Some ideas on

UTILIZATION REVIEW

for the Workers' Compensation Practitioner

Francis J. Lynch
WOLTER, BEEMAN & LYNCH
1001 South Sixth Street
Springfield, IL 62703
217/753-4220

UTILIZATION REVIEW

2005 amendments to the Workers' Compensation Act established a utilization review procedure for the purpose of determining the appropriateness, medical necessity, and quality of healthcare services in workers' compensation cases. That program became part of the Act under P.A. 94-277 which created Section 8.7 of the Act (820 ILCS 305/8.7). The utilization review provisions in the Act were recently changed by the 2011 Workers' Compensation Act amendments to expand the role of UR in Commission decisions.

HISTORY

Utilization review was a concept that was borrowed from cost containment principles associated with health insurance regulation and management. One of its first incarnations appeared in the Federal Health Maintenance Organization Act (42 USCA Section 300e). That Act was passed after experts attributed rising healthcare costs in part to the over-utilization of healthcare resources and lack of incentives within the reimbursement system for physicians to control those costs. The Act provided a financial incentive to physicians to reduce costs due to over-utilization of services. Unfortunately, the HMO Act did not accomplish its underlying goals and most people still enrolled in traditional fee-for-service plans (21 ILPRIC Section 13:1).

By the mid-90's, a new organization for health insurance companies called managed care entities accounted for most of the insured population. Managed care entities were defined as entities that managed risks, contracted with providers, were paid by employers or patient groups, and handled claims processing. The main characteristic of managed care entities was the creation of networks of physicians who agreed to provide care based upon certain limitations and restrictions. "Utilization Review" became an integral part of HMO's and MCO's. Those organizations employed some form of utilization review whereby the costs associated with healthcare were subject to the application of professional standards in a review of a treating physician's orders. For an excellent history of the origins of utilization review, see 21 Illinois Practice, the Law of Medical Practice in Illinois, Section 13:1 (3rd Edition).

2005 WORKERS' COMPENSATION AMENDMENTS

In an effort to control healthcare costs, the General Assembly added the utilization review process to the Workers' Compensation Act in 2005:

> "'Utilization Review' means the evaluation of proposed or provided healthcare services to determine the appropriateness of both the level of healthcare services medically necessary and the quality of healthcare services provided to a patient, including evaluation of their efficiency, efficacy, and appropriateness of treatment, hospitalization, or office visit based on medically accepted standards." (820 ILCS 305/8.7(a))

A utilization review evaluates healthcare services based on standards of care of nationally recognized peer review guidelines, nationally recognized treatment guidelines, and evidence-based medicine. (820 ILCS 305/8.7(a)) Utilization review programs are required to be registered every two years with the Department of Insurance. Registration must certify compliance with Workers' Compensation Utilization Management standards or Health Utilization Management Standards of URAC (Utilization Review Accreditation Commission) sufficient to achieve URAC accreditation, or otherwise submit evidence of accreditation by URAC for its workers' compensation UR program (820 ILCS 305/8.7(b)) The review can be prospective or before treatment is performed, concurrent which relates to ongoing treatment, or retrospective which is after the treatment is concluded. Retrospective reviews require a UR program to rely only on medical information which was available to the attending physician or ordering provider at the time the healthcare services were provided (820 ILCS 305/8.7(e)).

Under URAC guidelines, a physician's recommended treatment is initially evaluated by a nurse. If the treatment is certified, the utilization review ends and the treatment proceeds. If the treatment is denied, the claimant and/or the provider has an opportunity to appeal to a medical provider of similar qualifications and credentials. If the reviewing doctor at the second level agrees with the treatment, the treatment proceeds. If the reviewing doctor denies the treatment, the claimant and provider have the opportunity to appeal to a second medical provider with similar credentials. Under URAC guidelines, the third provider's opinion is dispositive and under the URAC standards, the dispute is to end. Of course, under Section 8.7 of the Workers' Compensation Act, utilization review conclusions

are not dispositive of reasonableness and necessity of bills and that issue ultimately is left to an Arbitrator (See Illinois Workers' Compensation law, Donald Ramsell, 27 ILPRAC Section 14.7).

PRE-2011 UTILIZATION REVIEW IN PRACTICE

As noted above, under URAC guidelines, the third level of physician review was dispositive of disputes on the question of healthcare utilization. That, of course, is not the case under the Workers' Compensation Act. The ultimate decision about the reasonableness and necessity of medical care still rests with the Commission. The original 2005 Act creating utilization review stated:

> "A utilization review will be considered by the Commission, along with all other evidence and in the same manner as all other evidence, in the determination of the reasonableness and necessity of the medical bills or treatment. Nothing in this Section shall be construed to diminish the rights of employees to reasonable and necessary medical treatment or employee choice of healthcare provider under Section 8(a) or the right of employers to medical examinations under Section 12." (820 ILCS 305/8.7(i))

In other words, under the 2005 amendments, a utilization review was evidence which was to be weighed with all other evidence. It's only binding effect was to shield employers from penalties. According to the 2005 Act, when an employer denied payment for bills under Section 8(a) and the denial complied with the utilization review, there was a rebuttable presumption that the employer should not be liable for penalties or attorney's fees (820 ILCS 305/8.7(j)).

There have been no Appellate Court cases addressing utilization review under the 2005 amendments. The Commission, however, has decided a few cases relating to utilization review. Those cases show a deference on the part of the Commission toward the orders of the treating physician. A quick review of the Q-Dex Quick Index to Workers' Compensation Decisions from the past few years demonstrates this point.

In 2008-0130, the treating physician recommended wrist surgery but the first and second reviewing doctors in a utilization review agreed that surgery was not necessary. The Commission found the treating physician's opinion more persuasive.

In 2008-0630, the Respondent asked for a retrospective utilization review of chiropractic bills. Billing statements showed that the Respondent continued to pay for chiropractic care after its examining MD found MMI. The Commission awarded the bills finding that a paid medical bill is presumed reasonable.

In 2008-1225, an Arbitrator determined that the Respondent's utilization review, which determined that physical therapy was not needed, was unpersuasive and defective because not all of the medical records were reviewed. The Commission found that the Act did not require all records to be reviewed but when considering UR in the same manner as other evidence, found that the award of prospective physical therapy should be awarded.

In 2008-216, medical was denied based on a utilization review. A nurse, and then MD, determined that a proposed epidural injection was not reasonable based on URAC guidelines. The Plaintiff did not appeal the UR decision.

In 2009-310, a UR denied a discogram and IDET procedure. The Commission held that while UR reports are relevant, they are not necessarily dispositive. The Commission noted that the UR appeared to discount the IDET procedure completely as a certified treatment due to a lack of precise proof of efficacy.

In 2009-0035, 2009-0171, 2009-0213, 2010-0314 and 2011-0919, utilization reviews denying ongoing chiropractic or physical therapy treatment because the treatment exceeded guidelines for conservative care all were upheld by the Commission.

In 2010-0788, a treating MD ordered a full body scan. The UR doctor determined the test was unnecessary and the treating physician appealed. A second UR doctor also found the test was unnecessary. Medical evidence showed the Petitioner's symptoms were increasing and so the treating MD's opinion was found more persuasive.

In 2011-0494, and 2011-1222, the Industrial Commission reviewed positive test results such as an EMG, an NCS, or an MRI to award medical treatment when a utilization review had denied the same.

It is obvious that utilization review was added to the Workers' Compensation Act under the 2005 amendment in an effort to control costs and provide Respondents another means of monitoring the Petitioner's medical care and expenses. Decisions from the Commission, however, show that the Commission

took seriously the legislature's statement that the UR was to be considered along with all of the rest of the evidence. There are a reasonable number of cases in which the UR report was relied upon by the Commission, but the notes of decisions also show the inclination of the Commission to continue to place great weight on a treating physician's opinions. As a result, the original 2005 amendments to the Act do not appear to have altered the ultimate outcome of the reported cases.

2011 AMENDMENTS TO SECTION 8.7 OF THE ACT

In 2011, the Workers' Compensation Act was amended by Public Act 94-2777. That amendment made several substantive changes to Utilization Review procedures. The clear intent of those changes was to strengthen the utilization review process so that it could have a greater impact on treatment decisions and medical costs. As one can see from the Commission's decisions, after 2005, utilization review was just a piece of evidence. After the 2011 Act, utilization review began creating presumptions.

Section i of the Act was amended to require medical providers to submit to the utilization review procedure and to follow accredited procedural guidelines. The provider is required to provide information that supports a recommendation or request for treatment. If it fails to do so, it's charges may not be collectable. Written notice of UR decisions including the rationale therefore are to be furnished to the provider and the employee. Interestingly, Section i adds the following provision:

> "(3) An employer may only deny payment of or refuse to authorize payment of medical services rendered or proposed to be rendered on the grounds that the extent and scope of medical treatment is excessive and unnecessary in compliance with an accredited utilization review program under this section." (820 ILCS 305/8.7(i)(3))

The literal reading of this new section is that denials based on the extent and scope of treatment must be supported by UR.

The real substantive change in the purpose and effect of utilization review and the 2011 amendments is found in subsection 4 of Section i. That Section reads as follows:

> "When a payment for medical services has been denied or not authorized by an employer or when authorization for medical services is denied pursuant to utilization review, the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standard of care used by the person or entity performing the utilization review pursuant to Section (a) is reasonably required to cure or relieve the effects of his or her injury (820 ILCS 305/8.7(i)(4)."

Subsection a, referred to in that new language, is the part of the Act which requires utilization review to be based on recognized national standards:

> "The evaluation must be accomplished by means of a system that identifies the utilization of healthcare services based on standards of care of nationally recognized peer review guidelines as well as nationally recognized treatment guidelines and evidence-based medicine based upon standards as provided in this Act."

Significantly, the 2011 Act also anticipates the trial of UR issues. Subsection 5 requires the employer or its insurer to make the utilization review professional available for a deposition either in person or by remote means at the expense of the employer. In other words, when challenging utilization review, the employee can require the employer to produce the UR professional for a deposition.

In addition to providing for evidentiary issues raised by a utilization review (subsection 5) and addressing the presumption attaching to a UR (subsection 4), subsection i also requires the trier of fact to specifically address the utilization review. After the amendment, Section i of the Act concludes as follows:

> "<u>An admissible</u> utilization review <u>shall</u> be considered by the Commission, along with all other evidence and in the same manner as all other evidence, <u>and must be addressed along with all other evidence</u> in the determination of the reasonableness and necessity of medical bills or treatment. Nothing in this Section shall be construed to diminish the rights of employees to reasonable and necessary medical treatment or employee choice of healthcare provider under Section 8(a) or the rights of employers to medical examinations under Section 12."

Currently, there are no reported decisions by the Commission or the Court on the 2011 amendments to the utilization review provisions in the Act. A review of the history of utilization review before its inclusion in the Workers' Compensation Act, since the 2005 enactment first creating workers' compensation UR, and after the 2011 amendments, can however lead us to some conclusions about how UR cases should be addressed by the practitioner.

First, the practitioner needs to be aware of the standards upon which a utilization review can be based. Both a Petitioner and Respondent should make sure that the utilization review service is relying on generally recognized and statutorily acceptable standards. Recall that "At registration (with the Department of Insurance), the utilization review program must also certify compliance with the Workers' Compensation Utilization Management Standards or the Health Utilization Management Standards set by URAC (a non-profit accreditation organization) or certify actual accreditation by URAC." The Act explicitly states that URAC standards must be met. (For a discussion on UR standards, see 21 ILPRAC Section 21:26: 820 ILCS 305/8.7(b))

Second, the Act requires that a utilization review be performed with full documentation and information needed to support a request for treatment. Bear in mind that the duty is placed on the provider to "make reasonable efforts to provide timely and complete reports".

> "If the provider fails to make such reasonable efforts, the charges for the treatment or service may not be compensable nor collectable by the provider or claimant from the employer, the employer's agent, or the employee." (820 ILCS 305/8.7(i)(1).

Make sure the UR provider makes a reasonable request for adequate information and make sure the healthcare provider makes a reasonable response.

Third, both the Petitioner and Respondent should be aware of any appeal or review rights contained in a UR decision. The standard utilization review practice gives the treating physician an opportunity to appeal an adverse decision and justify orders for unapproved treatment. Make sure the treating physician has followed through with any appeal rights offered.

Fourth, make sure to communicate with any physician regarding the results of utilization review. The practitioner may note that treating physicians may comply with the decisions of utilization review. On the other hand, if the treating physician can articulate to an attorney why a UR decision is incorrect or inadequate, they should be able to make that same case before the utilization review service and ultimately before an Arbitrator. If the doctor disagrees with UR, ask him to prepare an explanation why a divergence from the UR service's underlying standards is necessary in this case. If the doctor can do that, then a Petitioner has met his burden of proof. If the doctor cannot, then the Respondent remains entitled to the presumption in favor of the UR conclusion.

Finally, in appropriate cases, take depositions. The deposition of a treating physician gives each party an opportunity to explore the opinions of the treating physician and obtain admissible evidence on whether the utilization review process has in fact relied on appropriate standards of care and why a deviation from those articulated standards may be necessary in the case at issue. A deposition gives the parties an opportunity to explore the basis for the review, the nature of the standards, and the specific reason why the UR professional found that the treatment at issue is non-compliant.

In conclusion, the practitioner must address utilization review in its proposed decision. Section I now states that an admissible utilization review "shall" be considered and "must be addressed" in a determination of the reasonableness and necessity of medical care.