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Report to the Commissioner,  
Walter W. Turner

**Status Report on  
Utilization Review and  
Medical Bill Audit in  
Non-Managed Care**

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Kentucky Department of Workers Claims  
October 1997

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# STATUS REPORT ON UTILIZATION REVIEW AND MEDICAL BILL AUDIT

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## INTRODUCTION

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### **Why This Report Was Prepared**

This report was prepared to appraise the Commissioner of the Department of Workers Claims of the status of utilization review, including: effectiveness in achieving its objective of removing medical decisions from carrier adjusters; reducing under-utilization or over-utilization of medical services rendered to injured workers; and reducing medical costs. The purpose of this report is also to appraise the Commissioner of unforeseen issues that have arisen in the implementation of utilization review.

### **Method**

Since utilization review and medical bill audit were legislatively mandated on April 4, 1996, by provision of House Bill 928, the Kentucky Department of Workers Claims (hereafter referred to as DWC) has approved 45 utilization review and medical bill audit programs. (*See Appendix A.*) To assess the effectiveness of utilization review and medical bill audit, 13 “Quality Assessment Audits” of approved programs were conducted, numerous reviews were made of medical fee disputes brought before arbitrators at DWC, utilization review complaints received by DWC were reviewed, and other jurisdictions were contacted to achieve a fuller understanding of how utilization review and medical bill audits are handled. It was found that the issues, deficiencies, and concerns outlined in this report are common among the programs approved to provide utilization review and medical bill audit in Kentucky and elsewhere nationally.

### **Summary of Findings**

Through conducting individual program audits of utilization review and medical bill audit vendors, auditing medical fee disputes and reviewing state statutes in other states, the DWC has identified significant problems with the current utilization review process that need to be addressed. (*See Appendix B for sample reports.*) Commonplace within each program are technical deficiencies such as insufficient form letters. However, the more pervasive problems deal with interpretation and application of the utilization review and medical bill audit requirements.

The extent of confusion surrounding workers compensation medical bill issues is alarming, and many of the technical deficiencies result from this general confusion. For instance, questions of

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***At this time almost any carrier or self-insured employer chosen for an audit would be a certain candidate for penalties.***

“causation” and “work-relatedness” of injuries, rather than medical necessity or appropriateness of treatments, are most often at issue. Also, consistency does not exist among approved utilization review programs in identifying and responding to the selection criteria mandated by 803 KAR 25:190. No program handles utilization review selection criteria as envisioned by DWC when promulgating the regulation. In auditing medical fee disputes filed, DWC has determined that in many instances where utilization review is applicable, it is either not being performed or it is being performed incorrectly. Violating or failing to comply with utilization review and medical bill audit administrative regulations potentially entails a penalty. At this time almost any carrier or self-insured employer chosen for an audit would be a certain candidate for penalties.

### **What This Report Covers**

This *Status Report on Utilization Review and Medical Bill Audit* addresses the issues and deficiencies discovered in the recent “Quality Assessment Audits,” medical fee dispute audits and review of utilization review regulations in other states. The *Status Report* also makes recommendations for correcting the deficiencies and for monitoring the overall program. First, however, a history of utilization review is in order.

## **HISTORY OF UTILIZATION REVIEW**

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In recent years medical costs are estimated to account for 40-50 percent of the nation’s workers compensation benefits, according to the National Council for Compensation Insurance (NCCI). The group health insurance industry has used utilization review (UR) and medical bill audit (MBA) for many years as a cost-containment mechanism. The workers compensation industry has been slow to employ many of the cost-containment programs that have proven successful for group health. During the 1990s approximately 30 states, in addition to Kentucky, have adopted mandatory or voluntary UR and/or MBA. An additional seven states have adopted UR as part of managed care laws. (Data based on a 50-state summary of workers compensation UR and managed care prepared by the Massachusetts Department of Industrial Accidents.)

In 1994 the Kentucky General Assembly passed legislation that substantially reformed the system for the delivery of health care benefits to injured workers. The reform required the adoption of fee schedules that would result in a 25 percent reduction in medical fees, permitted the formation of managed care organizations, mandated

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**The workers compensation industry has been slow to employ many of the cost-containment programs that have proven successful for group health.**

utilization review and medical bill audit, and required designated physicians to coordinate medical care for injured workers. The Workers Compensation Act was revised and administrative regulations were adopted to meet the objectives of improving medical treatment, reducing over utilization of services, reducing litigation over medical matters and facilitating the exchange of information between physicians and payors.

As part of the 1994 workers compensation reform, KRS 342.035 required the Commissioner of DWC to promulgate administrative regulations governing medical provider utilization review activities conducted by insurance carriers, group self-insurers, and self-insured employers. To assist in drafting a UR and MBA regulation, DWC formed an advisory committee comprised of representatives from the legal, medical, and insurance industries. On September 19, 1995, 803 KAR 25:190 became effective. This regulation requires every individual self-insured employer, group self-insurance fund, and insurance carrier to implement a utilization review and medical bill audit program and to submit a written plan describing the program to the Commissioner for approval. Amendments to 803 KAR 25:190, which were primarily housekeeping measures, clarification of the utilization review process, and an attempt to ensure greater compliance, became effective December 13, 1996.

**Definition of Utilization Review & Medical Bill Audit**

**Utilization review** is a review of the medical necessity and appropriateness of medical treatment and services. For the workers compensation process, 803 KAR 25:190 defines utilization review as:

**Utilization review is a review of the medical necessity and appropriateness of medical treatment and services.**

. . . a review of the medical necessity and appropriateness of medical care and services for purposes of recommending payments for compensable injuries or diseases. Medical services which are rendered or requested for incidents which are noncompensable under KRS Chapter 342 are not subject to utilization review under this administrative regulation.

In other words, assessing the necessity and appropriateness of medical treatment ultimately serves the purpose of determining whether payment is warranted. Utilization review should ensure that an effective treatment plan is implemented and that over utilization of services is avoided, thus reducing medical costs. Medical necessity and appropriateness includes a review of the setting, frequency, and intensity of the treatment. The medical service or treatment is reviewed against objective clinical criteria and medical practice parameters such as the *Clinical Practice Parameters on the Acute*

**Medical bill audit is an examination of medical bills to assure compliance with adopted fee schedules.**

*Low Back Problems in Adults*, developed by the Kentucky Health Care Policy Board in 1995.

**Medical bill audit** is an examination of medical bills to assure compliance with adopted fee schedules. The medical bill audit process must also confirm that an injured employee has designated a physician as required by KRS 342.020(5).

## ISSUES IN UTILIZATION REVIEW

Through conducting “Quality Assessment Audits” of approved utilization review and medical bill audit programs, and medical fee disputes, reviewing utilization review statutes from other states, and from fielding numerous daily questions and complaints received, DWC has determined that many issues about utilization review are not only common among program participants within the State of Kentucky, but are being struggled with on a national basis. The main issues that have emerged are: compliance, causation/work-relatedness, selection criteria, preauthorization, managed care versus utilization review, physician designation and treatment plans, medical fee disputes, oversight of approved utilization review programs, and penalties.

### Compliance

**ISSUE:**

- **Many current problems in utilization review are a result of insurance carriers, self-insured employers, and group self-insurers noncompliance and lack of training, rather than poor utilization review and bill audit by utilization vendors.**

**One consistent complaint from utilization review vendors is carrier noncompliance with referral policies.**

To comply with 803 KAR 25:190, the majority of insurance carriers, self-insured employers, and group self-insurers employ utilization review and medical bill audit vendors who have been approved by DWC. A consistent complaint from vendors is of client noncompliance with referral policies. The regulation mandates that as soon as an employee has been off work for 30 days or has accumulated \$3,000 in medical bills, the case must be sent to the utilization review vendor for review. Vendors complain that clients fail to forward claims for review once the 30 day, or \$3,000 criteria is met. Since vendors frequently lack access to lost work day data and medical payments to date information, they are not in a position to



**As implementation trickles down to adjusters and out to branch offices, a breakdown in communication and understanding occurs.**

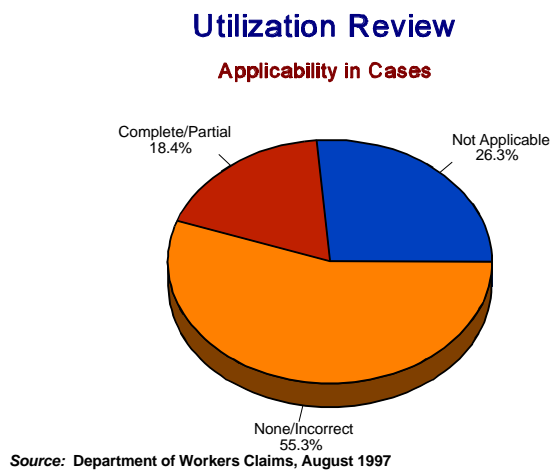
help clients achieve compliance. Vendors complain that clients view attempts to educate carrier personnel with resentment, deeming any intervention as subterfuge to increase the vendors profitability.

Similar complaints are heard from attorneys active in workers compensation practice. They frequently complain that adjusters either intentionally ignore or do not understand utilization review regulations.

In practice vendors and workers compensation attorneys seem to understand utilization review and medical bill audit strategies much better than do carrier staff. This is predictable. A vendor’s goal is to make a profit and to remain approved by DWC to perform the service. An attorney must understand the regulations since his or her income depends on providing accurate legal advice. A carrier, self-insured employer, or group self-insurer’s top management usually has a fair understanding of the regulations. However, as implementation trickles down to the adjusters and out to the field offices, a breakdown in communication often occurs.

An audit of 38 medical fee disputes filed at DWC for resolution reveals that in many cases utilization review is absent, incomplete, or incorrect. (See Appendix D for a summary report of the medical fee dispute audit.) In 10 cases, selection criteria did not apply. Therefore, utilization review was not applicable. In the 28 cases where utilization review appeared to apply, only seven cases had complete or partially complete utilization review reports. The remaining 21 cases where utilization review applied had either no utilization review or incorrect utilization review. (See Figure 1.)

**FIGURE 1**



**COMPLIANCE**

Deficiencies	Recommendations
<ul style="list-style-type: none"> <li>■ 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.</li> <li>■ 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.</li> <li>■ Adjusters only send complicated or disputed items to utilization review.</li> <li>■ 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.</li> <li>■ 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.)</li> <li>■ Carriers and self-insured employers often question the utilization review decision and pressure the utilization reviewer to change its expert conclusions.</li> </ul>	<ul style="list-style-type: none"> <li>■ Audit those who are required to implement utilization review: the carriers, self-insured employers, and self-insurance groups.</li> <li>■ 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.”</li> <li>■ Create a guidebook, the “Navigating Workers Compensation Medical Regulations.”</li> </ul>

## Causation/Work-Relatedness

**ISSUES:**

- Should a utilization review program render opinions on whether the medical condition and symptoms are causally related to the work?
- Should carrier’s determination of compensability precede referral for utilization review?

*Utilization review addresses only the clinical appropriateness and necessity of the medical treatment.*

### Utilization Review and Causation

Utilization review, as defined in general health care and in other states’ utilization review regulations, does not allow utilization review vendors to address questions of medical causation or work-relatedness. As defined by KAR 25:190 (*see Appendix C*), utilization review is allowed to address *only* the clinical appropriateness and necessity of the medical treatment. The Kentucky Cabinet for Health Services, which certifies utilization review agents in general health care, defines utilization review similarly as:

... a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a patient or group of patients for purposes of determining the availability of payment. (KRS 211.461 §5) (*See Appendix C*)

The Utilization Review and Accreditation Commission, a Washington, D.C. based organization which accredits utilization review firms for general health care, has developed standards for workers compensation utilization review. The new standards do not address causation and work-related issues specifically.

Kentucky utilization review programs are continuously asked to make decisions regarding causation and work-relatedness. These requests generally fall into four categories:

1. Whether the medical condition (diagnosis) reported has been caused by a work-related injury;
2. Whether the treatment is related to a work-related medical condition;
3. Whether a secondary diagnosis or additional treatment is medically related to the original diagnosis or injury;
4. Requests to separate (carve out) the work-related charges from the nonwork-related charges.

*Kentucky utilization review programs are continuously asked to make decisions regarding causation and work-relatedness.*

Answering these questions often requires formulation of medical opinions, a task for which the adjuster is not qualified. In a few

instances determination of the answer to one of the foregoing questions does not require medical expertise and the adjuster is equipped to give a prompt and correct answer. For instance where the reported injury involves the employee's right arm and medical bills are presented for treatment of the left arm, an adjuster is positioned to deny compensability. However, very few cases are so clear-cut. Most cases involve "grey areas" as to both causation and medical appropriateness.

**DWC regularly fields inquiries regarding when utilization review is warranted.**

As a result of confusion over the scope of utilization review, DWC staff regularly fields inquiries regarding when utilization review is warranted. For example consider the following actual cases:

### **Case 1**

A worker sustained an inguinal hernia while lifting boxes at work. Surgery was performed. The payor acknowledged the injury and voluntarily paid for the surgery. A few weeks later, the same worker developed a bilateral hernia and his physician requested preauthorization for another surgery.

*Question(s): Is the second hernia related to the original work injury? Could this type of second hernia medically arise from the same injury or from the first hernia?*

The utilization reviewer rejected the physician's request because the diagnosis relating to the second surgery (bilateral hernia) did not match the original diagnosis (inguinal hernia). Under the strict definition of utilization review, the reviewer should have rendered an opinion as to whether the second surgery was the appropriate treatment for the second type of hernia.

### **Case 2**

After a work-related knee surgery, a worker begins to experience chronic back pain. The treating physician says it is related to the knee injury because of a change in the worker's gait.

*Question: Could the back pain have medically been caused by the knee surgery?*

In strict utilization review, the utilization reviewer should only provide an opinion as to whether the treatment rendered for the back pain is the appropriate treatment for back pain, not whether the back pain is related to the knee injury. This is similar to the frequent question as to whether heart disease, etc., is caused by coal workers pneumoconiosis.

### **Case 3**

A woman injured her back at work and received treatment. A few months later, a physician requested preauthorization for an in-patient

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drug and alcohol detoxification program by calling the utilization reviewer directly.

*Question(s): Is the drug dependency related to the back injury? Should the request for utilization review be routed to the utilization reviewer through the adjuster?*

The utilization reviewer, applying strict UR, approved the admission as the appropriate treatment for drug and alcohol abuse. This example raised yet another question: Should requests for pre-certification go through the adjuster or directly to the utilization reviewer? In this case, because the request went directly to the utilization reviewer, the adjuster was unaware of the proposed admission and thus had no opportunity to challenge it as unrelated to the work injury. The patient was admitted for detoxification before the carrier knew it was approved. The utilization reviewer acted properly by only addressing the issue of medical relatedness, but the adjuster did not have the opportunity to deny on grounds of noncompensability.

**Nearly all Kentucky utilization review programs address causation questions regularly and frequently.**

The recent utilization review audits show that nearly all Kentucky utilization review programs address causation questions regularly and frequently. The programs handle these questions in a variety of ways. Some treat causation questions as typical utilization review and issue the same form letters, appeal rights, etc. Others address the questions; but recognizing that causation is not a true function of utilization review, label their review as a medical “consult.” One or two programs avoid addressing causation/work-relatedness issues.

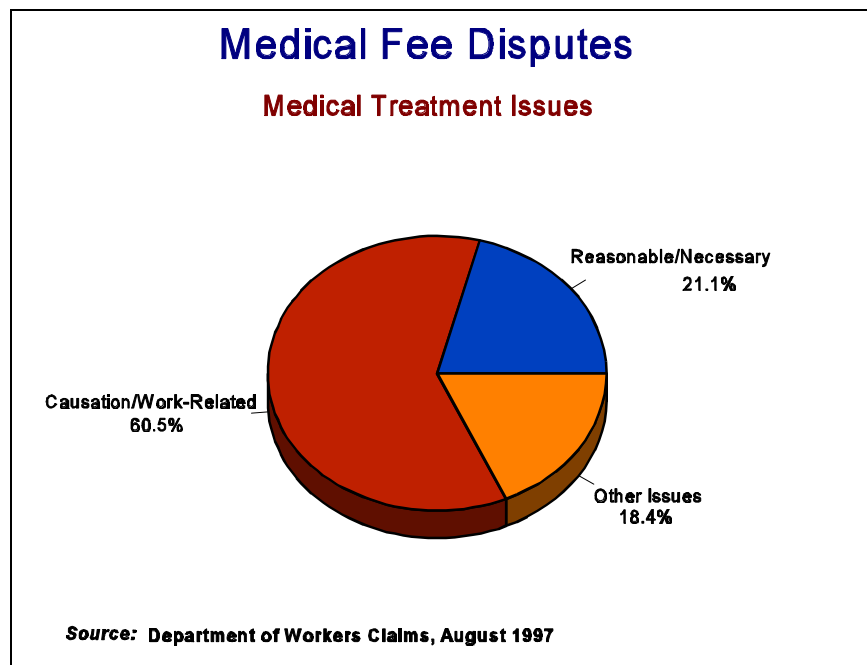
### **Medical Fee Disputes and Causation**

The audit of 38 medical fee disputes filed at DWC for resolution reveals that causation and work-relatedness, rather than medical necessity or appropriateness, are most often at issue. (*See Appendix D.*) In only eight cases is the sole issue whether the treatment was reasonable and necessary. In 23 cases, the issue is causation or work-relatedness. Failure to follow medical advice or inadequate statement for services are among the issues in the remaining seven cases. (*See Figure 2.*)

**An audit of recent medical fee disputes filed at DWC reveals that causation and work-relatedness are most often at issue.**

In most cases where the issue is cited as “reasonableness” of treatment by the party filing the fee dispute, investigation revealed the underlying charge to be that the treatment was “unreasonable because it is not related to work injury.” Usually clear lines do not divide the issues of reasonableness and work-relatedness. This significantly confuses the function and scope of utilization review.

FIGURE 2



### Utilization Reviewers and Causation

The Department of Workers Claims has consistently stated that causation and work-relatedness are legal issues, not within the scope of utilization review. However, carriers and self-insured employers believe using utilization reviewers for causation opinions is beneficial. It is “beneficial” in terms of cost. That is, carriers and self-insured employers do not have to incur the expense of obtaining independent medical exams (IME) for causation questions in addition to the cost of utilization review.

However, there are several problems inherent in using utilization review to obtain work-relatedness opinions. Utilization reviewers have limited access to medical records and are usually working within a narrow time frame. They only have enough information to determine whether the treatment at issue is reasonable. To provide opinions on causation and work-relatedness, utilization reviewers often need extensive medical and legal records, including physicians’ reports and relevant testimony as to what occurred in the workplace. In addition to the more extensive records that would be required for review, a physical examination of the injured worker might be necessary for a physician to render a competent opinion.

Accessing utilization review for questions concerning causation and work-relatedness detracts from the appearance of impartiality of

the utilization review program. Most importantly, utilization reviewers should not be placed in a position where they appear to be expert witnesses for one of the parties and might be called as expert witnesses beckoned by the carrier.

**The Massachusetts plan does not allow utilization reviewers to address causation or work-relatedness.**

### **The Massachusetts Plan**

Massachusetts, which has an extensive mandatory utilization review program, does not allow utilization reviewers to address causation or work-relatedness. Massachusetts utilization review, as in general health care, only determines the medical appropriateness and reasonableness of the treatment. In order to deal with the issue of causation, the state of Massachusetts has established an “impartial physician roster” consisting of approximately 750 physicians to make such determinations as appropriateness of treatment, causation, and permanent disability. The impartial physicians provide an independent medical exam at the expense of the movant in a fee dispute. The impartial physician’s report has *prima facie* evidence weight that is binding on all parties.

The theory behind the Massachusetts impartial physician program is similar to mechanisms adopted in Kentucky in 1996 for evaluation of workers asserting claims at our two university medical schools (KRS 342.315). If the universities are used as liberally as the statute implies “to make any necessary medical examination of the employee,” the Massachusetts and Kentucky models should function much the same. However, the Kentucky evaluation program may be too expensive and time consuming to handle many routine medical fee dispute questions.

Information regarding the Massachusetts plan was obtained from the article, “Massachusetts Turns the Tide,” *Journal of Workers Compensation*, Fall 1996, and from discussions with Donna Ward, the former director of the Massachusetts Office of Health Policy.

**CAUSATION/WORK-RELATEDNESS**

Deficiencies	Recommendations
<ul style="list-style-type: none"> <li>■ Kentucky utilization review programs are continuously asked to make decisions regarding causation and work-relatedness.</li> <li>■ 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.</li> <li>■ 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.</li> <li>■ Carriers and self-insured employers use utilization reviewers for causation opinions.</li> <li>■ Many questions relating to causation/work-relatedness are a mix of legal and medical issues.</li> </ul>	<ul style="list-style-type: none"> <li>■ Clarify whether utilization reviewers may make causation/work-relatedness determinations.</li> <li>■ 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).</li> <li>■ 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.</li> <li>■ Require approval letters to include language that preauthorization does not guarantee payment. Payment is ultimately the decision of the payment obligor.</li> <li>■ Require form letters to identify the utilization reviewer and to briefly explain the purpose of utilization review.</li> </ul>



## Selection Criteria for Utilization Review

**ISSUES:**

- Who is responsible for identifying claims which are subject to utilization review?
- What type of review should occur once selection criteria occur?
- What constitutes adequate review?

*No utilization review program observes the regulatory criteria as envisioned by DWC.*

### Identifying Utilization Review Selection Criteria

Pursuant to the utilization review regulation, claims are subject to review if:

- a. A medical provider requests preauthorization of a medical treatment or procedures; or
- b. Notification of a surgical procedure or resident placement pursuant to an 803 KAR 25:096 treatment plan is received; or
- c. The total medical costs cumulative total \$3,000; or
- d. The total lost work days cumulative exceed 30 days; or
- e. An administrative law judge (or arbitrator) orders a review.

Consistency does not exist among approved utilization review programs in identifying and responding to the selection criteria, especially the \$3,000 and 30 lost work days selection. No program observes the regulatory criteria as envisioned by DWC. Utilization review programs complain that the selection criteria are very difficult to track .

### Utilization Review Process

The DWC’s position has always been that upon meeting the 30 lost work days or \$3000 criteria, all the medical treatment provided to the injured worker is subject to retrospective review from that time forward. However, this is not specifically stated in the regulation. Consequently, utilization review agents have been left to interpret the rules on their own and have interpreted them in a variety of ways. Following are descriptions of the various types of review that occur when a criterion has been met:

*The various types of review that occur when a selection criterion has been met include: retrospective report, retrospective/prospective report, one-time bill review, and one-time bill review plus follow-up.*

- **Retrospective report.** Upon a 30-day or \$3,000 criteria being met, some utilization review programs perform a retrospective review of the case, going back either to its inception or back for 30 days. A report is generated and sent to the client as to whether the past treatment was appropriate according to the medical guidelines being utilized. The report is sent to the client, and usually the

utilization review agent does not handle the file again. Most carriers/employers believe if they send a case for a retrospective report when it meets a selection criterion, they have done their duty and are not required to submit the case for any additional utilization review as further treatment is performed.

- ***Retrospective/prospective report.*** The same type of retrospective report occurs as above. However, an additional opinion is rendered as to appropriate future treatment that should occur. Some utilization reviewers may monitor the case as a quasi-case manager, watching for treatment that does not conform to the guidelines. Other utilization review agents send the report to the client and never handle the file again.
- ***One-time bill review.*** The bill that pushes the case over \$3,000 is reviewed for medical necessity and appropriateness. No additional bills are reviewed, and the case is not followed. The claims adjuster must request or authorize any additional review. Most of the time the adjuster does not request any additional review.
- ***One-time bill review, plus follow-up.*** The bill that pushes the case over \$3,000 is reviewed for medical necessity and appropriateness. The case is diaried for approximately 30 days and then reviewed retrospectively by report, if it appears necessary. The follow-up that occurs in this situation is very loose, and no additional actual utilization review occurs unless the claims adjuster specifically requests it. Most of the time the adjuster does not request any additional review.

There are several reasons for eliminating the 30-day and \$3,000 criteria. The more conscientious programs believe that utilization review would be more effective if it began at the occurrence of the injury, instead of after \$3000 worth of bills have accumulated. They argue that delay prevents intervention in a case at the earliest stages, which is most crucial in ensuring appropriate treatment and successful return to work. Additionally, retrospective review for purposes of recommending payment does not work because the bills have often been paid before the case is flagged for review. Retrospective review would only have meaning if it had to occur prior to any bill being paid. Retrospective review is believed to be neither beneficial nor cost-effective. Also, many programs believe retrospective review actually causes adversarial situations leading to medical fee disputes. That is, retrospective review attempts to deny payment for services already rendered and not required to be preauthorized.

The DWC has recommended that each individual bill following a selection criteria being met should be reviewed. However, there has been some concern expressed about the cost of utilization review.

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***Retrospective review is believed to be neither beneficial nor cost-effective.***

Utilization review costs range from \$80 (simple) to \$300 (extensive) per review, depending on the amount of time the physician expends reviewing the file. If DWC requires every individual bill to be reviewed after a criterion is met, the cost of the review itself might often be more than the charge at issue, for example when the bill is only for an office visit or for one or two physical therapy sessions. Solutions include the batching of bills and the approval of entire treatment plans.

**SELECTION CRITERIA FOR UTILIZATION REVIEW**

Deficiencies	Recommendations
<ul style="list-style-type: none"> <li>■ Lack of uniformity in identifying and responding to the selection criteria.</li> <li>■ Selection criteria are difficult to track.</li> <li>■ Retrospective review does not work because the bills have often been paid before the case is flagged for review.</li> <li>■ Retrospective creates adversarial situations, leading to costly medical fee disputes.</li> <li>■ Utilization review is viewed as expensive, and without measurable savings.</li> </ul>	<ul style="list-style-type: none"> <li>■ Remove the utilization review selection criteria from regulatory requirements.</li> <li>■ Require utilization review to begin upon the occurrence of an injury.</li> <li>■ Allow utilization review of a treatment plan, rather than requiring utilization review of each individual medical procedure.</li> <li>■ Require telephonic conference between UR agent and treating provider prior to any denial</li> <li>■ If selection criteria remain, allow the batching of services for review on either a dollar or time basis.</li> <li>■ Clarify what type of review should occur when a selection criterion is met and a case is subject to utilization review.</li> <li>■ If selection criteria remain, require retrospective review to occur and be completed prior to payment being rendered by the payor.</li> </ul>

## Preauthorization

*In Kentucky, with the exception of managed care, nearly all workers compensation utilization review is retrospective.*

### **ISSUES:**

- Why is unlimited preauthorization acceptable in managed care but not in a non-managed care situation?
- Can utilization review succeed without significant prospective review?

In general health and in workers' compensation managed care, "preauthorization" is often used as a synonym for "utilization review." In Kentucky non-managed care situations, nearly all workers compensation utilization review is retrospective. Permissible preauthorization in non-managed care UR is very limited. DWC's policy is that an insurance carrier or self-insured employer can require preauthorization only in those situations defined by 803 KAR 25:096, specifically:

- In-patient non-emergency admissions
- Elective surgical procedures
- Pain management program admissions
- Rehabilitation facility admissions
- Mental health facility admissions
- Resident work-hardening programs

Preauthorization in non-managed care has little effect in reducing medical costs because failure to request preauthorization in one of the above situations may not be grounds to withhold payment.

803 KAR 25:190 provides that preauthorization (prospective utilization review) for any type of medical service or treatment must be performed upon a medical provider's request. Providers are generally unaware of this provision, do not know to whom to make the request, or complain that they cannot get timely responses.

Approved workers' compensation managed care organizations have more extensive preauthorization requirements. This is possible because they are not subject to the limitations and requirements of 803 KAR 25:190. Initial utilization review is usually performed by an in-house utilization review nurse. This nurse is salaried and is not paid on a per-case basis, thus greatly reducing utilization review costs. Furthermore, the UR nurse performs pre-certification of entire treatment plans rather than individual procedures.

A list of requisite items for preauthorization obtained from an approved managed care organization is set forth in Appendix E. Most

*Approved workers compensation managed care organizations have significant preauthorization requirements.*

**KRS Chapter 342 does not specifically address preauthorization for medical treatment.**

managed care organizations have similar lists or require pre-authorization of treatment plans.

KRS Chapter 342 does not specifically address preauthorization for medical treatment either in a managed care or non-managed care setting. KRS 342.020 states simply that the employer shall pay for the cure and relief from the effects of an injury or occupational disease. In providing statutory authorization for managed care organizations, KRS 342.020 §4 requires utilization review as a component of the managed care plan:

The managed health care system shall establish procedures for utilization review of medical services to assure that a course of treatment is reasonably necessary; diagnostic procedures are not unnecessarily duplicated; the frequency, scope, and duration of treatment is appropriate; pharmaceuticals are not unnecessarily prescribed; and that ongoing and proposed treatment is not experimental, cost ineffective, or harmful to the employee . . . (See *Appendix C.*)

KRS 342.035 §5(c), which mandates utilization review for non-managed care states:

The commissioner shall promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, group self-insurer, or self-insured employer pursuant to this chapter. (See *Appendix C.*)

**Utilization review mandated in other states typically permits more extensive preauthorization than in Kentucky.**

Utilization review processes in other states typically permit more extensive preauthorization than in Kentucky. Most preauthorization is procedure-driven, usually requiring preauthorization for surgeries, in-patient admissions, continued stay, physical therapy, chiropractic, MRI, and other diagnostic tests. It is strongly believed among utilization reviewers that early intervention is the key component in successful medical treatment and returning injured workers to work. Retrospective review is seen as increasing disagreement over medical issues.

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## PREAUTHORIZATION

Deficiencies	Recommendations
<ul style="list-style-type: none"> <li>■ In non-managed care, nearly all workers compensation utilization review in Kentucky is retrospective.</li> <li>■ Failure to request preauthorization is not grounds to withhold payment.</li> </ul>	<ul style="list-style-type: none"> <li>■ Allow utilization review programs outside of managed care to require more extensive preauthorization, particularly for certain procedures, physical therapy, and chiropractic treatment.</li> <li>■ Allow for preauthorization of entire treatment plans rather than for individual procedures.</li> <li>■ Allow failure to obtain preauthorization as grounds for denying payment of bills.</li> <li>■ Require each injured employee to be provided with a "utilization review card."</li> </ul>

### Managed Care Versus Utilization Review

**ISSUE:**

- Why does utilization review within managed care seem to accomplish more than utilization review pursuant to 803 KAR 25:190?

***Managed care allows a more pro-active role in the injured worker's treatment, beginning as soon as the injury occurs.***

Some utilization review programs that were audited are also part of an approved managed care organization. The same staff performs the utilization review component for both. During the audit of these programs, questions were routinely asked about managed care operations and policies.

Responses to questions about utilization review in managed care were resoundingly positive. Utilization review in managed care includes more liberal and extensive preauthorization mechanisms. Case managers and adjusters do not feel compelled to send cases to utilization review unless they involve complicated issues. Managed care facilitates a pro-active role in the injured worker's treatment, beginning as soon as the injury occurs. Other key components, absent in workers compensation outside managed care, are the oversight of medical providers, active relationships with the providers, and greater educational opportunities with the employer and medical providers.

**Responses to questions about managed care are always positive. In contrast, utilization review is viewed as confusing and difficult to manage.**

Within a managed care organization, complaints are seldom lodged that utilization review is too expensive. Case managers are given a good deal of discretion to make direct contact with physicians to discuss questionable medical practices and procedures. Sometimes, they negotiate an alternative treatment plan with the physician, thus obviating the need for formal utilization review. Additionally, many managed care organizations require pre-authorization of an entire treatment plan, eliminating the need for pre-authorization of individual procedures. Since the medical providers are all within the provider network, the managed care organization entrusts them to provide appropriate treatment. The managed care organization does not believe it necessary to submit all medical services to utilization review for approval.

In contrast, utilization review outside of managed care is viewed as confusing and difficult to manage. Nevertheless, carriers and self-insured employers still choose not to participate in managed care due to the perception that it involves an expensive initial outlay of funds and the relinquishment of control.

### **Designated Physician and Treatment Plans**

(803 KAR 25:096)

**The process of designating physicians and submitting treatment plans does not work as anticipated by DWC.**

For utilization review to function effectively, medical providers, injured workers, and payors must fully implement other medical regulations promulgated by DWC. Foremost is 803 KAR 25:096 establishing designated physician and treatment plan requirements. *(See Appendix C.)*

KRS 342.020 §5 states:

Except for emergency medical care, medical services rendered pursuant to this chapter shall be under the supervision of a single treating physician or physicians' group having the authority to make referrals, as reasonably necessary, to appropriate facilities and specialists.

803 KAR 25:096 sets forth the process by which injured workers will choose a designated physician. The carrier or employer must send the injured worker a "Form 113." The injured worker must complete the Form 113, identifying the designated physician. The physician must also sign the Form 113. Once the Form 113 is returned to the carrier or employer, the carrier/employer sends the worker a "designated physician card." All treatment should be rendered either by the physician named on the card or by a specialist to whom referral has been made.

This process does not in fact occur as designed by DWC. Many carriers and self-insured employers have not taken the regulation seriously and have made no effort to comply. Others have attempted to implement the requirements, but are unable to sustain compliance. There are several reasons for this inability to comply with the regulation, the foremost being that the injured worker fails to return the Form 113.

Often, by the time the injured worker returns the Form 113, he or she has already gone to a second or third physician; and the process must begin again. Due to a lack of education among physicians, many will treat injured workers without asking to see the designated physician card or without proper referral. It is virtually impossible for the payor or the utilization review agent to monitor and enforce the designated physician requirement.

As envisioned by DWC, the designated physician is in charge of the patient's care, must develop a treatment plan, and is responsible for referral of the patient to medical specialists. The injured worker is not to consult medical specialists without the referral from his designated physician. Adjudicators have seldom interpreted KRS 342.020 §5 as allowing a payor to withhold payment for medical treatment rendered by a physician other than the designated or referral physician. Since there is no perceived penalty for noncompliance with this provision, if the employee fails to designate a physician or goes to physicians without referral from the designated physician, the bills are nevertheless paid. Thus the regulation has little effect.

***The theory for the designated physician process is to stop "doctor shopping."***

The theory behind the designated physician is to prevent "doctor shopping" by having one designated physician assume responsibility for coordinating the patient's care, and referring the patient to additional physicians when necessary. The referral part of this process is virtually nonexistent in practice. The designated physician does not always understand that he is agreeing to coordinate the employee's care, or may be unwilling to assume the responsibility.

Unlike the group health care situation, the employee who seeks treatment for a work-related injury has little incentive to be concerned about seeing only a designated physician. That is because with general health care insurance, the insured must personally pay for unauthorized or nonreferred treatment. Patients in group health care plans face strong financial incentives to comply with designated physician and referral requirements. In the workers compensation system, non-managed care providers know they will get paid as long as the treatment is reasonable; and the employee knows that he will never be personally responsible for any part of the bill.

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**DESIGNATED PHYSICIAN AND TREATMENT PLANS**

Deficiencies	Recommendations
<ul style="list-style-type: none"> <li>■ Some carriers/self-insured employers have inconsistently complied with 803 KAR 25:096; others have made no effort to comply.</li> <li>■ 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.</li> <li>■ The referral part of the designated physician process is virtually nonexistent in practice.</li> </ul>	<ul style="list-style-type: none"> <li>■ 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.</li> <li>■ Revise the procedure for designating physicians again. The procedure was revised December 1996, but no noticeable improvement in compliance has occurred.</li> <li>■ 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.</li> </ul>

**Medical Fee Disputes**

(803 KAR 25:012)

**ISSUE:**

- What effect has UR had on the number of medical fee disputes filed at DWC?

When UR was implemented in April 1996, it was anticipated that the number of medical fee disputes filed would drastically decrease. It was also anticipated that any medical fee disputes which were filed would contain a complete UR report. The UR report was expected to aid the Arbitrator or Administrative Law Judge in resolving the fee dispute, since it could be considered an objective medical opinion. By way of historical perspective, figures for the past four full calendar years, 1993-1996, show that the number of medical fee disputes filed in pre-award or settlement cases has decreased from 2,322 claims in 1993 to 221 claims in 1996. During the past two calendar years, 1995 and 1996, the decrease in medical fee disputes has been less drastic but nonetheless significant from 543 claims to 221 claims.

*Medical fee disputes have substantially decreased and are leveling off; medical reopenings have remained rather stable but are now decreasing.*

FIGURE 3

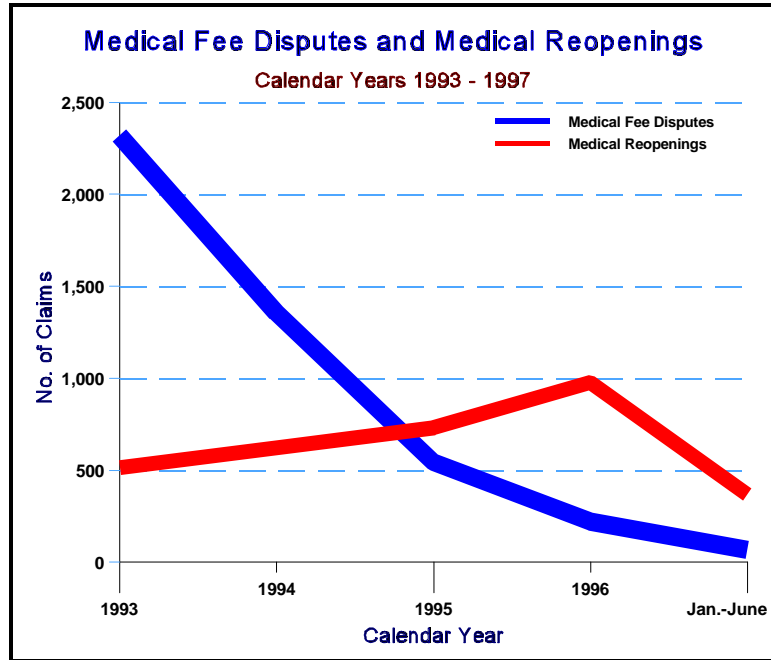
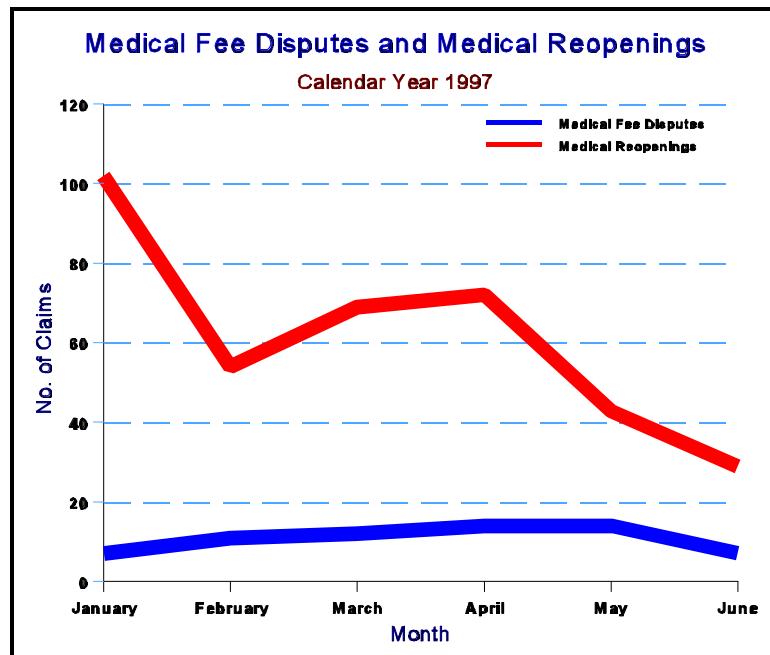


FIGURE 4



*During the first six months of 1997, the number of medical fee disputes filed has remained relatively low and stable, while the number of medical reopenings has decreased.*

During this same time frame, 1992-1996, the number of medical reopenings (medical disputes filed in a post-award or settlement case) has remained more stable, but peaking at 979 claims in 1996. (See Figure 3.)

Tracking the number of medical fee disputes and medical reopenings filed during the first six months of 1997, similar numbers are found, with a total of 434 having been filed (See Figure 4.)

It is difficult, if not impossible, to determine from this data whether UR has had an impact on the number of medical fee disputes filed at DWC. The number of medical fee disputes appears to have been decreasing prior to the implementation of UR and managed care. The implementation of managed care in 1994 may have contributed to the decline. The designated physician and treatment plan regulations were adopted in 1993 and may have also contributed.

Despite downward trending during recent years, DWC remains concerned about the incidence of medical fee disputes. Medical fee disputes are both time consuming and costly to the workers' compensation claims system. More importantly, they are an indication of frustration of one of the program's primary goals-- expeditious delivery of necessary medical services to the injured worker.

There are other problems relative to medical fee disputes and UR. 803 KAR 25:012 requires utilization review to be completed prior to filing the application for resolution of the medical fee dispute, and KRS 342.020 requires the payment obligor to pay a bill within 30 days of its presentation to the payor. (See Appendix C.) Although utilization review tolls the 30 days to pay or contest the bill, even if the payment obligor "wins" the utilization review (treatment determined to be unreasonable), existing rules have been interpreted so as to require the filing of a medical fee dispute. There is no provision that completed utilization review indicating medical inappropriateness is sufficient grounds for a carrier to deny a bill. Thus, utilization review does not serve its intended function of limiting medical fee disputes brought before the arbitrators and administrative law judges at DWC.

Also, providing an objective medical opinion to aid arbitrators and administrative law judges in resolving medical fee disputes has not occurred as expected. In auditing medical fee disputes, DWC has determined that in many instances where utilization review is applicable, it is either not being performed or it is being performed inadequately. Furthermore, utilization review is widely perceived as having no legal weight and, therefore, is seen as a waste of time. (See

Town Talk Manufacturing v. Ramona Lucas, 96-04259, *Workers Compensation Board Opinion, May 9, 1997, Appendix F.*)

#### MEDICAL FEE DISPUTES

Deficiencies	Recommendations
<ul style="list-style-type: none"> <li>■ Even if a payment obligor “wins” the utilization review, it must still file a medical fee dispute.</li> <li>■ In many instances where utilization review is applicable, it is either not being performed or it is being performed incorrectly.</li> <li>■ Utilization review is widely perceived as having no legal weight and, therefore, is seen as a waste of time.</li> </ul>	<ul style="list-style-type: none"> <li>■ Require only the aggrieved party to the utilization review decision to file a medical fee dispute.</li> <li>■ Provide some weight for utilization review decisions.</li> </ul>

### Oversight of Approved Utilization Review Programs

Massachusetts has a formal—and a successful—complaint process for utilization review programs in place. Every complaint, whether it is a failure to render timely opinions or a failure to provide an injured worker with a notice of rights, is investigated. Massachusetts attributes its program’s success to 100 percent compliance by insurers, group self-insurers, and individual self-insured employers. The state regularly audits its approved utilization review programs, carriers, and self-insured employers. In addition, Massachusetts’ data system tracks compliance with utilization review requirements, patterns of care, compliance with treatment guidelines, return to work, and other outcomes. During the first two years of utilization review, Massachusetts also made a significant effort to educate medical providers, attorneys, and payors concerning utilization review.

Although Kentucky’s utilization review regulation, 803 KAR 25:190, requires each utilization review program to maintain a database recording the instances of review, there is no uniform method of data keeping among the programs. When reviewing the data each program prepares, it is impossible to determine whether this produces a fair comparison to other programs. Each program records outcomes in different ways. Therefore, comparisons about percentages of denials submitted by any two programs may not be accurate. Also, since there is no data reporting requirement relative to utilization review, DWC cannot track the instances of utilization review.

*There is no uniform method of data keeping among the utilization review programs.*

OVERSIGHT OF APPROVED UTILIZATION REVIEW PROGRAMS

Deficiencies	Recommendations
<ul style="list-style-type: none"> <li>■ There is no uniform method of data keeping among utilization review programs.</li> <li>■ Since each program records outcomes in different ways, comparisons about percentages of denials submitted by any two programs may not be accurate.</li> <li>■ There is no data reporting requirement relative to utilization review.</li> <li>■ There is no formal complaint process for complaints regarding utilization review and medical bill audit programs.</li> </ul>	<ul style="list-style-type: none"> <li>■ Create a formal complaint process for complaints against utilization review programs and payors.</li> <li>■ Mandate data reporting—at least some type of annual report—relative to utilization review.</li> <li>■ Require uniformity in data collection, retention, and reporting by vendors, carriers, and self-insured employers relative to utilization review.</li> <li>■ Increase efforts to educate providers, payors, and injured workers about utilization review and other workers compensation medical requirements.</li> <li>■ Regularly audit utilization review vendors, carriers, and self-insured employers.</li> </ul>

**Many carriers and self-insured employers still have not reported to DWC that they have implemented utilization review and medical bill audit.**

**Penalties**

KRS 342.990 §7(e) provides for a \$100 to \$1,000 fine for each instance of noncompliance with utilization review and medical bill audit administrative regulations. (See Appendix C.) Any carrier or self-insured employer selected for an audit at this time would be a prime candidate for penalties. Failure to perform utilization review when selection criteria apply and failure to perform utilization review properly occur frequently and are easily documented.

Many carriers and self-insured employers still have not reported to DWC that they have implemented utilization review and medical bill audit. It would be unfair to penalize those who have attempted utilization review but have not performed it correctly until those who have ignored utilization review are penalized. Approximately 100 carriers and 70 self-insured employers have not reported a plan to DWC at this time.

## PENALTIES

Deficiencies	Recommendations
<ul style="list-style-type: none"> <li>■ Failure to perform utilization review when selection criteria apply and failure to perform utilization review properly are frequent occurrences.</li> <li>■ Numerous carriers and self-insured employers have not yet reported to DWC that they have implemented utilization review and medical bill audit.</li> </ul>	<ul style="list-style-type: none"> <li>■ First, penalize all carriers and self-insured employers who have not implemented utilization review and medical bill audit</li> <li>■ Second, penalize for improper utilization review.</li> <li>■ Clarify penalty for failing to comply with other medical regulations, such as the designated physician requirement.</li> </ul>

## CONCLUSION

During the course of the quality assessment audits, DWC had an opportunity to meet with a representative of a large third party administrator. The company was initially very much opposed to mandatory utilization review, believing it would take too much control from its claims adjusters. Now, approximately one year since the inception of utilization review, it is extremely pleased with the result of utilization review.

***One third-party administrator expressed that it is extremely pleased with the result of utilization review. . . This opinion is refreshing, especially since most comments about utilization review are negative.***

The administrator is glad to have the responsibility for making medical decisions removed from its adjusters and has used utilization review even more frequently than the selection criteria mandate. The company takes fullest advantage of the workers compensation medical regulations by enforcing the requirements of 803 KAR 25:096 (treatment plans and designated physicians), in addition to utilization review. Consequently, its medical management program is basically “mini-managed care,” the missing component being the provider network.

The opinion was refreshing, especially since most comments about utilization review were negative. However, even if generally pleased with utilization review, the administrator noted many of the same issues and frustrations as discussed in this *Status Report*. The foremost frustrations were the lack of “teeth” in the medical regulations and the complexity and limitations of the regulations.

In conclusion, with clarification of issues, increased oversight and enforcement, and more extensive preauthorization, utilization review can be a key element in ensuring that injured workers receive appropriate treatment in a timely manner, while also acting as an effective cost-containment measure. Until issues discussed in this

**Once some issues are resolved, carriers, self-insured employers, and self-insured groups should be included in the auditing effort.**

*Status Report* are addressed, however, it seems unnecessary to continue auditing utilization review programs, especially vendors. Once some issues raised in this report are resolved, it will be important to resume auditing, including carriers, self-insured employers, and self-insured groups in that effort. (See Appendix G for an at-a-glance listing of the deficiencies and recommendations discussed in this Status Report.)