THE FUND REPORTER

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UTILIZATION REVIEW

By Donald Rubin, *Editor*

Under our present system of health and hospital care, the physician almost always controls hospital utilization. A physician decides when a patient goes into the hospital and how the facilities are used. Tests, medication, surgical procedures and length of stay are based on decisions made by doctors. One important reason hospital costs are increasing at an alarming rate is the failure to bring physicians under hospital cost control programs.

Utilization review is one way to control hospital costs. In its simplest terms this means that when a hospital stay is advised, the doctor prescribing hospitalization is subject to review and control. There are many different ways to implement utilization review. This article will discuss the three main ones: pre-admission certification (including second opinion), concurrent review and retrospective review.

Pre-admission certification requires that a doctor confirm to a third party that each non-emergency hospital admission is necessary, before reimbursement for hospitalization is guaranteed. Very often this means that a physician has to file notice of a plan to hospitalize a patient. A second opinion is not necessarily sought to insure that hospitalization is required. Pre-admission certification works best when combined with concurrent review, including second opinion.

A number of self-insured welfare funds in the New York City area provide for second opinion consultations on members' elective surgery. These funds were disenchanted with provider control of existing review procedures, and developed programs where participants receive a second surgical opinion. Mandatory second opinion programs have proven effective in significantly reducing elective surgery, with twenty to thirty percent of all elective procedures found to be unnecessary.

Concurrent review takes place during the patient's hospital stay. Procedures are set up to make sure that the doctor has a plan for discharging the patient expeditiously, and that the tests and treatment ordered are justified by the patient's medical condition. The validity of hospitalizing the patient in the first place is not necessarily examined. Concurrent review also involves certification of need during a hospital stay. This means that a doctor states in writing on a patient's chart, at specified intervals after admission, that continued care is medically indicated. The necessity of days of care is certified as they occur. The physician is involved throughout the review process, and there is usually no later review.

Retrospective review takes place after the patient is discharged from the hospital. The review is supposed to insure that the admission was justified and was not prolonged, and that all tests and treatment were medically necessary. Because all conclusions are reached after the fact, the course of the patient's hospital stay cannot be affected. However, third-party payers can refuse to reimburse the hospital for what is perceived as unwarranted care. The education value of retrospective review is perhaps its greatest contribution. When hospitals and doctors know that their activities are subject to later scrutiny, they are less likely to indulge in improper procedures. This system involves extensive adjudication of cases where third parties refuse to pay for unnecessary care.

There are different means to employ in any review program. The most thorough involves reviewing all hospital admissions. This is also the most time-consuming method. A statistically valid sample of admissions may pinpoint abuses and the need for corrective programs. The American Medical Association has suggested that review procedures be applied only to physicians who are known abusers, although the AMA fails to suggest ways to identify abusers without reviewing all physician performance.

There are also questions about whether all reviews should be done by physicians, or whether nurses and other non-physicians can be trained to oversee physician habit patterns. There are good reasons why fund administrators should participate in these reviews. And, of course, very important questions exist about what penalties should be imposed for improper utilization of health and hospital servces.

There is no doubt that unnecessary hospitalizations and surgery increased as public funds and private health insurance became more widely available. Unethical practitioners, unscrupulous hospital proprietors, Medicaid mills and fraudulent billing are not figments of the imagination. One of the most productive uses of the information now stored in Blue Cross and other third party files would be the development of physician and hospital profiles so that providers abusing health insurance coverage can be identified.

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The Fund Reporter is a publication of the Consumer Commission on the Accreditation of Health Services, which also publishes *Consumer Health Perspectives*. An advisory board to this publication is being formed. It will consist of benefit fund trustees, administrators, attorneys and consultants.

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A Fund Reporter Editorial

WHO WILL PAY THE HOSPITAL BILLS FOR BABY JANE?

The swirl of the television cameras focusing on little Baby Jane Doe has centered on ethical and moral dilemmas. The tragedy of the moment has obscured another implication of the decisions being made. Who will pay the cost of Baby Jane's care?

Thousands of babies are born every year with severe handicaps—congenital anomalies, in insurance jargon. Medical science is learning, with highly technical and extremely expensive equipment and services, how to prolong the life of more and more infants who formerly would have died at or shortly after birth. Many of these children are kept alive through extraordinary medical means only to die within the first year or two of life. Medical and hospital care for such a child costs hundreds of thousands of dollars a year. If the Federal government had succeeded in requiring major surgery for Baby Jane, her care might have cost millions of dollars.

If our national social policy is to be that every human life must be extended by every available medical means, the financial implications of that policy must be considered. Who is to pay the cost of keeping alive every transplant patient, every terminally ill or comatose or brain-dead patient, every severely handicapped infant?

New York State requires insurance companies to cover hospital admissions and medical care for infants with birth defects and congenital anomalies. Self-insured welfare funds, which are not subject to this regulation, often exclude this type of coverage. Blue Cross and other commercial carriers as well as many welfare funds place restrictions on unnecessary care, diagnostic and custodial admissions, and experimental procedures such as transplants. Even one or two Baby Jane cases each year could place an unbearable strain on a welfare fund's reserve. Every fund's benefit language should be reviewed so that decisions about coverage or exclusion are not made by default.

Catastrophic medical bills are only partially paid by the insurance carrier or family. Insurance is quickly exhausted when payments can and often do exceed $200,000. The balance of the cost is often assumed by Medicaid or the federal program for physically handicapped children.

Welfare funds do not have the resources to assume financial responsibility in these cases. If funds and insurance companies routinely excluded or denied claims for infants with congenital anomalies, and for other extensions of life by extraordinary means, the question of public policy would be squarely confronted. A government mandate to provide such care should include a government promise to pay the bills.

DENTAL TREATMENT AND CARE—Part II

By Arthur A. Levin, M.P.H.

In the first part of this article on dentistry we looked at the profession in general, described specialty areas of practice and provided readers with a basic guide to judging quality care. This second article will discuss gum disease and the controversy surrounding its appropriate treatment. Recent scientific questions about the safety of too much exposure to fluorides are also presented.

For many years experts complained that much tooth loss in older Americans was the result of poor diagnosis and treatment of gum inflammation (gingivitis) and a more serious gum condition called periodontitis. The result has been greater emphasis on better diagnosis of gum problems, as well as aggressive treatments ranging from extensive cleaning to surgical incisions called "flap surgery". Given the health education proclivities of dentistry, there is a lot of cheerleading for flossing, regular brushing (less vigorously than previously advised) and regular "preventive" visits to allow professional removal of dental plaque.

As with other dental practices these are not well studied as to their efficacy, and there is little scientific evidence to support the notion that they achieve reduction or elimination of tooth loss. The cause of gum disease is also not well understood, although many experts believe that it occurs where bacteria collect, such as at the line where tooth and gum meet, or where there are irritations from previous, faulty dental work. It is the collection of bacteria that forms the film-like substance known as plaque. Plaque, if allowed to remain, will in turn form a hard material known as tartar or calculus, which can only be removed by a dental professional. The reaction of the gum to the irritating tartar is swelling and pain. This common condition is known as gingivitis. Many dental professionals believe that if untreated it will inevitably progress to the more serious condition of periodontitis—where the gum inflammation is more extensive and also involves other structures such as bone and root. This view is not well substantiated by scientific studies. There is evidence that gingivitis is potentially reversible and does not necessarily progress to more extensive disease even if untreated.

If a regular dental checkup strikes fear into the hearts of most of us, the thought of gum surgery reduces us to a gelatinous state resembling a well known dessert. Periodontal surgery is usually practiced by specialists called periodontists. The treatment they employ can range from cleaning, scaling and planing to surgical procedures such as cutting inflamed gums away from the tooth. Another procedure, flap surgery, allows periodontists to get deeper in order to clean tooth and root surfaces as well as remove inflamed tissue. While studies have shown that such procedures, among others, can improve bone conditions, they fail to find any difference in outcome between scaling and planing techniques alone and the more invasive surgery. No one periodontal technique has been conclusively shown to save more teeth than any other.

Symptoms of gum disease include not only inflammation and pain, but also bleeding gums and bad breath. Unfortunately these signs often do not appear until after the disease has progressed. The standard advice for self-care to prevent gum disease is as follows:

- ► Use dental floss regularly to remove plaque from between the teeth. Make sure that you are instructed as to the proper technique to use.
- ► Brush using a soft toothbrush. Have a dental professional show you the proper way to brush so as to remove plaque most effectively. Most dentists recommend the use of fluoride toothpaste.
- ► Schedule regular checkups that include removal of plaque and calculus from your teeth.

Another view on the proper treatment of gum disease has been promulgated by Paul Keyes, D.D.S. Keyes believes that not enough attention has been given the role played by bacteria in gum disease. He advocates the use of a special microscope to analyze the bacterial content of the mouth and to monitor the Keyes home-care regimen. This approach relies on the use of a baking soda/hydrogen peroxide mixture (see box) rather than toothpaste, followed by salt water irrigation using a WaterPik or similar appliance. As with many non-standard practices, the Keyes technique is subject to considerable controversy as to its value, and many question whether or not it can eliminate the need for most periodontal surgery. There is also question as to whether the Keyes home-care routine is a better preventive technique than the standard one of flossing and brushing. In some cases the Keyes method involves the use of antibiotics when people do not respond to the home-care routine. If antibiotics do not eliminate the problem, then surgery will be recommended. Many dental professionals, including hygienists, seem to recommend use of the baking soda/peroxide paste even if they do not advocate other aspects of the Keyes approach.

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The Keyes approach to gum disease treatment includes using a mixture of baking soda (bicarbonate of soda) and hydrogen peroxide, instead of toothpaste. The mixture (enough peroxide to make a paste when added to approximately one tablespoon of baking soda) is gently massaged into the gums and gum margins with a very soft toothbrush. This is followed by irrigation with a saturated salt solution. (Stir salt into water until no more dissolves. Pour this solution into a WaterPik without pouring in the undissolved salt at the bottom of the mixing container.) Be sure to flush the salt solution completely out of the WaterPik with plain water afterward.

For those who must limit their sodium intake, Epsom salt can be substituted for baking soda in the paste and for regular salt in the rinse solution.

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The fluoridation of drinking water is seen by many public health advocates as a successful and ideal preventive program, and there is considerable evidence that life-long exposure to fluorides does reduce the incidence of dental caries in the population. A small number of people and organizations have fought against fluoridation of public water supplies since it was started after the Second World War. Some of these groups have appeared to confuse science and geopolitics, labeling fluoridation part of a communist scheme. There is, however, some scientific concern that centers on the possibility of too much aggregated exposure to fluorides from drinking water, fluoridated toothpastes and mouthwashes, and fluoride treatments administered by dental practitioners.

If you do not live in an area where public water supplies are fluoridated, the risks of tooth decay may outweigh those of fluoride toxicity. Until the controversy about fluoride danger is resolved, concerned people whose water supply is fluoridated can limit their risk of over-exposure by avoiding oral products containing fluoride.

As noted in the previous article, quality dental care includes discussing treatment plans and their cost with the patient before work begins. If the plan includes periodontal surgery, a second opinion is as important as it is for any other elective surgery. Oral surgeons and periodontists are often predisposed to recommend surgery for the same reasons that medical surgeons recommend surgery more often than do internists. In fact, one might benefit by a second opinion on any major dental work, including extractions and restorations. Choose the second practitioner as carefully as you did the first.

Arthur A. Levin is director of The Center for Medical Consumers and Health Care Information, Inc.

BACK DOOR BENEFITS

America is in a fitness craze. Millions of us have become avid runners or sports enthusiasts, or have joined exercise clubs. More and more physicians recommend exercise to improve cardiovascular health and add to life expectancy.

Welfare funds are now beginning to receive claims for fitness programs as rehabilitation and physical therapy. In one recent case, the member went to small claims court after his claim for reimbursement of "cardio-fitness center" membership fees was denied. The small claims referee ruled that the plan's coverage of physical therapy included therapy at such centers, since they were not specifically excluded by the plan document.

Trustees design benefits to provide the best possible care for the majority of participants with the dollars available. Coverage for fitness centers, like coverage for nutrition therapy or acupuncture, is outside the main corridor of benefits defined by most plans. Unless trustees come to grips with the issue, they may find themselves providing coverage unintentionally.

The financial implications of this kind of coverage must be carefully considered. Health clubs charge fees of $500 to $1000 a year. That may be affordable for top executives of major corporations, who can make business deals in the gym as well as the boardroom. However, welfare funds would need substantial added contributions to fund such a benefit.

It is not clear how much exercise, of what kind, and at what intervals, best promotes good health. The member in the case noted above had a letter from a physician stating that the exercise program provided by the center was essential to his rehabilitation after a heart attack. Most doctors could write such a letter in good conscience, since it is generally agreed that exercise is good for cardiac patients. Some health centers are owned or supervised by physicians who, in a clear conflict of interest, recommend their own exercise programs as medically necessary.

Trustees who decide to exclude coverage for fitness centers might consider plan language excluding membership or other fees for use of health clubs, fitness centers, sports medicine centers, swim clubs and the like that are not maintained exclusively for medical rehabilitation purposes. The plan might cover only licensed medical facilities as defined under state law (Article 28 of New York Public Health Law), which sets uniform standards.

Trustees who choose to include this coverage in their plan might consider requiring precertification and/or second opinion, and developing standards for fitness programs. With precertification, any exercise program would be submitted to the fund for advance approval. It might then be reviewed by a medical authority in a second opinion procedure. Fitness program standards might include defining specific rehabilitation goals during a specific time period, and supervision of the program by a physician.

The key is to discuss and decide the question of coverage, and to review plan language to make the decision enforceable. Otherwise, trustees may discover they are paying unexpected "back door" claims.

UNNECESSARY CATARACT SURGERY

Dr. Ira H. Kaufman, clinical professor of ophthalmology at Cornell University Medical College and president of the Long Island Vision Foundation, writing to *Newsday,* October 24, 1983:

"Along with many of my colleagues, I am concerned about the recent sharp increase in the number of cataract operations in the U.S. Best estimates indicate an increase of about 75 per cent from 1979 to 1982...

"Nowhere in medicine do the physician's financial aspirations more severely test his professional ethics than in elective eye surgery. With 95 per cent satisfactory results, the risk is small and the rewards are great. However, not all cataracts need to be removed.

"Visual function and efficiency have to be considered in terms of practical needs. Only rarely is there an urgent reason to remove a cataract. All too often, the patient is swept onto a surgical schedule and the cataract removed as though the eye were in immediate danger when, in reality, there is a fear on the part of the surgeon that he will lose the case.

"Well over $4,000 can be spent by a patient on the combined costs of cataract surgery, intra-ocular lens implantation and attendant laser treatment. Unnecessary surgery carries risk, is unethical and is a dreadful waste of the health dollar. While this problem is not limited to eye surgery, that, for the past 30 years, has been my field and I am chagrined by the weakening of professional self-restraint."

FUND CHALLENGES NEW YORK LAW

By Roxanne Young, *Associate Editor*

Last year, in an attempt to hold down soaring hospital costs, New York State redesigned the way its hospitals set their rates. A self-insured ERISA fund has now challenged part of that plan, charging that it will have the opposite effect on the fund's hospital costs, resulting in severe hardship for the fund participants. On December 1, 1983 Sebastian Rebaldo, Chairman of the Board of Trustees of the United Optical Workers Insurance Fund, filed suit in federal court to prohibit New York from implementing and enforcing Public Health Law 2807-a, subsection 6[b].

This part of the law forbids hospitals to negotiate discount payment agreements with self-insured and self-administered groups. It forces hospitals to cancel all such agreements negotiated after May 1, 1982 and permits agreements negotiated before then to continue only until December 31, 1985. It does permit these discounts to so-called IX-C corporations, but only Blue Cross currently fits this description and offers hospital insurance. About 500,000 participants of ERISA funds are now covered by discount agreements. They comprise less than one percent of hospital admissions at discount rates, with the balance covered by Blue Cross.

Rebaldo v. Cuomo, naming Governor Mario Cuomo as one of the defendants, contends that there are four grounds on which the statute is invalid: 1) ERISA preemption; 2) impairment of contracts; 3) denial of equal protection of the law; and 4) violation of federal anti-trust laws.

The Optical Workers Fund self-insured hospital benefits for its participants effective January 1, 1983. Before then, the fund's trustees purchased hospital insurance through Blue Cross. As a result of large cost increases, they explored other alternatives. They learned that if the fund self-insured hospital benefits, many hospitals were willing to negotiate payment rates only slightly higher than those available through Blue Cross. Self-insurance also offered the advantages of lower administrative costs, better coordination of benefits, and other cost and quality control tactics not available under Blue Cross.

The trustees chose to leave Blue Cross and self-insure. Rather than negotiating a separate agreement with each of the many hospitals the fund's participants might use, they joined in existing discount rate contracts negotiated by Donald Rubin, Inc. In 1983 these contracts provided the Optical Fund with discounts averaging over 19 percent below full hospital rates.

The trustees estimate that, if the new hospital rate law is enforced, the fund's hospital costs will increase by $10,000 per month in 1984. They say they would have to cut benefits to cover this sudden increase, or abandon self-insurance and purchase hospital insurance from Blue Cross once again.

Perhaps the strongest of their legal arguments is ERISA preemption. The law clearly relates to benefit funds, as defined by ERISA, and none of the exceptions to preemption seem to apply. Recent court decisions, including *Blue Cross v. Peacock's Apothecary,* have affirmed the broad scope of preemption. In that case, Alabama attempted to forbid pharmacy discounts for benefit funds. The federal court ruled that a state may not regulate, directly or indirectly, what benefits may be included in ERISA fund plans.

The Optical Workers Fund is a multi-employer fund providing benefits for participants in five states. The trustees argue that this New York law will affect benefits for participants in four other states as well. They point to previous court decisions affirming that ERISA preemption was intended to eliminate the threat of conflicting or inconsistent state and local regulation of employee benefit plans.

ERISA also refers specifically to direct or indirect state regulation of the terms and conditions of these plans. The major advantage of self-insurance is the combination of hospital discount rates with other cost and quality control techniques. Without discount rates, self-insurance of hospital benefits may become financially impossible. The trustees claim that New York will thus be indirectly regulating the terms of ERISA fund benefit plans.

The Optical Workers Fund trustees also filed a request for a preliminary injunction to prohibit enforcement of this law. They have asked the state to agree to an injunction until the case is decided on its merits, or to agree to stay enforcement until then. The January-February *Fund Reporter* will include a full discussion of the issues of the case.

Utilization Review

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Self-insured welfare funds have a stronger incentive for utilization review than do large insurance carriers. Many such funds require pre-admission certification as well as second surgical opinion, and they review large claims retrospectively.

The federal government's programs to reduce costs through utilization review go far beyond those of welfare funds and insurance carriers. Federally-funded Professional Review Organizations (PROs) have been established in each area of the country to review Medicare and Medicaid cases. In New York City there are PROs in each county. They offer their services on a fee-for-service basis to welfare funds.

No matter how your fund is insured, utilization review should be a top priority. If insurance is purchased from an outside carrier, meet with the carrier's representatives to emphasize your concern. Review existing programs and design new ones to fit your needs. Train claims processors to spot questionable utilization. Utilization review can be one of the best tools to hold down health care costs. Better yet, it can also improve the quality of care provided to participants.

SPINA BIFIDA afflicts almost 8,000 infants a year. This birth defect results when the spinal column fails to fuse to surround and protect the spinal cord. It can mean paralysis, hydrocephalus, loss of bladder and bowel control and great risk of infection. The Spina Bifida Association and General Nutrition Corporation are cosponsoring a study of the possible usefulness of folic acid, a B-complex vitamin, in preventing this congenital malformation. Women who have had one or more children with spina bifida are given vitamin supplements free charge. Women who wish to participate in the study can call the Association toll-free at 800-621-3141.

PHONE NUMBERS TO KEEP ON FILE

BREAST CANCER affects one of seven American women. Women who discover a breast lump often postpone visiting a doctor out of fear. They suffer needless worry and anxiety if the lump is benign (and the great majority are). They take a needless risk by waiting if they do need treatment. Post-mastectomy volunteers, working through Adelphi University's Social Services Center in Garden City, NY have started a "Woman-to-Woman Hot Line". Volunteers who answer the calls understand the fears and are trained to clarify the issues. They will also offer follow-up support. Anyone who has found a breast lump or had a mastectomy, as well as family members and friends, may call Mondays 11 a.m. to 1:30 p.m., Wednesdays 6 to 9 p.m., and Thursdays 7:30 to 9 p.m. The number is 516-248-8866.

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