

DWC Educational Conference

(I) UR-IMR, Fee Schedule/RBRVS

(II) IBR, QME Changes

February 28-March 1, 2013, Los Angeles
March 4-5, 2013, Oakland

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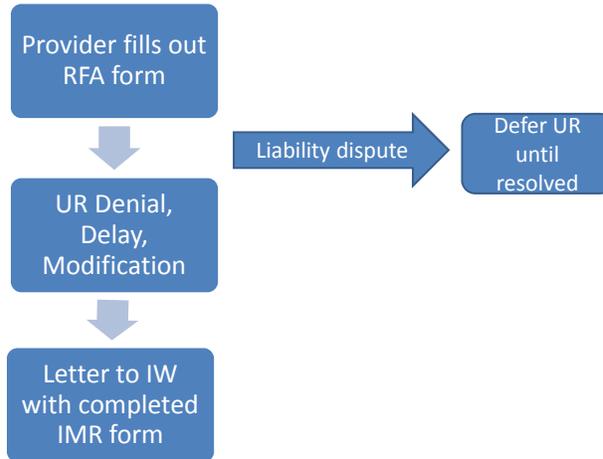
Changes to UR Regulations

Effective January 1, 2013 for all dates of injuries

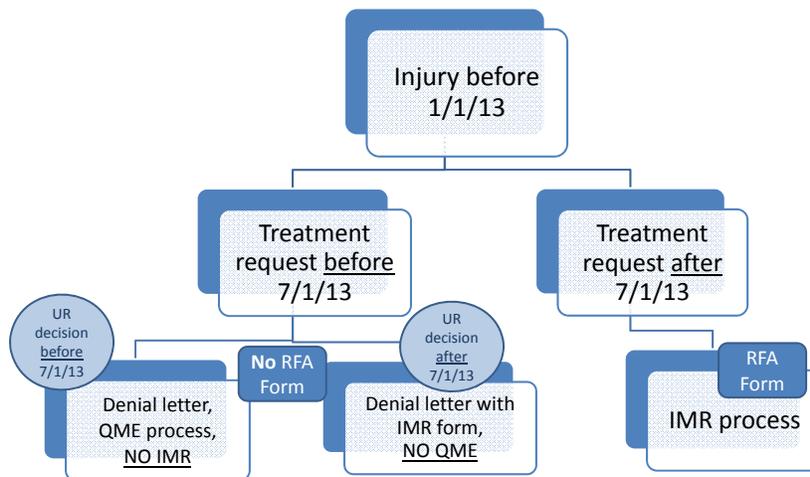
Labor Code section 4610

- UR may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity
- A UR decision to deny, delay, or modify (DDM) a request for authorization of medical treatment will be effective for 12 months from the date of the decision
 - No action needed on a request for the same treatment unless there is a documented change in material facts

UR Decisions for Injuries After 1/1/13



UR Decisions For Injuries Before 1/1/13



Changes to UR Regulations

For dates of injury after 1/1/13, and for all injuries where request for treatment is made after 7/1/13

- An explanation of benefits can serve as notification of a retrospective UR approval
- A request for authorization must be made by a treating physician on the “Request for Authorization for Medical Treatment” form, DWC Form RFA
 - (8 C.C.R. § 9785.5)
 - The form must be accompanied by documentation supporting the request
 - (i.e., Form 5021, Form PR-2, narrative report)



§ 9785.5. Request for Authorization
 State of California
 Division of Workers' Compensation
 Request for Authorization for Medical Treatment (DWC Form RFA)

To accompany the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or narrative report substantiating the requested treatment.

Check box if the patient faces an imminent and serious threat to his or her health.
 Check box if request is written confirmation of a prior oral request.

Patient Information		Provider Information	
Patient Name:		Provider Name:	
Date of Birth:		Practice Name:	
Date of Injury:		Address:	
Employer:		City, State, Zip Code:	
Claim Number:		Telephone Number:	
		Fax Number:	

Claim Administrator Information	
Claim Administrator:	
Address Name (if known):	
Address:	
City, State, Zip:	
Telephone Number:	
Fax Number:	

Requested Treatment: (See Instructions for guidance; attach additional pages if more space is required.)
 Either state the requested treatment in the below space or indicate the specific page number(s) of the accompanying medical report on which the requested treatment can be found. Include supporting evidence as necessary. More than one treatment request may be included.

Diagnosis:	
ICD Code:	
Procedure Requested:	
CPT/HCPCS Code:	
Other Information: (Frequency, Duration, Quantity, Facility, etc.)	

Date of Request: _____ Provider Signature: _____

Claim Administrator Response Approving Treatment:
 You may use this form for approving a treatment request. A request for additional information, or a decision to modify, delay, or deny a request for authorization cannot be made using this form. Please review all timeframes and requirements set forth in California Labor Code sections 4610 and California Code of Regulations, title 8, sections 9792.9 and 9792.9.1.

A decision on the requested medical treatment must be made within five (5) working days from receipt of this request for authorization, or 14 calendar days with a timely request for information necessary to render a decision. For an expedited request, one made in a case of imminent or serious health threat, the maximum is 72 hours. Authorizations may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information.

The requested treatment(s) is approved The request has been previously denied by utilization review

Date request for authorization received: _____ Claim Administrator/Authorized Agent Signature: _____
 Date of response to request: _____ Adjective/Authorized Agent Name (print): _____

DWC Form RFA (Version 12/2012) 1

UR: Claims Administrator Responsibilities

- Fax, email, phone access for requests
- Timely treatment decisions after RFA receipt:
 - 72 hours, expedited requests
 - 5 business days or 14 calendar days, regular requests
- Clear written explanations for decisions to:
 - Dispute liability
 - Deny, delay, modify treatment request

Changes to UR Regulations

For dates of injury after 1/1/13, and for all injuries where request for treatment is made after 7/1/13

- A written delay, denial, or modification of a treatment request must be accompanied by a postage-paid “Application for Independent Medical Review,” DWC Form IMR-1, with all fields, except for the signature of the employee, to be completed by the claims administrator
- Appeals of UR decisions for medical necessity must be made by independent medical review

Form IMR-1

State of California
Department of Industrial Relations
Division of Workers' Compensation
Application for Independent Medical Review
(All fields must be completed by the Claim Administrator)

Type of Review
 Expedited
 Regular

Claim Number (Required) Case of Injury (Required) Date of Onset (Required) Workers' Compensation Claim Number (Required) DWC File (if applicable)

Injured worker information (Completion of this section is required)

Injured Worker First Name _____ Injured Worker Last Name _____

Injured Worker Street Address/PO Box _____ Injured Worker City _____ State _____ Zip Code _____

Medical provider information (Completion of this section is required)

Medical Provider Name _____ License Number _____

Employer and Claim Administrator Information (Completion of this section is required)

Employer Name (Please have look upon Section numbers, names or initials) _____

Medical Administration Company Name (Please have look upon Section numbers, names or initials) _____

Medical Provider Name _____

Medical Administration Street Address/PO Box (Please have look upon Section numbers, names or initials) _____

Medical Administration City _____ State _____ Zip Code _____

Primary Diagnosis (See ICD Code where practical) _____ Contact the treatment (treatment, attach additional pages if necessary)

Is the claim administrator standing liable for the requested medical treatment besides the question of medical necessity?
 Yes No. If no, indicate why liability is being disputed _____

Consent to obtain medical records
 I am willing for an independent medical review (IMR) to make a decision about the requested medical treatment that was delayed, denied, or modified by my claims administrator. I allow my health care provider and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic, imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I give the independent review organization designated by the Administrative Director of the Division of Workers' Compensation (ICR) review these records and information used by my claims administrator and treating providers. My permission will end on the date below, except as otherwise stated. I can end my permission sooner if I wish.
 Date _____
 Signature _____
 (Signature of Injured Worker)

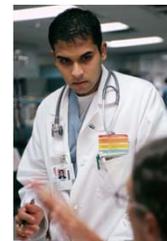
File this Application by mail by sending the form to: DWC/IME, c/o MARQUESS Federal Center, 625 Cordage Drive, Suite 100, Folsom, CA 95630
 The help also file the form by faxing the document to: Fax (916) 264-6124
 DWC form IMR-1 (1/2013)

http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRForm_Application.pdf

Independent Medical Review

Labor Code Section 4610.5-4610.6

- Medical expertise to resolve medical disagreements
- Decision from IMR binding on parties
 - IMR decision may be appealed
 - Medical expertise may not be “second-guessed”
- DWC will administer program
- Costs will be borne by the employer/carrier/adjuster
 - Varies by number and type of reviewer
 - Costs decrease in 2014



IMR Goals

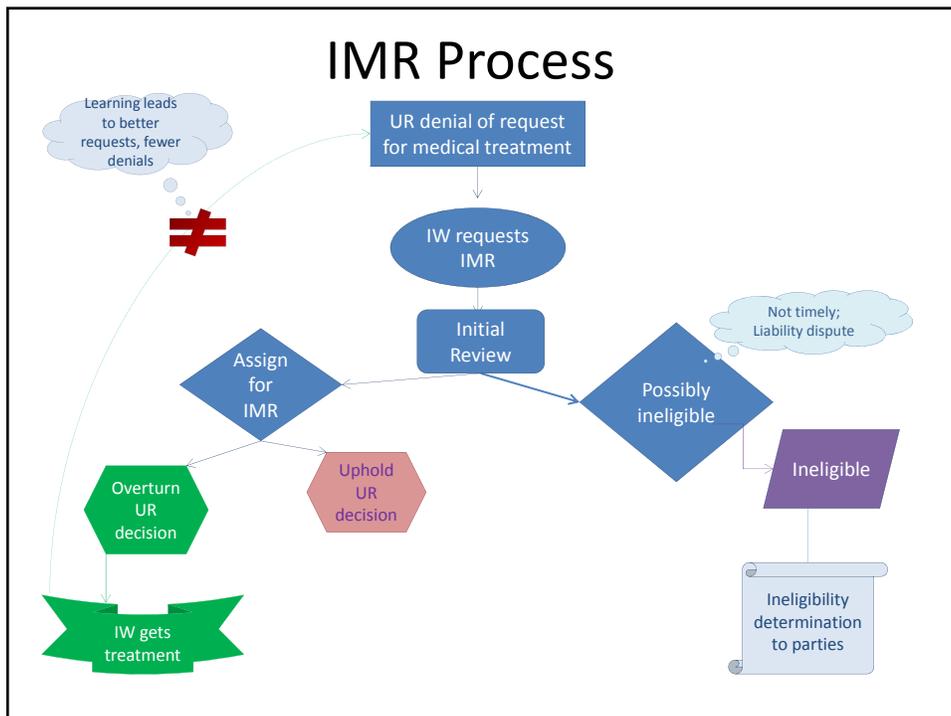
- Provide timely, medically appropriate treatment to injured workers
- Reduce inappropriate UR denials
- Enhance medically appropriate treatment and diagnostic test requests
- Reduce costs to system from treatment delays, prolonged disability

IMR Organization

- Designee of the DWC Administrative Director
- DWC has contracted with a single organization (Maximus) until 12/31/2014
- Maximus has rigorous standards for conflict of interest, qualifications of reviewers
- IMRO contracts with medical professionals
 - Manages qualifications, conflicts of interest
 - Names of reviewers are confidential in communications outside organization

IMR Process

- UR decision final unless IW requests IMR
 - Includes denial of spinal surgery
- IMR request must be initiated by IW/designee
 - 30 days from UR decision receipt
- IMR may be terminated at any time if employer approves treatment
 - Internal review of UR decision may occur concurrently with IMR and must be completed in 15 days
 - IW may not be asked to delay IMR request



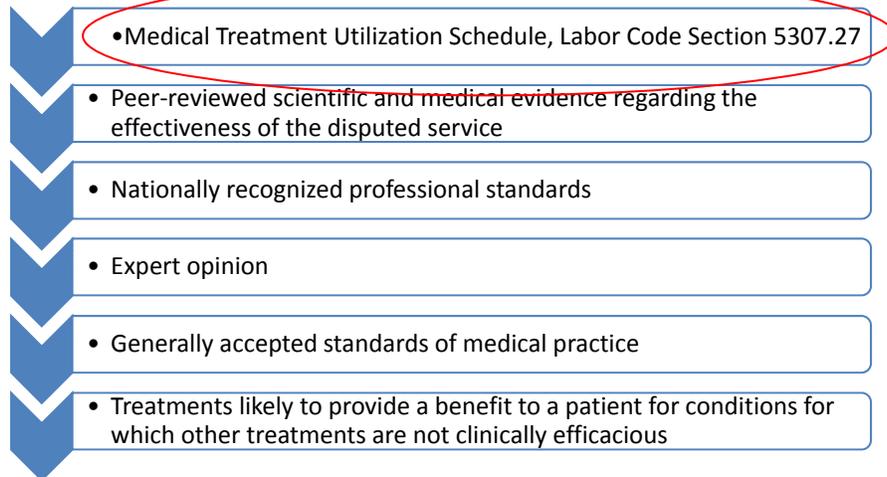
Timeframe for Completion of IMR

- Regular: 30 days of receipt of all records
- Expedited: 72 hours of receipt of all records
 - Written certification from physician that imminent and serious threat exists to the health of the IW
 - E.g., serious pain, potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the employee
 - Claims adjustor has conducted expedited UR

IMR Decisions

- Reviews must include
 - Individual assessment of case
 - Determination on disputed medical treatment
 - Medical qualifications of reviewers
 - License jurisdiction, subspecialty
- Multiple reviewers may confer
 - Majority recommendation prevails
 - Split decision favors treatment provision

IMR Decision Hierarchy



Labor Code Section 4610.5(c)(2)

Medical Treatment Utilization Schedule

- Doctors in California's workers' comp system are required to provide evidence-based medical treatment
- Guidelines are laid out in the MTUS
 - Based on studies that demonstrate treatment that is effective in improving medical outcomes in workers
- Developed by a committee of experts under the guidance of the DWC Executive Medical Director
- Promulgated by the DWC Administrative Director

IMR Quality Assurance

- Starting January 1, 2014, QMEs may not perform IMRs
- IMRO will confer with DWC to resolve complaints on specific cases
- DWC will monitor quality of reviews
 - Monthly summary reports from IMRO including
 - Timeliness, outcome, quality of decisions and reviewers
 - Ongoing communication, regular meetings
 - Random audits

Timely, medically appropriate treatment for injured workers

How to Reduce UR Denials, Delays

- Scrutinize UR denials—justified/necessary?
- Use and cite the MTUS for UR
 - MTUS intended to be used as treatment guidance, not a tool for denial
 - MTUS is presumed correct, but is rebuttable with adequate evidence
- Resolve non medical issues before UR
 - Liability; in or out of network; AOE/COE

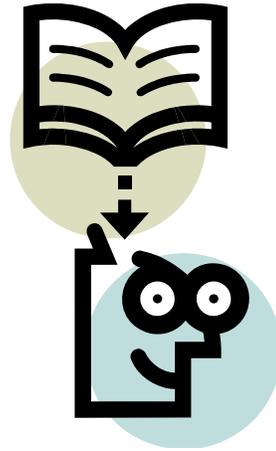
Making IMR Efficient: Tips for Claims Administrators

- Ensure UR denials are appropriate
- May conduct concurrent internal review of denials
 - Must be completed in 15 days
 - May not ask IW to delay IMR request
- Send completed IMR form with each denial letter
- Submit complete records for IMR requests
 - 15 days regular, 24 hours expedited
- Grant treatment prior to IMR completion
 - IMR request may be withdrawn with partial fee if review has been assigned

Making IMR Efficient: Tips for Requesting Providers

- Submit complete records with treatment requests
 - (RFAs)
- Use the MTUS to guide treatment
 - Submit adequate evidence to scientifically justify treatment not in MTUS
- Submit complete medical records when requested
- Offer to help the worker with IMR requests
 - E.g., if acting as designee, help to upload documents, obtain medical records from non-network providers

Test Your Knowledge



- How can a worker assign a designee?



- Does a provider need to submit an RFA for an X-Ray as part of initial treatment provided to a worker with a suspected wrist fracture on the first visit following injury?

True or False?

- The DWC IMR Application Form is mandatory and may not be modified
- If a claim is eligible for IMR, a lien may not be filed for resolution

Which of the following is not a reason for IMR ineligibility?

1. Date of injury 8/3/12; IMR requested 4/5/13
2. UR denied 1/20/13; IMR requested 7/30/13
3. Employer disputes work-relatedness of injury
4. Date of injury 2/5/13, no UR decision issued; worker requests IMR
5. Date of injury 2/5/13; employer accepts liability, UR denies treatment; claims admin. wants extra time to conduct internal review

Which of the following are reasons IMR may overturn UR denial?

1. UR did not apply the MTUS in making decision
2. UR applied the MTUS; IMR showed scientific evidence demonstrating that treatment is appropriate for injured worker; this met the MTUS “rebuttable presumption” standard
3. UR applied the MTUS; IMR did not agree with the MTUS

IMR Application Form

- How do I get the WCIS Jurisdictional Claim Number (JCN)?

State of California
Department of Industrial Relations
Division of Workers' Compensation
Application for Independent Medical Review
(All fields must be completed by the Claims Administrator)

Reset Form Print Form

Type of Review (Required) Expedited
 Regular

Claim Number <i>(Required)</i>	Date of Injury <i>(Required)</i>	Date of UR Decision <i>(Required)</i>	WCIS Jurisdictional Claim Number <i>(Required)</i>	EAMS No (if applicable)
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Injured worker Information (Completion of this section is required)

Injured Worker First Name	MI	Injured Worker Last Name
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Injured Worker Street Address/PO Box	Injured Worker City	State	Zip Code
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WCIS: Workers' Compensation Information System

IMR decisions may be appealed to the Workers' Compensation Appeals Board for all of the following reasons except:

1. AD acted in excess of her powers
2. Determination procured by fraud
3. Plainly erroneous mistake of fact
4. Disagreement with medical decision
5. Reviewer subject to material conflict of interest

Resource Based Relative Value Scale (RBRVS)



Background of the RBRVS

- Medicare began phasing in RBRVS in 1992
- Developed by Harvard School of Public Health
 - Updated annually by Medicare with input from AMA
- Each medical procedure assigned “relative value units” (RVUs) based on amount of resources required for the procedure relative to others
 - Physician Work
 - Practice Expense
 - Malpractice Expense
- RVUs multiplied by “Conversion Factor” (and for Medicare, a geographic adjustment) to produce the fee amount

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Benefits of Converting to RBRVS

- Creates savings and efficiencies:
 - Sets a value for many procedures not currently covered
 - Reduces disputes regarding reasonable value of services
 - Provides simple mechanism for updating fee schedule
 - Aligns with codes used in outpatient fee schedule, improves electronic billing and usefulness of WCIS
 - Reimbursement linked to resources used to provide procedures, increasing fairness and reducing the possibility of inadvertent fee-based incentives
- Used by a variety of payers:
 - Medicare
 - Federal Office of Workers' Compensation Programs
 - Many state workers' compensation programs
 - Various private payers

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SB 863 Requires the AD to Implement and Periodically Revise a RBRVS Fee Schedule

- Annual updates to reflect changes in procedure codes, relative weights, and inflation
- Maximum reasonable fees in the aggregate not to exceed 120 percent of amounts payable by Medicare in 2012 updated for inflation
 - Services not covered by Medicare included at the fee schedule amounts established by the AD
- Four year transition between current OMFS allowances and the RBRVS allowances
- Ground rules shall differ from Medicare rules as appropriate
- LC § 4600 continues to determine issues of medical necessity, frequency and duration of medical treatment

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Other General OMFS* Provisions Apply to the RBRVS Fee Schedule

- Fees must be adequate to ensure a reasonable standard of services and care for injured employees
- AD has authority to adjust the conversion factors, RVUs and other factors affecting payment amounts within the aggregate 120 percent limit
- Changes to conform with any relevant changes in the Medicare payment system shall be made within 60 days after the effective date of the changes
 - Exempt from formal rulemaking process
 - Changes accomplished by AD update orders posted on the DWC website

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Official Medical Fee Schedule

DWC RBRVS Study

Consultant Contract (RAND)

- Historical studies and current data to propose a RBRVS-based fee schedule that may be adopted by the AD by January 1, 2014
- Incorporate factors such as
 - Medicare fee schedule, adapted as warranted
 - Fiscal impact of RBRVS to stakeholders
 - Fee schedule for codes currently not in Medicare
- SB 863 provides “default” RBRVS fee schedule if AD has not adopted by January 1, 2014

Public Input on RBRVS

- Ground Rules Public Comments solicited
- Comparison of fee schedule and Medicare
- Comment period ended Feb 8

THANK
YOU



Independent Bill Review

- Applies to medical treatment under Labor Code section 4603.2(b)(1).
 - Any provider of services provided pursuant to Section 4600, **including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services**, shall submit its request for payment with an itemization of services provided and the charge for each service, a copy of all reports showing the services performed, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received.
- Medical-Legal expenses per 4622.

Independent Bill Review

- Prerequisites to requesting Independent Bill Review.
 - **Initial bill review** by the Claims Administrator (4603.2)
 - Explanation of Review (EOR)
 - Provides reasons for the rejection or reduction of the bill.
 - **Mandatory second review** requested by the provider with additional information requested by the Claims Administrator.
 - Explanation of Review (EOR)
 - Provides reasons for the rejection or reduction of the bill. (4603.6. (a).)

Independent Bill Review

- Providers File for Bill Review
 - Must use the form promulgated by the administrator (4603.6. (c).)
 - Pay a fee (4603.6. (c).)
 - May prescribe different fees depending on the number of items in the bill or other criteria determined by regulation adopted by the administrative director.

Independent Bill Review

Caveat

- If the employer has ***contested liability for any issue other than the reasonable amount payable*** for services, **that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622. (4603.6. (a).)**

Independent Bill Review

- Director shall assign the request to an independent bill reviewer within 30 days and notify the medical provider and employer of the independent reviewer of the assignment.
- 10 days after the assignment the requesting party shall submit the documents to the IBR.
(4603.6. (d).)

IBR Evidentiary Record-*Required*

- Copies of the original billing itemization;
- Any supporting documents that were furnished with the original billing;
- The explanation of review;
- The request for second review together with any supporting documentation submitted with that request;
- The final explanation of the second review.
(4603.6. (b).)

IBR Evidentiary Record

- The employer shall have no obligation to serve medical reports on the provider unless the reports are requested by the independent bill reviewer;
- IBRO may request additional information;
- Parties shall respond with the documents requested within 30 days, with copies to opposing party. (4603.6. (e).)

Independent Bill Review-Decision

- **The independent reviewer *shall make a written determination of any additional amounts to be paid* to the medical provider and **state the reasons for the determination within 60 days of the receipt of the administrative director's assignment.** (4603.6. (e).)**

Independent Bill Review-Impact

- Determination of the independent bill reviewer shall be deemed a determination and order of the administrative director.
- *Determination is final and binding on all parties* unless an aggrieved party files with the appeals board a verified appeal from the medical bill review determination of the administrative director within 20 days of the service of the determination. (4603.6. (f))

Independent Bill Review-Appeals

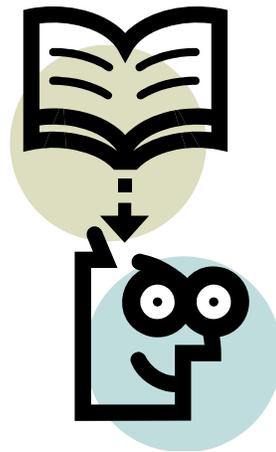
- Decisions in the IBR process are decisions of the Administrative Director.
- Decisions of the Administrative Director are appealable under Labor Code § 5300 (f).
- Appeals are likely at the beginning of the IBR process when decisions are made to accept or deny the matter into IBR and after the IBR decision is rendered.

Appeals at the Completion of the IBR Review-(4603.6. (f).)

The determination of the administrative director shall be presumed to be correct and shall be set aside ***only upon proof by clear and convincing evidence*** of one or more of the following grounds for appeal:

- The administrative director acted without or in excess of the administrative director's powers.
- The determination of the administrative director was procured by fraud.
- The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.
- The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.
- The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion.

Test Your Knowledge



IBR Early Review issues

- Disputes over liability issues re injured workers. (*Examples*)
 - No dispute requiring a QME
 - Entitlement under Labor Code section 3600
- Disputes over defenses that pertain just to the provider. (*Examples*)
 - 4603.2(a)(3)(Treatment in or out of the MPN)
 - 139.2 (*Physician self-referral*)
 - 139.32(e) (New self-referral rule)

IBR-Legal Issues (Examples)

- Was the correct fee schedule used?
- Is the decision adequately documented?
- Was the correct analysis applied?
- Was the record adequate to support the decision?

THANK
YOU



QME Process Changes

Changes effective January 1, 2013:

- QME panel requests for medical treatment disputes [DOI on/after 1/1/2013]-referred to IMR process
- Spinal Surgery Second Opinion Physician [LC 4062 repealed] – IW can request QME panel

QME Process Changes

- Limit on QME locations [LC 139.2 (h)(3)(B)]
- Changes to Chiropractor QME certifications [LC 139.2 (b)(4) – deleted certification by chiropractic post graduate program]

QME Process Changes

- Changes to scope of QME evaluations
 1. Medical treatment disputes
 2. No add-on impairments for Sleep, Psyche and Sexual dysfunction for physical injuries for DOI on/after 1/1/13 [LC 4660.1]

QME Process Changes

- Requests for correction due to factual error [LC 4061 (d)(1) and (d)(2)] – only for unrepresented injured worker panels; must be requested w/i 30 days of receipt of report; halts summary rating process when pending
1. QME form 37
 2. Different process and timeline than supplemental requests under Reg. 36

QME Process Changes

- Streamline QME process
1. No AME dance for represented panel requests
 2. Does the Messele case still apply?

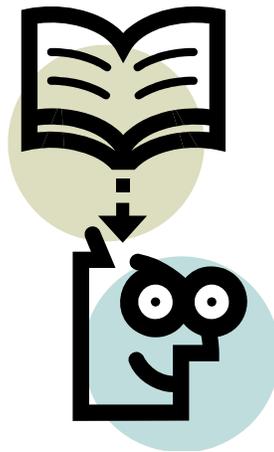
Does this change the current MU process of reviewing QME panel requests?

QME Process Changes

Changes effective July 1, 2013:

- QME panel requests for medical treatment disputes with UR determination decision communicated to physician on/after 7/1/2013
- referred to IMR process

Test Your Knowledge



QME determinations on medical treatment disputes

- Injured worker requests a QME panel for UR denial on spinal surgery request received 1/5/13; DOI 8/1/12

QME resolves treatment issue? Referral to IMR?

- QME panel issues 10/1/13 to determine P & S status

Does the QME make determinations on recommended medical treatment?

QME Location Unavailable

- Unrepresented QME panel issued on 8/1/2012 for active QME locations. QME selected, evaluation conducted and report issued on 10/15/2012. QMEs evaluation location closed due to 10 location limitation. Follow-up evaluation requested.
 1. Must the QME be replaced?
 2. Can the claims administrator choose another location?

QME Panel or IMR referral?

1. QME 105 request was received on 7/15/2013 for a 4062 QME panel with an injury date of 10/1/11 and the UR decision was delivered to the physician by fax on 6/20/2013.

Will a QME panel be issued by the Medical Unit?

THANK
YOU

