

Principles for Utilization Management and Medical Review Programs

Purpose of Medical Review and Utilization Management Programs

Quality of patient care and improvement in the health of the population through improvement across all physicians' practice should be the emphasis of any medical review process or outcome.

Utilization management systems should be structured to recognize and encourage high quality care, to identify practices requiring significant improvement, and to encourage peer assistance and education for all physicians as we strive for continuous improvement.

The thrust of any medical review activity should be to help the physician improve knowledge, skills or technique.

Review Criteria

The medical protocols and review criteria used in any health plan review program must be developed by physicians, and modified through the experience of physician application.

Protocols and criteria should be developed in accordance with national practice guideline development processes, similar to those used by the federal Agency for Health Care Policy and Research, including a consensus process of expert clinical physicians, review of the scientific literature and review of existing guidelines or criteria developed nationally or by specialty societies.

The guidelines used in medical review must be continuously reviewed and revised by physicians using them to reflect increased scientific knowledge, improved technologies, availability of resources, and other developments relating to the demand for and provision of medical care.

Health plans should disclose to physicians the screening and review criteria, weighing elements, and computer algorithms utilized in the review process and how they were developed.

Guidelines used in medical review should be presented to and understood by physicians in advance of their implementation.

Legal precedents established through medical liability cases and the status of the tort system may dictate the need for modifications in the principles for guideline development.

Reviewer Qualifications

Medical review should be conducted by physicians or under close supervision of physicians.

Physicians of the same specialty must be consulted before a decision by a health plan to deny or reduce coverage for services based on questions of medical necessity.

Review Process and Outcome of Review

Variations from review guidelines, protocols and criteria should not be used to deny care or as per se indicators of quality or medical necessity problems. Variations of concern should involve provision of a service or procedure deemed by the preponderance of medical opinion to be inappropriate in that clinical situation. Otherwise, variations should constitute only a signal for further peer to peer considerations relative to quality or payment issues.

A diagnostic test or procedure with normal results should not automatically be deemed medically unnecessary.

Denial of payment, coverage or prior authorization should be accompanied by a written explanation of the denial.

Upon request, the qualifications of the reviewing physician should be provided to the physician whose services are under review.

Judgments as to performance of specific physicians should be based on assessment of overall practice patterns, rather than on examination of single or isolated cases.

Reports and feedback from utilization management programs should be provided to physicians and only disclosed to payers and purchasers in a manner consistent with the "MSMS Principles on the Release of Physician Specific Data."

Precertification or prior authorization programs, if used, should:

- be conducted on a targeted basis;
- allow immediate treatment in an emergency;
- not use failure to obtain prior authorization for emergency care as a basis for denial of payment; and
- include strict time frames for responding to prior authorization requests.

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