



UR, UR Investigation and Treatment Guidelines

Presenters

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DWC 16th Annual Educational Conference

MTUS, UR, and the QME Process

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- Destie Overpeck
- Suzanne Marria
 - Christine King
- Avrum Gratch, M.D.

Medical Treatment Utilization Schedule (MTUS)

Update Package of 2008 –
Highlights, Design Features & Re-
Organization

Before the MTUS

It was ACOEM Guidelines per Labor Code §4604.5 effective from 2004 to June 15, 2007

Beginning 3 months after publication date for ACOEM Practice Guidelines 2nd Edition 2004 *and continuing until the effective date of the MTUS pursuant to 5307.27*, ACOEM Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment regardless of date of injury.

MTUS – Effective June 15, 2007

- California Code of Regulations, Title 8, Sections 9792.20 - 9792.23
 - MTUS Adopted ACOEM Guidelines and incorporated them by reference
 - Acupuncture Medical Treatment Guidelines
 - ACOEM's Strength of Evidence Methodology adopted
 - Medical Evidence Evaluation Advisory Committee (MEEAC) formed

Incorporation by Reference

- “Why can’t you just use the latest version?”
 - “How about ACOEM’s new Low Back Chapter”
 - “AMA Guides 6th Edition”
- California cannot delegate authority to other entities. Rather all regulations arise from formal rulemaking.

MTUS – 2008 Update now in rulemaking

- **11/26/08** Notice of 1st 15 day Comment
- **12/18/08** 1st 15 day Comment Period Ended
- A 2nd 15 day Comment period expected
- Anticipate filing final package of MTUS Regulations with Office of Administrative Law (OAL) in Spring 2009

2008 Proposed MTUS Update

- California Code of Regulations, Title 8, Proposed Sections 9792.20 - 9792.26
 - MTUS Reorganized
 - ACOEM Textbook Chapters Reconfigured
 - ACOEM's Elbow Chapter updated
 - Special Topics Added to MTUS
 - Chronic Pain Medical Treatment Guidelines
 - Postsurgical Treatment Guidelines
 - Acupuncture Medical Treatment Guidelines (reconfigured as a Special Topic)

MTUS - Reorganized

- § 9792.20 Medical Treatment Utilization Schedule—Definitions
- § 9792.21 Medical Treatment Utilization Schedule
- § 9792.22 General Approaches
- § 9792.23 Clinical Topics
- § 9792.24 Special Topics
- § 9792.25 Presumption of Correctness, Burden of Proof and Strength of Evidence.
- § 9792.26 Medical Evidence Evaluation Advisory Committee

ACOEM's 2004 Text Reconfigured

- A General Approaches Section is created in the MTUS to incorporate by reference some of ACOEM's Part I chapters
- Clinical Topics Section is created. Each of ACOEM's Part II Anatomic Complaints Chapters are assigned specific section numbers in the regulations
- A Special Topics Section is created in the MTUS to organize treatment guidelines that have special application to the Clinical Topics section.

Modular, Smaller, and Faster

- With each clinical and special topic assigned its own regulation section number, smaller rulemaking updates can be carried out on individual clinical sections without interaction with the rest of the MTUS.
- More than one rulemaking package can be launched at the same time. A delay in the rulemaking for one regulation update will not hinder the progress of another rulemaking in progress.
- Faster turnaround means we can update more frequently to stay current with the scientific evidence

§ 9792.22 General Approaches

- ACOEM Practice Guideline Chapters 1, 2, 3, 5 are incorporated by reference
 - Chapter 1 *Foundations of Occupational Medicine Practice*
 - Chapter 2 *General Approach to Initial Assessment and Documentation*
 - Chapter 3 *Initial Approaches to Treatment*
 - Chapter 5 *Cornerstones of Disability Prevention and Management*

ACOEM Chapters Omitted

- Chapter 4 Work-relatedness: *California has special considerations in determining causation and compensability*
- Chapter 6 Pain, Suffering, and the Restoration of Function: *DWC has replaced Chapter 6 with the Chronic Pain Medical Treatment Guidelines.*
- Chapter 7 Independent Medical Examinations and Consultations: *California has special requirements involving QMEs, AMEs, IMR, etc.*

§ 9792.23 Clinical Topics

- Commencing with § 9792.23.1 et seq. these clinical topics apply to *the initial management and subsequent treatment* of presenting complaints specific to the body part.
- For all conditions or injuries not addressed in MTUS, the initial management and subsequent treatment for presenting complaints shall be in accordance to other evidence-based guidelines

§ 9792.23 Clinical Topics

- § 9792.23.1 *Neck and Upper Back Complaints*
- § 9792.23.2 *Shoulder Complaints*
- § 9792.23.3 *Elbow Disorders (revised 2007)*
- § 9792.23.4 *Forearm, Wrist, & Hand Complaints*
- § 9792.23.5 *Low Back Complaints*
- § 9792.23.6 *Knee Complaints*
- § 9792.23.7 *Ankle and Foot Complaints*
- § 9792.23.8 *Stress Related Conditions*
- § 9792.23.9 *Eye*
- § 9792.23.10 et seq – **reserved for future topics**

Each Clinical Topic Section can be modified, replaced, or fine tuned (e.g. §9792.23.3 Elbow Disorders)

- §9792.23.3(a) ACOEM Elbow Disorders Chapter 2007 incorporated by reference
- §9792.23.3(b) Applies MTUS Acupuncture treatment guidelines, superseding text in ACOEM's 2007 Elbow Disorders Chapter
- §9792.23.3(c) Applies Postsurgical treatment guidelines, if surgery is performed in the course of treatment for elbow complaints
- §9792.23.39(d) Applies chronic pain guidelines when the patient has pain that continues beyond the anticipated time of healing

Special Topics:

Special treatment guidelines that apply across the clinical topics sections

- *To ensure proper application of special topics, the MTUS begins with the clinical topic sections.*
- *The initial and subsequent treatment guidelines start with the body part chapters.*
- *The special topic sections are then applied where referenced in the clinical topics sections.*

§9792.24 Special Topics

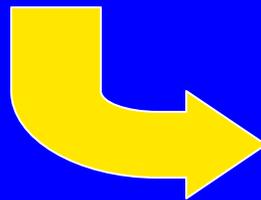
- § 9792.24.1 Acupuncture Medical Treatment Guidelines
(reconfigured to fit the new MTUS modular design)
- § 9792.24.2 Chronic Pain Medical Treatment Guidelines
- § 9292.24.3 Postsurgical Treatment Guidelines

Navigating Proposed MTUS



Start with the §9792.23 Clinical Topic

The clinical topic sections covers treatment guidelines for most work injury cases.



*Patient Treated
Heals & Recovers as anticipated
Released from care*

Getting to Special Topics

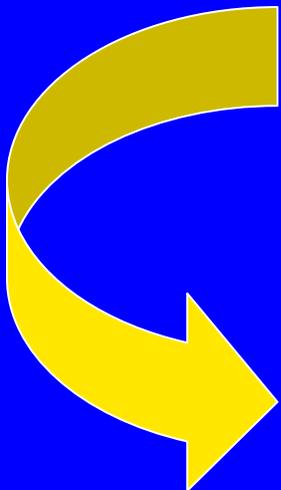


Start with the §9792.23 Clinical Topic

The clinical topic sections covers treatment guidelines with exceptions.

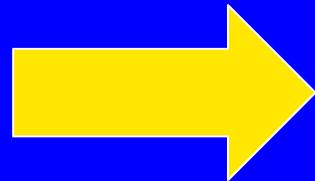


Following the clinical topic determines when a special topic applies in specific instances.



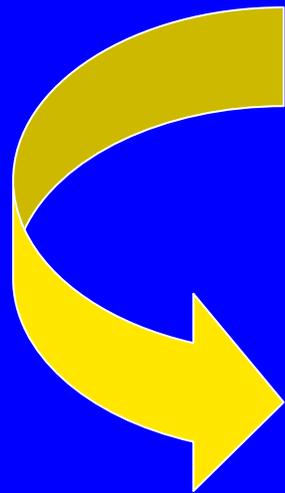
§9792.24 Special Topics apply when *clinically determined* by the Clinical Topic (chronic pain, postsurgical, or acupuncture)

Example: Clinical Topic Low Back



§ 9792.23.5 (a) ACOEM *Low Back Complaints* chapter
Following the clinical topic determines when a special topic applies in specific instances.

- (b) for acupuncture, go to special topic
- (c) for postsurgical therapy, go to special topic
- (d) for chronic pain, go to special topic



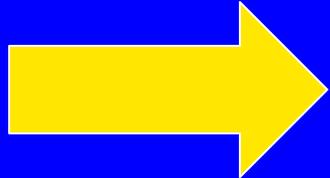
§9792.24 Special Topics apply when
clinically determined by the Clinical Topic
(chronic pain, postsurgical, or acupuncture)



Examples to Navigate the MTUS Topic Sections

- Example One: Injured worker presents with acute low back pain. No serious conditions were suspected at the initial assessment. The injured worker was seen weekly and has steady improvement. After **6 weeks**, the pain was completely gone, and injured worker was released from care.
- Only the Clinical Topic Section on Low Back Complaints apply for this case. No need to refer to special topics

Example One: Acute Low Back Pain with Prompt* Recovery



Start with the Clinical Topic

The clinical topic section on Low Back Complaints covers the initial and subsequent treatment of low back pain.

With improvement and without need for surgery or acupuncture, or chronic pain treatment special topics do not apply.

Patient is discharged.

*With steady week-by-week improvement recovery is expected and anticipated

Example Two: Same as prior case but it took 10 weeks to get better.

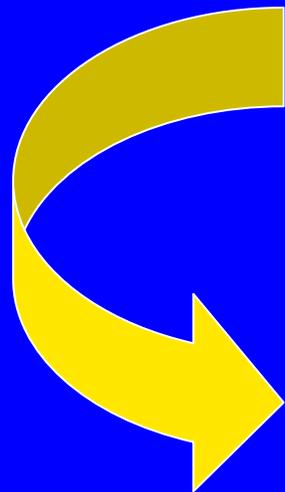
- The injured worker was followed weekly and has steady improvement. The patient did have problems using anti-inflammatory meds and requested acupuncture.
- Pursuant to proposed section 9792.23.5(b) *“In the course of treatment for low back complaints where acupuncture or acupuncture with electrical stimulation is being considered, the acupuncture medical treatment guidelines in section 9792.24.1 shall apply and supersede the text in the ACOEM chapter referenced in subdivision (a) above relating to acupuncture.”*
- After **10 weeks**, the pain was completely gone, and injured worker was released from care. Example One required 6 weeks to get better.

Example Two: Request for Acupuncture

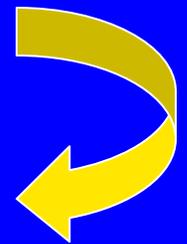


Start with the Clinical Topic § 9792. 23.5.
which covers treatment for acute low back pain.

*Acupuncture was considered; §9792. 23.5(b) applies.
go to special topic*



§9792. 23.5(b) refers to Special Topic §9792.24.1
Acupuncture Medical Treatment Guidelines which
covers the use of acupuncture as long as there is
functional improvement.



Example Three: Low Back Surgery

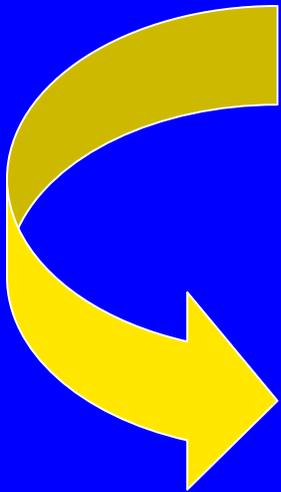
- Injured worker presents with acute low back pain. Patient had clinical weakness, reflex change, and sensory findings consistent with suspected disc herniation. Urgent imaging studies were performed confirming a large disc herniation. The patient was offered treatment options chose surgery. *After surgery, the patient had a course of therapy.*
- 9792.23.5(d) “If surgery is performed in the course of treatment for low back complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS or in accordance with section 9792.23(b). In the absence of any surgical options for the complaint and definitive treatment for the patient has chronic pain who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.”

Applying Postsurgical Treatment Guidelines



Start with the Clinical Topic § 9792. 23.5.
which covers treatment for low back pain and surgery.

Postsurgery Therapy requested; §9792. 23.5(c) applies



§9792. 23.5(c) refers to Special Topic §9792.24.3
Postsurgical Treatment Guidelines which
covers postsurgical physical medicine visits during
the postsurgical physical medicine period (6 months).
Functional improvement is necessary for more visits.

Postsurgical Treatment Guidelines

- §4604.5(d)(1) *“...an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury.”*
- §4604.5(d)(3) the above *“paragraph(1) shall not apply to visits for postsurgical physical medicine and postsurgical rehabilitation services provided in compliance to the postsurgical treatment utilization schedule...”*

Definition: Postsurgical physical medicine period

“*Postsurgical physical medicine period* means the time frame that is needed for postsurgical treatment and rehabilitation services beginning with the date of the procedure and ending at the time specified for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section. For all surgeries not covered by these guidelines the postsurgical physical medicine period is six (6) months.”

An Exception to the 24 Visit Cap

The postsurgical treatment guidelines apply to visits during the postsurgical physical medicine period only and to surgeries as defined in these guidelines. At the conclusion of the postsurgical physical medicine period, treatment reverts back to the applicable 24-visit limitation for chiropractic, occupational and physical therapy pursuant to Labor Code section 4604.5(d)(1)

Application of Postsurgical Treatment Guidelines

“Only the surgeon who performed the operation, a nurse practitioner or physician assistant working with the surgeon, or a physician designated by that surgeon can make a determination of medical necessity and prescribe postsurgical treatment under this guideline.”

UR Considerations in the Application of Postsurgical Treatment Guidelines

“The medical necessity for postsurgical physical medicine treatment for any given patient is dependent on, but not limited to, such factors as the comorbid medical conditions [*other illnesses eg diabetes, cardiac*]; prior pathology and/or surgery involving same body part; nature, number and complexities of surgical procedure(s) undertaken; presence of surgical complications; and the patient’s essential work functions.”

Applying the definition of chronic pain: “pain that persists beyond the anticipated time for healing”

- Example Two is not chronic pain even though it took 10 weeks to get better, it was clinically determined that week-by-week the patient was getting better and healing was still anticipated.
- 9792.23.5(c) “If recovery has not taken place with respect to pain by the end of algorithm 12-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.”

ACOEM's 5th Algorithm

- Algorithm 1: “Initial Evaluation...”
- Algorithm 2: “Initial and Follow-up Management...”
(Healing is still possible)
- Algorithm 3: “Evaluation of slow-to-recover patients...”
(Healing is still possible)
- Algorithm 4: “Surgical Considerations...”
(Healing is still possible)
- Algorithm 5: “Further management...no recovery”
(No recovery, healing is not anticipated. It is now beyond the anticipated time for healing)

Diagnosing Chronic Pain

- In the “Evaluation of slow-to-recover patients...” Algorithm 3 in all the chapters represents a *reconsideration of the diagnosis* and to assess whether there is a surgically treatable anatomic defect which leads to the surgery Algorithm 4. With surgery as an option, healing is still anticipated.
- With or without surgery, Algorithm 5 is utilized for persisting complaints. In the absence of recovery in Algorithm 5, the patient has chronic pain as further healing is no longer anticipated and it is now appropriate to diagnose “pain that persists beyond the anticipated time for healing”

Reconsidering the Diagnosis

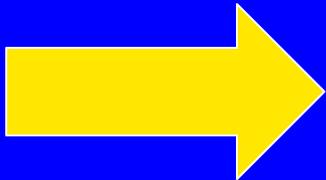
- When a patient is not recovering as initially anticipated, this naturally leads to the clinical question as to whether the initial diagnostic impression is still appropriate. Upon reevaluation, new or different diagnoses may be suggested. These diagnoses are likely to be different from the original diagnoses made earlier in the clinical course for the injury claim.
- Upon reconsidering the diagnoses, a primary clinical issue is to formulate whether or not there are any further treatments that could improve the condition, such as surgery.

Applying the chronic pain medical treatment guidelines

Example Four: Same as Example Three, a large disc herniation was identified, but the patient declined surgery. The patient was followed-week-by-week, but the pain persisted along with neurological deficit.

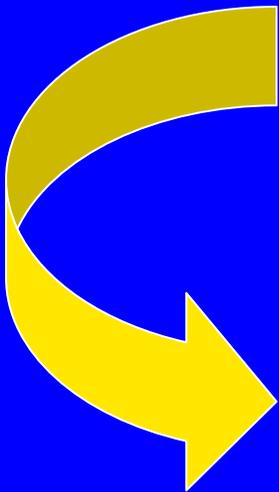
- *However, the patient continued to refuse surgical options.*
- *Without other definitive treatment options, the injured worker is now diagnosed with chronic pain and is beyond healing.*
- *The chronic pain medical treatment guidelines apply if the patient needs more treatment.*

Applying Chronic Pain Medical Treatment Guidelines



Start with the Clinical Topic § 9792. 23.5 which covers treatment for low back pain. Patient declines surgical options and still has pain. Going through Algorithm 12-5, it is determined that recovery has not taken place

therefore §9792. 23.5(c) applies



§9792. 23.5(c) refers to Special Topic §9792.24.2 Chronic Pain Medical Treatment Guidelines which covers management of chronic pain.

Purpose of MTUS

- The MTUS replaces the former “treating physician’s presumption”.
- It’s purpose is to define “presumptively correct” treatment in workers’ compensation.
- However, disputes will continue to arise in the treatment of injured workers.
- Dispute resolution for treatment issues is now scientific and evidence based.

§ 4604.5. Medical treatment utilization schedule and recommended guidelines

- (a) Upon adoption by the administrative director of a medical treatment utilization schedule pursuant to Section 5307.27, the recommended guidelines set forth in the schedule shall be presumptively correct on the issue of extent and scope of medical treatment. **The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury.** The presumption created is one affecting the burden of proof.

§ 4604.5. Medical treatment utilization schedule and recommended guidelines

- (b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices that are evidence and scientifically based, nationally recognized, and peer-reviewed. The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.

§ 9792.25 Presumption of Correctness, Burden of Proof and Strength of Evidence

- MTUS is presumptively correct. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required.
 - Applies to both UR and Treating Physicians
- If requested medical treatment is not in the MTUS, then physician must rely on other guidelines or provide scientific evidence to support treatment, such as newly published randomized controlled study

When do we use ACOEM's strength of evidence ?

When treating physician is requesting:

- treatment not addressed either in the MTUS or in other guidelines
- treatment recommendation at variance with the MTUS and other guidelines
- treatment recommendation addressed in a guideline not included in the MTUS which is at variance with another guideline not in the MTUS

Supplementing MTUS

- The Administrative Director Administrative Director, in consultation with the Medical Director, may revise, update, and supplement the MTUS as necessary
- The Medical Director shall create a medical evidence evaluation advisory committee to provide recommendations to the Medical Director on matters concerning the MTUS

UTILIZATION REVIEW

Utilization Review and the QME Process

- Request for authorization (RFA) of medical treatment - often the first benefit requested in a WC claim
- Sandhagen decision by California Supreme Court clarified employer options in disputing medical treatment
- Decided July 3, 2008
- Applies to medical treatment for all dates of injury

Sandhagen and Medical Treatment Disputes

- Employer must use UR for every treatment request
- Employer cannot object under LC 4062 as alternative to resolve medical treatment dispute
- Only Injured Worker may object under LC 4062
- Approvals *are* part of the UR process
- Approvals do *not* require physician review; only delay, denial or modification

Sandhagen and Medical Treatment Disputes

- “We conclude the Legislature intended to require employers to conduct utilization review when considering requests for medical treatment, and not to permit employers to use section 4062 to dispute employees’ treatment requests.” (State Compensation Ins. Fund v. WCAB (Sandhagen) (2008) 44 Cal. 4th 230; 79 Cal. Rptr. 3d 171; 73 Cal. Comp. Cas 981) (hereafter, Sandhagen).
- “In light of the comprehensive nature of section 4610 and the goals the Legislature sought to accomplish, we conclude the Legislature intended for the **utilization review process** to be employers’ **only avenue** for resolving an employee’s request for treatment.” (Sandhagen, supra, 73 Cal. Comp. Cas 992.)
- Note Court focus: disputes about **extent and scope of med treatment**

Sandhagen and Medical Treatment Disputes (con't.)

- “We also conclude that section 4062 is *not* available to employers as an alternative avenue for disputing employees’ requests for treatment.” (Sandhagen, supra, at pg. 993.)
- Court recognized that “medical review” is not required to approve treatment but a **physician** must decide to **delay, modify or deny** requested treatment.
- When the employer *approves* treatment as reasonably required, the employer *has engaged in* utilization review. (Sandhagen, supra, at 991.)

Impact on Claim Investigation and the AME/QME Process

- How does this affect investigation period?
 - Must authorize treatment until accept or deny entire claim
- Hazards of simply denying the claim to avoid treatment expenses while investigating
 - UR process faster, cheaper way to get initial medical opinion
- After accept claim, how object to treatment request when question causal relationship to claimed injury?
 - Use Simmons process and LC 4062 objection to PTP determination on causation

Impact on Claim Investigation and the AME/QME Process

- Within one business day after employee files claim form, employer *must authorize* all medical treatment that is consistent with the Medical Treatment Utilization Schedule (MTUS), up to \$ 10,000 *until* the date liability for the claim accepted or rejected (LC 5402(c).)
- If liability is not rejected within 90 days of filing of claim form, claim is presumed compensable and presumption rebuttable only by evidence discovered subsequent to 90-day period (LC 5402(b).)
- Utilization review (UR) addresses “medical necessity to cure and relieve”, consistent with the MTUS (LC 4610(a) and (c).
- UR “does not include determinations of work-relatedness” (8 Cal. Code Regs. § 9792.6(s).)

Impact on Claim Investigation and the AME/QME Process (con't.)

- What if deny claim upon receipt of first RFA for treatment without UR?
 - UR time line runs from receipt of RFA
 - Decide or ask for more info within 5 business days; decide within 14 calendar days
 - AME dance/QME panel for LC 4060 compensability exam takes much longer
 - \$25,000 UR penalty if non-physician (i.e. claims administrator or nurse case manager) denies, delays or modifies treatment (8 CCR 9792.12(a)(7).)

Impact on Claim Investigation and the AME/QME Process (con't.)

- “Thus, by section 4610’s express terms, utilization review is directed solely at determining the ‘medical necessity’ of treatment recommendations. Therefore, section 4610 does *not* authorize a utilization review physician to *determine* whether the employee’s industrial injury caused or contributed to a need for treatment. (*Simmons v State of California, SCIF* (2005) 70 Cal. Comp. Cases 866 (en banc)) (hereafter, *Simmons*)
- “When UR physician finds that requested treatment is medically necessary but questions whether the need for that treatment is causally related to the industrial injury, the *defendant* must either: a) authorize the treatment; or b) timely deny authorization based on causation’ within the deadlines in LC 4610(g)(3)(A) and ‘timely initiate the AME/QME process’ within the time limits under LC 4062(a). If defendant decides to deny authorization for concurrent or prospective treatment based on a question arising in utilization review regarding the treatment’s causal connection to the injury then the defendant must reach this decision to deny within the time deadlines established by section 4610.” (*Simmons*)

Impact on Claim Investigation and the AME/QME Process (con't.)

- Use two step process:
 - UR Physician: Is requested treatment medically necessary?
 - If no, deny request for authorization (RFA) on medical necessity alone;
 - If yes, state medically necessary but add clinical observation and reasoning for questioning causal link – whether need for treatment arises from claimed injury, AND send report to ADJUSTER first
 - Adjuster: Deny RFA *in reliance on attached* UR physician report AND make separate LC 4062 objection to PTP's medical opinion treatment is causally connected to claimed injury
- Must send to requesting physician and IW within UR timelines
- See UR and Causation section of FAQs at:
http://www.dir.ca.gov/dwc/UtilizationReview/UR_FAQ.htm

Accepted Claim- TX for New Body Part

- LC 4060 *does not apply* once *any* part of body is accepted (LC 4060(a).)
- Do UR per Sandhagen
- Use two step process and make LC 4062 objection per Simmons, not on med tx but on PTP causation opinion
- How? LC 4062(a):
 - “ If either the *employee or the employer* objects to a *medical determination* made by the *treating physician* concerning *any medical issues not covered by* Section 4060 or 4061 *and not subject to Section 4610*, the objecting party shall notify the other party in writing of the objection” within 20 days (represented) or 30 days (unrepresented) of the report.

Utilization Review Investigations

Utilization Review Enforcement Regulations

Effective date of penalty regulations

- UR penalty regulations effective June 7, 2007
- First routine investigations conducted in November 2007
- Conduct subject to penalties must occur on or after effective date of regulations

UR Enforcement Regulations, Title 8, CCR:

- **§9792.11** – Investigation procedure
- **§9792.12** – Penalty schedule
- **§9792.13** – Penalty adjustment factors
- **§9792.14** – Liability for penalty assessments
- **§9792.15** – Order to Show Cause, notice of hearing, procedures

Utilization Review Investigations

What type of investigations are there?

- Routine investigations
- Target investigations
 - Return target
 - Special target

Who is subject to UR investigation?

- Utilization Review Organizations (UROs)
 - 79 UROs to be scheduled on a 3 year cycle
- Claims Administrators
 - 432 locations to be scheduled on a 5 year cycle

Basic facts for UR:

- The Utilization Review process is to ensure that decisions are based on the medical necessity to cure and relieve the injury
- Treatment is consistent with current evidence based medical guidelines or other scientific medical evidence
- Authorization is assurance that appropriate reimbursement will be made for the specific course of treatment (certify = authorize)

Request for Authorization (RFA)

- When does UR start?
- What is an RFA?
 - Doctor's First Report of Injury (Form 5021)
 - PTP's Progress Report (PR-2)
 - Narrative report labeled at top of report as an RFA
- New form for RFA is being considered

Request for Authorization (RFA) *(cont'd)*

- Does everything have to go to a reviewing physician or external URO?
- The distinction between prior and pre-authorization
 - The UR plan can have provision for prior authorization
 - Pre-authorization is a response to a prospective RFA

Request for Authorization (RFA) *(cont'd)*

- Only a physician can modify, delay or deny (MDD) an RFA
 - Reviewing physicians must be licensed in any state or the District of Columbia
 - Specific issues in review must be within the reviewer's scope of practice and clinical competence

Request for Authorization (RFA)

(cont'd)

- All decisions must be conveyed in writing
 - Initial decisions, conveyed verbally, must have written confirmation
 - A MDD must have documentation for action taken
- The performance rating for a UR investigation is based upon the timeliness and provision of decisions for RFAs

Mandatory penalties ~ Type “a” violations

- Individual violations with penalties ranging from \$100 to \$50,000 cited for
 - Issues related to filing and content of the UR plan
 - Authority/credentials of decision maker
 - Failure to respond or faulty handling of RFA
 - Lack of compliance with results of UR investigation
- May be subject to mitigation

8CCR§9792.12(a) ~ Mandatory penalties

- (1) Failure to establish a UR plan – \$50,000
- (2) Failure to include elements in plan - \$5,000
- (3) Failure to file plan or letter w/ AD - \$10,000
- (4) Failure to file modified plan within 30 days after material modification - \$5,000
- (5) Failure to have a medical director - \$50,000

8CCR§9792.12(a) ~ Mandatory penalties *(cont'd)*

- (6) Decision out of scope of practice - \$25,000
- (7) Non-physician delays, denies or modifies an RFA - \$25,000
- (8) Lack of written documentation of amended RFA by non-physician reviewer - \$1,000
- (9) Failure to timely respond to an expedited RFA - \$15,000
- (10) Denial of RFA solely because it is not addressed by MTUS/ACOEM - \$5,000

8CCR§9792.12(a) ~ Mandatory penalties (cont'd)

- (11) Failure to discuss care plan with TP for denial of a concurrent RFA - \$10,000
- (12) Failure to respond to a non-expedited concurrent RFA - \$2,000
- (13) Failure to respond to a non-expedited prospective RFA- \$1,000
- (14) Failure to respond to a retrospective RFA - \$500

8CCR§9792.12(a) ~ Mandatory penalties

(cont'd)

- (15) Failure to disclose UR guidelines to the public - \$100
- (16) Failure of URO or CA to provide documentation of compliance in accordance with 8CCR§9792.11(v)(5)
\$500
- (17) Failure to timely comply with any compliance requirement for the Final Report of UR Investigation \$500

Additional Penalties ~ Type “b” violations

- Single incidence penalties based on a pass rate of 85%
- Violations cited with penalty amounts of up to \$100 each
 - Faulty notices
 - Timeliness
 - Communication to appropriate parties
- Possible to stipulate to abate and waive penalties when failing a routine investigation

8CCR§9792.12(b) ~ Additional penalties

- (4)(A) Failure to provide, to all parties, timely notice of need to extend decision date of RFA - \$100
- (4)(B) Failure to document efforts to obtain information from requesting party prior to denial of RFA - \$100
- (4)(C) Failure to make and communicate approval, modification or denial of RFA within 5 days of receipt of needed information -\$100

8CCR§9792.12(b) ~ Additional penalties *(cont'd)*

- (4)(D) Untimely decision for retrospective RFA within 30 of receipt of requested information - \$100
- (4)(E) Incomplete MDD notice for RFA - \$100
- (4)(F) Failure to provide UR criteria/guidelines when requested by patient - \$100

8CCR§9792.12(b) ~ Additional penalties *(cont'd)*

- (5)(A) Failure to timely request additional info for review of a prospective/concurrent RFA -\$50
- (5)(B) Untimely initial communication of approval of prospective/concurrent RFA - \$50
- (5)(C) Untimely communication of MDD decision for prospective/concurrent RFA -\$50
- (5)(D) Untimely notice to all parties of a decision for a retrospective RFA - \$50

8CCR§9792.12(b) ~ Additional penalties *(cont'd)*

- (5)(E) Failure to immediately notify requesting party that decision for RFA cannot be made within the prescribed timeframe - \$50
- (5)(F) Failure to document need/basis for delay in making decision - \$50
- (5)(G) Failure to provide, in writing, the reason for delay in making a decision - \$50

8CCR§9792.12(b) ~ Additional penalties

(cont'd)

- Violations cited with no associated penalty amount of dealing with an RFA without a time extension for decision:
 - Failure to make a timely decision for a prospective/concurrent RFA
 - Failure to provide a timely written notice of decision for prospective/concurrent RFA
 - Failure to provide an initial notice for MDD of a prospective/concurrent RFA

Type “b” penalty increases

- If CA fails return target investigation, the amount of penalty is subject to increase and cannot be waived
 - Times two if 2nd investigation, not to exceed \$100,000
 - Times five if 3rd investigation, not to exceed \$200,000
 - Times ten if 4th investigation, not to exceed \$400,000

Investigation Process

- Notice of UR Investigation
 - §9792.11(j) details information to be provided by the investigation subject which includes but is not limited to
 - List of every RFA received in specified 3 month period
 - Description of hard and software used in transmission and storage of data
 - Submission of copy(ies) of UR plan(s) for review
 - Response required within 14 days

Investigation Process *(cont'd)*

- Sample drawn from list of RFAs for three full month calendar period preceding investigation commencement
- Table from audit regulations (8CCR§10107.1) adopted for statistically valid sample for the randomly selected RFAs
- Sample: All if less than 5, to a maximum of 59 RFAs
- Notice of Investigation Commencement
 - Issued 14 days prior to commencement
 - Provides the random selection of RFAs and any complaints on file with the Medical and/or Audit Unit

Investigation Process *(cont'd)*

- Investigation consists of review of each RFA
 - Findings provided to CA for response
 - Performance rating calculated
 - Analysis of UR plan(s)
- Preliminary Report of Findings
 - Performance Rating for UR Investigation
 - Preliminary Notice of Utilization Review Penalty Assessments
 - Memo - UR Plan Review
 - *may also include*, Plan for Correction of Violations and/or Request for Mitigation

Investigation Process *(cont'd)*

- Post-Investigation Conference will be conducted, if necessary
- Final Report of Investigation
 - Narrative
 - Performance Rating
 - Notice of Penalty Assessments
 - Memo of UR Plan Review
 - *Order to Show Cause and Stipulations*
- Appeal

Investigation Process *(cont'd)*

- Investigation closure
 - Compliance for investigation
 - Compliance for UR plan review
- Investigation results posted on DWC website
 - Performance Rating
 - Summary of Violations

Utilization Review Investigations

Additional information for the Utilization Review Process and associated investigations is available on the DWC website

http://www.dir.ca.gov/dwc/UR_Main.htm

Perspective about the preceding presentations

- the interest/goal of DWC is the best care possible for injured workers
- this purpose has produced a regulatory structure designed to encourage the participants in the system toward that objective

- the system is not static, and its components evolve as result of of legislative and regulatory changes--with the intent of better accomplishing the objectives described

The purpose of utilization review is to assure

- that injured workers receive medical treatment that is medically necessary to cure and relieve a medical condition,
- and that the treatment is consistent with current evidence based medical guidelines or other scientific medical evidence

The purpose of investigations of claims administrators and utilization review organizations is

- to assure that utilization reviews are conducted expeditiously
- to assure that the denial, delay, or modification of a treatment request is medically/scientifically appropriate

- and to assure that there are safeguards of patients' interests, whereby providers, patients, or patients' advocates have means to dispute decisions with which they disagree

Concurrent with the investigation/review of files from a utilization review organization

- there will be a review of the organization's current utilization review plan for compliance with regulations; if needed, recommendations for changes will be made

Prior to the review of tiles

- DW/C team will triage the requests for authorization (RFAs) which have been received (to assure that the requests conform to regulations) to provide a correct random sample

There is a checklist for review of a file which addresses a treatment request

The following are commonly problematic items

- identification of a date stamp or its equivalent to show when a request for treatment was received
- documentation of the time a utilization review decision was made
- documentation of the time contact was made by phone or fax to inform the requesting provider of the initial decision

- documentation of the time a written notice was sent to the requesting provider, the patient, and other required recipients
- evidence that a decision to delay, deny, or modify a treatment request conformed to requirements (including the concise citation of Medical Treatment Utilization Schedule (MTUS) or other scientific medical evidence, and a rationale that is applicable to the request under consideration)

Problematic areas noted in utilization review letters/notifications

- the medical necessity of a treatment request is not addressed

- statements are made that do not reflect the intent of the regulation, which states, “‘Authorization’ means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment...” 8 CCR §9792.6(a)
- an example of inconsistent language: “This pre-certification is for medical necessity only and is not a guarantee of payment. Authorization for payment must be obtained from the insurance adjuster...”

Following completion of the initial review

- there may be a second, independent, review of a case where deficiencies have been found
- requests may be made for additional information about cases which appear to have deficiencies, or where multiple requests (in an RFA) appear not to have been addressed

Some problematic areas in utilization review which are not addressed by DWC regulations

- voluminous material is included in letters and notices which is not relevant to the treatment request at hand
- contact between a reviewer and a provider during the course of a review. (It is required is that there be a mechanism for a provider to make telephone contact with a reviewer following a review to discuss the review.)

- authorization of tests and treatments which may not be well supported by guidelines
- the internal appeal process of a utilization review organization