

Independent Medical Review, Patient Protection, and Behavioral Healthcare

There is an overwhelming consensus in the U.S. for the need to improve the healthcare system and to provide comprehensive patient protections for all Americans.¹ In 2001, the federal government made healthcare a priority by initiating a federal Patients' Bill of Rights.² At the same time, states were also passing comprehensive legislation that would ensure patient protection in healthcare. Common to all the legislative initiatives was the need for independent medical review.³

In 1978, Michigan became the first state to establish an independent review program. In the 1990s, states were diligently passing patient protection legislation. At the same time, Congress was considering passage of a national Patients' Bill of Rights. The federal legislation appeared to be a summary of the recently enacted state laws.

The two houses of Congress agreed that a national Patients' Bill of Rights should include the right to independent review. But the houses disagreed on several other points, including whether the federal law should supercede the existing state laws. The two houses both passed patients' rights legislation but disagreed over whether lawsuits could be filed against health plans⁴ and on the amount of awards.

In May 2000, URAC accredited the first five independent review organizations (IROs). The URAC standards addressed concern that appeal decisions often appeared to be based on financial considerations rather than what is best for the patient. By July 2004, URAC had fully accredited 22 independent review organizations.⁵

In May 2001 in Chicago, the National Association of Independent Review Organizations (NAIRO) was formed by the majority of URAC-accredited independent review organizations. That June, NAIRO issued a white paper⁶ calling for the preservation of the integrity and viability of independent review.

By June 2001, the patients' rights debate began in the 107th Congress. In late January 2002, efforts by Senator Edward M. Kennedy (D.-Mass.) and White House officials to reach agreement on compromise legislation stalled. The main point of contention remained consumer lawsuits against health plans. By July 2004, 44 states had enacted independent review laws. The federal Patients' Bill of Rights legislation had quietly faded away.

The need for independent review is especially critical in behavioral healthcare. Psychiatric and addiction patients were already experiencing unequal treatment within the medical profession. Health benefit coverage limitations most often included a different and more restrictive benefit plan for psychiatric and addiction care. Only recently have the healthcare community, state legisla-



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tures and Congress started to recognize the need to treat and serve this population as a specialty group.

Recognition is a vital first step. Single-specialty IROs help to further equalize the treatment of psychiatric and addiction patients by recruiting and training highly experienced psychiatrists, psychologists and clinical peer reviewers to conduct external independent reviews.

The practice of excluding single-specialty IROs from some of the state application processes has emerged as an issue among medical organizations as well as organizations that protect the rights of the mentally ill. This practice does not appear to support the goal of protecting patients. Some view this practice as anti-patient protection, particularly for patients wishing to appeal denied payments for psychiatric or addictions treatment.

The single-specialty exclusion by many states adds to the already de facto discrimination against patients with mental illness by denying them access to specially trained appeal review psychiatrists and clinical peer reviewers. In its white paper, NAIRO recommends ending the exclusion of single-specialty independent review organizations.

Currently, 44 states and the District of Columbia have independent review laws where the health plan or payer has denied reimbursement for a healthcare treatment. Ten of the 44 exclude single-specialty IROs from being certified to provide specialty reviews.⁷ The primary reason given by states for excluding single-service IROs is *procedural*. The excluding states understandably want the ability to easily rotate all incoming cases through a list of state-certified IROs, and single-specialty IROs preclude simple rotational assignment.

Some states do not specifically exclude the certification of single-specialty IROs but have a limited number of IROs they will certify. These states do not

include single-service IROs on their restricted panels. Whether implicit or explicit, such exclusions come at a price to behavioral health patients.

In medicine, behavioral healthcare is recognized and organized separately from other medical specialties. The American Psychiatric Association (APA) is separate from the American Medical Association (AMA). The American Accreditation HealthCare Commission (URAC) accredits single-specialty independent review organizations and the National Committee for Quality Assurance (NCQA) accredits utilization review organizations (UROs) and managed behavioral healthcare organizations (MBHOs) separately.

Most states with independent review laws have found ways to address procedural/clerical rotational case assignment issues without compromising patient protection and patient rights. Certifying single-specialty IROs assists many states in better meeting their mission of patient protection by offering the very best selection of specialists, particularly in the area of behavioral healthcare.

Protecting the rights of patients with mental illness seems worth an additional procedural step. Eliminating the exclusion of single-specialty IROs from state accreditation is possible. All states should follow the example of states that have successfully certified single-specialty IROs so that patients with mental illness and addictions have equal protection. ☺

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Endnotes

¹ *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation*, prepared for The Henry J. Kaiser Family Foundation

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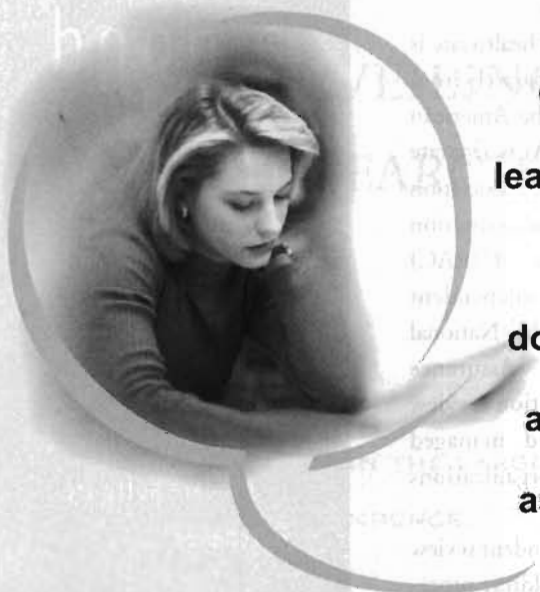
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by Georgetown University, Institute for Health Care Research and Policy, March 2000, Revised May 2002.

² H.R. 2563, the "Bipartisan Patient Protection Act, 2001" introduced by Ganske-Dingell-Norwood-Berry.

³ The term "independent medical review" as used in this article is also referred to as external review, external independent review, and other similar terms.

⁴ The term "health plan" refers to an array of managed care programs and insurers providing healthcare insurance or benefits coverage.

⁵ URAC, *Accredited Independent Review Organizations*, June 1, 2004, www.urac.org/prog_accred_orgs.asp.

⁶ *Preserving the Integrity and Viability of Independent Medical Review*, National Association of Independent Review Organizations (NAIRO), 2001, www.nairo.org

⁷ In response to a single-specialty IRO, Steve Boruchowitz from the Department of Health in the State of Washington responded, "Yes, we interpret Washington state law, and have drafted our rules to reflect it to mean that there are no "specialty" IROs. (E-mail dated 12/8/00 to Prest & Associates, Inc.). The state of Indiana wrote, "Indiana HMOs are required to rotate through a list of IROs certified by the Department of Insurance. In order for the rotation process to work efficiently Indiana is choosing to certify only full-service review organizations." (Letter from Joy S. Long, Deputy Commissioner for the State of Indiana, dated 5/30/00 to Prest & Associates, Inc). The state of Colorado replied, "To be certified as an external review entity in Colorado, you would have to be able to provide UR services for the full scope of medical services-both physical and mental." (Letter from Susan Gambrell, Special Assistant to the Commissioner, State of Colorado, dated 2002 to Prest & Associates).