EDITORIAL

Towards a healthier provider–payer tandem

Messages from IVIg utilization reviews

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In the third-party insurance realm, good relationships among patients, providers, and payers are essential. Within this triad, the provider–payer interactions are often dysfunctional. Even in 1798, as the young Union was laying its foundation for prepaid medical insurance, there was cognizance of the potential for misuse of funds.[1] Such deep roots lend some credence to prevailing assumptions that providers and payers, while interdependent, are also at odds, each party viewing the other as difficult and unyielding. One author viewed the Medicare payer as an "unrecognized…nonparty" in the provider–payer tandem.[2] In contrast, providers consider care oversight and payer's administrative requirements as undue burdens.[3] Providers can never stop dealing with diagnostic ambiguity and varying patient wishes, while payers often struggle to satisfy diverse and strident interests to both cover (pay) and control costs. Is there a middle ground with scope for a healthier open-minded dialog among the parties? After all, an important aim of ours is to improve patient care and reduce waste.

In this issue of *Neurology® Clinical Practice*, Levine et al.[4] demonstrate how a focused expert chart review of submitted IV immunoglobulin (IVIg) claims for immune neuropathies uncovered deficiencies. It revealed suboptimal documentation, inappropriate usage, and unsatisfactory follow-up information. Only 32% of 248 patients were appropriate therapy-eligible candidates. A sizeable percentage of immune neuropathy diagnosis was inaccurate. Some patients responded to IVIg when experts had predicted otherwise. We do not know the ultimate resolution of reviewed claims—whether denied, appealed, contested, or reversed. The findings by Levine et al. parallel a recent Canadian experience by Shih et al.[5] from a McMaster University audit. Their chart review of all IVIg uses (178 patients) found that 33% of charts lacked adequate documentation for a confirmable diagnosis, even for Guillain-Barré syndrome in some instances. Usage criteria were unmet in 52% of patients. Hematologists (38%) and neurologists (11%) were the most frequent users.

Both articles relied on retrospective chart reviews of claims. Medical reviews, before or after a rendered service, are onerous for all parties, with escalating appeals and administrative costs. They consume time and resources but manage to dissatisfy at least 1 of the triad. Nevertheless, claims medical review by clinicians, especially peers, survives as one of the enduring mechanisms for ensuring appropriate resource utilization. In these 2 IVIg reviews, it took peers with subject matter expertise to identify incorrect use. A well-written updated insurer/payer coverage policy is another mechanism for prudent utilization. Even such checks and balances are porous enough to allow wasteful use of resources.

Is there a broader message?

Beyond their focused findings, these reviews carry broader messages. Despite extant coverage policies and guidelines, and awareness of the need to preserve scarce, expensive therapeutic agents, we still do not use resources appropriately.[6,7] Why is this disheartening? Because both our diagnostic processes and insurance review methods are less than ideal. Some providers use IVIg inappropriately; payers, in turn, allow payments without expert input to audit the usage. Neurologists are not the only contributors; other specialties, such as dermatology or immunohematology, follow similar patterns. What about other therapies and diagnostic tests—stents, epidural steroids,

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oncolytic drugs, MRIs, carotid imaging? Each deserves benchmarking analysis to understand its usage spectrum. Policies and guidelines alone do not assure proper utilization. For instance, there are questions about carotid stenting and endarterectomy done for preventing future occlusions in asymptomatic patients.[8] One author even advocated a Medicare coverage moratorium for these procedures.[9] Thus, this nexus, where potential for ambiguous usage exists despite policy and guidelines availability, requires cooperation among providers, reviewers, and payers. There is a shared goal here for all of us.

The Canadian audit showed that, compared to unsurveilled practices, questionable use was the least when there is an ongoing surveillance. The work by Levine et al. also indicates that an expert input, if sought, clearly identifies inappropriate use. Enforcing payer's coverage policies, while justifiably curtailing questionable use, may also deny benefits to deserving patients. Cardiologists encountered such a predicament, both inappropriate and also missed underuse, with implantable cardioverter defibrillators.[10] These occur if understanding of disease mechanisms and treatments evolve, thus leaving behind the currency of guidelines, criteria, and policies. These realizations, although self-evident, point to a continuing need for claims reviews. We should go beyond the experience of Levine et al.[4] and Shih et al.[5] to recognize the need for improvement in diagnostic and review processes.

We could undertake these steps for the path ahead.

1. Payers should reduce the complex and demanding multiple review mechanisms. One extreme example of the claims review process is Medicare's use of 4 separate review contractors for some claims (Medicare Learning Network Matters Document SE1521). A time-limited review should follow only an expert-identified postpayment detection of questionable use. In complex situations, it is imperative that payers consult peers with focused subject matter expertise to ensure accuracy of medical need determinations. In that case, an online concurrent prepay review with timely decisions will reduce anxiety and wait times for patients and providers.
2. Payers should undertake mandatory coverage policy updates every 12–24 months. Feedback from audits and big data, where available, will direct us to areas that need core changes to policy.[11] This is especially vital for emerging issues such as IVIg for autoimmune encephalitis, brain stimulation/ablation (magnetic, electrical, ultrasound) therapies, or serum biomarker testing for degenerative diseases.
3. Periodic unbiased tolerant dialogue between payers and providers is a healthy practice. Medicare, through its Carrier/Contractor Advisory Committees, and the American Academy of Neurology through its Medical Economics and Management subcommittees, already undertake such professional liaisons among providers, insurers, and policy writers. These efforts deserve continued and enhanced nurturing to become a part of our remit for specialty societies.
4. Documentation is vital when a provider chooses a course of action deviating from known guidelines or policies. Well-written notes render innate uncertainties of clinical medicine explicit as payers review them post hoc. Notes should include rationale for selecting a test or treatment, and literature support if available.
5. Benefits of claim reviews are bidirectional, resulting not only in cost recovery for inappropriate use, but also revisions of deficiencies inherent in outdated policies.[10] Coverage decisions must not be static; policies are living documents that need support from payers, providers, and specialty organizations.

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