



REHABILITATION V

Through the techniques of Managed Health Care, insurers are able to restrain runaway rehabilitation costs, demand accountability and come to grips with conflict of interest and other abuses.

THE MANAGED-CARE CURE

By Brenda Rusnak, President, Active Physiotherapy Rehabilitation Group, Toronto

A FULL YEAR has elapsed since Bill 164 no-fault automobile insurance was legislated.

While it has encouraged insurers and rehabilitation providers to seek ways to more effectively manage bodily injury claims, the legislation also opens the door to conflicts of interest and to abuses by some multi-disciplinary facilities.

The initial change from a tort to a no-fault system in 1990 was welcomed by health care providers, because it caused dramatic increase in the number of patients who previously were not motivated to rehabilitation due to a pending tort settlement.

It also resulted in greater interest by insurers to provide rehabilitation for claimants injured in auto accidents.

However, the increased funding for rehabilitation also sparked a sudden interest in this field by health care providers that previously had no interest or experience (physicians are an example), as well as by individuals with no health care background whatsoever (lawyers and business people).

As a result, 1994 witnessed the substantial growth in rehabilitation facilities that claimed to specialize in motor vehicle accident injuries — to the point supply now far exceeds demand.

To benefit from this apparent oversupply, insurers look to tools to help them determine which facilities offer the best service and to find a method to pass on



this information to their claimants.

Their solution is Managed Health Care. Although insurers are moving at different speeds and using slightly different means to get there, there is no doubt all are moving in the same direction.

Managed Health Care involves monitoring rehabilitation providers to ensure the service they provide is producing results, that is, moving injured accident victims closer to their pre-injury level of function in a timely manner.

Health care providers must now be must now be accountable to insurers, which are purchasing services directly from them. This is a new concept for most practitioners in Ontario, who previously viewed their only responsibility to

be with the end-user or patient.

(There has certainly never been any requirement, now or in the past, to be accountable to the Ontario Ministry of Health).

One method used by insurers to effect accountability is to monitor statistical data to pinpoint providers and facilities that produce the best results — an approach that also increases awareness of the need to continually evaluate the effectiveness of different treatments.

Ineffective treatment modes and approaches will not be tolerated in the future.

Communications between health care providers and insurers has dramatically improved in the last year. Insurers have made it very clear they require continuing reports and updates to properly manage claims.

Health care providers also realize it is in the best interest of their patients to communicate with everyone involved in returning the injured victim to a normal lifestyle. This includes the insurer.

Another developing trend, again reflecting the Managed Health Care approach, is the move by some insurers to identify preferred service providers to achieve a close working relationship, to set common goals and work toward them; provide consistent quality of service; and reduce the need to continually monitor a seemingly limitless number of clinics.

Unfortunately, barriers still block the

insurers' efforts to manage claims and control costs. These are basically problems of dealing with "conflict of interest" and "regulation of multi-disciplinary facilities".

Most insurers are acutely aware of these problems, but feel relatively powerless in doing anything about them.

Conflict of interest occurs when a health care professional, or a family member, or a corporation owned or controlled by the professional, or a family member, receives any direct or indirect benefit from a supplier to whom the professional refers clients.

This encompasses health care products, as well as professional services, such as physiotherapy.

It is becoming more and more evident that a large number of health care professionals are currently involved in conflict of interest situations, the most common being self-referral (referring patients to facilities owned or partly owned by the referrer) and payment for referrals, that is, kick-backs.

This is very serious, and will stifle improvement in the rehabilitation industry if it is not stopped.

Studies on the issue of self-referral to physiotherapy clinics clearly indicate that conflict of interest situations result in many individuals being referred for unnecessary physiotherapy treatment, as well as a higher than average number of treatments being provided.

The only way to effectively deal with this issue is to pass legislation that prohibits conflict of interest situations from existing.

The second problem is complex — the lack of regulation over multi-disciplinary facilities. It is an issue that has not yet begun to be dealt with.

Although individual professionals working within these clinics are regulated by their respective professional associations and Colleges, there is no regulation that prohibits excessive concurrent treatments by different disciplines.

To effectively manage claims and contain costs in the rehabilitation field, without jeopardizing the quality of service and the rights of patients to choose where they receive treatment, conflict of interest and regulation of multi-disciplinary centres must be ended.

Only after these "abuse mechanisms" are removed, or controlled, can health care providers and insurers turn their full attention to working together to continually improve the cost-effectiveness of specific treatment protocols. CU



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