Nearly 90 percent of all Americans have some kind of health insurance today. Whenever they receive health care services, claims for payment are sent to those who are responsible for validating the benefits and paying the health care providers. Among those responsible for this evaluation and payment of health claims are (1) insurance companies, (2) service companies like Blue Cross and Blue Shield, (3) self-funded health plans, usually sponsored by employer-employee benefit trusts through designated Administrative Services Organizations (ASO) and (4) by fiscal intermediaries contracted with governmental entitlement programs like Medicare and Medicaid.

Effective health claims administration requires a staff of highly trained claims examiners. In many cases it also requires the services of a physician, who is trained in the general areas of medical care and knowledgeable about the legal mandates for insurance carriers as stipulated in federal and state laws and regulations. The purpose of this paper is to describe how health claims are selected for medical review and how the medical review physician functions in a health claims administrative setting.

The science of medicine has become so complex that it is no longer possible for any physician to be thoroughly knowledgeable with the many branches and subdivisions of medicine. It is therefore preferred that the physician who does medical review have the broadest possible scientific base from which judgements are to be made. This physician should be trained either in general practice, general surgery, family practice or internal medicine.

1. The physician should be licensed and a respected member of the health care community.

2. The physician should be familiar with federal and state laws and regulations that mandate compliance by insurance carriers regarding the adjudication of health claims.

3. Although affiliations with medical schools and medical societies are not required, such associations enhance credibility and acceptance by the physicians who may be subject to review.

4. The physician must have a thorough knowledge of the contractual obligations contained in the health plan (contract) and in the patient’s summary plan description that reflects that contract.

5. The physician must be able to make medical decisions based upon current knowledge of the state of the art of medicine and consistent with the accepted standards of medical practice.

6. The physician must be able, in the majority of cases, to make medical decisions based upon the information in the claim. In some cases additional information must be requested from the provider to explain the reasons for the services and the charges.

Determination of Reimbursement

At the risk of being simplistic the author of this paper will describe in some detail how claims are evaluated for payment to providers. Every health care provider can charge any price whatsoever for an item of service. This does not mean that the price will be met with an equiv-
alent payment. Insurance companies strive to contain payments within a range often referred to as being "usual, customary and reasonable" (UCR). In many instances the provider may hold the patient liable for any difference between the UCR payment and the original charge. In practice today, because of the increased competition for medical services, some providers accept the UCR payment as payment in full. In the past it was not uncommon for the insurance contract to contain a schedule of payment that was less than the UCR rate and the provider was reluctant to accept such payment as payment in full. Today with the advent of Preferred Provider Organizations (PPO) many physicians are signing contracts with insurance companies that specify rates lower than UCR in return for encouraging subscribers to use these so-called preferred providers. Physicians in many areas have shown a willingness to accept less per unit of service in the hope of serving more patients.

In determining the dollar value for a specific medical service, insurance carriers have generally used one of several systems:

1. One of the most widely used systems is the California Relative Value Studies. This system was first published in 1956 by the California Medical Association and revised five times, the last being in 1974. In 1979 the Federal Trade Commission ruled that this was an illegal system that potentially represented price fixing and the FTC prohibited its continued publication and distribution. In spite of this injunction, it has proven to be of such great utility that the CRVS is still in use today on a nationwide basis. This system lists the majority of all medical and surgical procedures, laboratory tests and radiological procedures. Each procedure is assigned a numerical "unit" value which remains constant until revised by a panel of medical peers. The "dollar" value per unit is a variable factor that changes over time consistent with the actual prices charged in a particular geographic area and is often referred to as the "conversion factor". The insurance company using this system determines the allowed charge by multiplying the unit factor by the conversion factor. For example, if the service is an appendectomy valued at 40 units and the conversion factor is $25, the insurance carrier would allow a charge of $1000 (i.e., 40 x $25 = $1000). The dollar values are computed annually from statistical data accumulated from actual claims experience. The two principal sources for these data come from Blue Cross, Blue Shield and the Health Insurance Association of America (HIAA).

2. The HIAA publishes its data each year and distributes this information to its subscribing members. For surgical procedures in particular it indicates the average charge for a particular service in specific zip code areas throughout the United States. It does not attempt to identify relative value units. In many cases the dollar amount allowed does not coincide with the value as determined by the CRVS system.

3. The other coding reference system is the Physicians’ Current Procedural Terminology. This was originally published in 1973 by the American Medical Association and has recently been revised to include many of the newer procedures not listed in the other two references. This classification system provides only for the coding of procedures and does not identify any "units" in reference to relative value or dollars. Therefore, when this system is employed, the insurance administrator must determine the dollar value it will allow for each procedure.

Selecting Claims for Medical Review

When a health claim is received, the insurance carrier or ASO must first determine if the patient is an eligible participant in the health plan. If eligible, the claim is passed through the system and a dollar value allowance is determined for each service in accordance with the process previously described. If each item can be clearly identified by the claims examiner in relation to the name of the service or procedure, then it is a simple exercise to compute the total dollar value that can be allowed. But this is not always that easy or correct. There are many instances where it is not possible for the claims examiner to complete these functions. There may be conditions that require medical decisions before insurance decisions can be made. It is not possible within the limits of this paper to describe each and every triage pathway that leads to medical review. Some of the major guidelines for selecting claims for such medical review include the following:

1. All procedures for which no unit or dollar value has been assigned.

Unlisted procedures. These may include new medical, surgical, laboratory or x-ray procedures developed since 1974. They
also may include unique procedures developed in a specialty area unfamiliar to
the claim examiner.

"By Report" procedures. In these instances the provider must submit a medical report that clearly describes the technical procedure. Such reports nearly always require physician evaluation.

"RNE" procedures. These are procedures for which no prior determination has been established about the relationship between the charges for this procedure and for other services listed in the coding system. Allowed fees for these procedures usually require justification similar to "By Report" procedures.

2. Inappropriate codes. It is not uncommon for a provider to use a code number which would qualify the service for a dollar value that is higher than the service warrants.

Surgical repairs. Surgical repairs may be listed on the claim as "complex" when medical review of the operative report indicates that the surgical repair was either "simple" or "intermediate" and therefore should be assigned a lesser dollar value.

Consultations. Consulations are coded from "limited" to "unusually complex". A provider may list a consultation as complex when in truth it was intermediate. The proper designation can best be made by a medical review evaluation of the actual consultation report.

3. Cosmetic procedures. Most insurance companies and health plans exclude these from coverage. Providers may state that these procedures were medically necessary and should not be considered as cosmetic. Medical review is required to validate such allegations. This category frequently includes nasal surgeries, face lifts, eyelid reconstructions, breast reductions and the removal of excess fat.

4. Experimental procedures. A procedure may be acceptable in some conditions and experimental in others, as is the case with plasmapheresis. Until 1985 radial keratotomy was considered experimental and disallowed by many carriers. This procedure for the correction of refractive myopia deficiency can best be disallowed now by making this an "exclusion" within the health plan.

5. Procedures unrelated to the diagnosis. Examples here are unlimited. Many would be detected by an informed claims examiner while others would have to be sent to medical review. An obvious disallowance would be a CT Scan of the head with a diagnosis of peptic ulcer.

6. Procedures where the standard of medical acceptance is questionable. These include the use of intravenous chelation in the treatment of arteriosclerosis, acupuncture in the treatment of anxiety and intestinal by-pass surgery for conditions that do not qualify as intractable morbid obesity.

7. Excessive utilization. It is difficult to deny or limit payment for services that are considered excessive, since there are few standards that can be applied. When a claim examiner suspects over-utilization, that is a subjective determination. If the medical review physician agrees, a request may be made for the provider to submit clinical data to justify the extended services. In every case it is an uncertain environment for the insurance carrier to retroactively deny payment since such action could lead to disputes and litigation. Some of the areas most commonly encountered are hospital lengths of stay, excessive office visits for benign or self-limited conditions, physical therapy treatments following injuries related to legal suits and extended allergy desensitization programs.

8. Excessive charges. When a claim examiner determines an allowed dollar value that is considerably less than the fee charged, there is the possibility of an error in the claim evaluation process for that particular claim. It may be that the procedure is incorrectly coded and it would be both unfair and insulting to issue a payment that was grossly inadequate. If it is determined that the fee is indeed excessive, it is prudent that the insured be notified in carefully selected language so as not to impugn the reputation of the provider. The insurance carrier is responsible for making the appropriate decision only in regard to the amount payable under the provisions of the health plan contract.

9. Questionable "UCR" limits. It is not uncommon for a claim examiner to seek medical review assistance in cases where there are problems determining whether the claim judgments are correct in refer-
ence to the “UCR” guidelines. A concise explanation of “UCR” follows: “Usual”: This is the “usual” fee charged for a given service by an individual physician in his or her personal practice.

“Customary”: This refers to that range of usual fees charged by physicians of similar training or experience for the same service within a given geographic area.

“Reasonable”: This is a vague term. In general it means a fee that meets the “usual and customary” criteria or is justifiable in the special circumstances of the particular case in question. If one was to apply the antonym “unreasonable”, it would be a very difficult position to defend in a disputed case. This is probably a term that should no longer be used.

Extended Role of the Medical Review Physician

In an efficient health claims evaluation system the vast majority of health claims can be properly managed by a competent clerical staff including an experienced health claim administrator. A physician with experience in performing medical review is a valued adjunct for the training of claim examiners. Such training can include participation in workshops to enhance the understanding of medical terminology, new medical procedures, recognition of outmoded procedures and ways to recognize the improper use of code numbers by providers. Even in the most advanced computer based claims review systems it is estimated that approximately one to two percent of all claims will require medical review. Although this percentage seems small, these claims often represent the highest dollar values as well as those claims that are most likely to be disputed by the provider and the insured. Such disputes can lead to law suits with high financial risks to the insurer and/or the ASO. An experienced medical review physician can significantly lessen such risks.

It was stated previously how important it is for all claims decisions to be made in compliance with the health plan contract. A physician trained in medical review can provide valued assistance in the selection of explicit language both for the health plan contract as well as for the patient’s summary plan description. The sections related to exclusions from coverage are particularly sensitive and must be expressed in clearly understood terms. Most legal consultants who participate in the final approval of contracts would welcome the assistance of a medically trained co-worker.

But how does a physician learn how to do medical review? There are no schools, no courses and no workshops that provide such instruction. For the most part such learning is achieved by the traditional guild system. A physician who wishes to do this kind of work is best advised to serve an apprenticeship with an experienced medical review physician already engaged by an accredited insurance or administrative carrier. Insurance companies that may be facing the need to replace review physicians who are either planning retirement or moving to a new environment are well advised to train a competent replacement while the experienced physician is still aboard. Moreover, it is most important to recognize the fact that it is not possible for any one physician to be all knowing in every field of medicine. This is especially true today with the rapid advances in knowledge and the increased diversification of medical specialties. It is mandatory that there must be a panel of medical specialists who can assist the primary medical review physician. It is advisable that these specialists should be selected from the health care community whence the claims originate. When this is not practical, the primary medical review physician should be able to make decisions based upon adjustments for variations in the standards of medical care, or for the charges, that come from other geographical areas. The panel specialists are best used as peers in the evaluation of problem claims within their own specialties. In all cases the final decision must be made by the primary medical review physician retained by the insurance company.

In addition, the medical review physician should be available to discuss questionable claim decisions with health care providers when these providers request clarification regarding the “medical” judgment made by the claim adjudication process. In some cases the provider may be unable to distinguish between a medical judgment and an insurance judgment but is not content to discuss the issue with a non-physician. The availability of a medical review physician in such cases can greatly enhance the credibility of the insurance company or administrator or even the health plan itself. If disputes arise relevant to health claims decisions, or result in legal actions, the medical review physician should be prepared to assist in the resolution of such disputes.

In conclusion, the most important role for the medical review physician is to provide the hi-
ghest level of professional input in validating that every claim submitted for review is considered in a fair and equitable way, that allowances are determined in accord with the health plan contract, that benefits are provided in compliance with state and federal laws and regulations that govern the adjudication of insurance health claims and that all medical decisions are consistent with the accepted standards of medical practice.

Addendum:
The California Medical Association is currently trying to get the Federal Trade Commission to lift its 1979 ban against the use of CRVS. If successful, the entire nation will benefit.