



## **ANTHEM BLUE CROSS LIFE & HEALTH INSURANCE COMPANY WORKERS' COMPENSATION SERVICES**

### **UTILIZATION REVIEW PLAN**

**October 10, 2008**

#### **Credentials:**

Anthem Blue Cross Life and Health Insurance Company Workers' Compensation Services (WCS) holds American Accreditation HealthCare Commission (URAC) accreditation in Workers' Compensation Utilization Management through November 1, 2010. Accreditation number: W070311R-373.

#### **Staffing:**

##### **Medical Director**

Anthem Blue Cross Life and Health Workers' Compensation Services employs a full time Medical Director dedicated to the Workers' Compensation Services who is responsible for all Utilization Review decisions. Theodore Blatt, M.D. holds an unrestricted medical license in the state of California (G27506), is a board certified Orthopedic Surgeon and a Fellow of the American Academy of Orthopedic Surgery. His office location is 2170 Towne Centre Place, Anaheim CA. 92806 and telephone number is 800-422-7334.

##### **Physician Advisor Program (Reviewer)**

- Anthem Blue Cross Life and Health Workers' Compensation Services department maintains a multi specialty proprietary Physician Advisor panel. They provide specialty-matched peer reviews for the purpose of evaluating medical necessity of Provider requests with direct contact with the treating Physician when necessary. All Physician Advisors are trained by the Medical Director and supplied with pertinent Medical Treatment Utilization Schedule guidelines and pertinent portions of the McKesson Workers' Compensation Care Management Guidelines and Anthem Blue Cross Medical Policy. These guidelines are nationally recognized, evidence-based, developed on sound clinical processes and principles by

Physicians in active clinical practice and are peer-reviewed annually and updated annually.

Physician Advisor qualifications:

- Unrestricted medical license
- Board Certification in their specialty

A Physician Advisor is a “reviewer” who is a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist or chiropractic practitioner licensed by any state or the District of Columbia, , competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the Physician Advisor’s (reviewer’s) practice.

### **Nurses**

The Workers’ Compensation Services department maintains a growing medical management staff of over fifty (50) Registered Nurses, who hold unrestricted nursing licenses. Average case management/disability experience: 8.5 years, average Utilization Review experience: 4.6 years. Nurses perform case management activities and apply utilization review functions to Provider requests.

Additional nurse certifications:

- 8 nurses with CCM (Certified Case Managers)
- 2 nurses with Occupational Health Nurse Certification
- 1 nurse with MFCC credentials (Marriage and Family Counseling)
- Completion of IEA classes by 7 nurses

### **Utilization Review Process and Workflow:**

- Workers’ Compensation Services (WCS) provides utilization management functions that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays or denies, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians as defined in Labor Code section 3209.3 prior to, retrospectively, or concurrent with the provision of medical treatment pursuant to Labor Code section 4610. Utilization review is limited to a review on the basis of medical necessity.
- Utilization review does not include determinations of the work-relatedness of the injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed.
- Claims adjuster sends UR referral for expedited (urgent), prospective, concurrent or retrospective service request to WCS with any pertinent medical reports by fax, phone, or email

- Urgent / Expedited review means utilization review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his/her health. The requesting Physician must indicate the need for an urgent / expedited review upon submission of the request. Decisions related to urgent / expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. Decisions related to urgent / expedited review refer to the following situations: 1. When the Injured Worker's condition is such that the Injured Worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function or 2. The normal timeframe for the decision making process described for prospective or concurrent review would be detrimental to the Injured Worker's life or health or could jeopardize the Injured Worker's permanent ability to regain maximum function.
- Failure to obtain prior authorization for emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an Injured Worker presenting for emergency health care services. Documentation for emergency health care services shall be made available to WCS upon request of the Provider.
- Emergency health care services as defined by 9792.6 (f) means "health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy".
- WCS acknowledges the receipt of the referral to the claims adjuster
- WCS Nurse reviews the request for services
- If pertinent clinical or diagnostic information is needed to process this request, the WCS Nurse telephonically contacts the Provider to obtain this information.
- A toll free number is available twenty-four (24) hours a day (800-422-7334) to Providers and Injured Workers. On normal business days, during the hours of 8:30AM to 5:30 PM PST, a nurse is available to speak with Providers and Injured Workers. Additionally, each nurse has confidential voice mail which offers after business hours voice mail caller access.
- A toll free fax number is available twenty-four (24) hours a day (866-459-0637 to receive communications.
- If unsuccessful in obtaining the information, the WCS Nurse issues a Lack of Information Fax to the requesting Provider, citing the specific information that is needed. A medical decision will be made within seventy- two (72) hours of receipt of the information requested for an expedited request and five (5) business days of receipt of the information requested for a non urgent request but no later than (14) fourteen calendar days of the provider request. For a retrospective review, a medical decision will be made within (30) thirty calendar days from receipt

- of the requested information. For an expedited concurrent review the decision will be made within 24 hours of receipt of the requested information but not to exceed seventy-two (72) hours from the receipt of the written information.
- If requested information is not received within 14 days of the date of the original written request, a Physician Advisor (reviewer) may deny the request. When a denial is made due to lack of information, the denial states that the decision will be reconsidered once WCS has received the requested information.
  - Once the necessary clinical information is received, the WCS Nurse accesses the department's approved decision support tools: Medical Treatment Utilization Schedule as described in 9792.21 or if necessary, McKesson Care Enhanced Review Manager guidelines or Anthem Blue Cross / WellPoint Medical Policy. These guidelines are nationally recognized, evidence-based, developed on sound clinical processes and principles by Physicians in active clinical practice and are peer-reviewed annually and updated annually.
  - WCS Nurse certifies the request if it passes the decision support tool.
  - For certifications the WCS Nurse verbally notifies the Provider the same day as making the determination, and issues a written certification letter to the Provider within two (2) business days of the prospective review and within (24) twenty-four hours of the decision for the concurrent review.
  - Authorization means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provision of section 5402 of the Labor Code.
  - All letters are compliant with the current California Labor Code as outlined in 9792.9 (i), (j), (k). (l).
  - For a certification of a retrospective review, the letter is sent to the Provider within two (2) business days of the decision with a copy sent to the Injured Worker, and the provider of goods or services if known. but not to exceed thirty (30) days from receipt of the request from the Provider and the requested information if necessary.
  - If the request does NOT pass the decision support tool, the WCS Nurse may discuss with the requesting Provider that the authorization request is inconsistent with criteria. The requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, which the WCS Nurse may approve.
  - If the request does not pass the decision support tool, **or** if an alternative treatment plan is not successfully agreed upon with the requesting Provider, **or** if the WCS Nurse has not received a response to the Lack of Information Fax requesting specific medical information, the WCS Nurse summarizes the case and sends it to a specialty matched Physician Advisor (reviewer).

- If appropriate, the Physician Advisor certifies the request without attempting Provider contact.
- A Physician Advisor may delay the request under the following conditions: 1) WCS is not in receipt of all of the necessary medical information reasonably requested. 2) the Physician Advisor has asked that an additional examination or test be performed upon the Injured Worker that is reasonable and consistent with professionally recognized standards of medical practice, 3) The claims administrator needs a specialized consultation and review of medical information by an expert reviewer. Expert reviewer means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, who has been consulted by the reviewer or utilization review medical director to provide specialized review of medical information.
- When a request is delayed by a Physician Advisor, the requesting Physician, the Injured Worker and if the Injured Worker is represented by an attorney, the Injured Worker's attorney is notified in writing immediately that the decision cannot be made within the required timeframe and will specify the information still needed but not received, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. This notice shall include a statement that if the Injured Worker believes a bona fide dispute exists relating to the medical treatment, the Injured Worker or Injured Worker's attorney may file an Application for Adjudication of Claim and Request for Expedited Hearing. The written notification will also be sent to the provider of goods or services and the anticipated date on which the decision will be rendered.
- Upon receipt of the information outlined in the above circumstance, a decision to approve, modify or deny the request shall be made within five (5) working days of receipt of the information for prospective or concurrent review and (30) thirty-days of receipt of the information for retrospective review.
- If the Physician Advisor is unable to certify the request, the Physician Advisor attempts to contact the requesting provider to discuss specific issues or to obtain additional medical information.
- If the Physician Advisor is not successful in contacting the requesting Provider, the Physician Advisor renders an opinion based on the information provided regarding certification or non-certification of the request within the timeframe specified by the WCS Nurse.
- When a treatment is denied, during a concurrent review, that treatment will continue until the treating Physician is notified of the denial, and an alternate care plan is agreed on, which is appropriate for the Injured Worker.
- If the recommendation of the Physician Advisor is for non-certification or partial certification of the request, the Physician Advisor informs the

requesting Provider of the decision and explains that an internal appeal process is available.

- All Physician Advisor determinations are communicated by the WCS Nurse to the requesting Provider by phone the same day the UR determination is received from the Physician Advisor.
- All letters are issued within two (2) business days of receipt of the Physician Advisor transcription for prospective and retrospective review and within twenty-four (24) hours for concurrent review. For non-certification or partial certification of the request, the WCS Nurse informs the requesting Provider of the voluntary internal appeal or reconsideration process, if applicable.
- For non-certification, partial certification, or delay of the decision of the request, the WCS Nurse provides a copy of the letter to the Injured Worker, the attorney of the Injured Worker if applicable and the provider of services if known within the above timeframes.
- For non-certifications or partial certifications, a copy of the Physician Advisor review and a copy of the relevant portion of the guideline are enclosed with the letters to the requesting Physician, the Injured Worker, and the attorney of the Injured Worker. The copy of the Physician Advisor review contains the Physician Advisor's California license number, area of specialty or if applicable, area of practice.  
The provider of goods receives a copy of the non-certification or partial certification letter only.
- All letters of non-certification, partial certification or delay of the decision of a request to the requesting Provider include the name of the Physician Advisor, telephone number of the reviewer and hours of availability.
- All letters of non certification, partial certification or delay of the decision of a request to the Injured Worker and attorney of the Injured Worker include a statement that any dispute shall be resolved in accordance with the provisions of Labor Code section 4062 and that an objection to the utilization review decision must be communicated by the Injured Worker to the Injured Worker's attorney on behalf of the Injured Worker to the claims administrator in writing within twenty (20) days of receipt of the decision. In addition the letter notes that the Injured Worker and attorney of the Injured Worker may use the same twenty (20) day period to apply for and participate in the voluntary internal UR appeal process, parallel to applying for the 4062 process.
- All Physician Advisors are available a minimum of (4) four hours per week.
- All letters to the requesting provider include the name of the WCS Nurse, the toll free telephone number and hours of business operation as well as reference to the internal appeal process for the requesting Provider and a statement of access to the appeal process for the Injured Worker.
- Non certifications or modifications of a request for a spinal surgery have a different process from that outlined above. Per SB228, a second opinion is arranged for by the Administrative Director when the request for spinal surgery is contested by the employer. WCS does make available

however an internal reconsideration process to the requesting Provider for a spinal surgery if no contact was made between the requesting provider and the Physician Advisor.

- The second opinion process by the Administrative Director is referenced in the non-certification or modification letter to the Provider.
- Upon request by the Provider for an internal appeal, the WCS Nurse will review any additional information submitted with the request for the appeal. If the additional information does not result in a certification of the request per guidelines, the Nurse refers the case to a different specialty matched Physician Advisor forwarding any additional information that may have been received, along with the original Physician Advisor review.
- Upon request by the Provider for an internal reconsideration (second review of spinal surgery request), the WCS Nurse will review any additional information submitted with the request for the second review. If the additional information does not result in a certification of the request per guidelines, the Nurse refers the case to the same Physician Advisor if possible forwarding any additional information that may have been received, along with the original Physician Advisor review.
- All internal appeal requests will be completed within five (5) business days of the receipt of the request for appeal or from the Provider but no greater than fourteen (14) calendar days from receipt of the request from the Provider
- All internal eligible reconsideration requests (second review of spinal surgery requests) will be completed within five (5) business days of the receipt of the request for reconsideration (second review of spinal surgery) from the Provider but no greater than nine (9) calendar days from receipt of the request from the Provider..
- On appeal or reconsideration (second review of spinal surgery requests), the Physician Advisor attempts to contact the requesting Provider to discuss the requested service.
- If the services are certified, the WCS Nurse notifies the requesting Provider telephonically the same day the determination is made, and issues a certification letter within two (2) business days of the determination.
- If the Physician Advisor upholds the original non-certification or partially certifies the original request, the WCS Nurse notifies the requesting Provider by phone the same day the UR determination is received from the Physician Advisor Letters are issued within two (2) business days of the determination.
- For non-certification or partial certification of the appealed request, the WCS Nurse provides a copy of the letter to the Injured Worker, attorney of the Injured Worker if applicable and the provider of service, if known.
- In addition, for non-certification or partial certification, a copy of the Physician Advisor review and a copy of the portion of the relevant guideline are enclosed with the letters to all parties, except the provider or goods or services. The copy of the Physician Advisor review contains the

Physician Advisor's California license number, area of specialty or if applicable, area of practice. The provider of goods or services receives a copy of the non-certification letter only. .

- All letters of non-certification or partial certification of an appealed request include the name of the Physician Advisor, telephone number of the reviewer and hours of availability.
- The complete UR plan and appropriate policies and procedures are available to the public on request.

