

# **Navigating the Utilization Review and Case Management Process: *How to Function Efficiently and Effectively***

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# The Functions of a Concentra Physician Review (CPR) Advisor

*CPR Advisors perform the following services:*

- Utilization Review/Medical Necessary Review
- Peer Reviews

*The following indemnity benefit reviews are performed:*

- Workers' Compensation
- Short Term Disability
- Long Term Disability
- General Liability
- Group Health
- Pharmacy Benefit Management Drug Utilization Review

# CPR Process and Function

## The Basics

- The insurance company, third party administrator (TPA), attorney or case manager sends the review request to the Utilization Review Department
- If the requested service does not meet the screening criteria for automatic approval, using specified medical necessity practice guidelines criteria, the request is referred to CPR.
- ***Note: Review nurses cannot issue a denial of care determination.***
- Intake coordinator assigns the case to a reviewer based on case jurisdiction, the reviewer's scope of practice, training, state licensure and availability.
- The Advisor downloads the case from the Advancer website.
- After reviewing the submitted clinical information, applying the appropriate evidence-based practice guidelines, the Advisor will decide to certify, modify or non-certify the request and complete the review.
- If additional information is needed, 2 attempts at telephonic communication should be made to contact the requestor. An expedited case (1 day turn-around) requires only 1 call/attempt.
- The Advisor will review, document and complete the case (including completion of the template information and spell-checking) within the required completion date and time.
- The intake coordinator monitors the turn-around- time, receives the completed determination and performs a final quality check before returning the case to our customer.
- The UR nurse (case owner) then prepares and sends the denial or authorization letter to the appropriate individuals

# Utilization Review Definition (CA DWC)

- "Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. Utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed.

# The CPR Definition of Medical Necessity

*A health care service will be considered medically necessary if it is:*

- *safe and effective*
- *not experimental or investigational*
- *appropriate, including the duration and frequency considered appropriate for the service as to whether it is:*
  - furnished in accordance with accepted medical practice for the diagnosis and/or treatment of the patient's condition or to improve the function of an injured body part
  - furnished in a setting appropriate for the patient's medical needs and condition;
  - ordered and/or furnished by a qualified person
  - one that meets but does not exceed the patient's medical needs; and
  - at least as beneficial as an existing and available medically appropriate alternative

# **CA Guidelines for Private Health Plans Cal. Wel. & Inst. Code § 14059.5 (2001)**

“Medically necessary” / “medical necessity”:  
A service is “medically necessary” or a  
“medical necessity” when it is reasonable and  
necessary to protect life, to prevent significant  
illness or significant disability, or to alleviate  
severe pain.

# State Fund (California)

**“Medical Necessity** *The following themes describe what is considered ‘medically necessary’, ‘reasonable and necessary,’ or ‘medically appropriate’.*

The procedure, test, or service:

- *Is necessary to cure or relieve the effects of the injury*
- *Is safe and effective*
- *Is consistent with the recipient’s symptoms, diagnoses, condition, or injury*
- *Is likely to provide a clinically meaningful benefit*
- *Is likely to produce the intended health result*
- *Is likely more effective than more conservative or less costly services*
- *Is provided not only as a convenience to the patient or the provider*
- *Represents a benefit that outweighs any risk*
- *Is reasonably expected to diagnose, correct, cure, alleviate or prevent worsening of illnesses or injuries, and*
- *Enables a patient to make reasonable progress in treatment*
- *Meets the prevailing standard for medical care, as outlined in the ACOEM or other accepted evidenced-based guidelines [unless the treating physician has presented reasonable information to explain why the particular patient does need atypical, unexpected treatment] “*

# CA LAB Section 4600

“Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment. “

## **DWC CA § 9785. Reporting Duties of the Primary Treating Physician.**

“(4) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall, unless good cause is shown, within 20 days of receipt of each report incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator. “

# Conflict of Interest Policy and Concepts

- CPR and all of its reviewers will be free from any conflict of interest that might unduly influence the outcome of the review process.
- All CPR advisors have signed a letter attesting that the Conflict of Interest policies have been read and understood, confirming that they will contact the operations department immediately and decline the case if there is a conflict of interest.

Definition: Having a material professional, familial, or financial conflict of interest regarding any of the following:

- The referring entity;
- The health benefit plan;
- The consumer;
- The attending provider or any other CPR Advisor previously involved in the case;
- The facility at which the recommended healthcare service(s) would be provided, or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the consumer;
- Accepts compensation for independent review activities that are dependent in any way on the specific outcome of the case; or
- Has a personal and/or professional involvement with the case prior to its referral for independent review.
- If a CPR Advisor determines that a conflict of interest exists, he/she will contact a CPR staff member immediately to decline the case. The case will be reassigned

# Workers' Compensation Reviews

**Definition: *A program that provides replacement income and medical expenses to employees who are injured or become ill due to their jobs. Financial benefits may also extend to workers' dependents and to the survivors of workers who are killed on the job. In most circumstances, workers' compensation pays relatively modest amounts and prevents the worker or dependents from suing the employer for the injuries or death***

- The only universal health care insurance coverage in the United States
- Many states (CA, TX, IL, MA, etc) have enacted reform legislation designed to rein in excess costs and have identified mandated practice guidelines against which requested services are judged for medical necessity

# State Fund (California)

## Mission Statement

The State Fund's Utilization Review (UR) Program is founded on the principle that appropriate medical care for a work-related injury or illness improves medical outcomes while containing costs. Quality medical care for injured employees is enhanced through education and timely communication between State Fund and the medical provider. The Utilization Review Program ensures that medical care is consistent with evidence-based practice and meets current peer-reviewed medical standards and guidelines.

## Objectives

- 1. Reduce medical costs by eliminating unnecessary, inappropriate treatment.*
- 2. Deliver timely responses to physician requests for treatment.*
- 3. Reduce temporary disability costs by promoting Return to Work and use of transitional duty for the injured employee.*
- 4. Improve communication between the medical community and State Fund.*

# Zenith (CA, TX, etc)

- It should be no mystery why healthcare costs are soaring. The people who receive treatment rarely see the bills, so they may never know if their providers charge reasonable fees for medically appropriate services. Left unchecked, healthcare is a runaway cost. That's why Zenith takes a vigilant stand against abuse and fraud.
- Overuse of medical services and prescribing treatments that are medically unnecessary.
- Increased use of outpatient surgery centers (where fees are unregulated).
- Use of brand-name prescription medications instead of generics.
- Over-billing for medical services, including inflated or fraudulent bills from healthcare providers.
- Injured worker's lawyer teams up with medical providers to exaggerate the worker's disability from the injury.

# Workers' Compensation Reviews

- These state reforms have utilized a matrix of evidence-based practice guidelines
- There are also a variety of requirements and penalties associated with performing medical necessity reviews
- The Utilization Review Accreditation Commission (URAC) has provided a standardized process for analyzing, standardizing and certifying review organizations
- State and Federal regulations also provide standardized requirements
- Managed care has come to the world of workers' compensation insurance!

# Physician Pharmacotherapeutic Review

- Developed to respond to the increasing overutilization of controlled substances and off label prescribing
- Limited to reviewers who have the ability to prescribe and have experience with the clinical issues (e.g. pain management, addiction, behavioral conditions, etc.)
- In addition to evidence based practice guidelines, the use of Food and Drug Administration medication determinations, state medical board guidelines for pain management and pharmacotherapeutics, and other nationally recognized mandates are used in determining medical necessity

# Philosophy and Expectations

## Part 1

- Multilateral professional behavior, language and demeanor.
- Careful review of all relevant clinical information submitted with the request.
- Nationally recognized, evidence-based, peer-reviewed practice guidelines used, state-mandated where applicable.
- Conflicts of interest must be recognized and avoided.
- Objective, consistent analysis is essential in making medical necessity reviews; these requests are for healthcare services – not for patient convenience or anecdotal provider preference
- Reports should be CLEAR, CONCISE, UNDERSTANDABLE and TO THE POINT
- You are NOT a mind reader-DO NOT ATTEMPT TO READ THE REQUESTOR'S MIND; if in doubt give the requestor the opportunity to answer your questions and, if appropriate, permit that the requestor to supply the nationally recognized, evidence-based peer-reviewed literature-source medical effectiveness guidelines to support the request

# Philosophy and Expectations

## Part 2

- We expect the Advisor to analyze the requested services in order to ensure the right healthcare service(s) for the right patient and the right time
- All reviewers undergo InterRater Reliability Testing before starting reviews for CPR and will be expected to undergo annual retesting
- All reviewers will be expected to participate in at least one Quarterly Advisor Educational meeting per year. More frequent participation is desirable and recommended.
- Reviewers are encouraged to use an educational mode when discussing medical necessity issues with requesting providers
- When in doubt, ASK!!!

# Medical Necessity Criteria

- Use appropriate/mandated nationally recognized evidence-based peer reviewed practice guidelines
- All criteria listed must be completely cited with complete source (e.g. on line version), page (if paper edition used), section, etc
- Make sure you are using the most current edition
- Be aware of any copyright restrictions
- Provide the reference if you use the reference
- Do not cite articles with bias
- Do not cite newspapers, trade journals, biased web sites, or previously discredited sources

# Quarterly Advisor Educational Meetings

- CPR hosts quarterly educational meetings telephonically.
- Agenda and supporting information is distributed prior to the meetings
- Continuing Medical Education credits are available.
- Post meeting feedback is valued and solicited in order to assess the meeting and plan for future meetings
- All Advisors are required to attend at least one meeting per year.
- Topics for discussion are always welcome and considered.

# State Mandated Guidelines

- State mandated guidelines take precedence over any other guidelines/criteria and must be cited as the initial or primary practice guideline in the Criteria used section of the Advancer determination document
- These mandated guidelines are **PRESUMED TO BE CORRECT** by the state legislature
- Examples:
  - CA: ACOEM, MTUS Guidelines (primarily acupuncture)
  - MA, CO, KY: state developed guidelines
  - TX, OH, HI, ND: ODG

# California

- The American College of Occupational and Environmental Medicine (ACOEM) Guidelines second edition is **presumed to be correct** (by the CA legislature) and **MUST BE CITED IN EVERY CASE**.
- You must document specifically what section of the ACOEM guidelines applies [must list the Chapter number].
- If the issues you are reviewing fall outside of the ACOEM guidelines, you must still cite that you reviewed the ACOEM guidelines and document that they do not apply. It will suffice to document that ACOEM Guidelines are silent on this issue. Please cite the Chapter reviewed.
- If the case involves issues that involve chronic illness, injury or chronic pain, please review Chapter 5-6 of the ACOEM guidelines.
- You may then also cite a second guideline source ( e.g. ODG) if appropriate
- Acupuncture requests require the additional Acupuncture guidelines (MTUS) be applied

# Texas

- All reviewers must be licensed in Texas (as of 09/01/07)
- Texas has mandated the use of ODG (as of June 2007)
- Treatment modifications can be applied to the requested service(s)
- Concurrent reviews
- Discuss and document rationale for portion approved
- Discuss and document rationale for portion not approved
- You must offer the requesting provider an opportunity in a peer to peer setting, to discuss the reason for non-certifying the requested service(s)
- Document the clinical evidence supplied and the practice guidelines used for review

# Contacting the Requesting Provider

- Certified reviews do not necessarily require a phone call
- If you have **ANY** question about the medical necessity and effectiveness of the requested service, **make the attempt to contact the requesting provider in order to clarify your question(s)**
- Call between 8am-5 pm in the requestor's time zone
- Make every attempt to make the contact call on the day that you receive the case
  - - First phone call within first business day
- Expedited case ( 24 hour turnaround)
  - - Only one call is required [first day of receipt is day zero and next is first business day
- Goal is requestor contact unless approval is appropriate and adequate relevant clinical information has been reviewed.
- Document , in the Rationale section of Advancer, the contact attempts (date and time in your time zone), name and title of person with whom you have spoken

# Disclaimers and Appeals Rights Documentation

- Disclaimer 1: Concentra reviews an episode of care for medical necessity and efficiency. Talking to Concentra does not assure payment. There are many reasons why benefits may not be paid on any given claim. If you have questions about benefits, please call your (the) insurance company.
- Disclaimer 2: The medical management of the case always rests with the private physician. Concentra is only making recommendations with regard to the medical necessity and efficiency of care.
- Discuss the appeal process and document using the template checkbox

# Decision Making Process

- If review question is outside your scope of practice – please return the case AS SOON AS POSSIBLE for reassignment.
- Answer ONLY the question(s) submitted **DO NOT MAKE UP A NEW REQUEST! Only the adjuster can do that.**
- If the submitted information is inadequate, explain what information is needed and why
- Document any discrepancies encountered in the clinical information, etc submitted for the request
- Quote from the submitted records to provide the basis for your determination.
- If applicable, document source and date of quotes, specific clinical exam findings and diagnoses, co-morbidities that are relevant to injury and results of diagnostic tests and treatment]
- Verify essential facts of case before approving [for example, have radiologist interpretation of diagnostic imaging studies faxed if not available in medical records provided if surgery is being considered]
- Document if medical records are illegible or difficult to read

# IMPORTANT ELEMENTS

- Review ALL relevant clinical records submitted.
- Document that you have read any peer reviews, independent medical exams, AME or designated doctor exams sent with the review as well.
- Document discrepancies encountered in the clinical information reviewed.
- Diagnostic imaging should be interpreted by a radiologist at a minimum and should be considered as the most accurate interpretation.
- Document the summary of the number of pages reviewed.

# Professional Conduct

- Please identify yourself to the provider and/or staff and remember to keep all conversations polite and professional.
- If you encounter unpleasantness during a phone call you should disclose your lack of comfort and offer to continue the conversation at a later time when the other individual can communicate appropriately and terminate the conversation. *YOU DO NOT HAVE TO BE ABUSED.*
- Documentation of unusual calls is advised.
- Tape recorded calls are permitted in Texas (but are not admissible as evidence unless you agree to be taped).
- Complaints will be handled by the CPR Quality of Service review process.
- Errors and Omissions insurance is required.

# Confidentiality/HIPPA

- Remember that patient/employee confidentiality and privacy is of critical importance in healthcare.
- Please be aware of sensitive to and compliant with all applicable HIPAA and privacy issues.
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- Please visit the following web site for more information <http://www.hhs.gov/ocr/hipaa>
- Concentra policy and website

# Release of Medical Information Records

- A release of information agreement is implicit in any insurance coverage situation. If a requestor raises the issue requiring you to provide the release of information document, please notify the intake coordinator that the adjustor needs to resolve the issue with the requestor.
- Document in your determination if the provider will not discuss the case and document.
- Document any conversations that you have with the provider about privacy concerns.

# Fax and Phone Issues

- Your fax device must be in a secure location that prevents unauthorized access to case files and information.
- Phone conversations:
- Use local land line or cellular phone that cannot be easily overheard.
- Do not speak where others can overhear your conversation.

# Continuous Quality Improvement

QA indicators, tracking, trending, monitoring results

- Completion Date and Time Compliance
- Assignment to appropriate specialist
- Spelling and grammatical errors
- Both Disclaimers and Appeal Process explained and documented
- Two phone calls to provider on two separate days [if applicable]
- Appropriate determination made
- All questions answered
- Rationale complete
- Rationale based on clinical facts of the individual case
- Specific evidence based criteria, guidelines or peer reviewed literature sources cited on each case
- Complaints from clients, requesting providers, etc

# Hints and tips

- *Purchase, train and use a voice-recognition dictation software*
- *Develop templates for commonly used statements*
- *Make sure to regularly check guidelines if you place them in a template library. ODG is updated monthly and guideline recommendations will occasionally changed Do NOT assume that your template is accurate and defensible unless you are regularly updating it*
- *Type/dictate in a word processor and copy and paste into Advancer*
- *Being kept on hold by provider (Maximal on hold time is 5 minutes)*
- *In the event you are provided with erroneous contact numbers and/or accessibility information, you must notify the intake coordinator as soon as possible*

# Key Elements

- *LEGIBILITY*
- *Start with the History and Physical*
- *Accurate information: read your dictations; correct errors (gender, age, site of injury, etc)*
- *Submit relevant clinical information when requesting a service*
- *Use evidence-based support for your request*
- *Take advantage of peer to peer opportunities (they are not mandatory in CA)*
- *Avoid hostile confrontation with the reviewer*
- *Resolve discrepancies in your data (Radiologist and diagnostic studies reports)*