Utilization Review in Worker's Compensation

Current Status and Opportunities for Improvement

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Workers' compensation (WC) systems have multiple components that affect the delivery of patient care and are potentially susceptible to the application of quality assurance (QA) and quality improvement (QI) principles.[1] Utilization review (UR) is an element of WC systems in some jurisdictions and under consideration in others. Insofar as UR can influence physician and payor behavior, it can be a valuable tool for improving clinical outcomes, decreasing disability, and controlling costs.[1] However, certain elements of UR in WC are needed to guard against undesirable consequences. The American College of Occupational and Environmental Medicine's (ACOEM) Utilization Review Task Force is providing this initial high-level overview of UR as it relates to WC, with the intent of surveying the WC-UR landscape for recommendations on desirable components of an effective and fair system.

DESCRIPTION OF UR IN WC

UR is intended to be a collaborative process in which proposals to perform medical service for reimbursement are compared with high-quality, evidence-based guidelines for the purpose of assuring that patients receive the reasonable appropriate care necessary while avoiding ineffective, potentially harmful, and low-value care. When proposed care does not appear to be medically supported and comport to the guideline being used, a mutually respectful discussion needs to occur between the treating provider who is proposing care and the reviewing physician. This is to clarify that guideline criteria are met and if not, is there a compelling medical rationale for departing from the guideline. UR typically does not review causation and is not a guarantee of carrier payment. When the UR process works well, patient care can be optimized, outcomes improved, risk of patient harm decreased, costs controlled, and care efficiently delivered.

The fundamental goals of the UR process are to be "patient-centric" in order to address the injured worker's symptoms and functional limitations and to safely and efficiently return the patient to work both healthy and functional. Meeting these goals may be impeded if the UR process does not minimize financial or other conflicts of interest or does not function in an efficient, expedient, fair, and confidential manner.

Open and transparent evidence-based guidelines are at the heart of an efficient UR process. Criteria from medical literature and evidence-based guidelines used for UR modified certification or denial rationale should be stated clearly in peer-review reports so the evidence-based criteria that were not met can be shared with treating providers and injured workers. By following these concepts, the UR process will be open, fair, and instructive for all parties.

ELEMENTS

Types of WC Jurisdictions

Each state and the federal government has its own system of dealing with workplace injuries and illnesses. In addition, at the federal level, multiple regulatory systems address these issues (eg, the Railway Labor Act, Jones Act, Longshore and Harborworkers' Act, etc). Each system has its own specific structure, legislative underpinning, and regulatory realities.

Stakeholders/Parties-in-Interest

In the WC setting, the three principal stakeholders are 1) workers/patients (and their legal/union representatives); 2) employers and their insurers; and 3) providers. In many WC systems, a stakeholder in each of these categories is considered a party-in-interest to the UR decision and can formally protest or appeal a decision considered inappropriate. UR organizations that provide peer-review services and organizations that accredit UR agents are also stakeholders, but not parties-in-interest.

Timing of UR Requests

There are multiple points along the care-delivery timeline when UR can occur. UR begun before care is delivered is "prospective UR." UR occurring during delivery of care (eg, for continued physical therapy) is "concurrent UR." UR performed after care is "retrospective UR." UR may also be performed for treatment requests for which an appeal has been requested.

GUIDELINES

In addition to the quality of medical documentation submitted and the efficacy of peer-to-peer attempts or successful discussion, the quality of a UR process will in large part be determined by the quality of the guidelines that are used in the process. A number of states have developed their own guidelines while others specify required or approved guidelines and may indicate the hierarchy for guideline selection.[3,4] In some states, there are no designated guidelines. Commonly used measures by which guidelines quality can be evaluated include the AGREE II tool,[5] and IOM,[6] AMSTAR,[7] and GRADE criteria.[8] A key element of each of these criteria is that guidelines be developed based on best-available evidence that includes information from evidence-based medical literature and input from multi-disciplinary providers with recognized expertise in the areas under consideration.

MEASURING UR QUALITY

In addition to timeliness of the process itself, measures of UR quality include success in preventing unsafe or unnecessary

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care; contribution to patient recovery and return to work; stakeholder satisfaction with the process; and the extent to which the process contributes to the delivery of cost-effective quality care. UR agents must implement effective QA auditing systems to ensure that UR decisions are timely, high quality, and where deficiencies are noted, provide effective solutions, and continued oversight to maintain quality of UR decisions. Finally, to achieve QI, the process should include useful feedback to stakeholders.

Essential phases in any UR process are as follows:

- Provider submits a request.
- Request is reviewed and possibly approved at the entry-level process.
- If the request is not approved at the first-level of peer review (typically nurse review), it must be reviewed by a physician.
- If not initially approved by the physician peer reviewer, then the opportunity for provider/peer reviewer communication is offered to the requesting physician.
- Final UR recommendation is issued to approve, modify, or deny the request.
- Provider and patient receive timely notification of the UR decision, and rationale/guidelines used to render the decision. Reviewer name/qualifications and any reconsideration or appeals processes may be included based on jurisdictional requirements.

In addition, the provider, not peer reviewer, is responsible for the medical management of the injured worker's case. The peer reviewer neither examines the patient nor establishes a direct patient relationship. In some instances, providers may need to submit their requests on state-specific forms or transmit them by specific means within specific timeframes to facilitate injured worker care and recovery.

Exactly how each of those elements are implemented may vary significantly from one UR jurisdiction and process to the next, but regardless of the specific manner of implementation, the UR process functions best when

- All stakeholders acknowledge the described goals of an ideal UR process and act in a professional and collaborative manner despite any differences in opinions regarding individual care requests.
- The provider's request is supported by legible, accurate, objective, complete, and concise documentation of the specific request and duration, and demonstrates that the proposed care is reasonable, necessary, and appropriate.
- Requests for concurrent or subsequent treatment (eg, physical therapy, medication use, recurrent injections) must document sufficient evidence of worker treatment compliance, and continued medical necessity for ongoing or repeat treatment including significant objective evidence of functional gains secondary to the specific requested treatment.[9]
- Appropriateness of the provider's request is determined by comparing the request and individual injured worker's supporting medical documentation to relevant, high-quality, evidence-based guidelines.
- Any communication between provider and reviewer is conducted in a timely, respectful professional manner. Respect for the provider's time as demonstrated by a reasonable effort to schedule or accommodate a discussion at the provider's convenience can help assure communication starts out in a positive manner.
- The reviewer should submit a clear specific determination including frequency and duration of care with sufficient medical documentation and explanation of the rationale for the request. The reviewer must be familiar with any required forms, state regulations regarding the specific UR request (ie, license requirements, Board certification, scope of practice, etc), and regulatory time frame for UR decisions and applicable guidelines, in order for the provider/reviewer interaction to proceed as efficiently as possible.
- As the reviewer's telephone skills generally have a substantial impact on the success of the provider/reviewer interaction, the value of such skills cannot be overemphasized.

While communication offered by the UR process for the provider/reviewer discussion is geared to resolving a specific provider request, it also offers an educational opportunity. To the extent that the discussion can help providers understand what is necessary to obtain a ''yes'' response to their request, future requests may then go through the UR process without need for provider/reviewer (peer to peer) discussion.

The UR process must ensure that confidentiality and data security is always maintained.[10] Electronic transfer of information and the review process itself must be secure. Telephonic conversations must be completely private and confidential. As required by applicable regulations and laws, there must be a process in place for secure maintenance or destruction of confidential records that are no longer required in the UR process.

There is opportunity for all stakeholders to improve their participation in the UR process and a need for quality research that will lead to improvements. A data-based understanding of the elements in the UR process that truly lead to cost savings—by addressing injured worker symptoms and reducing disability through timely authorization of care that safely and efficiently assists workers return to health, function, productivity, and employment—can have a substantial and beneficial impact on the health of workers and overall system outcomes.

CONCLUSION

Essential features of a quality UR system in WC should include robust features to encourage peer-to-peer phone contact; recognize that guidelines used in UR must be utilized in a sensible, flexible manner with attention to the realities of each specific case; and ensure a QA mechanism is in place for those performing the UR reviews. The principal goal of UR should be the safe and efficient return of the patient to health and function. To achieve this goal, the UR process must function efficiently. Decision-making should be based on medical facts and evidence-based guidelines, and should also carefully consider requests that present a compelling rationale for departing from those guidelines.

Each element of the UR process discussed is worthy of elaboration. A more expansive review of UR will be presented in a subsequent white paper, including recommendations for improvement pertaining to systems and stakeholders, as well as considerations for future actions to improve education, quality, outcomes, satisfaction, fairness, system performance, and cost efficacy.

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