EP54 | "The Invisible Hand" Series - Behind the Curtain of Utilization Management Transcript

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Conflict, negotiation, identity. Welcome to the Scalpel and Sword Podcast, where I, Dr. Lee Sharma, physician and conflict analyst, explore the hidden negotiations behind modern medicine. Let's trade burnout for boundaries [music] and learn the art of healing with precision and power.

>> [music] >> Hello, my peaceful warriors, and welcome to the Scalpel and Sword Podcast. I am your host, Dr. Lee Sharma, physician and conflict analyst. And I'm going to ask that all of you who are followers of the podcast, if you've already listened to episode 51, which is the invisible hand on the scalpel, thank you for listening and thank you for your feedback. And if you haven't listened to it, I'm going to ask that you pause this one right now and go back and take a few minutes and listen to that episode because that episode is going to play directly into what our guest is talking about today. And my guest today is a practicing surgeon who does utilization management work.

And they've chosen to remain anonymous so that our conversation can focus on the work.

What Utilization Management Is

We want to focus on the process, the potential, and we also want to talk about how this affects the practice of medicine and what it means for us as doctors, but even more broadly, what does this mean for healthcare in general and how is this changing our environment and how can we work within the system to actually make healthcare better?

So, thank you, guest, for being here. I'm really happy to have you. Thank you for having me. I'm excited to be here and talk about this. So, for those of us listening, cuz we do have some non-medical people who listen to the podcast, explain to us what utilization management is.

Absolutely. So, we'll start out in broad strokes. So, what happens is when you go to doctor sees you, they examine you, they maybe think of that there's a series of tests that might need you to order or not, come up with a diagnosis and a treatment plan. At any part in that process, whether that's diagnostics or whether that's treatment, they'll have to order something, whether that's a test or medication or a treatment or even plastic surgery. And that service that they're offering has to be paid for. There's a There's a fee for that in this country, the way that our healthcare system is structured.

And who pays for that fee? In many cases, it's an insurance company. So, the insurance company pays for the service, whether that's a test, whether that's a procedure, whether that's a medication.

They don't pay for everything that's ever ordered, however. They pay for things that they deem are medically necessary. So, the product, the insurance coverage, is regulated and it's regulated by the payer. The payer in this case is not the patient. The payer is the insurance company. So, there's that third party that lives in between the doctor and the patient. And utilization management is essentially the review of the process of payment for those services.

So, I think this is a great explanation because I think a lot of people who patients, a lot of people in healthcare don't understand how this relationship works. And one of the things I used to tell people when people come with come to see me in the office and ask, is my insurance going to pay for this? And one of the things I would say is when you go to the grocery store and you buy milk, you don't ask the cashier how much money you have in your bank account to buy the milk. You know how much is in your bank account. So, as patients interact with the healthcare system, I think there is an expectation that they think that we understand how that insurance works. That we are somehow in control of those purse strings or have an understanding of them. And so, I think one of the biggest things about understanding third-party insurance, but especially what you're doing with utilization management, is how this system is functioning. So, at what point in practicing medicine did you decide to get involved in this process of utilization management?

That's a great question. It wasn't actually a decision on my part to get involved in this. It almost happened and I can give you an overview of what that was like. So, I had just started in a new position and there was a ramp up period that was, let's say, a little slower than I expected. So, I had some free time on my hands. Out of the blue, I noticed that a recruiter from utilization management company reached out. Uh and they asked if I would ever consider doing this kind of work, utilization review. Well, I was first asked about it, I didn't even know what it was, like probably most physicians who hear the first time, they don't know what that is. They hear UR, they don't know what that is. And so, I initially I don't even know if I answered the first time I got the message. But, it took me a little while, a few weeks here, a few months to warm up to the idea and I did a little research uh and I figured out what it was. And at that point, when I realized okay, this is doing the review of cases that have already been denied by insurance is going to pay for it and someone independent of the insurance is deciding do they or do they not have to pay for it. That's that seemed somewhat interesting to me and so I looked into a little bit and started out really slow, picked up a let's call it a review stream where a company will send you cases and it was a case here, a case there.

How the Surgeon Got Into Review Work

Almost started out like one of these little side hustles that you might do like medical surveys or something like that. And then I realized that it could build into something a little bit more meaningful once I started seeing more of it.

Wow, so this is one of those things that kind of almost fell into your lap and as you had this time and you started getting this work, you could find another way to put your medical expertise to work and so you were able to do that. What were some things as you launched into this process that really surprised you? Uh absolutely, that's a great question.

So, I would say one of the first things about it that surprised me was how straightforward it is for the reviewer in some cases. So, there would be some cases where and I've worked for several companies so this is just a general observation about the industry but there are some reviews that a reviewer might do where it comes across your desk and physician X wants to prescribe medicine Y to patient Z and it then the question that you're asked as a reviewer is basically is this medically necessary? And patient has a condition that the standard of care treatment according to a litany of research would be this medication that was prescribed and of course the answer is obviously yes. That was a pleasant surprise to me because as I think a lot of docs have heard about utilization management might think one of my initial hesitations about doing this was oh, this is just going to be my name as a rubber stamp on a denial. I'm not going to be able to overturn anything. This this is all just going to be me being Dr. No all the time 24/7 as 365 but that was was a pleasant surprise to me initially was that sometimes the review will come across my desk and it's just the course. This absolutely isn't indicated and I would overturn it and I'd wait a few days and see if someone sent me an email said, "No, you can't do that." And that didn't happen. And it was like, "Okay, I'm making something happen. I'm working within the system. We're making positive change here." I love that you said that because and I think that is a perspective that so many people have about and a lot of that I think is some of that's bolstered by personal experience that we've had as physicians having to work with denials or work with peer-to-peers. And I do want to put this commercial in here that as I have dealt with that 100% of the time and where I see it again, you're a surgeon, you probably see this as well is when we're getting surgeries denied. We're applying for patient having a hysterectomy and she has fibroids and she's anemic and she's tried medical therapy and nothing's worked. This is a fairly clear-cut process applying for surgery and we'll get a denial and I'll ask for a peer-to-peer and I get on the peer-to-peer and I ask if this person is in my specialty and I get a name and an NPI and then once we've had that, I just usually 10 seconds of fibroids, anemia, failed medical therapy and they go, "Yeah, you're good." And I think that's been the majority of my experience.

Surprising Benefits of Doing Peer Reviews

But I do think you have a lot of people and I think on social this is becoming more common of doctors who have talked about their negative experiences with where they've gotten denials that are egregious in terms of people applying for, let's say, lymph node dissections after breast cancer surgery having reconstruction. But you you do hear some of the negative. Did that affect your decision or did you feel like that was something that made you more invested in being positive in this process? You mean seeing the negative feedback, social media? Yeah. Uh I would say yes, although I'm not the most social media present individual. I'm not super into that world intentionally, but I do know that exists and I have seen that. But I'm also aware of the negativity bias, and so a lot of people will report negative interactions, and those will get more eyeballs because of the way the algorithms work. And so, if somebody has a positive interaction at peer to peer, I don't think that they're going to be posting about it on social media. And if that even is the majority, you probably won't hear about it. So, certainly those negative stories do occur. But, yeah, like you said, those positive stories, that's often the majority of the cases when I'm getting on the phone with a physician. And a lot of times, what happens is there's some sort of clerical mix-up. Whether the documentation was incomplete, or the documentation wasn't all sent over, so maybe the surgeon who was evaluating this patient did all the right steps, did all the right workup, has tried the step medication and everything, but the note didn't get sent to or the fax got lost or it was tied up or it didn't get to the third-party review, and so it was denied. And then a lot of times you get on the phone with that doctor, and just like you said, same specialty, understand what you have, you tried X, you tried Y. Oh, of course this is indicated. Absolutely, 100% approval. So, it's sometimes a little frustrating being on this side of it because sometimes I'm on that side of it, less so now that I do more of this work, but still sometimes I am. And I understand, oh, I wrote that. No, I wonder why you don't have that as the reviewer, and you just don't always know. One of the things that you just said I want to drill down on because I think it's really interesting. The you said that since you've been doing this work as a reviewer, that when you actually have to submit and you're going to you're getting trying to get approval for a treatment or a procedure, that this is less so of a problem for you now since you've been doing this work. Why is it less of a problem now? Absolutely. You're touching on a great point there. It's definitely and this is obviously anecdotal, I don't have numbers, but it's definitely less so now. I will say that the UNM experience that I have has, in addition to being

meaningful to just staying up on literature, and seeing what's out there, seeing what other procedures we staying up on what other procedures are occurring what other surgeons are doing and helping patients get what they need paid for.

I'm also learning how to write better notes. So, the more cases that I do the more policies that I'm exposed to, the more cases I review, the more that I know that okay, if I'm going to try to recommend procedure Y for my patient or if I think the medication X is indicated, I've got to try this first, I've got to try that first. And I should document that I tried that first. A lot of times I've seen cases where a doctor will write on their note, "Patient has tried conservative treatment, failed, indicated for surgery." Now, that'll get you by with you're trying to defend yourself in a case conference or at M&M or something like that or even on your boards. If you write, "We tried conservative treatment for for a while, it didn't work, etc." Unfortunately, in some cases that to standardize things, the policies will say "Conservative treatment of X, Y, and Z must be tried for X, Y, and Z weeks or months or etc." So, you might have to specify that and if you don't as as frustrating as it can be, sometimes that can be the reason that it's denied. So, even though you may have even done that all that step therapy and all that required pre-therapy with the patient or pre-treatment and sometimes it's not documented and that's the reason that the denial's made.

Wow. So, you really have gotten a much greater understanding of the system and by getting this greater understanding of the system, you've actually gotten more efficient at providing care for your patient. Because you understand the system. And you've got little kids. I don't know how much you guys watch movies, but that was a big thing with us and our kids. And we love The Incredibles. We've probably seen that movie a billion times. And there's a scene at the very beginning where our hero was working at an insurance company. And he has a little old lady in front of him and she's crying because the insurance company has denied her claim and he's writing down for her specifically, "Go to this floor, talk to you person, and tell them you have this, and then you will be fine. Then his boss comes and yells at him because it's like, why is it that your clients have this intricate knowledge of how our system works? But you can't get away from the fact that because you have somebody like you that understands the system, ultimately what's happening is you are facilitating getting that care for your patient.

Absolutely. It's a double-sided win. You get to help people on the other side of it. So, I get to be the reviewer and help people get what they need approved.

And I can also help my own patients. So, I'm doing things more efficiently. I don't remember the last time I've had a test or a surgery denied and had to do a peer-to-peer. I honestly don't. Just because now I really know all the policies that are relevant to my specialty. I'm familiar with all of them. They're mostly similar from payer to payer, so I don't really have to, in general, look up, "Oh, which insurance does this patient have? Do I have to try X, Y, or Z treatment first?" Majority of the time, if I document what I need to document in the note, it's going to go through. So, it's really helped me to work within the system and help other people, but also just to help me learn how to navigate the system better.

100% and look who's benefiting from that. Your patients are benefiting from that. And I'm sure that benefits you, too, because that gives you less stress at work. Already having knowing all of these things definitely has to make your work day feel a lot better.

Documentation, Denials, and Better Approvals

Yeah, they always talk about the administrative burden, the added extra time that peer-to-peers and prior authorizations will add to a physician's day. When you can minimize that, you're you're hitting a home run. Yes, absolutely. And I think that's eliminating something really important about the work that you're doing. And I think this kind of goes back to episode 51. We have so many people trying to put hands on that scalpel. We have so many people trying to get their hands into healthcare. And as physicians, one of the things we always think about is how do we get our seat at the table back? How do we actually start to bring some of that control back into the hands of the clinician who's making the decision?

And I think so often we might think about this is we just have to blow up the system, we have to just destroy how the system works and that seems we just have to get rid of all of this. And unfortunately, that's just probably not practical in terms of continuing care for the patients who depend on us. But what you're doing, you are working

within the system and it's not only being I don't want to say secret agent, but you are in the system that maybe on some level might have been designed to deny care or save some money to the third-party payer. But what you're doing in that system is you're actually facilitating care within a structure that already exists.

Yeah, we're using it to make things better. It's unbelievable turning it a little bit on its head sometimes if you look at it from that perspective, which honestly, I hadn't until now. So that's a remarkable statement and I really like how you phrase that. I'm and I think this is one of the things I loved as we were talking about these forces that shape medicine is that we can we all understand it. We can understand that these are forces that are shaping what we're doing. How do we use those to actually improve the face of medicine and improve how we provide care? You are doing it. You're actually absolutely doing that in real time, which I love.

It sounds like you do feel as you're working through this because you've definitely got a lot out of this process. Did you feel sometimes maybe that peer-to-peer is legit? It's a good thing to have peer-to-peer kind discussion. Oh, I think it's good. I almost always still dread it. I've been doing this for years already and I always dread when I get a case and it says you're going to have to do a peer-to-peer if you deny this case and I say, "Okay, I'll I guess I'll take I'll talk to the doc." And I don't like it because it hurts. I don't I don't I like I don't like to call a doc and say, "Hey, listen, I here are the here are X Y and Z reasons why I can't approve this test or this procedure, but I will say that in in retrospect over 90% probably almost all of the cases where I do they're very congenial calls. I'm speaking to a physician who is a peer. They're happy enough that I'm a peer in their same specialty and often even their same subspecialty field. I totally understand they're not I get everything that they're saying. I know the evidence. I'm familiar with the same studies they're some I I've even cited a study to a doctor who published that study one time. Wow. Yeah, I said, "I've read your paper on X Y and Z and I understand why you're indicating this procedure." And so it's nice to get to do that. But I still something it's time I still still dread it every time I have to make one of those peer-to-peer calls there's still a little part of me that says, "I don't know if it's going to go well." It always does go well, but it's very rare that somebody flies off the handle or something like that. But it's interesting to look at it like I said in in hindsight I get Yes, the peer-to-peer conversation can be very uncomfortable, but usually it's pretty rewarding.

That's it really does sound like you feel like the majority of the time even though I think in the sort of this era where we're talking about prior auths and gold cards and this is a kind of a very big discussion in the national questions with medicine that it sounds like you feel like this the peer-to-peer process in general or your process in general works or at least it provides something that's beneficial. It can. Now, I will make generalizations about the industry. I'm not going to speak about any particular service or or company or anything. We talk a lot about the positives of you as in any industry there are things that work really well and there are things that perhaps there's room for improvement. I wouldn't say that every case that comes across my desk is a win is positive. There are sometimes there's where I get it and I look at this case and I say, "There's just zero chance that I can overturn this. There's no way that this insurance company's going to pay for this on this review." So, often I'll know that I have to do something that it's a policy-based review or whatever the case may be that at this level of review it's not going to be overturned.

But, to understand that fully, you need to understand the process of appeals. Now, the way that these appeals for claims work is that the patients have multiple layers of appeal so they can have a first appeal, there can be a second appeal, and then there's an external appeal, which is a federal-level appeal. On those final appeal levels there is no internal policies, so no individual insurance company policy can be used. This is just standard of care. You have to use evidence. You have to look at the textbooks. You have to look at the published literature, and you have to find an evidence-basis for the question, yes or no, approve or deny, overturn or uphold. And so there's always that last avenue that exists.

Peer-to-Peer Calls and Appeal Levels

In some of the lower levels of appeals it's not exactly that way. So, sometimes you can't really bring in literature. So, there are cases where I know that any reviewer's desk that this case comes across, this will be denied, whatever the physician says, whatever letter they write. I've seen some very heartfelt appeal letters written by patients, written by physicians, and they they're very emotional, they're very strongly worded. Some of them are very ferociously worded, even, which is not a great strategy, but some of them are. And unfortunately, at certain

levels of appeal, that's just not going to work. It just won't. But, I do know that in those cases, the way or what I tell myself anyway is that listen, that case, that's an automatic loss. That's the cost of doing business. Being in this position and overturning the cases I'm able to overturn comes at the cost of the cases that I can't win. We don't overturn every case, and that's just a fact of life. I can't I have to accept the fact that there will be cases where that's just how it goes, and I have to stay in the game in order to do the ones where I can do what I want to do. And I think that's such a great point is that as you're working within the system during this work that you are picking your battles. That you really it's like there are things that I'm able to I'm going to be able to help patients, I'm going to be able to help clinicians, but maybe not every single person on every single day. But you're still moving the needle in a way that you can and I think there's huge value in that.

Yeah, you certainly have to pick your battles in this field. You cannot win them all. If you do, I think you'll burn out very quickly. You get a lot of emails probably that say, "Did you look at this or did you look at that?" And since you do this for multiple organizations, I think this is another thing that's really important to talk about is that I think we sometimes and some of this is going to be more popular news and things like that right now in terms of certain third-party payers maybe doing more denials, maybe doing AI denials, and then maybe certain ones that are not.

But it sounds like you consistency across most of these as you're working through these. In some ways, yes. I will say that some of these different streams and some of the insurance companies as well, there is consistency. It's often hard to know what the internal policies are cuz again, I don't do any work directly for any insurance company. So all of this is independent work. So I'm not always It's a black box sometimes before it gets to my desk what has happened in this case. A lot of times I can see the previous denial clerical documentation. Why was it the denial issued? Sometimes it can literally be just We don't have any notes from your doctor. And then in the appeal process, I have 400 pages of notes from the doctor. I've got plenty of information.

So sometimes it's just as much as that, but a lot of times I don't know exactly what's happening behind the curtain. So I can't tell you for sure that I that's the case. I think that's a really important point too because I think that's one of the misunderstandings about is that you have access to those policies or you know what's going on and you are strictly a another pair of clinical eyes that's looking at this and you are giving your clinical opinion. And so I think that's huge in terms of understanding how this work is and the physicians that do it that they're not necessarily working for an insurance company. And I think that's a huge misunderstanding people have about this.

Yes. Yeah, I can't tell you how many times I get on the phone with a physician assistant or nurse practitioner or physician and I introduce myself as I'm calling from we're doing the peer-to-peer. And then they say, "So you work for Blue Cross or you work for this one or that one?" I say, "No, actually I don't. Not at all. This is completely independent." So it's a big misunderstanding. Yeah, that's for sure. I agree and I think that's one of the misunderstandings that I think keeps from physicians from considering it. Is like you said, it's an opportunity to actually change health care from within in a way that you are actually improving your own clinical skills. You're improving patient care and this is outside the exam room or outside the operating room. And that's what makes this so powerful is that you're able to do that. So if there were physicians that were listening to this podcast today and said, "Oh my gosh, I didn't know that this was a way that actually maybe I could get the doctor's hand more on the scalpel than off of it by actually doing this kind of review work." And let's say you encouraged someone was encouraged to try to do this work after listening to this podcast. How would you advise them to start?

That's a great question. So some people think that there's some secret handshake or of a locked door that you need to find in order to get into this, but sometimes it's as simple as just scouring LinkedIn. It really can be that mundane. Where you I found a couple of opportunities through that where I'm just I'll sit there and browse through the opportunities remote. You could there's a way to set filters so that you get jobs like that and then you can find ones within your specialty. There's lots of companies that are hiring in many specialties. I will say there are some specialties. So, each company will have panels and mental medicine. They'll have general surgery. They'll have fibroid and endocrine. They'll have rheumatology and pediatrics, neurosurgery, all these different fields. And they'll have panels in each of those fields. And your specific specialty, to the listener, may or may not be in demand. So, if it's an in-demand specialty, you're a lot you're going to probably find a way to to get into a review stream fairly easily.

How Physicians Can Get Started in Utilization Review

But if you happen to be in a specialty that is that doesn't have a lot of I would say high-cost medications or procedures or something like that, things that are going to commonly run into this, you may not see a lot of opportunities within your field. And that's just the nature of certain fields.

Yeah. But that's a great way to for you to find opportunities. And then, as they're finding these opportunities, let's say this specialty that's in demand, then they can kind of get into those. Having some having the time to do this, I think is important. But there's definitely, and I really love how you talk about this, that doing this work has really, not only changed how you document, but it's also making you very aware of the literature and staying very current. We were talking off mic about how doing this kind of work makes you stay current. And in all of our specialties, no matter what we do, there are advances every single day. I just got back from my state OBGYN meeting, and they're talking about doing these special robotic films and products we can use in robotics, and it's just incredible even in the last 5 years. So, it does make you stay current being able to review. It absolutely does. And it highlights another side of this that I meant to mention before, which was that sometimes you do these cases and you learn that not everybody is staying current. That there are cases where things are coming in and you know that may have been evidence-based 20 years ago, but what this doctor is saying to you right now is not up to the bar of current evidence. And because you say current and because you're on this, you understand why this was tonight. And some of these physicians have been practicing a certain way for a certain amount of time, they might be very uncomfortable with the fact that you might say, "Listen, the evidence doesn't show that. We don't do this anymore." If you go to enough for meetings, they say, "Yes, we've stopped treating patients with this is." And that to me uncomfortable discussion. Thankfully, that is very rare situation. But you do see that. Not every single submission Not every single request that is submitted does a reviewer actually think, "Oh, yeah, this is medically indicated. We should do this." Which is such a fascinating part of what you're doing. And I do think on some level that's on the intent behind having you is that you are trying to stay at that level. You We all want to practice at or above the standard of care. We all want to practice at the top of our license. We all feel that's important to us as physicians. But it sometimes is easier said than done in terms of if you've done something for a really long time in a certain way. I've used this antibiotic for this for forever and now standard of care says we don't use this antibiotic for X anymore.

I think those are really hard things to do, but that's why I love that and I think we all have different avenues for doing what you're doing. That's why I love that you're doing it in this way. Because I never thought of until we really started having this conversation. The fact that doing was actually going to make somebody a better doctor. But it totally That was a big surprise for me. It really was. I was not expecting that facet of it. I was just that's thinking, "Hey, this is a little thing I can do.

This is It's a little more exciting than medical surveys about this somehow medicine for it. Hey, you, I think we'll pay you seven bucks for some of these surveys." That's why I'm doing this. And I will say some of these cases that you get for UN, they it's not like they're paid that much. These cases don't pay a tremendous amount either. It's not that you would necessarily do this for the money. But it's a nice thing to do just to supplement the way that you are practicing in your spare time if you have that, which not everybody certainly has that luxury. But but yeah, like I said, it's just a phenomenal adjunct and you can fit it into your day. I think we were talking about if someone has time for it. You can fit it into your day or your week, however you see fit. So we didn't really get into too much of the specifics of how this work goes.

But there for most of them they'll have like I said a stream. I used that word before. And what that basically means is that they've got a whole list of cases of denials that were already issued and they're appealed in this state. In this stage. And so there's an endless an endless list at any point in time of these cases.

Flexible Case Streams and Final Takeaways

And they're sent from the insurance company to the third party and the third party sends it out to their panel. And these cases can just appear randomly at any time. And some of them will send you a text, some of them will send you an email or some of them even have their own app. And they'll say, "Hey, there's a case available. Do you want it?" It's not "Hey, there's a case available. This is yours. You're assigned to it." It's "There's case available. Do you want it?" Some streams are very busy. You might get several of those days. Some of them are very quiet and then you get one a month or something like that. And again, it's very specialty specific. But if you're on vacation, if

you're out of the country or something, you you'll think, "Yeah, that's fine." You just no one's holding you accountable to that. It's just Okay, someone else on the panel will grab it. So it's a very flexible kind of thing. It's nice. You can build it up if you have a slow week, you can turn it down if you have a busy week. It's really nice in that way.

That's huge. And I'm really glad you said that because that was not my thought process. When I think about people doing medical reviews, I think it's you sit down and you have six cases and you're having to go through all of those. But that's so not what it is. It's something that you definitely have a choice in terms of which you take and you can definitely play with that based on your schedule. That's what >> Yeah, it can really be tailored. It's very individualized. I love that. This has been a great conversation and a fabulous insight into how utilization medicine it can really this idea of looking at you it's not something that's evil and terrible. It is something that within it has potential to make us better doctors also help us give better care for our patients but it is a way to take back some control of that scalpel and I cannot thank you enough for being here on the podcast and being giving of your time. It really means a lot. Of course, yeah, like I said, thank you so much for having me. I'm really glad that we were able to do this and I hope that this inspires some of your listeners to look into you or think about doing it or at least at the very least just to think a little less poorly of those of us who choose to do it. 100% For all of our peaceful warriors who have joined us today on the Scalpel and Sword, thank you so much for being with us. If this episode resonated with you, please share it with a colleague and until next time be at peace.

Every episode is an invitation to speak, >> [music] >> to negotiate, to choose. I'm Dr. Lee Sharma. Join the dialogue by subscribing [music] to Scalpel and Sword. Until next time peaceful warriors. May your choices be sharp >> [music] >> and your voice be even sharper.

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