



Center for Health and
Safety in the Workplace

RAND's SB 863 Evaluation: An Update

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CHSWC Presentation
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DIR asked RAND to Evaluate the Impact of the SB 863 Medical Provisions

- **Comprehensive evaluation of the impacts of the various medical care provisions on access and quality of care and work-related outcomes, volume and mix of services, medical spending, and administrative burden**
 - **Final report is due in one year**
- **Interim reports are forthcoming on priority topics**
 - **Medical necessity dispute resolution process**
 - **Fee schedule issues**
 - **WC-required reports**
- **Today's presentation provides an update on our review of the utilization review (UR) portion of the medical necessity dispute resolution process**

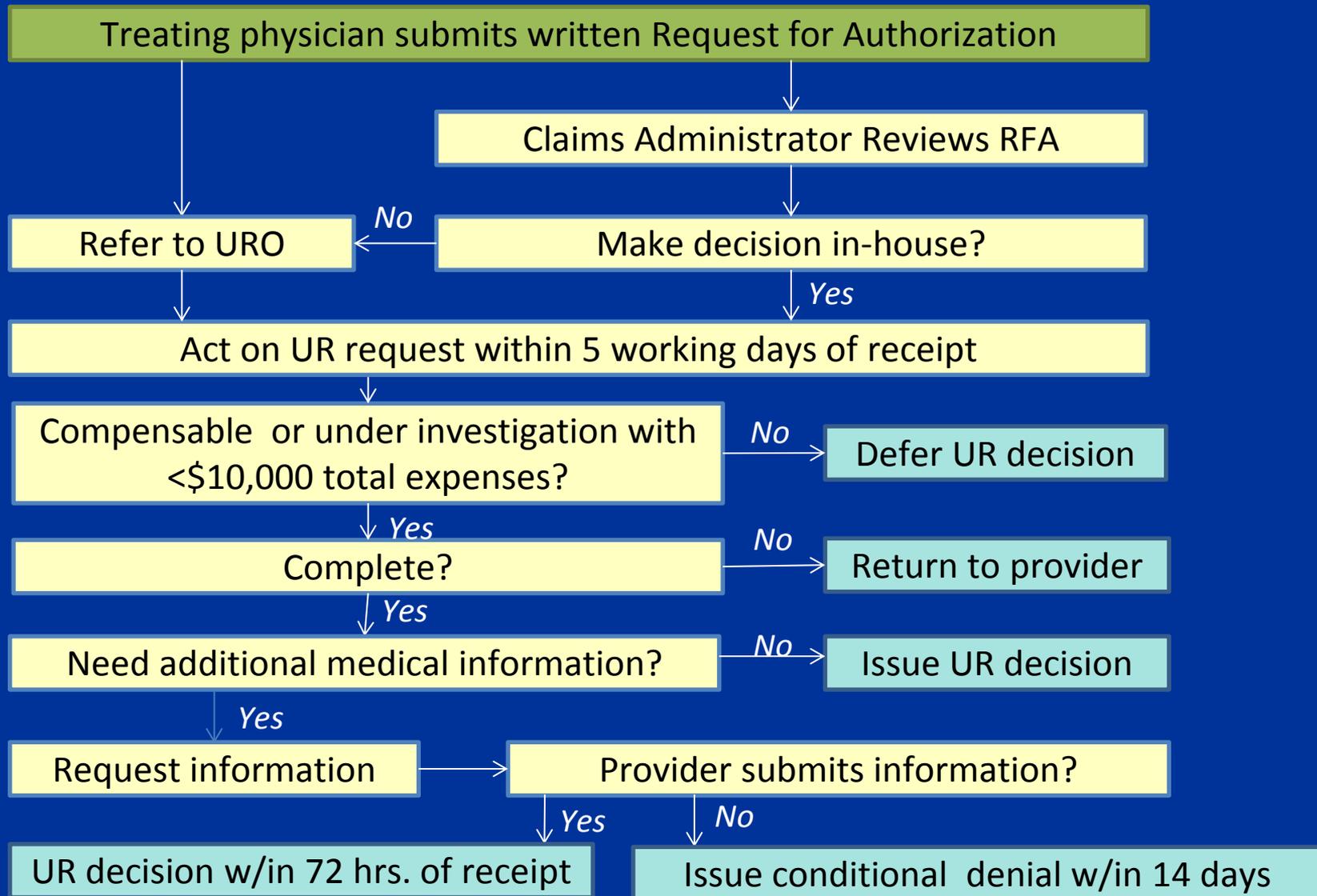
The medical necessity determination process involves several components

- **Care should be consistent with the *medical treatment utilization schedule* (MTUS) maintained by DWC.**
- **The payer must have a *utilization review* (UR) process to review the medical appropriateness of requested care.**
- **An injured worker may request that an adverse UR decision be reviewed by an *independent medical review* (IMR) organization.**
- **SB 863 added the IMR process, with spillover effects on other aspects on the medical necessity dispute resolution process.**

Today's Presentation Provides Additional Findings and Summarizes Recommendations

- **March 2015 CHSWC presentation shared findings from**
 - **Interviews with individuals from key stakeholder groups concerning changes in medical necessity dispute process**
 - **Analysis of data associated with DWC audits investigating compliance with UR regulations by selected claims administrators and UROs**
- **Our recommendations concerned potential refinements in the UR and IMR processes**
- **Today's update provides new findings from subsequent activities:**
 - **Review of UR plans associated with the 2014 UR investigations**
 - **Review of WC UR policies in states that have both UR and treatment guidelines**
 - **Additional analyses of the UR listings and IMR data**

Overview of Prospective UR Decision Process



We reviewed 23 UR plans (out of 60)

- Each claims administrator or external Utilization Review Organization (URO) that performs UR for the claims administrator must file a plan that describes its UR policies and procedures
- Our objective was to identify potential best practices and to inform our estimates of UR denial rates
- Two policies of particular interest for our study are:
 - *Prior authorization* or advanced approval for treatment without requiring a request for authorization from the physician
 - Services that may be approved by a claims adjustor versus those that must be *elevated* for clinical review

Prior Authorization Is Uncommon

- **Only 4 of 23 reviewed UR plans described prior authorization policies**
 - **Policies were limited to a few payers using the URO**
 - URO 1: 50 percent of payers (9)**
 - URO 2: less than 5 percent of payers (6)**
 - URO 3: standard prior authorization for payers (11)**
 - URO 4: tailored plan for a few payers (3)**
 - **Some payers further limited the policies to specific occupational medicine clinics or to initial care following injury**
- **Several payers with PA policies represent a significant portion of WC market**

Limitation: Approved UR plans may not be complete.

RAND Preliminary results for presentation at CHSWC meeting. Do not cite or quote.

Services Eligible for PA Vary Widely Across Payers

Range of PA Services for MPN Physicians (URO 1)

Service Category	Limited PA	Broad PA
Initial PT/OT	Up to 6 PT visits only	Up to 24 visits (+ 24 chiropractic)
Post-op PT/OT	None	Up to 24 visits (+ 24 chiropractic)
Drugs	None	OTC (including Ibuprofen and NSAIDS), 2 weeks non-narcotic pain relievers and muscle relaxants during 1st month
Consultations	None	For accepted body parts other than psych
Diagnostic tests	Initial x-ray for recent significant trauma or suspected fracture	Initial X-ray, MRI, or CT for red flags, initial EMG/NCS to confirm carpal tunnel or nerve root compression diagnoses
DME	<\$100	<\$500
Surgery	None	Hernia repair, carpal tunnel arthroscopy, initial knee arthroscopy, trigger finger release, DeQuervain's release
Injections	None	Corticosteroid injections for elbow(1), knee(3), or shoulder (3 for rotator cuff)

We also found wide variation in the services that claims-adjustors may approve

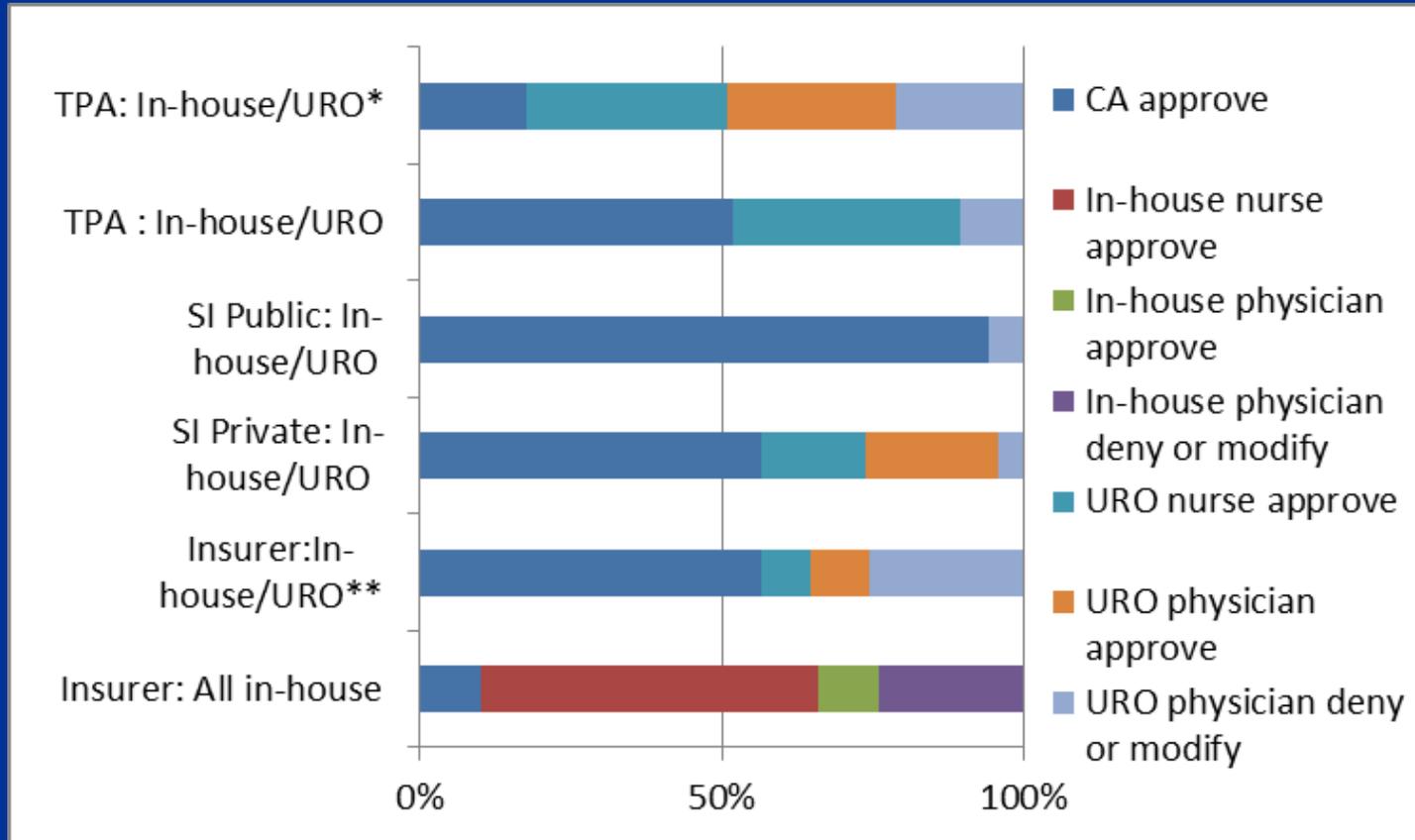
- **10 of the 23 UR plans did not describe services that claims adjustors may approve**
 - 3 indicated that the payer determines the policies for claims adjustor-approved (CAA) services
 - 7 make no mention of CAA services
- **Of the remaining 13 plans:**
 - CAA services are typically early low-cost treatment of low medical risk to injured worker
 - Range and variation in services is similar to PA services
 - 8 describe policies that vary by claims administrator (ranging from none to broad policies)

Limitation: Approved UR plans may not be complete.

We Used Our Findings to Refine Earlier Analyses of UR Audit Listings

- **DWC audits each claims administrator and URO every 3-5 years**
- **At the outset of an investigation, DWC requests a listing of every RFA received during the preceding 3 months**
- **Claims administrators vary in their practices concerning which RFAs are included in the listings**
 - **DWC asks for every RFA but some claims administrators include only RFAs referred to UROs or elevated for in-house clinical review**
- **Approval rates for initial RFAs computed from URA listings are:**
 - **Understated if RFAs approved by claims adjustors are not on listing**
 - **Overstated if RFAs are withdrawn and resubmitted to meet claims adjustors criteria**
- **We used the audit listings that report all RFAs as case studies to:**
 - **Estimate UR approval rates**
 - **Determine level at which UR decisions are made**

Approval Rates Ranged from 74%-96% for the UR Investigation Cases



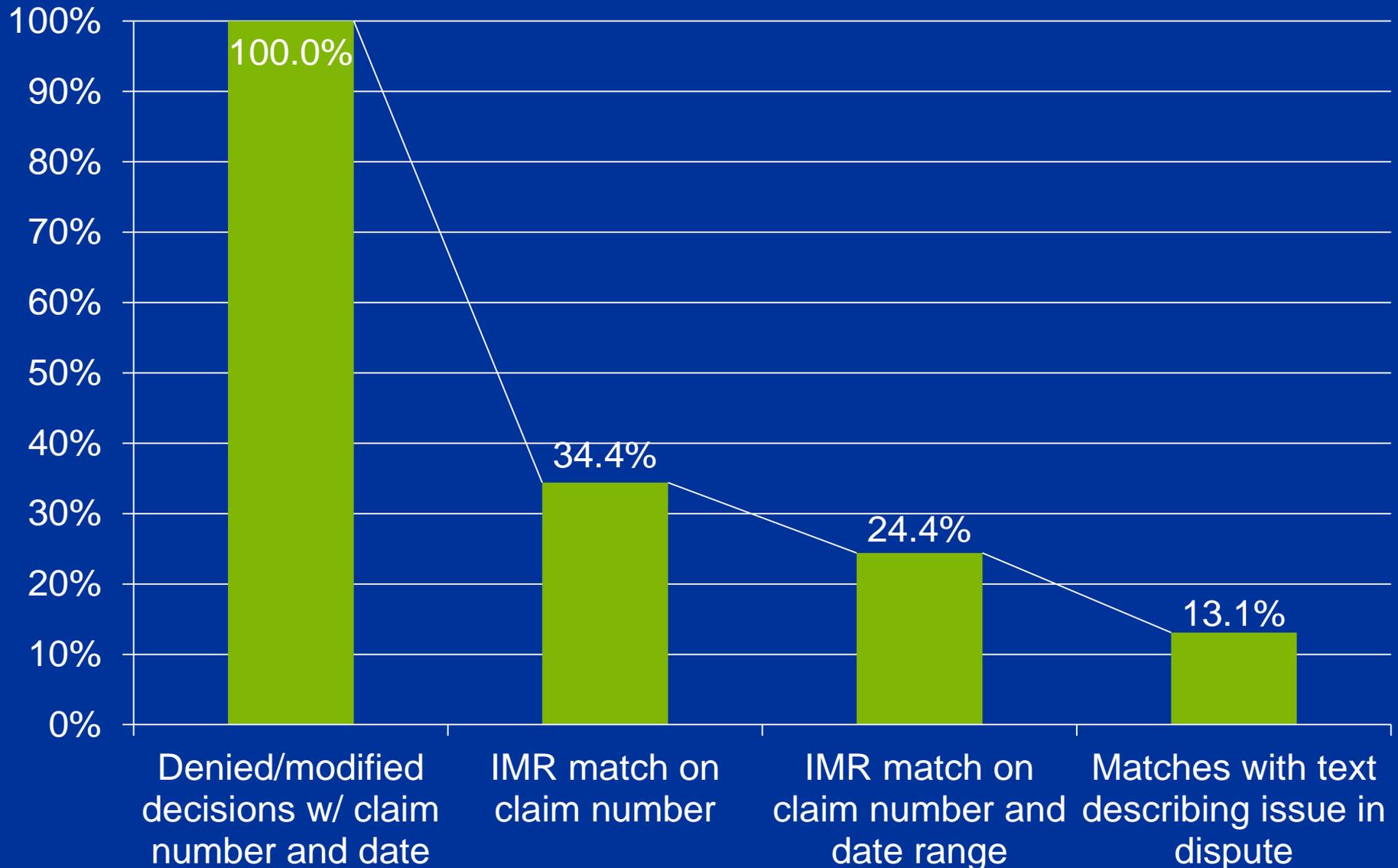
* Includes non-clinical reviewers in the URO nurse percentage

** Insurer has prior authorization policy for three occupational medicine clinics

The percent of UR denials appealed to IMR is uncertain but it appears many are not appealed

- **We matched the audit listing denials to a file provided by Maximus of its 2014 IMR decisions using a hierarchy of matching logic**
 - **Not all UR audit listings have date of UR denial or type of service**
- **We matched on claims administrator number, dates of UR denial and date of receipt for IMR appeal and type of service (which wasn't on all UR listings)**
- **An unknown portion of non-matching cases could be conditional denials (insufficient medical necessity documentation) or initial IMR decisions that were reversed on appeal**

Matching 2014 UR Decisions to IMR Decisions



Note: Of 10,963 2014 denied or modified UR decisions.

We Reviewed Rules of Other WC Programs

- **Our objective was to identify potential “best practices” that would reduce administrative burden and increase efficiency of UR process for medically appropriate care**
- **We identified 16 states that have both medical treatment guidelines and UR regulatory policies**
- **Most states do not require UR for all proposed treatment**
 - **Some have requirements for non-managed care only**
 - **Some incorporate UR requirements into their treatment guidelines for specific procedures**

Sample Requirements for Pre-Authorization in Other WC Programs

- **Care inconsistent with guidelines (CO, NY) or is not addressed by guidelines (MT)**
- **Care exceeds dollar threshold**
 - KY: surgical treatment or resident placement > \$3,000 or > 30 days lost work
 - LA: non-emergency medical services > \$750 or hospitalization
 - NY: \$1,000 exclusive of services covered by guidelines
 - TX: DME >\$500; Diagnostic study> \$350
- **Initial treatment is presumed medically necessary and does not require pre-authorization**
 - Ohio: within 60 days of injury: 10 physical medicine visits, diagnostic studies, up to 3 soft tissue injections, E&M visits and consultations
 - TX: first six PT or OT visits within first two weeks of injury or surgery

Sample UR Requirements in Other WC Programs (con't)

- **Specific treatments that require pre-authorization**
 - **FL: specialist consultations, surgical operations, PT/OT, X-ray examinations, or special diagnostic laboratory tests > \$1,000**
 - **NM: FCE, PT, caregiver services, DME**
 - **NY: spinal procedures (e.g., lumbar fusions, artificial disks, spinal stimulators), knee replacements, repeat procedures**
 - **TX: hospitalizations, outpatient surgery, spinal surgery, PT/OT (other than first 6 visits), investigational or experimental services, psych testing and psychotherapy, repeat diagnostic studies**
 - **WA: Lists preauthorization requirements by code in its fee schedule (including whether elevated review is required)**

Exempting Select Services from Pre-Authorization Would Improve Program Efficiency

- **Common perception voiced in our provider interviews was that formalizing the RFA process increased the volume of services undergoing prospective UR**
- **Exempting low-cost services that pose low-risk for injured workers from RFA process would reduce administrative burden for physicians and medical cost containment expenses and increase timeliness of care**
- **Starting point could be the types of services that are currently prior authorized or CAA-services**
 - **Could limit to care provided within an MPN**
 - **Could focus on care provided within one month of injury , e.g., PT/OT, low cost diagnostics and DME**

Increased Transparency in UR Process Should Improve Program Performance

Consideration should be given to:

- **Posting UR plans to facilitate understanding of UR review process used by different claims administrators**
- **Revamping the audit program to include new performance measures:**
 - **Submission of complete audit listings with all RFAs**
 - **Consistency between UR plan policies and levels at which decisions are made**
 - **Percent of reviews with requests for additional information**
 - **Percent of conditional denials**
 - **Average number of days for elevated review**
 - **Successful peer-to-peer contacts**

Some States Require URAC Accreditation

- **DWC rules require that entities performing UR management functions file a UR plan that outlines UR policies and procedures consistent with UR rules**
 - **UR investigation audit every 3-5 years is the main “look-behind” activity**
- **URAC is a national organization that accredits range of health programs, including entities performing WC UR**
 - **Estimate 26 of 60 UROs active in California are URAC-accredited**
- **Accreditation would provide more assurance that the URO has the infrastructure and processes in place to comply with UR requirements**
 - **Raises a “low bar” higher without imposing more burden on the state**
 - **Establishing new standards only for non-accredited UROs would be less burdensome on small UROs but poses additional burden on DWC**

Summary of Findings from Review of UR Process

- **Implementation of the IMR provisions had spillover effects on UR processes**
 - Increased reliance on evidence-based medicine
 - Increased administrative burden on providers
- **UR practices vary widely and subject providers to payer-specific rules**
- **Improvements to improve quality and efficiency of UR process should be considered :**
 - Combining RFA and progress reports into single form
 - Electronic submission and processing of RFAs
 - Exempting low-cost low risk services from UR
 - Revamping the DWC performance measures for UROs
 - Establishing additional standards for UROs



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