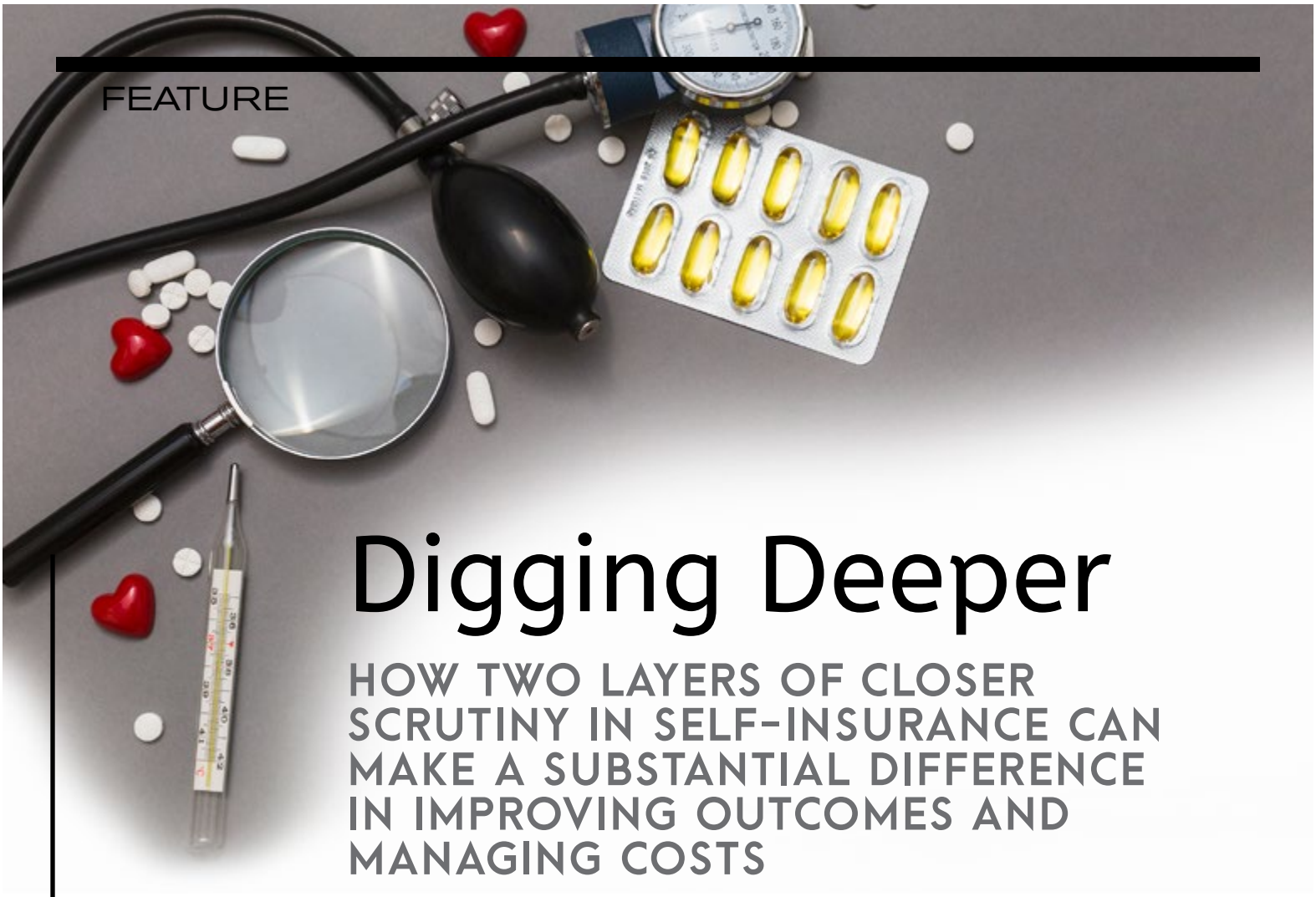

# Digging Deeper

## HOW TWO LAYERS OF CLOSER SCRUTINY IN SELF-INSURANCE CAN MAKE A SUBSTANTIAL DIFFERENCE IN IMPROVING OUTCOMES AND MANAGING COSTS

Written by Bruce Shutan

There's no denying that closer scrutiny of clinical decisions and health benefit claims can save both lives and dollars. In short, the power of deeper examination is that it not only can prevent medical and financial catastrophes but also promote transparency and hold health care facilities accountable for the services they provide to self-insured employers.

### MEDICAL SECOND OPINIONS

One such strategy involves medical second opinions. Some proponents have gone as far to suggest they should become a mandatory part of self-insured health plans in certain instances. Others caution against thinking of this service primarily as a cost-containment tool or remedy for bad medicine.

Whatever the case may be, second opinions are considered good medicine at a time when physicians struggle to stay abreast of all the latest treatments or protocols for serious or chronic medical conditions, says Tina Karas, VP of marketing for WorldCare International Inc.


Todd Thames

As many as 75% of the more than 25,000 medical second opinions her firm has offered over the past 26 years have involved a change in treatment, while 26% resulted in a new diagnosis. She describes the return on investment as ranging from 2:1 to 6:1, depending on changes in treatment or diagnosis.

Leveraging different levels of clinical expertise can generate the most comprehensive view of any given medical condition for more accurate diagnoses, according to Todd Thames, M.D., regional medical director, senior staff physician with Grand Rounds, which provides second opinions as well as connects patients with local and remote specialty care.

"The old adage is medicine is an art as much as it is a science," he observes, noting some change in diagnosis or treatment plan in 65% of cases that are run through a second-opinion service.

An independent second opinion should be required for specified diagnoses and treatment plans given the propensity for misdiagnoses and medical errors, suggests Keith McNeil, co-founder of Arrow Benefits Group (ABG), which is part of the TRUE Network of Advisors. In fact, a large client of his will decide next month whether to pursue this avenue.

"The number of errors in diagnosis and treatment plans is frightening," he observes, while unnecessary surgeries in just orthopedics alone "is astounding."


Jennifer Grubbs

While a big believer in second opinions, Thames cautions self-insured employers against making the service mandatory. By doing so, they risk a negative shift in the patient mindset to where it's viewed as more of an obstacle, rather than an adjunct or augmentation, to care. For example, he says having to always endure an additional round of paperwork may further frustrate health plan members who are already predisposed to the system's delays and economic burden.

Several industry observers caution that the perception of second-guessing doctors is misleading. "Not all cases we review, or even a preponderance of cases, involve any sort of misdiagnoses or medical errors," says Jennifer Grubbs, independent medical review operations manager for Mitchell MCN.

Part of the process simply helps determine if any information could be missing, she explains, while having a peer-to-peer call with the treating doctor helps gain a better understanding of the situation. Receiving an unbiased opinion helps self-insured health plans prevent unnecessary or costly procedures and demonstrates to patients that their needs are being addressed. Grubbs says this effort can help guard against escalating disputes and avoid costly appeals.

The collaborative aspect is reflected in ABG's recent partnership with MORE Health, a medical second opinion service it offers on behalf of employer clients to help those who face a serious, life-changing illness. Mindful of the need for a speedy resolution, the service provider guarantees that it will respond within five business days of receiving relevant medical records.

One key selling point of this service is that the vendor is more inclined to work alongside each doctor to come up with a combined diagnosis treatment plan that makes sense. "If for some reason those two simply cannot come to a meeting of the minds, they can even get another doctor in there who's independent to give a third opinion, " McNeil notes.

## AN ORTHOPEDIC SURGEON'S VIEW

Perhaps no one can appreciate the value of second opinions more than Ira Weintraub, M.D., chief medical officer for WellRithms, a leader in health care cost-containment reimbursement methodology and network replacement solutions for the self-funded market. An orthopedic surgeon for more than 40 years, he knows his specialty has

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Ira Weintraub

come under fire for performing too many surgical procedures. He also has seen scores of unnecessary MRI and CT scans ordered through the years, as well as trips to the ER that could have been avoided.

Total hip or knee replacements are "almost always very complex," Weintraub notes, while complications may arise even after successful operations. He deems another pair of eyes in these cases worthwhile, though cautions that the additional scrutiny isn't intended as a cost-containment tool.

"The problem with centers of excellence is they tend to jack up the prices because they think they're the best and they should get paid more than anybody else,"

he says. Another conundrum involves patients wanting a tie-breaking view if the first two opinions differ.

Without a doubt, Karas believes second opinions make sense for serious or deadly medical conditions such as cancer, cardiovascular conditions or rheumatoid arthritis and can help self-insured employers avoid unnecessary or costly treatments. Other areas where they may be considered particularly valuable include genetic testing, experimental and investigational services, and high-cost drugs, according to Grubbs.

Eagle eyes are perhaps best cast on high-stakes diagnoses involving extremely dangerous treatment options. "We've been amazingly successful in developing some really effective treatments against many cancers," Thames says, "but they have significant side effects and are also expensive. So you want to make sure that you have an accurate diagnosis." Close scrutiny of both the clinical and pathology aspects of care can serve as "a lynchpin towards making an accurate diagnosis," he adds.

Acute care episodes such as a broken bone or upper respiratory infection frequently don't require second opinions because of the short-term and resolvable nature of these scenarios. But there could be issues hidden from view that may be worth another look.

For example, "if the same person with a broken bone has a history of multiple other fractures there may be a more serious underlying cause such as bone cancer, which warrants a medical second opinion," Karas explains. The same is true for an

Tina Karas

upper respiratory infection that lingers or recurs, which she says could be a chronic pulmonary issue such as asthma or chronic obstructive pulmonary disease, both of which would warrant a closer look.

Two medical procedures that stand to benefit most from greater scrutiny are back surgeries and joint replacements, both of which Thames believes are overdone and costly. He also notes that "the five-year outcomes from many back surgeries are not that good," citing the potential for complications down the road.

Clinical rigor is hugely important when it comes to procuring second opinions. As the only institution-based medical second opinion provider, WorldCare has the luxury of deploying multi-disciplinary teams of leading specialists and sub-specialists at top-ranked U.S. hospitals.

"On average we have four physicians involved in each medical second opinion," Karas reports. Others simply have one physician they select from a Rolodex to review their cases, she adds, and sometimes they even use residents. WorldCare also routinely rereads all radiology studies and pathology samples because they're prone to error rates of between 10% and 30%.

One related area that could benefit from second opinions is behavioral health. WorldCare recently completed a pilot program that applied mental health medical second opinions to long-term disability cases. The impact was significant, with 80% of claimants returning to work, a 70% change in diagnosis, 90% change in treatment plan and 100% participant satisfaction rating. Karas says it resulted in an average reserve release of $200,000 or $25,000 in annual discounted disability payments.

## INDEPENDENT BILL REVIEW

Another popular method for at least putting a lid on soaring health care costs involves independent medical bill review. A comprehensive approach is essential for spotting abusive billing practices at a time when medical bills are rising at unprecedented levels, according to Weintraub, who also stresses the importance of contracting with providers at fair rates. In addition, he says that understanding medicine gives him a leg up in all bill reviews.

His firm uses a proprietary approach to identify any incorrectly entered medical diagnostic codes and edits or what he labels "shenanigans" to up-code surgeries. "Coding has become a game," he laments, recalling several experiences with this widespread unscrupulous practice.


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After reviewing the medical records, X-rays and operating notes of a patient's spine surgery, for example, Weintraub found that as many as eight of 14 codes weren't possible and just half a dozen ended up being paid. In another case involving a total knee replacement, the patient was charged for two prostheses, rods and screws.

But charging for a second prosthesis is verboten, he explains, surmising that the patient's leg more than likely was broken during the surgery and, therefore, required another-size prosthesis. The hospital has to eat the cost of a second prosthesis, he says.

## A FORENSIC APPROACH TO RECOVERING FUNDS

With a growing emphasis on algorithms and health care analytics, some emerging industry solutions are tearing a page from the CSI TV show playbook to sell their value proposition. "We are forensically analyzing medical claims to maximize payment integrity systems," says Jeff Borglin, a health care strategist and partner with Iron Sky Advisors.

Whereas medical claim audits involve a sampling of health plan data, a specialty vendor whose service he offers employer clients actually reviews 100% of all claims about half a dozen levels deep. This forensic hunt checks improperly billed payments against rule sets provided by the National Correct Coding Initiative, Medicare and Medicaid. The next phase is to recover those payments.

"We want to bring to the marketplace truth and accountability," explains Borglin, describing the effort as "a post-payment forensic claim review and recovery program" that differs from scores of prepayment systems already in place. "Every administrator of a self-funded plan has a fiduciary responsibility under ERISA to manage that plan to the best of their ability." But not having a complete set of medical claims data can only lead to trouble.

One valuable resource for bill reviews involves the National Association of Independent Review Organizations, which Grubbs says develops guidelines for solving common industry problems and promotes standards for medical reviews. Founded in 2001, the nonprofit group has demonstrated the value of Utilization Review Accreditation Commission (URAC) accreditation and their processes for IRO.

Her firm of Mitchell MCN is a URAC-accredited IRO that works with providers in more than 90 medical specialties. The company compares appropriate vs. erroneous billing or coding errors against claims trends. Other services include independent provider audits for a holistic view of billing history and inter-rater reliability system to detect outliers.

The trouble with some health care analytics vendors is when financial reports from their population health system don't square with numbers that the third-party administrator provides, explains Mark Combs, founder and CEO of Self Insured Reporting.

Mark Combs

In a nutshell, he says any data discrepancies from highly segmented information simply fail to reveal

"a comprehensive view of the total costs to a self-insured employer, which is what the CFO is interested in… Having a common data source is critical because when certain parties only have certain things, and then they start trying to communicate with one another, it just doesn't work."

Combs pulls together raw data from disparate sources into a single Excel spreadsheet that includes not only medical claims, but also benefits eligibility, administrative fees, reinsurance and stop-loss reimbursements, projected renewals and other key variables.

One cause of inflated hospital charges is that many providers are pushing back on reference-based pricing agreements that peg their compensation to a percentage of Medicare, which Weintraub says is "just an arbitrary number" that wouldn't stand up in court on a billing dispute. That's why WellRithms employs methodologies associated with the legal principle of quantum meruit in re-pricing medical services. The Latin term means "a reasonable sum of money to be paid for services rendered or work done when the amount due is not stipulated in a legally enforceable contract." ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.