Tufts Health Care Institute

Mini-Rotation on the Health Care System

Theme: Cost, Access, Care Management and New Models of Care

Topic: Utilization Management

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Objectives:
By the end of this session, participants should be able to:

- Define utilization management as practiced by health plans and purchasers.
- Identify the rules and processes applied by health plans when reviewing clinical decisions.
- Describe the steps required of physicians when seeking a determination.

Overview of the presentation (August 2015):

Utilization management (UM) defined

- Institute of Medicine: "a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision"

Context and rationale

- Data on increase in health care costs as percentage of gross domestic product (GDP)
- Some recent reduction in annual rate of increase

Tools of utilization management

- Guidelines
- Staff

Health plan's application of utilization management

- Goals:
    - Effective care at lowest reasonable cost
    - Keeping the patient healthy (and reducing their subsequent need and use of services)

- Decision rules: who reviews the request (e.g., which MD by specialty); who makes determination (e.g., all UM staff can approve; only MD can deny)
- Illustrations (e.g., step therapy: antidepressants; expensive drug)

Implementation of utilization management

- Burden: takes time
- Strategy: designate types of review for each physician reviewer to limit the number of guidelines they need to master
- Post guidelines and materials online for easy access
- Simplify request forms
- More efficient for physicians themselves to fill out the clinical information, rather than delegating to staff; staff can fill out demographics