Utilization Review in the California Workers' Compensation System

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Definition of Utilization Review

''Utilization review'' means "utilization review or 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 and relieve, treatment recommendations by physicians, prior to, retrospectively, or concurrent with the provision of medical treatment services." [LC 4610(a)]

It has also been defined as "a system used to manage costs and improve patient care and decision making through case by case assessments of the frequency, duration, level, and appropriateness of medical care and services to determine whether medical treatment is or was reasonably required to cure or relieve the effects of the injury." [Title 8, California Code of Regulations, Rules of the Administrative Director §9792.6]

Utilization review concerns the determination of reasonable medical necessity and has nothing to do with the reasonable monetary value of medical treatment which is governed by the Official Medical Fee Schedule.

Model Utilization Protocols per LC §139(a)(8)

As part of the 1993 reform package, Labor Code §139(a)(8) was amended to require the Administrative Director to adopt Model Utilization Protocols in order to provide uniform standards with which all insurers were to comply. The review process involved written requests for authorization of medical treatment services before the treatment was rendered, as well as requests for payment of bills for services that had already been performed.

Only "medically based criteria" were to be used in the utilization review and decision-making process. The criteria used in the decision-making process were to be based on professionally-recognized standards; using sound clinical principles and processes; developed by physicians, with the involvement of actively practicing health care providers, and be peer-reviewed. Only a licensed physician was given the power to deny authorization or to deny or reduce payment of a bill on the basis that the services were unnecessary.

Adjudication of disputes over reasonable medical necessity arising out of application of the Model Utilization Protocols encountered significant evidentiary problems at the WCAB. If authorization was denied by the insurance company's utilization review doctor, the applicant's attorney would promptly request an expedited hearing and offer into the record a report written by the treating physician whose request for authorization had been denied. When the defendant tried to counter with the utilization review doctor's opinion, the report couldn't be taken into evidence because the doctor hadn't examined the applicant and the report was obtained prior to

the expiration of the time period given to the parties to select an Agreed Medical Examiner. [Labor Code §§5703; 4062; *Czarnecki v. Golden Eagle Insurance Company* (1998) 63 CCC 742, Appeals Board significant panel decision.] Thus, the only way the defendant could obtain evidence to support the decision to deny authorization was to immediately have the UR doctor examine the applicant which defeated the purpose of utilization review in the first place.

IMC Treatment Guidelines

In 1995 and 1997, the Industrial Medical Council issued guidelines for the treatment of various types of disabilities, including injuries involving the low back, neck, occupational asthma, contact dermatitis, post-traumatic stress disorder, shoulders, knees, elbows, and hands and wrists. These guidelines can be found in Title 8, California Code of Regulations §§70 et seq. However, they were never widely used as utilization review standards.

Medical Treatment Utilization Schedule and the ACOEM Guidelines

Senate Bill 228 which went into effect on January 1, 2004, introduced the concept of evidence-based medicine as the standard for utilization review. As the first step in the implementation process, Labor Code §77.5 authorizes the Committee on Health and Safety and Workers' Compensation (CHSWC) to conduct a survey and evaluation of evidence-based, peer-reviewed, nationally recognized standards of care and to complete its investigation by July 1, 2004. The survey will focus on existing medical treatment utilization standards, including independent medical review, as they are used in other states, at the national level, and in other medical benefit systems. The Commission will then have until October 1, 2004 to issue a report of its findings and recommendations to the Administrative Director to be used for the purpose of devising and adopting a medical treatment utilization schedule.

Thereafter, per Labor Code §5307.27, the Administrative Director must, on or before December 1, 2004, consult with the Commission, conduct public hearings, and adopt a Medical Treatment Utilization Schedule that incorporates the "evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission." The new schedule must address "...at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases.

Prior to the promulgation of a permanent Medical Treatment Utilization Schedule, the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines, Second Edition (ACOEM Guidelines) are to be used as the standard for utilization review. The ACOEM Guidelines are a temporary measure. However, CHSWC may, if finds it to be appropriate, recommend to the Administrative Director that the ACOEM Guidelines, or portions thereof, be incorporated into the permanent schedule.

Senate Bill 899 amended the statutes governing the medical treatment utilization Schedule and the ACOEM Guidelines by inserting some additional explanatory language. Labor Code § 4600 was amended to provide that the phrase, *"medical treatment that is reasonably required to cure or relieve ... from the effects of [the] injury"* is defined as *"treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27 or, prior to the adoption of those guidelines, the updated ACOEM Guidelines."* Language was also added to Labor Code §4604.5 concerning the presumption of correctness given to the medical treatment

utilization schedule and the ACOEM Guidelines.

Labor Code 4604.5

1. Presumption of Correctness

Upon adoption by the administrative director of the Medical Treatment Utilization Schedule, the recommended guidelines set forth in the schedule shall be presumptively correct on the issue of extent and scope of medical treatment, regardless of the date of injury. In the interim, the second edition of the ACOEM Guidelines will be entitled to that same presumption beginning three months after the publication date of the current edition and continuing until the effective date of the Medical Treatment Utilization Schedule. This is a rebuttable presumption, affecting the burden of proof, which can be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury. Additionally, both the permanent and interim guidelines may be taken into evidence either at or subsequent to a hearing, and used as proof of any fact in dispute. [Labor Code §5307]

Declaring the guidelines themselves to be evidence and giving them a presumption of correctness solves the problem that was faced in connection with the prior utilization review regulations. It doesn't matter if the utilization review doctor examined the injured worker or whether the doctor's opinion is inadmissible because it is the guidelines on which the doctor based the opinion and not the opinion itself that constitutes admissible evidence.

The presumption of correctness of the ACOEM Guidelines went into effect on March 22, 2004, three months after the current edition was published in December 2003. Since the Governor signed SB 228 into law on September 30, 2004, at the time §4604.5 was enacted, the current edition of the Guidelines had not yet been published.

It is unclear what degree of proof would be necessary to rebut the presumption. Per the statute, it must be established that a *variance* from the guidelines is *reasonably required to cure or relieve*; yet the legal definition of *reasonably required to cure or relieve* is treatment *based* on the guidelines. This is somewhat circular and the proper interpretation may have to await guidance from the Appeals Board and the appellate courts.

2. Injuries not covered by the Utilization Schedule or the ACOEM Guidelines

Section 4604.5 also provides that for all injuries not covered by the ACOEM Guidelines or the Medical Treatment Utilization Schedule after it has been adopted, authorized treatment shall be in accordance with other evidence based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based.

As of yet, no specific "other guidelines" have been identified and there is no reference to other guidelines in the proposed utilization review guidelines which had not yet been adopted at the time of the publication of this update. However, there is agency called the National Guideline Clearinghouse (NGC) which describes itself as "a public resource for evidence-based clinical practice guidelines." NGC is sponsored by the Agency for Healthcare Research and Quality

(AHRQ), U.S. Department of Health and Human Services, in partnership with the American Medical Association and the American Association of Health Plans-Health Insurance Association of America. NGC's web site can be found at <http://www.guidelines.gov/>.

Labor Code §4610

1. Responsibilities of the Employer or Insurer

Every employer is required to establish a utilization review process either directly or through its insurer or by way of a contractual agreement. The utilization review process must be governed by written policies and procedures to ensure that decisions based on medical necessity are consistent with the Medical Treatment Utilization Schedule. Prior to adoption of the schedule, they must be consistent with the recommended standards set forth in the ACOEM Guidelines. These policies and procedures, and a description of the utilization process, must be filed with the administrative director and disclosed by the employer to employees, physicians, and the public upon request.

In requesting medical information from a physician, the employer can only request the information reasonably necessary to make the determination. The employer or insurer must employ or designate a medical director who holds an unrestricted license to practice medicine in this state as an M.D. or a D.O. Only a licensed physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity, and that physician must be competent to evaluate the specific clinical issues involved in the medical treatment services where the services are within the scope of the physician's practice.

2. Criteria for the utilization review process

The criteria or guidelines used in the utilization review process must be characterized by all of the following:

- Developed with involvement from actively practicing physicians.
- Consistent with the Medical Treatment Utilization Schedule and prior to that, the ACOEM Guidelines.
- Evaluated at least annually, and updated if necessary.
- Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.
- Available to the public upon request.

However, an employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means.

3. Timeframes for Employer or Insurer Action

In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees, all of the following requirements must be met:

- Prospective decisions must be made within five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.
- Retrospective decisions shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.
- In emergency situations, the decision must be made within 72 hours after the receipt of the information reasonably necessary to make the determination.
- Decisions to approve, modify, delay, or deny prior or concurrent requests for authorization must be communicated to the requesting physician within 24 hours of the decision.
- Decisions resulting in modification, delay, or denial of all or part of the request require oral notice within 72 hours, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as If the request is not approved in full, disputes shall be resolved in accordance with Section 4062.
- In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee.

4. Civil Penalties

If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

Practical Application of the ACOEM Guidelines

1. The ACOEM Guidelines Are Recommendations, Not Mandates

The ACOEM Guidelines were originally developed by occupational medicine physicians as a practice guide for the treatment of common industrial injuries. They were not originally intended as standards for utilization review. In the context of workers' compensation, they are to be applied as guidelines, not mandates.

In a letter dated March 22, 2004, to the Honorable Richard Alarcon, Senator and author of Senate Bill 288, Barry S. Eisenberg, Executive Director of the American College of Occupational and Environmental Medicine stated the following:

"We have emphasized two key points:

- Our guidelines are recommendations, and are not intended as mandates; and
- Most cost savings will come from workers getting the care that is most likely to help them, as close as possible in time to their first need for that care, versus applying the guidelines as mandates."

Lee S. Glass, M.D., J.D., Editor of the ACOEM Guidelines has described the treatise as, "Guidelines, providing guidance, not mandates."

2. Acute and Subacute Conditions versus Chronic Conditions

The focus of the ACOEM Guidelines is on treatment during the first three to six months following the injury. It is therefore unclear how the Guidelines are to be applied once the acute phase has passed. Although the Guidelines do contain a chapter devoted to chronic pain, its application to long-term treatment is a subject of controversy. The argument has been made that chronic injuries are not covered at all under the Guidelines and since a requested procedure can only be modified or denied based upon a specific guideline, a request for authorization of treatment for an injury that has become chronic cannot be denied or modified.

3. Medical Conditions Not Covered by the ACOEM Guidelines

The ACOEM Guidelines contain chapters devoted to the neck and upper back, the shoulder, the elbow, the forearm, wrist and hand, the low back, the knee, the ankle and foot, stress and eye injuries. They make no mention of internal injuries and post-surgical treatment is missing in many areas. How are medical utilization issues to be determined for conditions that are not included in the Guidelines? This is probably where *other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based* [Labor Code §4604.5] will come into use.