



## **ANTHEM WORKERS' COMPENSATION**

### **UTILIZATION REVIEW PLAN**

**June 14, 2011**

#### **Credentials:**

Anthem Workers' Compensation (AWC) holds American Accreditation HealthCare Commission (URAC) accreditation in Workers' Compensation Utilization Management through November 1, 2013. Accreditation number: W070311R-373.

#### **Staffing:**

##### **Medical Director**

Anthem Workers' Compensation employs a full time Medical Director dedicated to the Anthem Workers' Compensation who is responsible for all Utilization Review decisions. Theodore Blatt, M.D. holds an unrestricted medical license in the state of California (G27506), an active restricted license in the state of Colorado (45354), an Active Status Special Purpose Medical License in the state of Nevada (SP122). He is a board certified Orthopedic Surgeon and a Fellow of the American Academy of Orthopedic Surgery. His office location is 3080 South Bristol Street #200 Costa Mesa, CA 92646 and telephone number is 800-422-7334.

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

- Anthem Workers' Compensation department maintains a multi specialty proprietary Physician Advisor panel. They provide specialty-matched peer reviews for the purpose of evaluating medical necessity of Requesting Physician 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 Interqual Guidelines and 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.

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**

Anthem Workers’ Compensation maintains a growing medical management staff of over sixty (60) 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 Requesting Physician requests.

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

- Anthem Workers’ Compensation (AWC) 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 AWC 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 decision. 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 AWC upon request to the Requesting Physician.
- 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".
- AWC acknowledges the receipt of the referral to the claims adjuster
- AWC Nurse reviews the request for services
- If pertinent clinical or diagnostic information is needed to process this request, the AWC Nurse telephonically contacts the Requesting Physician 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 AWC Nurse issues a Lack of Information Fax to the Requesting Physician, 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 Requesting Physician 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 AWC has received the requested information.
- Once the necessary clinical information is received, the AWC Nurse accesses the department's approved decision support tools: Medical Treatment Utilization Schedule as described in 9792.21 or if necessary, McKesson Interqual 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.
- AWC Nurse certifies the request if it passes the decision support tool.

- For certifications the AWC Nurse verbally notifies the Requesting Physician the same day as making the decision, and issues a written certification letter to the Requesting Physician within two (2) business days of the prospective review decision and within (24) twenty-four hours of the concurrent review decision. A copy of the letter is sent to the Injured Worker, the attorney of the Injured Worker if applicable and the provider of goods or services if known.
- 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 Requesting Physician within two (2) business days of the decision with a copy sent to the Injured Worker, the attorney of the Injured Worker if applicable and the provider of goods or services if known, but not to exceed thirty (30) days from receipt of the request from the Requesting Physician and the requested information if necessary.
- If the request does NOT pass the decision support tool, the AWC Nurse may discuss with the Requesting Physician 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 AWC 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 Physician, **or** if the AWC Nurse has not received a response to the Lack of Information Fax requesting specific medical information, the AWC Nurse summarizes the case and sends it to a specialty matched Physician Advisor (reviewer).
- If appropriate, the Physician Advisor may certify the request without attempting to contact the Requesting Physician.
- A Physician Advisor may delay the request under the following conditions: 1) AWC 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 medial 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 Physician to discuss specific issues or to obtain additional medical information.
- If the Physician Advisor is not successful in contacting the Requesting Physician, 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 AWC 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 Physician of the decision and explains that an internal appeal process is available.
- All Physician Advisor decisions are communicated by the AWC Nurse to the Requesting Physician by phone the same day the UR decision is received from the Physician Advisor.
- All letters are issued within two (2) business days of receipt of the decision for prospective and retrospective review and within twenty-four (24) hours for concurrent review. For non-certification or partial certification of the request, the AWC Nurse informs the Requesting Physician of the voluntary internal appeal or reconsideration process, if applicable.
- For non-certification, partial certification, or delay of the decision of the request, the AWC 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 Physician 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 Physician include the name of the AWC Nurse, the toll free telephone number and hours of business operation as well as reference to the internal appeal process for the Requesting Physician 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. A second opinion is arranged for when the request for spinal surgery is contested by the employer utilizing form 233. To accommodate this timeframe all requests will be completed within five (5) business days of the receipt of the request for a spinal surgery from the Requesting Physician but no greater than eight (8) calendar days from receipt of the request from the Requesting Physician.
- AWC does make available however an internal reconsideration process to the Requesting Physician for a spinal surgery if no contact was made between the Requesting Physician and the Physician Advisor.
- Upon request by the Requesting Physician for an internal appeal, the AWC 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 Requesting Physician for an internal reconsideration (second review of spinal surgery request), the AWC 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 from the Requesting Physician but no greater than fourteen (14) calendar days from receipt of the request from the Requesting Physician

- 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 Requesting Physician but no greater than eight (8) calendar days from receipt of the request from the Requesting Physician..
- On appeal or reconsideration (second review of spinal surgery requests), the Physician Advisor attempts to contact the Requesting Physician to discuss the requested service.
- If the services are certified, the AWC Nurse notifies the Requesting Physician telephonically the same day the decisions made, and issues a certification letter within two (2) business days of the decision.
- If the Physician Advisor upholds the original non-certification or partially certifies the original request, the AWC Nurse notifies the Requesting Physician by phone the same day the UR decisions received from the Physician Advisor Letters are issued within two (2) business days of the decision.
- For non-certification or partial certification of the appealed request, the AWC 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.

