APPENDIX G

At-A-Glance

Utilization Review & Medical Bill Audit: Deficiencies & Recommendations

Compliance

Deficiencies	Recommendations
■ The client will not authorize the UR vendor to perform a review, even though specific selection criteria have been met. For example, during medical bill audit, the vendor notices that the payment threshold of $3,000 has been met and notifies the client of that fact. Yet the carrier never authorizes utilization review. ■ Carriers and self-insured employers are allowed to undertake a “split” plan. That is, the carrier/employer performs its own bill audit but contracts with a vendor for utilization review or contracts with separate vendors for utilization review and medical bill audit. Clients who perform their own medical bill audit only send a few, or no, cases for utilization review even though selection criteria are often met. The utilization review agent does not have access to the bills or records unless the client specifically sends them. When the client contracts with the vendor, the client says it understands its responsibility to select claims based on the selection criteria and forward them to the vendor. However, the client often fails to do so. When separate vendors perform the utilization review and medical bill audit, often these activities are not coordinated. ■ Adjusters only send complicated or disputed items to utilization review. ■ Even if the carrier or self-insured employer does not intentionally ignore utilization review, a serious lack of education exists among claims adjusters. Many adjusters only know utilization review as a preauthorization process for surgeries and in-patient admissions, or they know nothing about it. ■ Carriers and self-insured employers consistently refer cases to utilization review for determinations outside the scope of utilization review—causation and work-relatedness. (Causation and work relatedness is discussed in a later section of this report.) ■ Carriers and self-insured employers often question the utilization review decision and pressure the utilization reviewer to change its expert conclusions.	■ Audit those who are required to implement utilization review: the carriers, self-insured employers, and self-insurance groups. ■ Provide extensive education to carriers, self-insured employers, and medical providers through personal appearances, “train the trainer” seminars, and wide distribution of educational materials such as “Navigating Workers Compensation Medical Regulations.” ■ Create a guidebook, the “Navigating Workers Compensation Medical Regulations.”

CAUSATION/WORK-RELATEDNESS

Deficiencies	Recommendations
■ Kentucky utilization review programs are continuously asked to make decisions regarding causation and work-relatedness. ■ An audit of recent medical fee disputes filed at DWC revealed that causation and work-relatedness are most often the issue, not appropriateness of treatment. ■ Usually there is no clear distinction between the issues of appropriateness of treatment and work-relatedness. This significantly confuses the function and scope of utilization review. ■ Carriers and self-insured employers use utilization reviewers for causation opinions. ■ Many questions relating to causation/work-relatedness are a mix of legal and medical issues.	■ Clarify whether utilization reviewers may make causation/work-relatedness determinations. ■ If utilization review is permitted to make causation determinations, limit those reviews to only questions that are strictly medical (can be answered by medical textbooks or knowledge). ■ Provide a mechanism for opinions from disinterested third-party physicians on intricate medical questions and questions relating to medical causation, such as at the universities per KRS 342.315. ■ Require approval letters to include language that preauthorization does not guarantee payment. Payment is ultimately the decision of the payment obligor. ■ Require form letters to identify the utilization reviewer and to briefly explain the purpose of utilization review.

SELECTION CRITERIA FOR UTILIZATION REVIEW

Deficiencies	Recommendations
■ Lack of uniformity in identifying and responding to the selection criteria. ■ Selection criteria are difficult to track. ■ Retrospective review does not work because the bills have often been paid before the case is flagged for review. ■ Retrospective review creates adversarial situations, leading to costly medical fee disputes. ■ Utilization review is viewed as expensive, and without measurable savings.	■ Remove the utilization review selection criteria from regulatory requirements. ■ Require utilization review to begin upon the occurrence of an injury. ■ Allow utilization review of a treatment plan, rather than requiring utilization review of each individual medical procedure. ■ Require teleponic conference between UR agent and treating provider prior to any denial. ■ If selection criteria remain, allow the batching of services for review on either a dollar or time basis. ■ Clarify what type of review should occur when a selection criterion is met and a case is subject to utilization review. ■ If selection criteria remain, require retrospective review to occur and be completed prior to payment being rendered by the payor.

PREAUTHORIZATION

Deficiencies	Recommendations
▪ In non-managed care, nearly all workers compensation utilization review in Kentucky is retrospective. ▪ Failure to request preauthorization is not grounds to withhold payment.	▪ Allow utilization review programs outside of managed care to require more extensive preauthorization, particularly for certain procedures, physical therapy, and chiropractic treatment. ▪ Allow for preauthorization of entire treatment plans rather than for individual procedures. ▪ Allow failure to obtain preauthorization as grounds for denying payment of bills. ▪ Require each injured employee to be provided with a “utilization review card.”

DESIGNATED PHYSICIAN AND TREATMENT PLANS

Deficiencies	Recommendations
▪ Some carriers/self-insured employers have inconsistently complied with 803 KAR 25:096; others have made no effort to comply. ▪ Even if an employee fails to designate a physician or goes to a physician without referral, the medical bills are nevertheless paid. Employees generally fail to return Form 113. ▪ The referral part of the designated physician process is virtually nonexistent in practice.	▪ Allow carriers/employers to deny a bill on grounds that the treatment was provided by a physician other than the designated physician or without a referral from the designated physician. ▪ Revise the procedure for designating physicians again. The procedure was revised December 1996, but no noticeable improvement in compliance has occurred. ▪ Eliminate Form 113 and replace it with a pre-authorization card which must be presented to each physician by the patient. On this card it should state that no services will be paid unless preauthorized. This is the procedure used in Massachusetts.

MEDICAL FEE DISPUTES

Deficiencies	Recommendations
■ Even if a payment obligor "wins" the utilization review, it must still file a medical fee dispute. ■ In many instances where utilization review is applicable, it is either not being performed or it is being performed incorrectly. ■ Utilization review is widely perceived as having no legal weight and, therefore, is seen as a waste of time.	■ Require only the aggrieved party to the utilization review decision to file a medical fee dispute. ■ Provide some weight for utilization review decisions.

OVERSIGHT OF APPROVED UTILIZATION REVIEW PROGRAMS

Deficiencies	Recommendations
■ There is no uniform method of data keeping among utilization review programs. ■ Since each program records outcomes in different ways, comparisons about percentages of denials submitted by any two programs may not be accurate. ■ There is no data reporting requirement relative to utilization review. ■ There is no formal complaint process for complaints regarding utilization review and medical bill audit programs.	■ Create a formal complaint process for complaints against utilization review programs and payors. ■ Mandate data reporting—at least some type of annual report— relative to utilization review. ■ Require uniformity in data collection, retention, and reporting by vendors, carriers, and self-insured employers relative to utilization review. ■ Increase efforts to educate providers, payors, attorneys, and injured workers about utilization review and other workers compensation medical requirements. ■ Regularly audit utilization review vendors, carriers, and self-insured employers.

PENALTIES

Deficiencies	Recommendations
■ Failure to perform utilization review when selection criteria apply and failure to perform utilization review properly are frequent occurrences. ■ Numerous carriers and self-insured employers have not yet reported to the DWC that they have implemented utilization review and medical bill audit.	■ First, penalize all carriers and self-insured employers who have not implemented utilization review and medical bill audit ■ Second, penalize for improper utilization review. ■ Clarify penalty for failing to comply with other medical regulations, such as the designated physician requirement.