HEALTH PERSPECTIVES

A NON-PROFIT TAX EXEMPT ORGANIZATION

Vol. 3 No. 1 PUBLISHED BY THE CONSUMER COMMISSION ON THE ACCREDITATION OF HEALTH SERVICES, INC. Jan.-Feb. 1976

Pub. 7/76

Utilization Review: IMPORTANCE TO THE CONSUMER

HOSPITAL COSTS UP! WHY?

People tend to feel powerless in the face of rising health costs. When they are sick they move into a seller's market and are not able to shop around for cheaper goods or postpone a needed purchase. Sick people have to pay what the doctor, laboratory, or hospital charges. We all pay for inflated hospital and medical bills even when we are healthy. Nationwide 40 billion dollars were spent for hospital care in 1974. In that same year in New York City, Blue Cross paid member hospitals over 700 million dollars and the Medicare-Medicaid payments to these same hospitals brought the total to over 2 billion dollars. These dollars are provided by healthy consumers in the form of high Blue Cross premiums and taxes.

Hospital costs continue to rise at a rate considerably greater than the rate of inflation in the general economy. While undoubtedly many explanations are made by providers for this rise—hospital workers once underpaid are finally receiving living wages, hospitals provide better care, hospital services are labor intensive, but require more costly equipment, etc.—consumers feel that inefficiency and unnecessary admissions are often the cause. No matter who is right unless something is done it will soon be beyond the means of the public to fund these costs. Although not mentioned above, one of the important reasons hospital costs are increasing at an alarming rate is the failure of present reimbursement mechanisms to bring physicians into hospital cost control programs. Reimbursement methods have no control on practicing physicians. Admissions, discharges, surgical procedures, case mix, treatment, ordering of tests, use of the facilities and length of stay are in fact controlled by decisions made by doctors. A physician having once obtained privileges to practice at a facility is subject to few sanctions. The physician uses the hospital facility and directs nurses, laboratory and x-ray technicians and interns and residents as if they were private employees. The physician does not have to pay for the equipment and services used in treating private patients in a hospital, and therefore has not had to be cost-minded. To the contrary, the physician's main concern has been to ensure access to a bed in a hospital where a full range of services is available to patients.

UTILIZATION REVIEW: U-R NEEDED

Utilization review (UR) is one method that may be used to control admissions, discharges and cost factors while the patient is in the hospital. It is increasingly evident that a strong regulatory system, or financial incentives, are needed to guarantee that each admission to a hospital is medically necessary, and that appropriate care is delivered in more appropriate settings. Numerous studies indicate that as many as 15% to 40% of the inpatients each year do not need to be admitted or stay as long as they do in the hospital. It was estimated that 11,900 lives were lost as a result of unnecessary operations. Hospital administrators and trustees have little or no control over the private practicing physician, nor is it in their interest to prove that their institution is not needed, by eliminating unnecessary services.

Although numerous studies have pointed out the fact that a large proportion of hospital stays are unnecessary, few attempts have been made to date to stop these practices. In most cases where there have been efforts to control hospital admissions: they failed. Physician performance remains the most unregulated sector of the American economy.

PREPAID: LOWER COST

Pre-paid group practice is one way to prevent unnecessary surgery and hospital stays. Pioneered by Kaiser in California, this method changed the way doctors were reimbursed. Physicians were paid a per person (capitation) fee per year to provide both physician service and hospital care. After changing the way physicians were compensated for services, there was a dramatic drop in the number of patients hospitalized. Consumers using pre-paid practice doctors are hospitalized one-third to one-half less than patients using fee-for-service physicians as well as substantial reductions in surgical procedures. Pre-paid health programs throughout the United States have proven to both medical experts, government officials and more sophisticated consumers that there is a definite correlation between the method of doctor compensation and the utilization of hospital services. This is not, however, the way in which most medical services are

currently delivered. Fee-for-service medicine is and is likely to remain the dominant way doctors will be paid in the foreseeable future in the United States.

In England doctor services are paid for by a national health system. Most doctors are paid a salary. In England the rate of surgical procedures and the number of surgeons is one-half that of the U.S. These facts also indicate that methods of compensation can influence hospital use.

SHORTER STAYS SAVE $

Some form of control is obviously necessary. Even if the per diem hospital cost remains high, perhaps a decrease in the number of days of hospital care will be a partial answer. If the hospitals continue to be reimbursed at a rate of roughly $200 per patient day, then shortening the hospital stay of only 1500 patients by only one day could result in immediate savings to the public of $300,000. These savings can be maximized if accompanied by controls over all admissions, so that empty beds are not filled and the need is reduced for construction of new beds.

UNNECESSARY CARE COSTS $ AND LIVES

This is not to say that necessary hospital care should be denied to sick people merely to save public dollars. However, there are indications that there are many unnecessary hospitalizations and surgical operations performed each year. One recent report, prepared for a Congressional sub-committee, estimated that as many as 2.4 million elective surgical procedures done in the United States in 1974 were unnecessary, or would have been considered so by a second consulting surgeon if a second opinion had been sought. If just half this volume of surgery were truly unnecessary, then over one million operations would not have been required that year and only the surgeon's pocketbook and the hospital's financial statement would have been any the worse.

There is also some reason to believe that patients are frequently kept in the hospital longer than seems medically necessary. It is difficult to make precise judgments on this subject because so many variables are involved: a poorly nourished patient may need a longer time in the hospital than a patient in good condition even though both suffer from the same disease, or one patient may live alone or in such a crowded household that earlier discharge from the hospital may not be as feasible as for a patient with a family and a good home. Although there may be reasons to justify a particular stay that is longer than average, it is also true that some hospitals have encouraged longer stays in order to keep beds filled. Another method used to fill beds is the admission of patients on Friday or Saturday so that the bed is occupied until Monday when routine medical services resume. It costs the hospital almost as much to maintain an empty bed as a full one. Empty beds produce no income. Hospitals with a low occupancy rate therefore welcome prolonged patient stays while overutilized hospitals may discourage them.

UTILIZATION REVIEW: THREE WAYS

Under our present system of health and hospital care, the physician is the sole determiner of hospital utilization in most cases. As the person who decides when a patient goes into the hospital, the physician is also the only one who can sign the discharge order. Of course a few patients exercise their right to leave a hospital against orders, but the number is small. However, patients cannot admit themselves to a hospital. This is the prerogative of the physician or in a few cases a lay hospital representative.

One method that has been suggested to supervise this responsibility, or even to share it with others, has been utilization review. In its simplest terms this means that when a hospital stay is advised, the doctor prescribing hospitalization will be subject to review and control by peers. There are many different ways in which utilization review can be implemented and different procedures have been suggested to achieve the desired goals. The three main methods would be retrospective review, concurrent review (second opinion) and pre-admission certification.

RETROSPECTIVE REVIEW: LOOKING BACKWARDS

Retrospective review means that a review takes place after a hospital admission is made. The review is supposed to insure that the patient admission was justified and not prolonged. Statistical norms for different clinical diagnoses are used for comparison with each record under review. Because all conclusions are made after the fact, the course of the patient's hospital stay cannot be affected. However, third-party payers can refuse to reimburse the hospital, after appropriate appeal mechanisms have been followed, for what is perceived as unwarranted care. In addition, if continuous retrospective review finds that a particular physician has a higher proportion of unwarranted hospitalizations, this physician may be reprimanded, economically penalized, or have hospital privileges curtailed. It is thought that the educational value of retrospective review is its greatest contribution. When hospitals and doctors know that their activities are subject to scrutiny later, 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. Hospitals will fight vigorously to recover losses of unreimbursed stays. Retrospective review penalties put pressure on the hospital.

CONCURRENT REVIEW: OK AS YOU GO

Concurrent review takes place during the patient's hospital stay. Special committees are set up to make sure that the doctor has a plan for discharging the patient expeditiously and that the tests and procedures ordered on the patient are called for by the patient's medical condition. In a sense, concurrent review equals a constant second opinion in the care of patients. If a perfectly healthy patient is sent to a hospital by a surgeon for a hysterectomy, for example,

concurrent review would ensure that proper pre-operative tests were ordered and that discharge was planned in accordance with current norms. The validity of hospitalizing the patient in the first place is not necessarily examined, although tissue reports and retrospective review might identify this case as one of totally unnecessary hospitalization. Concurrent review also involves recertification of need during a hospital stay. Certification of need means that a doctor states in writing in the patient's medical chart at specified dates after admission that continued care is medically indicated. This is advantageous to the hospital because days of care are being certified as being needed as they occur. There is no later review and the physician is involved throughout the review process.

PRE-ADMISSION CERTIFICATION

Pre-admission certification requires confirmation by a doctor to a third party that each non-emergency 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 the hospitalization is required. Ideally, if pre-admission certification were combined with concurrent review (including second opinion), there would be better control over physician hospital performance. Experimental programs to evaluate the cost and quality aspects of this combined medical review would be invaluable.

SECOND OPINION: YOU ONLY LIVE ONCE

A number of trade unions in New York City have begun programs for second opinion surgical consultation for members' elective admissions. These unions were disenchanted with the provider control of existing utilization review procedures and developed a program where members would receive a second surgical opinion. Second opinions have proven to be effective in significantly reducing elective surgery. Between 20% and 30% of all elective surgical procedures were found to be unnecessary.

Blue Cross and Blue Shield of Greater New York have begun a program to pay for a second surgical opinion. Although the second surgical opinion is not now considered an official utilization review technique its initial success has proven that it can reduce the number of surgical procedures and save so much money that pressure is growing to include second opinion as a major way to control unnecessary admissions.

AMA SUGGESTS "CATCH 22"

In any review program there are different means that can be employed. All admissions to a hospital can be scrutinized; though this may be time-consuming it is the most complete and thorough way to proceed. A statistically valid sample of admissions has been suggested as adequate to pinpoint abuses and the need for corrective programs, or a 10% review by physician would be another way to monitor the need for admission. The American Medical Association has suggested that review procedures be applied only to those physicians who are known abusers and who therefore should be stopped from hospitalizing patients unnecessarily and performing unneeded operations. How these abusers are to be identified unless all physician performance is reviewed is left unanswered by the AMA.

CONSUMER REVIEW: WHY NOT?

There are also questions about whether or not all review should be done by physicians or whether nurses and social workers are competent to oversee physician habit patterns. Although at first blush it appears to be completely radical and new, there are good reasons why consumers and patients should also be included in health care reviews. And, of course, very important questions exist about what, if any, kind of penalties might be imposed for mis-utilization. Should hospitals be disqualified from receiving public funds? Should doctors lose their hospital privileges? Should government programs and other third-party payers restrict reimbursement to those institutions and physicians who do not meet specified utilization performance criteria? How can utilization patterns be influenced by the people who pay unless there is some real incentive for efficient performance? Should providers be financially rewarded or punished for their performance? Should providers not meeting standards be required to take educational and training programs to correct technical deficiencies and gaps in knowledge?

FEDERAL REGULATIONS: AMA REWRITE

The 1965 Amendments to the Social Security Act called for utilization review (UR) to be applied to Medicare patients. Medicare legislation mandated UR committees to perform retrospective studies in order to discover patterns of inappropriate utilization so that suitable educational programs could be developed for physicians. In 1968, Congress mandated more stringent statutory UR requirements for Medicaid patients, these to be enforced under regulations devised by each state for its own Medicaid program. Believing that the regulatory provisions under Medicare and Medicaid should be the same, to the extent that program differences permit, the Department of Health, Education and Welfare (HEW) has recently promulgated new regulations to apply to both programs.

The presently proposed regulations represent a slight compromise after objections prevented the implementation of previous regulations applicable to Medicaid patients only. In 1974, HEW gave notice that all Medicaid and Medicare patients must have admission review within one work day after admission with the review function to be carried out by a hospital committee composed of two or more physicians with the participation of other professional personnel. The

American Medical Association obtained a preliminary injunction against the application of these rules on the grounds that use of "other professional personnel" interfered with the practice of medicine, and that review within one working day of admission was unacceptable as a practical procedure.

The AMA suggested that UR be restricted to those physicians with a demonstrable history of over-utilization and to certain medical conditions and procedures which are considered frequently misused. They also wanted review of admissions to be done on a sample basis only, by duly licensed physicians, and within a "reasonable time." Special waivers were asked for small rural hospitals, and it was proposed that in doubtful cases great weight be given to the judgment of the attending physician.

As a result of discussions between HEW and the AMA the following proposed regulations have been agreed to:

I. Preliminary Screening: plans for utilization review in each hospital must provide for preliminary screening after each admission to determine which cases should be referred to physicians on the review committee. Criteria established by medical and other professional personnel will be used by the screening personnel who can pass on admissions, but cannot by themselves declare an admission unnecessary. A list of diagnoses or procedures for which admission can be presumed to be necessary without further review must be developed by the medical staff of each hospital for use in the screening process.

II. Physician Review: all admissions questioned by the screening committee will be referred to a physician member of the committee who can alone declare the admission justified. A determination of non-necessity can be made only after the physician has notified and consulted with the admitting physician and has obtained concurrence from another physician member of the committee.

III. Continued Stay Review: at the time of the admission review a date for future review on the necessity of continued hospital care will be set, according to norms for that particular diagnosis, these norms to be established by the medical staff of that particular hospital, based on available regional norms for length of stay by diagnosis where possible. When the assigned date is reached, review and, where indicated, assignment procedures shall be followed as with admission review and completed no later than two working days following the assigned date.

IV. Time Limits: review of an admission must take place within three working days after the date of admission. Admission review must be completed prior to the performance of elective surgery, unless such elective procedure is listed among those which justify admission without further inquiry. The actual determination of what constitutes an elective admission is left to the hospital's medical staff.

These proposed regulations will have to be distributed for comment according to law before being implemented.

HEW claims that the use of the "screening procedure" and the extension of the time limit from within one to within three days of admission obviates the special problems of small hospitals. The regulations also disallow any medical personnel directly involved with the care of a particular patient to be on the review committee for that patient. Variances may be given to facilities unable to meet the requirements of the proposed regulations, but only if the request for a variance is backed up by proof of inability.

If these regulations take effect it will mean that every hospital will be required to have a clearly written UR plan in operation. If not, the hospital would be denied reimbursement for the care of Medicare and/or Medicaid patients.

NEW YORK STATE UR REQUIREMENTS

In March 1975, the New York State Health Department developed a system of Utilization Review "To assure effective and efficient utilization of hospital facilities and services.... To assist in the promotion and maintenance of high quality care through the analysis, review, and evaluation of clinical practices within the hospital." By July 1975, all the hospitals in the State had drawn up plans which were acceptable to the State Health Department.

UR requirements summarized below are applicable to *all* patients, regardless of payment source.

STATE HEALTH DEPARTMENT REQUIREMENTS FOR UR PLANS

1. The statement of purpose must include the following goals at minimum: A) To assure effective and efficient utilization of hospital facilities and services and B) To assist in the promotion and maintenance of high quality care through the analysis review and evaluation of clinical practices within the hospital.

*2. Designation of a UR agent. This "agent" is not necessarily a physician.

3. The organizational details regarding the relationship between the hospital and the UR agent must be indicated.

4. Statement of methods and procedures by which the UR agent will carry out responsibilities.

5. Provision for use of written criteria and standards by UR agent in UR activities.

*6. Review the necessity of admission for each patient admitted. Admission review to be conducted within one working day of admission.

7. Identification of methods and norms used by UR agent for continued stay reviews.

8. Provision for review of the necessity for continued stay of each patient still in the hospital on the date assigned for continued stay review.

9. Medical care evaluation studies: including evaluation of admission, duration of stay, provision of ancillary services including drugs and biologicals, professional services rendered to patients, efficiency and co-ordination of services provided.

Follow-up procedures to assure recommendations for change are implemented.

10. Provision for the UR agent and hospital administrative staff to review data outputs from the New York State Hospital Utilization Review (NYSHUR) data system.
11. Provision for corrective action.
12. Discharge planning co-ordination.
13. UR procedures open for review by fiscal intermediaries, state agencies and HEW.
14. Statement of the role of the administrative staff of the hospital in the UR process and provision of support and assistance to the UR agent.

*Requirements #2 and #6 have been withdrawn after litigation by the American Medical Association vs. the U.S. Department of Health, Education and Welfare (see above).

LAW GOOD: ENFORCEMENT LAX

Although the New York State UR regulations are strict enough so that one might expect them to have a significant effect on utilization patterns, and all hospitals have adopted written plans for implementing the regulations, there has been little actual change. The reason: the monitoring of the UR plan by the State has been weak.

Late in 1975, State inspectors found that more than 60 per cent of the hospitals in New York City were not fulfilling the requirements of the NYSHUR Program. All of these hospitals had written plans which have not been implemented in compliance with the remaining twelve requirements. The 69 hospitals not in compliance with UR requirements included 32 voluntary, 21 proprietary and 16 municipal hospitals.

PLAN FAILS: REASONS ABOUND

It is impossible to single out one reason why hospitals have not implemented the NYSHUR program regulations. The scope of failure ranges from several easily corrected technical deficiencies to total lack of compliance. These first inspections were, according to a State Health Department representative, for educating and helping UR agents. No fiscal sanctions have been imposed.

FAILURE REASON #1: NO ENFORCEMENT

The above underscores the academic character of requirements which are not implemented or enforced. Government officials who fail to impose penalties to enforce the regulations can expect non-compliance. Consumers, unaware of the laxity of enforcement, cannot know of the failure of UR. Once informed, the public can demand that corrective measures be taken: including constant monitoring and implementation of appropriate penalties.

UR: ANOTHER TRY

Despite this lack of compliance, UR is seen by New York State as an important method for minimizing federally mandated health costs to it and local government entities. On May 14, 1976, regulations even more stringent than the existing ones for Medicaid patients were promulgated.

Under these new regulations, all elective surgery is considered deferable unless a second opinion, obtained from a designated physician, agrees that the surgery should be performed at that time. Specifically, this rule applies to tonsillectomy-adenoidectomy, hysterectomy, spinal fusion, joint cartilage surgery, and operations for hernias, hemorrhoids, and gall bladders. The second opinion and subsequent authorization from a government official must be obtained before the patient can be admitted to a hospital.

Other requirements place a twenty day limitation on any hospital stay, a maximum of one patient day in hospital prior to surgery (except for stated conditions), and exclusion from Medicaid reimbursement of any surgical procedures or care not on the authorized list. Of course there are medically indicated exceptions and no patient is likely to bleed to death or be deprived of urgent or even necessary care unless the bureaucratic structure places an uninformed patient in a dangerous situation. Despite all precautions it is possible that some patients may be denied needed care (as in the past).

BLUE CROSS: POOR WATCHDOG

Blue Cross could play an important part in any attempt to control over-utilization. Not only does Blue Cross reimburse its member hospitals for care rendered to its subscribers but, in many instances, it acts as fiscal intermediary for Medicare and other governmental programs. Under the Social Security Act (Sec. 1862), the fiscal intermediary is responsible for monitoring the effectiveness of utilization review committees and for bringing any negative findings to the attention of the Social Security Administration. If noncompliance with UR regulations is verified, continued reimbursement may be terminated and the costs of any retroactive denials by the intermediary would be absorbed by the hospital.

BLUE CROSS USE VARIES: WHY?

The very nature of its activities and the techniques it has developed to carry these out (computerized records for payment purposes, etc.) places Blue Cross organizations in an ideal position to institute actions against hospitals and physicians guilty of gross abuses. The information to identify abusers is already in Blue Cross' files, but has not been used to monitor physician and hospital practices. For example, a recent comparison of hospital use patterns by Blue Cross patients in different parts of the country showed 122 admissions per 1,000 Blue Cross subscribers in the United States, 105 admissions per 1,000 subscribers

in the Northeast, and 87 admissions per 1,000 subscribers in the New York City area. If Blue Cross records show hospital use patterns, average lengths of stay, admission rates by diagnosis, etc. for each hospital, a comparison of that data might reveal misutilization of hospitals. Similar data by doctor could pinpoint misuse of hospitals by some physicians.

CARROT AND STICK: FEW STICKS NEEDED

It would *not* be necessary for Blue Cross and Blue Shield to apply financial sanctions very many times before hospitals and doctors would themselves begin to control abuses. Unfortunately, the deterrent power of fiscal control based on utilization data has not been attempted. Hospitals and doctors are not overly concerned with utilization: after all, the insurance company pays for it. In fact, it is not in the hospitals' interest to control admissions since many institutions now wish to run high occupancy rates to justify their existence. And, the Blue Cross plans have been able to avoid confrontation with providers by applying for and usually receiving raises in premium rates to cover rising hospital and doctor costs.

PATIENTS BEAR BRUNT: PROVIDERS UNTOUCHED

Under current conditions in most states, if Blue Cross applied its fiscal power to penalize providers, it is likely that patients would be the first to suffer. A patient admitted to a hospital by a physician incurs the expenses of treatment to the extent that they are not covered by Blue Cross or another insurance carrier. If retrospective review determines that the hospitalization was medically unnecessary and the insurance carrier refuses payment to the hospital or physician, the patients will be billed for those services. The patient is penalized for the errors made by others. It was not the patient's choice to go into the hospital. The patient was only following the doctor's orders. Unless this system is changed, UR can place an unfair burden on the patient, while the provider is left relatively untouched.

HOLD HARMLESS: A CLAUSE THAT SATISFIES

It is not necessary for patients to bear the brunt of utilization control. Two Blue Cross plans in the United States already have "Hold Harmless" clauses in their contracts with member hospitals. These clauses specify that if a hospital's claim for payment is denied by either a utilization review committee or the third-party insurance carrier, the hospital may not sue the patient for payment of the bill. If all Blue Cross plans introduced "Hold Harmless" clauses into their contracts with member hospitals, consumers would be protected against the costs of unnecessary hospitalization and would not be in the middle of a struggle between the hospital and the third party payer. Under Medicare, hospitals must absorb cost of a retroactive denial by the intermediary if the hospital was found not in compliance with federal UR regulations.

LOOK MA: A UR THAT WORKS!

There are hospitals with functioning utilization review committees. It is helpful to examine the key factors of one of these committees and attempt to understand its effect on consumers and the hospital. A voluntary teaching hospital in New York City has a utilization review committee (URC) composed of one physician from each of the major clinical departments and representatives from administration, nursing, social service and medical records. The URC has successfully implemented a pre-admission review program to determine medical necessity. A subsequent review date is assigned based on expected length of stay tables prepared by the NYSHUR Program. Emergency admissions are reviewed within *one* working day of admission. A final determination of necessity of admission and notification of an adverse decision is made within two working days in non-emergency cases. Continued stay review is first done by the nurse UR coordinator located on each floor of the hospital. The attending physician must document in the patient's chart the precise reasons for continued stay and the estimated additional length of stay. The physician is also expected to provide information regarding changes in treatment plan and the plan for post-discharge care. Discharge planning is an integral part of UR, beginning prior or soon after admission. Final determination about pre-admission and continued stay review are made by the URC physician in the clinical specialty responsibility for the patient.

EVALULATION STUDIES: INTEGRAL PART OF PROGRAM

Another important element of this URC is the medical care evaluation studies. The average length of stay has decreased one day since UR was put into effect. This is an important way of achieving cost containment, if the beds are not filled unnecessarily. UR requires a constant monitoring of hospital stays. Although there is a tendency to move patients out of the hospital faster than is medically correct, a good UR ensures that patients needing a longer hospital stay are not discharged prematurely.

To manage this comprehensive program, additional staff had to be hired. It was also pointed out that a successful URC may appear to hurt a hospital financially; i.e., per diem costs to patients increase during shorter stays because more services are provided in the first few days of stay. The days immediately before discharge are usually less costly. The institution, however, was able to accommodate 2500 additional patients last year. The final tally, according to the administrator of this URC, was that UR costs the hospital $200,000 per year. One problem in the imple-

mentation of UR is that hospitals do view them as threatening to their source of income and physicians view UR as an intrusion into their *private* practice.

SAVINGS DEFINED

Savings in the health field due to utilization review can be looked at in two ways: in macro terms, we talk about savings in the hospital industry, throughout the United States. In micro terms we talk about savings at a particular institution. In economics, you may have savings on a micro scale, but not necessarily savings at a macro scale, and vice versa. When a hospital experiences a reduction in its length of stay (LOS), that hospital, in fact, may save or lose money, or it may increase or decrease costs. So as not to further confuse the reader, we give a few examples:

EXAMPLE I: DEMAND GREATER THAN SUPPLY

A shorter LOS may save money by eliminating unnecessary care. However, if the demand for beds is greater than the supply of beds, the shorter LOS will only increase the number of admissions. A shorter LOS will then result in a higher cost per stay, as the productivity of the institution is increased. Therefore at the end of the year, the hospital experiences greater utilization of its ancillary services, nurses, physicians, technicians, etc., and incurs higher costs for the year. Assuming that the number of patient days is constant, although the number of patients may have increased, the per diem and annual costs at that hospital would increase. On the other hand, the need to build more beds may decrease causing net savings in the industry.

EXAMPLE II: DEMAND LESS THAN SUPPLY

In an institution where the LOS decreases and the demand for beds equals or is less than the supply of beds, the hospital will experience an increase in empty beds. Assuming that the hospital cannot generate a greater need for those beds, there will be cost savings at the institution as admissions decrease. There will also be net savings in the industry.

KNOTTY PROBLEMS CAN BE UNTIED

Many people believe that a strong regulatory system is needed to guarantee that each admission to a hospital is medically indicated. In a period when there is a great amount of competition for fewer public dollars, it is indeed necessary to ensure that public funds are properly spent for hospital and medical services. However, emphasis on cost control alone may have unwanted and deleterious effects on the quality of medical care.

Hospitals that have implemented UR have found that these programs have a positive impact on the quality of patient care. They feel that the educational experience of the UR process is beneficial to the attending staff physician. UR, started as a cost control mechanism, has become inextricably linked to the quality of care.

Doctors have also expressed displeasure about paperwork required by insurance companies and government. UR procedures require extra meetings, justification of each admission, evaluation for continued stay, discharge plans and additional paperwork.

There is no doubt that unnecessary hospitalizations and surgery have increased as public funds became available. Unethical practitioners, unscrupulous hospital proprietors, and 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 the providers abusing health insurance coverage can be identified.

Pre-admission certification and concurrent review are the two steps which hospitals can implement to insure that only patients needing hospitalization are hospitalized. The UR program will work at hospitals which are running at full capacity and have a backlog of patients waiting for admission. Admitting physicians will support UR so that they can have access to beds at the better institutions. The UR programs have no support at under-utilized hospitals. In the United States most hospitals are operating at less than 80% of capacity. In these facilities, UR programs may cause financial losses to the institution and physicians. These institutions attempt to increase the number of patients admitted so that their occupancy rates will be higher. URC's at under-utilized institutions are not as effective as URC's higher utilized hospitals because of the lack of support by the hospital's administration and physicians. Retrospective review of claims by third parties can force these institutions to comply with UR requirements.

SOCIAL ROLE IMPORTANT

Utilization review committees should rely on the social service department of hospitals to prepare an evaluation of the patient's ability or social history regarding discharge from the institution. This evaluation of the patient should include input from the patient.

In many cases, utilization review committees work in a vacuum because they are not involved in assessing the individual patient. Assessments are made strictly on chart review or physician input. It seems an appropriate function of a hospital's social services department to conduct evaluations of a patient's social history and the patient's ability to function outside the institutional setting. This will minimize the tendency of UR physicians to overlook the social history of the patient and the ability of patients to function in their environment.

The Consumer Commission recommends:

1. That all Blue Cross-Blue Shield plans and other third party payers develop "hold harmless" clauses whereby a hospital admission disallowed by the third party payer cannot be charged against the patient;
2. That all hospitals institute strong UR plans, with strict enforcement and careful monitoring by outside parties. These UR plans must be coordinated with medical payment agencies to regulate need for care;
3. That all hospitals check the legitimacy of surgery and postsurgical stays by creating a doctor profile in which the tissue committee findings and the detailed record of treatments would confirm or reject the surgery as being necessary;
4. That each hospital have adequate staff and machinery to assure prompt, but appropriate discharge, and that UR review include information on the patient's ability to function outside of the hospital;
5. That hospitals failing to maintain adequate UR programs have their Medicare/Medicaid/Blue Cross reimbursement rates reduced;
6. That federal UR standards include provisions for mandated second opinion consultation (non-emergency cases) and that the need for hospital admission be certified within 24 hours;
7. That the New York State Health Department enforce NYSHUR requirements notwithstanding the disposition of the federal regulations being challenged by the AMA;
8. That hospitals failing to maintain UR programs have government UR staff assigned to the facility to prevent payment for unnecessary hospital care;
9. That UR reports, Blue Cross, Medicare and Medicaid statistical reports on occupancy rates, average length of stay and admissions by diagnosis by doctor be made public;
10. That patients having been admitted to a hospital or having undergone surgery unnecessarily be allowed to sue for malpractice, and not be required to pay for those services; and
11. That governing body members be held responsible for their hospital's failure to satisfactorily perform UR.

PSRO's

We bring to our readers' attention the fact that PSRO's are mandated by recent federal law to replace UR as a cost-quality control mechanism for in-hospital care of patients whose services are paid for by the federal government.

Utilization review programs will be replaced (rather than simply "waived") by PSRO review. The major difference is the shifting of the responsibility and authority to make final determinations of medical necessity, from fiscal intermediaries and governmental agencies to the PSRO of its delegated hospital. This includes shifting the federal authority for survey of compliance with review requirements for Medicare and Medicaid from intermediaries and governmental agencies to the PSRO. There will be monitoring of PSRO decisions and actions by HEW and by intermediaries and agencies.

It is not clear when or how effective PSRO will be. In the interim, we believe UR should be strengthened so that in the event implementation of PSRO is delayed there will be continuity of quality review.

PUBLISHED BY CONSUMER COMMISSION ON
THE ACCREDITATION OF HEALTH SERVICES INC.

381 PARK AVE. SO., NEW YORK, N.Y. 10016
TELEPHONE: 689-8959