide services to its employees. A second network similarly refused to invite the practitioner to join its network. The practitioner was uncertain about how to approach the dilemma.

Intervention: Working for the dominant employer in the marketplace, a consultant (Pro Pharma Pharmaceutical Consultants Inc., dba Pro Pharma) was working with the practitioner on the management of patients under the general medical and pharmacy benefits programs of that employer. Pro Pharma was made aware of the situation by the practitioner during a performance QM review working session.

Pro Pharma offered to support the practitioner with worker's compensation in exchange for the practitioner's achieving "Best in Class" performance results adopted by the employer and administered by Pro Pharma under the medical and pharmacy benefits programs.

Intervention approach and content were defined through a structured review process that included review of practitioner's knowledge of managed worker's compensation, understanding of network operations, usage of appropriate guidelines for treatment and return to work; practitioner's work flows, medical record keeping, billing and collection methods; patient expectation approach; and ability to centralize and streamline communications between the practice, network management, employer and patient.

Results of initial interviews, surveys and practice operations included the development of an action plan that was acceptable to the practitioner and key office staff.

Timeline for Intervention and Scope of Effort: A timeline was established that included making change within the practice sufficient to support the practice's ability to confidently approach both workers' compensation networks within six months of beginning work.

A goal of acceptance into one network was established for eight months and for the second (the network that had previously declined to accept the practice) within 18 months. (The dominant employer had by this time contracted with the network that had previously rejected the practitioner.)

Scope of effort was determined to include an assessment of operating work flows within the practice with recommendations for change. It appeared that policies and procedures were generally not evident within the practice, and that URAC standards (as applied to networks certified by URAC for both networks and for UM related to worker's compensation; namely, URAC Workers Compensation Network and UM Certification Requirements) would be utilized to guide both policy and procedure and work flows.

This could only happen after agreement that they would be established as educational tools, for use in developing an understanding of managed networks. Results of the reviews, study of URAC standards and determination of those changes needed were to be used to determine and to set action planning and other milestones.

Initial Assessment and URAC Standards Adoption: A lead and staff member was assigned the task of drafting how typical cases currently flow through the practice, including charting, billing, recordkeeping, using of and referencing appropriate guidelines, and complying with typical network UM department interfacing.

Separately, a review of URAC network standards helped the practitioner and key staff to understand fundamental requirements that result in policy and procedures governing participation agreements for practitioners.

More precisely, a separate effort to review criteria for a network to meet in order to be certified by URAC was carried out. From that review, specific policies and procedures were identified as needing to be developed and to be utilized in defining a revised work flow.

Initial assessment, review of URAC standards and work-flow documentation were reviewed over two lengthy working sessions. Products of working sessions were the drafting of key policies and procedures, modification of work flows, development of key record keeping forms, establishing separate medical records for worker's compensation and routine medical, and change to billing and collections procedures.

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It was determined that one "accountable" person would serve in an oversight capacity to facilitate changes within the practice and to be the point of contact for the practice with worker's compensation networks, insurers, patients and employers.

Execution: Staff proceeded with consultant support to make the changes identified as being appropriate and necessary. Staff documented current activities, including their revised duties as job descriptions, while change was being implemented by staff and under the leadership of accountable persons.

This step led to refinement in operational methods and streamlining of efforts. Each staff person prepared a final draft depicting their component of the work flow. Numerous test cases were dry-run, old cases were reviewed and critiqued, and other activities prepared the practice for approaching networks for participation.

Both workers' compensation networks were contacted and asked to consider adding the practice to their provider base. One network had, as noted above, previously reviewed and had refused to consider a re-review. A second network sent a team (care coordinator and network development staff) to review the practice, its workflows, its standards, its policies and procedures, and its compliance with and knowledge about URAC standards related to qualitative and quantitative guidelines.

The second network offered a "probationary" agreement to the practice contingent upon ongoing use of appropriate guidelines, communications with employers and the network's care coordinators, referral appropriateness and timeliness, lost time from work, disability award and the like. Accordingly, probation would end after 12 months of data had been obtained and reviewed. The agreement was signed and the practice met its goal of engaging one network within eight months.

The first network agreed to review the practice and sent its medical director to review the practice and to interview key staff, after 15 months. An assignment was given to the practice that resulted in its reviewing a sample of more than 50 closed and open cases for compliance with treatment and return-to-work criteria, for compliance with communication requirements with the care manager, and for overall management patient expectations and quality of care.

A spreadsheet was prepared by the practice to memorialize findings from the in-depth review, after review of each case. A meeting was held between a physician representative of the network's QM Committee and the practice to review findings, knowledge about treatment guidelines, knowledge of return-to-work guidelines, appropriate reasons for referral, appropriate patient expectation setting, appropriateness of medical record documentation and the like.

At month 18, the practice was offered a probationary agreement. Probation would be contingent upon quarterly case reviews and a final annual review. Central to continuing as a network provider was the demonstration by the practice of its ability to centralize and standardize communications between practitioner and patient, practice and care manager, practice and employer. Finally, meeting standards for treatment and for return-to-work would carry a heavy weight in the ongoing evaluation of the practice.

Summary: URAC and the requirements that it places upon networks seeking certification were used as both educational tools and as heuristic tools for shaping work flows and P&Ps within the subject practice.

It was advantageous having a practitioner become conversant with and interested in how networks are held accountable. This set the stage for the target practice to understand the need for setting its internal work flows and policies in parallel to the networks. Focus upon UM certification standards enabled the practitioner to more fully appreciate the need for managing patient expectations, for making good use of return-to-work and treatment plan decision-making.

Results: After working through its policies and procedures, workflows, systems issues and staff management issues regarding workers' compensation cases, the subject practice was granted probationary status in the state's dominant practitioner network.

The practice was required to summarize its managing of cases on a quarterly basis to be submitted to the network for its review and comparison to findings generated within the network's care management review team, as a requirement of probation. The practice was promised a formal review with recommendations during the third or fourth quarter of 2007, which would be based upon a 100 percent review of all cases for which the practice had billed during the first six months of the calendar year.

Subsequent results were produced by the network's care management staff, were reviewed by the appropriate quality management committee and were communicated to the practice in writing by that committee. Results demonstrated that compliance was achieved for 100 percent of cases managed by the practice. The practice was subsequently rewarded by the network with nonconditional status.

This case serves to demonstrate that a proactive approach to managing patient health outcomes can indeed be successful when approached in a rigorous manner and where a thorough understanding of expectations for performance, and the rationale for managing to defined standards of care, is the basis for education and operational change.

Implications: Two fundamental and unique conditions were apparent in the case study. First, the practitioner had a long history of participation in worker's compensation programming (run by an agency of state government as the exclusive network and insurer within that jurisdiction). The practitioner had been rejected as a participant in the new network.

Second, the new networks offered little if any training for practitioners, were unable to describe how practitioners would be evaluated, and had no plans for intervention and corrective action with practitioners. The networks expected practitioners to learn to comply with network operations on their own initiative, to receive evaluations and requirements for corrective action as sent by the networks periodically, or to cease being a practitioner.

While the two networks operating within the state were making claims about their ability to control quality and costs, one did indicate that it was able to comply with URAC standards; neither was certified for worker's compensation network or UM operations.

Conclusion: Practitioners may be willing to make positive and sustainable change when presented with information such as that produced by URAC. As noted above, the practitioner did respond when he understood expectations of a URAC certified (network and UM) operation; what managing the expectations of workers would entail; what recordkeeping and forms management would mean operationally; the power of participating in coordinating communications between network/care manager, employer and injured worker; the necessities of managing billing and collections operations; and the need to organize work flows using one centralized person responsible for all aspects of communications, file maintenance and patient scheduling.

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The authors believe that an alternative approach for utilizing the URAC tools achieved an improvement in practitioner prescribing and practice patterns overall. Additional opportunities exist for objective measurement and data feedback directed to provider training, measurements of performance, development of corrective action intervention services, consultation support for networks, building high performance networks, and in developing positive reward systems for quality outcome and performance improvement. The primary lesson from this exercise was that physicians can make marked improvements when engaged as part of the solution.

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