

Research Brief

Utilization Review in California's Workers'
Compensation System:
A Preliminary Assessment

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Utilization Review in California's Workers' Compensation System: a preliminary assessment.
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Executive Summary

Utilization management is a set of techniques used to manage health care costs through the assessment of the appropriateness of care in individual cases. The primary focus of utilization management is reduction of the use of unnecessary or inappropriate medical services. The Division of Workers' Compensation (DWC) promulgates "Utilization Review Standards" pursuant to California Labor Code Section 139. The utilization review (UR) standards govern the conduct of utilization management or utilization review by workers' compensation claims administrators in California.

While utilization review is ubiquitous in health care, little is known about how it has been implemented in California's workers' compensation health care system, and few studies have assessed its impact on costs in workers' compensation health care. The impact of UR on quality of care is also currently unknown. The purpose of this preliminary assessment was to:

- Review the summaries of utilization review plans of California's largest workers' compensation claims administrators, to learn more about UR in our workers' compensation system;
- Review the published literature with regard to the impact of utilization review on health care services costs and/or quality; and
- Identify differences between DWC's utilization review standards and the standards governing utilization review in other California health care systems or in private accreditation programs.

The review of UR plan summaries suggests that there is considerable variability in current UR practices, including variation in clinical criteria used in the UR process and in the use of an internal appeals process.

There are several potentially significant differences between DWC's utilization review standards and the requirements for UR in the California Insurance Code governing disability insurers and in the California Health and Safety Code governing Knox-Keene Health Care Service Plans (HMOs).

Recommendations:

- Further study of utilization review in California's workers' compensation is necessary to evaluate its actual impact on medical and transactional costs and quality of care.
- Increased uniformity and consistency in UR practices and processes would reduce administrative burdens for workers' compensation providers.
- Regulations and statute governing utilization review in workers' compensation should be more consistent with those in other health care sectors in California.
- The use of an independent medical review system should be considered.

Background

Utilization management has been defined by the Institute of Medicine as "a set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision." [1] Utilization management is used in an effort to discourage the use of unnecessary or inappropriate medical services, without jeopardizing necessary high-quality care. The terms "utilization management" and "utilization review" (UR) are used interchangeably in this report.

By the late 1980's, UR had become ubiquitous in health care, effecting virtually everyone with any form of health insurance coverage in the U.S., and many workers' compensation claims administrators had also begun to use UR as a cost-containment tool. The Utilization Review Accreditation Commission, a not-for-profit health accreditation agency, established accreditation standards for workers' compensation utilization review organizations in 1996. Currently, 30 states have some type of statutory provisions for utilization management in workers' compensation. Seventeen states regulate workers' compensation utilization management organizations or activities, 9 of them with a comprehensive regulatory framework; 6 states "recognize" URAC accreditation for workers' compensation utilization review. [2]

UR was formally introduced into the California workers' compensation system in 1993, with the adoption of legislation that mandated the administrative director to "adopt model utilization protocols in order to provide utilization review standards", and required all insurers to comply with this protocol. [3] California law requires that employers pay for all medical care that is "reasonably required to cure or relieve from the effects of the injury." [4]. UR is intended to provide a structured process for making determinations regarding whether or not particular medical services meet the statutory definitions of care for which the employer is liable.

California's Division of Workers' Compensation regulations define utilization review 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.”[5] The regulations specify that only medical necessity determinations fall within the UR definition; billing or payment for medical services, and determinations of the work-relatedness of disease, are not within the scope of utilization review. DWC’s regulations also require that claims administrators who implement a UR program meet certain process requirements, including timelines for response and criteria for personnel involved in review. (<http://www.dir.ca.gov/t8/9792%5F6.html>)

In order to better understand current UR operations in California, DWC, with funding assistance from the Robert Wood Johnson Workers’ Compensation Health Care Initiative, conducted this preliminary assessment of current utilization review programs. The goals of the assessment were to:

- Review the summaries of utilization review plans of California’s largest workers’ compensation claims administrators, to learn more about UR in our workers’ compensation system;
- Review the published literature with regard to the impact of utilization review on health care services and/or quality; and
- Identify significant differences between DWC’s utilization review standards and the standards governing utilization review in other California health care systems or in private accreditation programs.

Methods

Overview: The DWC UR regulations require insurers who implement a UR system to maintain, and make available to the administrative director, a written summary of the system.[5] This study used a template-based review and analysis of the written summaries of the UR plans of California’s largest workers’ compensation claims administrators. A second component of this study reviewed case files in which there were requests for expedited medical hearing over a two month period from one northern and two southern California Workers’ Compensation Appeals Board offices. The purpose of the review was to see if any information pertinent to the UR process was available in the WCAB files of cases in which there were disputes over provision of medical services.

Identification of large claims administrators: The DWC Audit Unit's annual claims inventory was used to identify claims administrators who processed more than 10,000 claims in 1999. A formal request for the written UR plan summary was sent to these 28 claims administrators.

Review template: A template for the review of UR summaries was developed based on the DWC UR regulations. In addition, the template incorporated elements from the Workers' Compensation Utilization Management Standards of the American Accreditation HealthCare Commission/URAC.[6] The template allowed the reviewers to (a) determine if a particular characteristic is specifically referenced in the UR summary, and (b) if referenced, to identify details provided in the UR summary.

Analysis: The percentage of written plans addressing various features of the UR program was calculated. Specific characteristics of the programs were categorized based on the information that was available in the UR plans. In some instances, the reviewers made inferences from materials submitted. For example, the claims administrator may have submitted a cover letter indicating the implementation of a UR program, accompanied by a written UR plan on the letterhead of a UR company; in these cases, it was inferred that the claims administrator contracted out for UR services.

Expedited medical hearings file review: Presiding judges in three Workers' Compensation Appeals Board offices (two southern, one northern) were asked to pull case files in which expedited hearings had been requested in the previous several months. Sixty-four WCAB case files were reviewed to identify the reasons for which expedited hearings were requested and the case outcomes, and to assess whether there was any indication of the use or role of utilization review prior to expedited hearing request.

Literature review: MedLine, an electronic bibliographic retrieval service of the National Library of Medicine, was searched using the keywords "utilization review" and "utilization management". Retrieved articles were reviewed and summarized with the assistance of a graduate student research assistant.

Legislative and standards review: California legislative history was searched through the electronic legislative inquiry service available on the website of the California State Senate, using the keyword “utilization review”. The most recently chaptered legislation regulating performance of utilization review by licensed disability insurers (Insurance Code 10123.135) and Knox-Keene health care service plans (Health and Safety Code 1367.01) was reviewed. Additionally, the UR accreditation standards of the Utilization Review Accreditation Commission were reviewed.

Results

Review of written UR summaries

Response: Twenty-four of 28 claims administrators (86%) responded to the request letter in a timely manner. One respondent rescinded their response, reporting a corporate decision to stop conducting utilization review. Two claims administrators submitted responses after the summary analysis had been completed; addition of information from these late submissions would not materially change the results of the study.

Respondents who contract out UR services often sent a cover letter with the summary UR plan of the contractor. Several respondents submitted the same summary plan (either due to contracting with the same UR vendor, or because one respondent performs UR for the other). Twenty-two separate UR plans are represented in the analysis.

Contracting for UR services: Ten of 22 (45%) respondents conduct UR in-house and 12 of 22 (55%) contract to another organization for at least some UR services. One respondent contracts with 2 UR organizations (URO). 8 plans (36%) specify the use of out-of-state UR services, 9 (41%) specify in-state, and the remainder are unclear regarding location of UR service providers. Three summary plans mention that the UR process varies depending on client preferences.

Accreditation: Only 2 of 22 plans (9%) indicate that they are URAC certified for utilization management.

Prospective review: Prospective review – conducted prior to the delivery of health care services - is a component of all UR plans reviewed. 19 plans (86%) list the specific services for which prospective review is conducted. (Table One)

Table One: Prospective Review: Services listed by California summary UR plans

Services	Plans “requiring” prospective review (N=22) (#/%)
“all planned treatment”	19 (86%)
all hospital admissions	19 (86%)
all inpatient surgery	19 (86%)
ambulatory procedures	all ambulatory procedures 19 (86%)
myelograms	myelograms 2 (9%)
other	home health and prescriptions 1 (5%)
durable medical equipment	3 (14%)
physical therapy	>12 visits 1 (5%)
any	other 18 implied as part of “all planned rx” (82%)
pain management	2 (9%)

Concurrent and retrospective review: 19 plans (86%) mention concurrent review for inpatient length of stay. 15 plans (68%) mention retrospective review, after services have been provided.

Criteria for review: 20 plans (91%) specify the criteria used to perform reviews; 1 states criteria are “in accordance with state regulations”, and 1 does not address criteria. Of the 20 plans specifying criteria used, 80% use externally developed criteria (Table Two); the others utilize both internally and externally developed criteria. Almost 1/3 of respondents use more than one set of criteria, although the method for selecting which criteria to use in a particular case was not specified in any of the plans.

Table Two: Criteria used in workers' compensation UR

Criteria	# of UR plans specifying use
Milliman and Robertson (M&R)	10
Presley Reed Medical Disability Advisor	4
Interqual	3
Intracorp	3
HCIA	2
IHQ	2
AHCPR/AHRQ	2
IMC	1

Hours of business: Only 9 (41%) plans listed business hours of operation. Of these, 6 (67%) are available at least between the hours of 9 AM and 5:30 PM, PST, on normal business days, making them consistent with the law requiring that utilization reviewers be available during those hours (Labor Code Section 4600.4) which took effect in 1999. Of the remaining three plans, one lists 40 hours per week, one lists 9 AM-5 PM CST and one lists 8 AM-5 PM. Emergency access is specifically referenced in just 8 (36%) of the summaries.

Response time: All plans have policies that require a response time within 7 days, and many provide for a faster response (Table Three).

Table Three: Response time policies of workers' compensation UR plans

Response time	#/% company policies (N=22)
≤ 24 hours	5 (22%)
≤ 3 days	6 (27%)
≤ 7 days	22 (100%)
Expedited review (≤ 24 hrs) explicitly stated	3 (14%)

Personnel: Most plans (18, 81%) indicate that initial review can be conducted only by a registered nurse (RN); 1 plan requires initial review by an RN or physical therapist, while 3 (14%) allow RNs or licensed registered nurses (LVNs) to do initial review. All plans state that second level review must be conducted by a physician; one permits chiropractors to conduct second reviews, while the remainder specify MD second reviewers.

Although only 3 plans list the number of staff, the wide range in number of first level (6 to 61) and second level (5 to >500) review staff demonstrates the varied capacity of different utilization review organizations.

Denials and appeals: 20 (91%) summaries itemize the content of denial forms or letters sent when a proposed treatment is not authorized: all provide the reason(s) for denial and the criteria upon which the denial was based; 1 proposes alternative treatment. 20 (90%) plans reference an appeals process, though few provide details about the appeals process. Only 1 plan specifies that only an MD who was not previously involved in the claim can handle an appealed denial of authorization. Only 2 plans (9%) mention the legally mandated process for handling disputes over medical treatment (Labor Code Section 4062) in the denial letter. Two of 22, 9%, mention 4062 explicitly in their descriptions of the appeal process; however, one of these does not mention it in the denial letter.

Confidentiality: Only 5 (23%) plan summaries specify a medical information confidentiality policy, and require a signed release from the patient for disclosure of confidential medical information to other involved parties. Two plans mention a company confidentiality policy prohibiting employees from revealing information about company operations. Parties mentioned as having access to confidential information include: “agencies with authority”, UR staff, “staff directly involved in the case”, claims administrators, employers, insurers, personnel specified in the release form, and “other”. Two plans reference recent legislation (AB 435) limiting the release of medical information from claims administrators to employers, and one plan states that confidentiality procedures adhere to the Federal Uniform Health Information Act (Federal UHIA).

Review of requests for expedited hearings on medical issues: In 49 of 64 (77%) case files reviewed, expedited hearings were requested because of disputes over medical treatment. Of these, 14 (29%) involved requests to authorize surgery, 8 (16%) were requests for diagnostic evaluations (including 2 for diagnostic arthroscopy), and 6 (12%) were requests for referrals to other physicians (see Table 4). In 18 cases, other treatment was requested, such as continued chiropractic or physical therapy treatment, acupuncture, herbal remedies, or weight loss programs. In the remaining cases, insufficient information was available to determine nature of dispute or outcome.

Thirty-three cases (67%) were taken off calendar before the scheduled hearing. 4 cases (8%) were resolved with Findings and Awards or stipulations; the remaining cases were either not yet resolved, deferred to AMEs, or, in one case, hearing was denied based on defense objection.

Table Four: Outcomes of a series of requests for expedited hearing on medical treatment issues

<i>Treatment Requested</i>	<i># requests</i>	<i>Authorized (#/%)</i>	<i>Denied (#/)</i>	<i>Unresolved or Unclear in File</i>
Surgery	14	12 (79%)	1	1
Diagnosis	8	5 (63%)	1 (no longer need per PTP)	2
Referral	6	4 (66%)	0	2
Other	18	14 (77%)	0	4
Total	46	35 (76%)	2	9

While the date of initial request for treatment authorization was often not apparent in the case files, there appeared to be a lag time of 3 – 6 months (or more) before the request for expedited hearing. Documentation pertinent to the utilization review process appeared in only one case file.

Review of other legislation and standards: The California legislature recently enacted laws governing utilization review in both the Insurance Code and the Health and Safety Code. These laws are considerably more stringent and detailed in their requirements of utilization review programs than Labor Code Section 139(e)(8), which governs UR in the workers’ compensation system (see Appendix A). The URAC Workers’ Compensation Utilization Review Standard is similarly more stringent, requiring, for example faster turnaround times and a mandated appeals process.

California law governing other health care systems also spells out the UR appeals process in some detail. When a UR decision to deny a medical service based on medical necessity is upheld in the appeals process, or is unresolved within 30 days after an appeal, patients and providers have the right to request an independent medical review through the Department of Insurance or the Department of Managed Health Care. The independent medical review system is intended to ensure that qualified medical professionals, free of conflict of interest, make decisions about

medical necessity based on the best available medical evidence.(Health & Safety Code Section 1374.30 et. seq., Insurance Code Section 10169 et.seq.)

Discussion

Limitations: This preliminary assessment of UR practices in California’s workers’ compensation program is based largely on a review of the written summaries of UR programs that were submitted to DWC by large claims administrators. Conclusions that can be drawn based on this methodology are limited, because it does not examine the actual operational practices of UR organizations (URO), provide extensive detail on URO policies or procedures, or measure the actual impact of UR on outcomes. Because only the largest claims administrators were asked to submit summary plans, the findings from this small sample of claims administrators may not be representative of all claims administrator’s UR programs. Nonetheless, this preliminary assessment identifies several concerns that merit further investigation and/or intervention.

Variability: It appears, on paper, that the UR policies of large claims administrators are largely in compliance with DWC UR regulations. However, the lack of uniform processes seems likely to cause confusion and difficulty for providers. The most notable sources of variability lie in the differences among plans in which services “require” prospective review, and in the use of many different guidelines or medical criteria for review of requests for authorization of treatment. These findings are consistent with the 1989 Institute of Medicine report on utilization management, which found that UR practices were highly variable. [1] UR variability has implications for equity of access to medical care – if different claims administrators have different criteria and processes for approval of medical services, then workers whose care is provided through these different claims administrators may have a different likelihood of receiving certain types of care.[7]

Variability in the criteria used by URO organizations also raises questions as to the scientific basis for medical decisions of UROs. The most commonly used guidelines appear to be consensus, rather than the “evidence-based” guidelines recommended by the federal Agency for Health Care Research and Policy (and other experts). [8] Because the guidelines are proprietary,

it is difficult to assess the extent to which they are consistent with currently available medical evidence, or the extent of variability among different guidelines. A recent review commissioned by the Texas Research and Oversight Council similarly found great variability in the use of guidelines, and recommended a shift to evidence-based guidelines.[9]. A more systematic review of the guidelines currently used by California workers' compensation UROs is required to ascertain the degree of variability and concordance with available evidence.

Imprecise appeals process: The UR regulations specify that only a physician with case-pertinent expertise and experience can issue a denial for medical care. But there appears to be considerable variability in what happens after such a denial. The study found that almost all UR programs currently include an appeals process for providers. The DWC UR regulations neither require nor prohibit an appeals process, while the URAC Workers' Compensation Utilization Management Standards and other California health care law require an appeals process.[10],[11]

Labor Code Section 4062 [12] provides a process for handling disputes over medical treatment, including disputes about medical necessity; however, neither the section nor the regulations specify the point at which a UR denial becomes a dispute requiring notice to initiate the 4062 QME process. The intended interaction, if any, between the UR process, the 4062 dispute process, and the expedited hearing process remains unclear, and few UR summaries explicitly reference Section 4062.

The Labor Code does not permit the introduction of UR documentation (e.g. rationale or basis for denial of authorization) as testimony at the WCAB. Therefore, we cannot tell whether the lack of any reference to a UR process in the vast majority of WCAB files of claimants requesting an expedited medical hearing reflects WCAB evidentiary rules or failures in the UR process.

An extremely high proportion of requests for expedited hearing result in a settlement with provision of the requested service. In the absence of more detailed medical review, we cannot determine whether these outcomes represent a perception on the part of the insurers that hearings will result in the same outcome at greater cost, or last-minute recognition by insurers that the requested treatment is, in fact, medically necessary. Few files had sufficient medical records to

make an informed decision regarding the appropriateness of requested treatment, perhaps because issues were resolved without proceeding to hearing.

In some cases, the denial of treatment authorization was difficult to understand; this was particularly true in several cases in which the treating physician requested consultation or referral for treatment of depression, and one case in which inpatient treatment was requested for severe post-traumatic stress disorder. The appropriateness of treatment in other cases appeared rather questionable. For example, one orthopaedic surgeon, who had served as the primary treating physician for many months before a patient sought a new physician, wrote: “This procedure has absolutely no likelihood of helping this patient. There is no radiculopathy or radicular pain. I challenge Dr. XXX to provide me with one article in the peer review literature which even suggests that this procedure has any likelihood of helping the patient.” The treatment was, however, agreed to.

In another DWC study, many participants in the workers’ compensation system have commented on the irony of requiring judges, with no medical training, to make final determinations on medical necessity, often on the basis of scant medical evidence.[13]

Existing mechanisms for resolution of disputes over medical necessity in workers’ compensation generally take many months. While “expedited” hearings must occur within 30 days of the request for hearing, it appears that even in cases in which an expedited hearing is set , the time from denial to resolution often exceeds 3 months. The 4062 process may take far longer.

Outside of workers’ compensation, 40 States now have statutory provisions for appealing UM decisions [14]. Both indemnity health insurers and HMOs in California (and many other states) are now required to participate in an Independent Medical Review (IMR) process, in which the State assigns cases with disputes over medical necessity to State-contracted Independent Medical Review organizations. Independent external review of disputed medical necessity decisions has emerged as an important consumer protection in the commercial health care market, as well as in MediCare and Medicaid. [15],[16],[17] Thus, in California health care delivery systems *except* workers’ compensation, medical necessity disputes go through a clear three-step process

(utilization management, insurer/HMO appeals, IMR), in which the final determinations are made by independent physicians with case-pertinent expertise on the basis of established medical criteria and the best available medical evidence. Each step in the process also has clearly defined time limits. While IMR determinations are binding on the insurer/HMO, patients still maintain the right to seek court appeal.[18], [19]

Confidentiality: We cannot determine from the study whether the lack of mention of confidentiality policies in UR summaries reflects the absence of specific UR confidentiality requirements in the DWC regulations, or the lack of confidentiality policies in UROs. However, the many categories of individuals who may have access to confidential medical information in the UR process suggest a need to address this issue in rules governing UR.

Impact of UR: The primary goal of UR is to increase the cost-effectiveness of medical care by optimizing the quality of care and patient outcomes, while reducing the unnecessary use of resources. [20] The value of utilization management – for cost containment and quality improvement - can thus only be determined with reliable information on medical and transactional costs (for employers and providers), quality of care, and patient outcomes. This assessment is not able to measure any of these outcomes.

A brief review of the published literature on UR suggests that utilization review has helped to reduce inpatient hospital use, but its impact on net health care costs is less clear, as is its impact on long-term increases in health care costs.[1] Various studies have found that UR reduces hospital admissions, length of stay after admission, and performance of certain diagnostic and surgical procedures. [21] , [22], [23]

Several studies have found that the reductions in inpatient stay (for psychiatric care, cardiovascular disease, and pediatric admissions) increased the risk of early readmission; the authors of these studies have recommended further research to elucidate the effects of UR on quality of care and patient outcomes. [24], [25], .[26] Questions have also been raised about the ability of UR to adequately address common quality problems, such as under-use and misuse of medical services, because UR tends to focus on cost versus quality improvement [27] .

One study, however, suggests that UR may not even efficiently address overutilization. Kleinman et.al. found that physician reviewers were more lenient than the explicit criteria that their reviews were designed to implement, recommending 78% of cases for surgery (ear tubes in children), of which only 29% were appropriate according to explicit criteria or extenuating circumstances.[28]

Most cost savings from UR have been found to be concentrated in a small number of conditions and/or procedures. appear to be accrued from a deterrent effect (similar to a tax audit), with physicians less likely to request unjustified treatment and more likely to choose more efficient treatment when they believe they will be reviewed. [29] Several researchers have therefore suggested that UR be focused on certain provider groups, or targeted to identify those categories of cases which are “at risk” for inappropriate or unnecessary care.[21],[23], [30], [31] Some large managed care organizations are moving in this direction; for example, United Health Care recently decided to eliminate prospective and concurrent UR for all but a very small number of targeted procedures. [2]

Such efforts to reduce the intrusiveness and inefficiency of UR could alleviate some of the concerns of physicians, who view UR as burdensome, inefficient, and clinically unscientific; UR may contribute to physician resentment over perceived reduction in professional autonomy. [1] A recent survey in the Texas workers’ compensation system similarly concluded that providers find UR inconvenient, causing delays in treatment and requiring additional office resources.[9]

UR in workers’ compensation: Although the overutilization of certain medical services in workers’ compensation has been well documented, [32], [33], [34] there have been few studies to date of the effectiveness of UR in workers’ compensation health care. Wickizer, et.al., in a study of UR in a large national workers’ compensation insurer, found an overall denial rate of under 3%, but denial rates of over 5% for spinal surgery requests and over 8% for CTS release requests. However, 94% of denials which were reviewed on appeal were subsequently approved. The estimated savings from reduced hospitalization and a decreased number of procedures was substantial. However, the authors suggest caution in interpreting UR cost-

savings claims, because reversal of denials after appeal reduced actual cost savings by over 42%. No evaluation of the impact on quality of care or patient outcomes was performed.[30] Another study of workers' compensation UM also found that hospital use could be reduced by 10 – 15%, but that the impact of these programs on quality of care for workers' compensation patients remains unknown.[35] The implementation of State-approved guidelines, linked with strict guideline-based UR, was demonstrated to significantly reduce the rates of lumbar fusion surgery in Washington State. [36]

One knowledgeable reviewer identified the following pitfalls in workers' compensation utilization review, as currently practiced: variability in personnel and computer systems; uneven application of criteria, lack of integrated data systems, criteria not based on best available evidence, and lack of attention to patient belief systems. "Together with the use of outdated, inaccurate, and inconsistent criteria, key UM decision-makers and supporting personnel have failed to provide uniformity and establish a track record of sound medical management practices. ...Many systems now used in managing workers' compensation medical care are at best third generation systems written on non-compatible platforms." [37]

Recommendations for improving UR: A number of researchers and observers have recommended steps to make UR work better. [23], [29], [37], [1], [2] These include:

- focused utilization management;
- use of explicit evidence based criteria and availability of guidelines/criteria to providers and patients;
- tracking of decisions to monitor the patterns of UR decisions;
- requirements that UR organizations consider underuse and outcomes;
- improved education of UR personnel;
- computer system integration;
- on-going evaluation of effects on costs(including provider burden) and outcomes;
- clear linkage with quality improvement programs;
- clear appeals process; and
- decreased variability (and increased standardization) in UR process.

The recent Texas Research and Oversight Council study of workers' compensation UR recommended better monitoring of UR agents, either certification of UR vendors or state selection of a single or select list of UR vendors for eligibility to conduct UR in the workers' compensation system, and better access to medical expertise for judges.[9]

Conclusions and Recommendations: While this preliminary assessment of utilization review in California's workers' compensation system was limited in scope, the study suggests that there is substantial room for improvement in current UR processes. Certainly, further evaluation of the actual impact of utilization review on costs and quality is warranted. The authors recommend the following:

1. Evaluate actual UR practices, including consistency with existing statutory and regulatory requirements, and the extent to which currently used UR criteria are consistent with evidence-based guidelines for the treatment of common occupational injuries and illnesses.
2. Study the impact of utilization review on medical and transactional costs, quality of care, and patient outcomes in California's workers' compensation system, to determine if current UR practices produce desirable effects at reasonable costs.
3. Conduct on-going monitoring of UR, including assessment of patterns of denial of authorization by UR programs, and timeliness of determinations.
4. Consider ways to increase uniformity and consistency in UR practices, in order to reduce burdens on providers and transaction costs, and improve the likely impact of UR on quality of care.
 - a. Consider limiting UR review to care which falls outside of specified evidence-based treatment guidelines (e.g. no UR for chiropractic care for first 4 weeks of non-specific low back pain);
 - b. Consider mandating accreditation of UROs performing UR in California's workers' compensation system

5. Clarify in statute and regulation the relationship between UR, UR appeals processes, LC 4062, and the use of UR documentation and records in WCAB proceedings.
6. Consider the use of an Independent Medical Review process similar to that now required for California health insurers and HMOs, in order to expedite medical necessity determinations and strengthen the medical basis of determinations in disputes about medical necessity.
7. Require linkage of UR with systematic quality improvement programs, and explore mechanisms other than utilization management to improve the quality of care for injured workers in California's workers' compensation system.
8. Improve accountability for medical decision-making, through expanded DWC audits of medical benefits issues, IMR, and/or mandated reporting of all denials of medical treatment.
9. Increase protections for confidentiality of medical information in the UR/medical review process.

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Appendix A. Utilization Review: DWC vs. H&S and Insurance Codes

(Labor Code : NO specific requirements)

DWC Regs 9792.6	Insurance Code 10123.135	H&S Code 1367.01
authorization to determine if medical rx. reasonably required?	prospectively, retrospectively, or concurrently reviews, approves, modifies, delays, denies, in whole or in part based on medical necessity	
make available to a.d. written summary of ur plan on request: a. describe review process b. describe criteria utilized and personnel who develop/reviewcriteria c. describe personnel in ur	file written policies/procedures w/director for review/approval and disclose to providers/enrollees/public on request, to ensure decisions consistent with criteria supported by clinical principles	
regs apply to written request for authorization only	requires insurer to maintain telephone access for providers for authorization; law applies to phone or written requests	
no requirements re: med director	requires medical director w/unrestricted California medical license for HMO, or insurer if >50% health beneficiaries are in state; med.dir. shall ensure ur process complies with law	
Criteria used for review shall be: a. based on professionally-recognized standards b. developed using clinical principles/processes c. developed by physicians, peer-reviewed d. evaluated annually for update if necessary e. signed and dated by responsible physician	Criteria same except also: a. if used as basis of decision in case, must be disclosed to provider and policyholder in that case b. must be available to public upon request	

DWC Regs	Insurance and H&S Codes
Written notice to provider required if authorization for services denied, and “provider has not agreed to the denial or reduction”	Notice to provider required if request approved or denied or altered.
No approval notice requirements	Approval must specify specific health care service approved
Response must be placed in mail to provider no later than 7 working days after receipt of request and necessary supporting documentation. No initial notification required	Decisions prior to authorization must be “timely”, not to exceed 5 business days from receipt of reasonably necessary information. For concurrent review for care underway, decisions communicated to treating provider within 24 hours. Concurrent or prior denials shall be communicated to providers initially by phone or fax.
No notice to worker required	Written notice to insured required.
No requirements for expedited review	If necessary, expedited review not to exceed 72 hours
Denial notice must include: <ul style="list-style-type: none"> a. name of reviewer b. phone number and hours available of reviewer c. medical criteria basis for denial 	Denial notice must include: <ul style="list-style-type: none"> a. name of reviewer b. phone number of reviewer c. clear and concise explanation of reasons for decision, description of criteria, and clinical reasons for decisions re: medical necessity d. how to file grievance or appeal or seek review
No provision for not cutting off care	For concurrent review, no discontinuation of care until provider notified and care plan agreed on by provider

DWC Regs

May not deny due to lack of info w/out documenting attempt to obtain info

Insurance and H&S Codes

If lack of info will make decision untimely, as soon as aware of lack of info, shall notify provider and insured in writing that won't meet timeline, specify information not received, and anticipated decision date.

If a.d. finds non-compliance, notify insurer of finding, give 90 days to correct. If still non-compliant, may take action under 129.5.

If insurer fails to meet any timeframes or any other requirement, may assess administrative penalties for each failure

HMOs shall assess compliance with UR requirements as part of QA program

DMHC shall review UR in onsite medical surveys