MLS Group of Companies, LLC

Eliminating Conflicts with Benefit Determinations

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Healthcare providers in the United States are increasingly being tasked with ensuring transparency to consumers, especially as consumer spending in this area continues to grow. Patients want high-quality care and comprehensive treatment for the investment they're making in their health. The same goal of transparency and high-quality care is true for the healthcare insurance industry as most premiums continue to rise.

A key method for addressing this issue is by ensuring appropriate medical care is provided, which can mitigate higher costs and risks for patients, medical providers and insurance payers. Conflicts of interest may arise in the process of benefit determination, prompting problems for both healthcare organizations and consumers. Before we get into these conflicts of interest, let's focus on the broader definition of benefit determination.

Adverse benefit determination: any decision for a denial, reduction of, or failure to provide or make payment for a healthcare benefit.

The patient who received the medical treatment and the medical provider who performed them are notified in writing through an explanation of benefits (EOB) that part or all of a patient's claim is denied.

Denial of benefits may be based upon:

- utilization review
- medical necessity
- a concurrent care decision
- an individual's ineligibility to participate in a health plan
- retroactive terminations of coverage
- out-of-network provider services
- exclusions due to preexisting conditions
- appropriateness of care

The adverse benefit determination process is then performed internally by the insurance carrier to meet regulatory standards. If the patient or provider disagrees with the benefit determination, they may request an external review of the case. The carrier completes a preliminary review of the request after which a notification is issued in writing to the patient informing them whether or not their request is eligible for an external review.

The carrier is required to contract an independent review organization (IRO), accredited by a nationally-recognized accrediting organization such as URAC, to conduct this external review.

URAC is a Washington DC-based non-profit organization that helps promote health care quality through the accreditation of organizations involved in medical care services.

An IRO utilizes board-certified, medically-trained physicians to review medical evidence in a case in a timely and unbiased manner. Once the doctor finishes their review of a case, the IRO gives written notice of the final external review decision to the claimant and insurance carrier.

Unlike an internal appeal, external appeals performed by an IRO are binding decisions. External reviews help ensure the final decision of an individual's care is based on medical evidence and expert judgement.

Conflicts and Challenges

As with any decision, conflicts of interest can arise with benefit determinations. This is especially of concern with physician reviewers involved in external review cases because they're the expert and primary decision-maker on behalf of IROs. A reviewer must not have any professional or financial relationships with the parties involved, such as the consumer, health plan, providing doctor, etc. IROs are utilized for their ability to provide an unbiased opinion for each case, so it's essential that any possibility for conflict is eliminated.

Conflicts of interest can occur when the reviewing physician can give the affirmative for any of the following:

- They wrote any of the patient's health plan.
- They served (or are currently serving) on the insurance carrier's executive board.
- They worked on a board studying certain regulations involved in the case.
- They worked with the patient, the treating physician(s) or practice.
- They have a financial interest in the pharmaceutical company that produces the drug under question.
- They live in close proximity to the patient.
    - Note: This may not be a direct conflict, but the potential for conflict is higher.

In any case where there is the potential for a conflict of interest, a reputable independent review organization (IRO) will take the steps necessary to ensure that issue is negated.

IROs and the third-party medical review industry in general have grown rapidly over the past few years. This is in large part because the employment/employer relationship between insurance companies and the physicians they employ as part of their review panel has been called into question due to potential conflicts of interest.

Addressing and eliminating conflicts of interest is vital to ensuring that patients trust the healthcare system as a whole and understand the costs that come with their health. Consumers should be confident that medical decisions are not driven by the financial interests of providers, pharmaceutical companies and other organizations. Any conflicts of interest in a case may have a ripple effect on other patient care decisions or result in a negative reputation for a specific healthcare organization or facility.

Overview of Independent Review Organizations

A third-party external review provides unbiased opinions on medical cases and streamlines the process of a medical review. IROs offer advantages for clients and their patients, including:

- reduced costs
- access to board-certified physicians across specialties and subspecialties
- improved compliance
- objective decision-making
- added security measures to protect sensitive information

All of these benefits provide a seamless arrangement to insulate these conflicts of interest.

IROs are called upon when a claimant requests an appeal of a benefit determination. An IRO will then perform their review based on medical evidence from the case, consulting up-to-date, evidence-based medical guidelines to determine medical necessity and appropriateness of care.

For example, if the reviewing physician finds that a claimant does need a specific prescription drug or MRI, IROs confirm through medical evidence that the benefit was improperly denied. They also review cases to mitigate fraudulent claims and unnecessary treatment.

Benefit Determination with IROs

IROs utilize evidence-based reporting along with clinical research, regulatory requirements and practice guidelines to support their unbiased decision-making. They tailor the review process to meet the needs of each client to ensure the highest quality assurance and clinical accuracy. Having the resources to tap into the highest level of expertise in each medical specialty and board-certified in the specialties and subspecialties of their expertise, IROs become a reliable and impartial resource with an extensive and specialized knowledge of healthcare services.

HIPAA, HRRP and the HITECH Act are only a few of the guidelines and regulations that govern the healthcare industry. IROs have staff in place who know, adhere to and stay informed of any changes on all the state and federal rules and regulations.

A physician must undergo a thorough credentialing process with an IRO before being able to perform reviews. The most important data requested as part of the credentialing process includes verification of education including verifying board specialties and board certifications. A solid credentialing process is at the crux of the integrity and quality of a credible IRO. Along with primary and secondary verification is a thorough background check with delegation to a third-party to corroborate the physician's medical license, degree completion, and board certification, ensuring the lack of gaps in their licensure.

Most IROs require a physician on their reviewing panel to have a minimum amount of practice experience in their field of expertise and to be actively practicing. These physicians are subject to re-credentialing every couple of years. Most IROs also contract with doctors in a variety of specialties and subspecialties to ensure they have the appropriate resources available for each unique case. The number of specialists in a certain field of study typically depends on client demand.

A Bevy of Benefits

A study by the American Association of Health Plans (AAHP) found that independent reviews have a positive influence on health plans' internal review processes, such as accelerating time frames for review and engaging more external specialists for complex cases. This quick turnaround is beneficial for both patients and health plans to resolve the case in a short time period.

According to the National Association of Independent Review Organizations (NAIRO), other substantiated benefits of independent reviews include positive impact on health plan review process and other health care management activities, reduction of costly litigation and patient protection in regards to preventing unnecessary medical treatment.

IRO benefit determinations are made based on medical information, not profit, thereby eliminating one of the biggest conflicts of interest. The physicians they panel don't work for an insurance provider and are medically-trained experts able to provide a quick turnaround of claims. For health plans, external reviews provide unbiased and evidence-based benefit determinations that can improve member satisfaction.

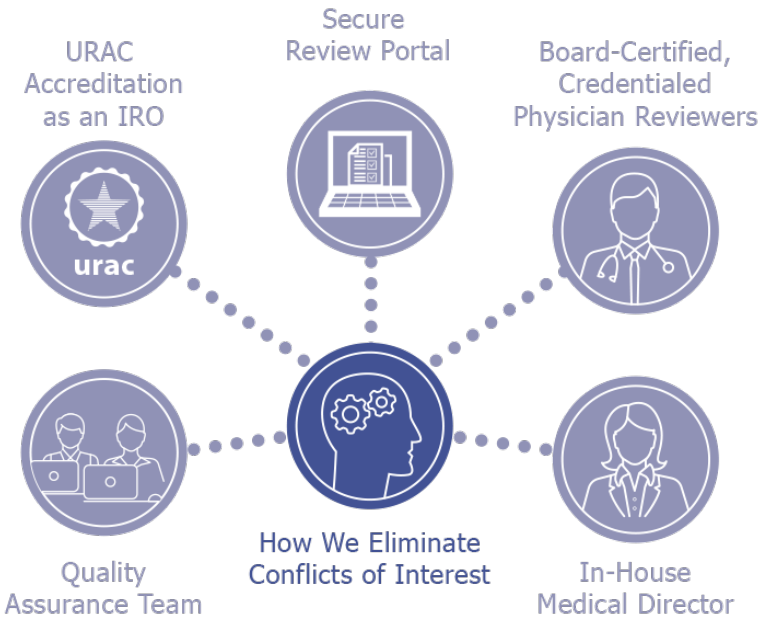
The benefits achieved through IROs don't only apply to organizations who employ their services. These reviews benefit the healthcare industry by improving productivity, increasing patient safety and further securing the rights of patients. They promote consumer rights, provide another resource for medical expertise and knowledge and reduce costs through more effective claim management and better allocation of staff resources.

The MLS Advantage

MLS Group of Companies, LLC is a leading URAC-accredited national provider of peer review services, independent medical examinations and Family and Medical Leave Act (FMLA) medical assessments. In addition to being recognized for our experience and commitment to providing exceptional client service and objective medical assessments through cutting-edge information technology, we boast a nationwide network of credentialed physician reviewers covering all major specialties and subspecialties with expertise in a wide variety of areas.

By utilizing a process unlike other IROs, the MLS team is able to handle benefit determinations in a streamlined fashion, mitigating the risk for errors and omissions. Here's an overview of this process:

- Once a claim is received from a client, we review it to ensure there are no conflicts with the case.
- Next, a physician who has experience in that area is selected. Our goal is to ensure the physician performing the review is able to speak to the diagnosis, treatment and outcome or lack thereof from the treatment being requested.
- Once we find a board-certified physician who meets those qualifications and is actively practicing in his or her respective field, the case is sent to that doctor.
- Before reviewing the information, the physician is required to sign off to confirm they have no conflict with the case and are qualified to complete the review.
- The physician then reviews and confirms that they examined the entire medical file, provides a summary of all the pertinent information and completes a report on it.



At MLS, self-regulation is what sets us apart from others in the industry. Once a benefit determination case is received, we make sure we haven't reviewed it before and have no investment in the involved client or health plan. Our quality assurance team performs an audit of the physician-provided report to confirm the entire file was reviewed, the pertinent information was addressed and the decision makes sense. Once this process is complete, the report is submitted to our client.

At MLS, we don't have a stake in the claim outcomes. Our goal is to ensure the review is done correctly and follows the applicable rules and regulations. We have the internal resources to follow up on issues when appropriate and make sure deadlines are met on behalf of the client.

"We have staff in place who know all the rules and regulations of state and federal law. Plus, we follow up with our physicians to make sure all deadlines are met, and our quality assurance staff reviews all the reports to make sure there are no medical inconsistencies in it. Our clients feel comfortable using a company like MLS because they know they're going to get their case reviewed appropriately and on time with evidence-based medicine to make their claim determination."

—Michelle Chamberlain, Senior Account Manager

Reputable Results

With an on-time review percentage of approximately 98 percent, our success rate speaks for itself. The quality assurance process and checkpoints we have in place guarantee that a client gets the case done correctly and returned on time.

We also maintain a return rate of five percent or less. As an IRO, we provide opinions and make sure we're experts in what we do. Unlike a medical director for an insurance company who is responsible for all claim decisions, the MLS team chooses a physician who is an expert in their field, so clients can be confident in the end result. The conflict of interest is already eliminated because of our highly-qualified, vetted physician network combined with our quality standards and advanced technology.

State-of-the-Art Technology

The MLS client and reviewer portals are comprised of technology that differentiates us from our competitors. The secure, HIPAA-compliant portals offer two levels of access: one for users through which they can see cases submitted to us and another for supervisors that allows them to see all cases for a specific company.

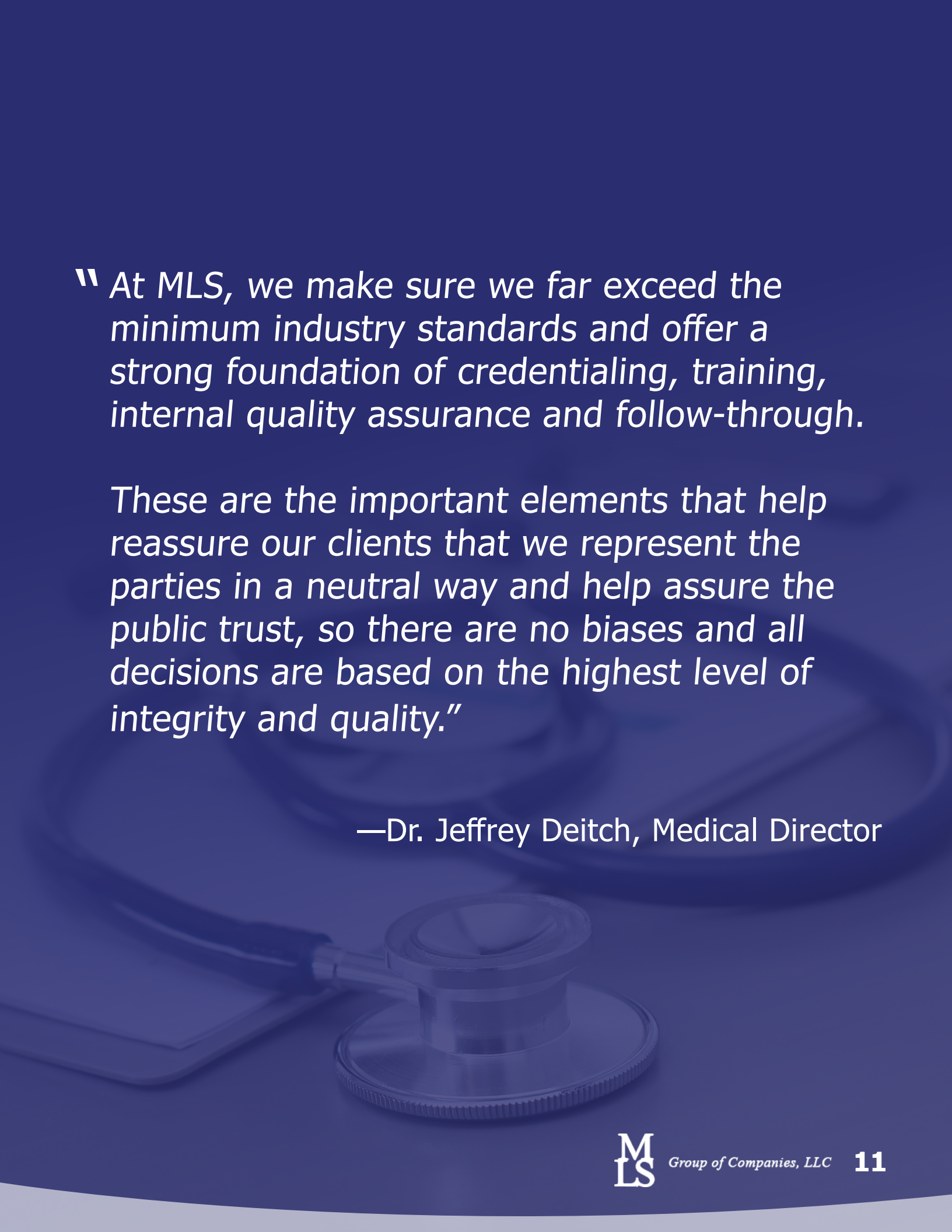
Each user is assigned a unique login ID and password that is not shared with anyone for any reason. Clients can chat with us through a support window in the portal and even upload records or supporting documentation for a file on a case. On our end, the portal provides the ability to assign a case back to a client to gather additional information. This method of communication not only makes it easier for clients to communicate with us but also maintains the integrity of the process.

Reliable Physician Review

The MLS nationwide physician network is comprised of 1,500 actively practicing doctors who have at least three years of experience in benefit determination cases. Follow ups are performed with the contracted physicians to ensure all deadlines are met, and our quality assurance team reviews the final report to confirm they don't include any medical inconsistencies or contradictions. The QA team also verifies that all questions in the case are addressed appropriately using the correct criteria for that specific state or case. By training our staff in such processes, we mitigate human error and are able to achieve a high level of accreditation.

At MLS, we conduct additional verifications on the doctors we panel to ensure the correct physicians are performing our reviews. We consistently check their background and make sure our database is up-to-date. Our system of checks and balances and our strong physician network help eliminate conflicts of interest. This dedication is unparalleled in the IRO industry.

Unlike many IROs, MLS has an in-house medical director responsible for overseeing all physicians and double-checking their work. The role of the medical director is based on managing the quality and integrity of the process and resolving any conflicts of interest. He has direct oversight when it comes to any medical personnel who are involved in a case and is responsible for maintaining the highest standards of clinical quality and integrity.



"At MLS, we make sure we far exceed the minimum industry standards and offer a strong foundation of credentialing, training, internal quality assurance and follow-through.

These are the important elements that help reassure our clients that we represent the parties in a neutral way and help assure the public trust, so there are no biases and all decisions are based on the highest level of integrity and quality."

—Dr. Jeffrey Deitch, Medical Director

Board-Certified Physicians

Physicians who contract with MLS go through an extensive, dedicated training and screening process. If a doctor doesn't pass our training, they are removed from the physician panel.

Along with our training sessions, a physician orientation is comprised of webinars, self-teaching disks and internal quality reviews. Every physician reviewer is under the scrutiny of the medical director, who evaluates the doctor's first two cases to make sure all compliance issues are followed and a high-quality product is achieved.

Once a physician receives and completes the credentialing packet, they complete URAC training, which covers guidance and policy with respect to avoiding conflicts of interest and scrutiny of financial incentives. Because MLS is URAC-accredited, we follow specific guidelines in the credentialing process and review those credentials every two years. Prior to each case review, the physicians' primary verification source is re-examined. Then, the National Practitioner Data Bank is scrutinized to certify the physician is qualified to be a reviewer.

At MLS, we rely on the continuing medical education (CME) process to confirm our physicians are knowledgeable about recent healthcare trends and any changes in the insurance industry. Any actively practicing physician who is board-certified has their own internal standards to meet to renew their medical license every three years.

Streamlined Safeguards

The IRO industry continues to change due to HIPAA laws, newly required security levels, a higher level of standards and an expansion in client demands. More clients want to implement the services of an IRO that not only has oversight from a medical director but is also accredited by a third-party entity such as URAC.

MLS serves clients by addressing three primary types of conflicts: organizational, peer and client. Our reviewers are required to sign an attestation statement confirming they've received the case and haven't encountered any of these conflicts. That statement is the final seal of approval that ensures there's no conflicts of interest within these cases—from start to finish. Plus, our firewalls and adherence to standards set forth by HIPAA provide a seamless arrangement to insulate those types of conflicts. We take pride in the bulletproof parameters in place to guard against any conflict.

Making MLS Work for You

The MLS advantage is our ability to offer a strong, high-quality medical review program with integrity. Our strong foundation of credentialing, training, quality assurance and eliminating conflicts of interest allow us to consistently evaluate cases and fortify our panel of reviewers, all of which benefits our clients. As a URAC-accredited, comprehensive IRO, we maintain a large, credentialed and diversified physician reviewer network that includes all 50 states. Providing our clients with the most thoroughly vetted and trained, actively practicing professionals is crucial.

MLS is recognized for our experience and commitment to providing exceptional client service, objective medical assessments and the protections associated with cutting-edge information technology. Our external review services are performed with high-integrity to ensure all decisions made are evidence-based and unbiased for effective claim resolutions. We strive for appropriate and high-quality medical care in the healthcare industry.

Disability

Peer Reviews and IME

Group Health

Liability and Auto

Workers' Comp

Peer Reviews and IME

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