Improving Care, Reducing Costs, Minimizing Delays: Best Practices for UR in Tennessee Workers' Compensation

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Improving Care, Reducing Costs, and Minimizing Delays: Best Practices for UR in Tennessee **Workers' Compensation**

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Important Disclaimers:

- This is just a "snapshot".
  - Not comprehensive.
  - Statutes, regulations, case law, are subject to change.
  - Formulary and treatment guidelines are subject to change.

- Not legal advice.
  - For questions about application in a specific case, consult a TN-licensed attorney.

Basics of Utilization Review

- What it *is*:
  - Quick
  - Independent
  - Guideline-based
  - Review of documentation
  - To determine medical necessity/reasonableness
  - A means of communication.

Basics of Utilization Review

As a general rule, more (effective) communication in UR:

-- reduces delays in care;
-- increases understanding of the guidelines/formulary;
-- reduces appeal requests/formal disputes/angry phone calls;
-- increases quality of care.

Basics of Utilization Review

- What it *is*:
  - Intended to protect all "sides" of the claim:

    Injured employees: protected from inappropriate treatments, treatments that are unlikely to succeed or that create undue risk of harm; helps to facilitate quick return to work.

    Employers: protected from being forced to pay for treatment that is experimental, investigational, or otherwise not medically necessary; provides an objective, clinical tool to evaluate medical necessity.

    Healthcare providers: protected against arbitrary denials by the payer; provides an independent, clinician-led process for confirming medical necessity in accordance with evidence-based medicine. If care doesn't align with guidelines, UR provides an opportunity for communication to discuss why it does not align or whether an exception is appropriate.

Basics of Utilization Review

- What it ***isn't*:**
  - Comprehensive
  - Outcome determined by a party.
  - Purely up to the reviewer's medical judgment.
  - An examination of the patient.
  - An opportunity to review/dispute:
    - Fees charged by the provider. (Bill review)
    - Compensability of the condition. (IME)
    - MMI/impairment rating. (IME)
    - Employee's ability to return to work. (IME)

Basics of Utilization Review

UR entities are restricted by:

- Law
- Standards of Accrediting Organizations (ex: URAC, NCQA)
- Contracts
- Internal plan documentation

UR in Tennessee Work Comp

Treatments/Services NOT Subject to UR.

- Diagnostic procedures IF:
  - recommended by ODG and authorized by authorized treating physician or chiropractor within first 30 days from DOI.

    OR
  - Requested after initial treatment* if that treatment (1) was non-surgical, (2) was performed without diagnostic testing, and (3) was unsuccessful in returning the injured employee to work.

* *"Initial treatment" means the first series of treatments or therapies or first two medication trials ordered by the authorized treating physician in accordance with the ODG within 60 days of a reported injury.*

Authority: T. C. A. § 50-6-124(j) (Claims with DOI on/after 7/1/2014)

Treatments/Services NOT Subject to UR.

- Treatments approved by UR appeal within previous 6 months (absent new material information).

  "A determination by the Bureau of a utilization review appeal, whether to uphold, overturn, or modify, shall be effective for six (6) months unless significant new material medical information, as determined by the Administrator or Administrator's Designee, is presented to require a new utilization review determination by the utilization review organization or the Bureau on appeal."

- -- Tenn. Comp. R. & Regs. 0800-02-06-.06(9)(b)

Important Timeframes: Generally

- Deadline to submit referral:
  If UR is required, payer must submit the treatment to request to UR within four business days of receipt of request from the provider.

- Deadline to issue determination:
  URO must issue a determination within seven business days of receipt of referral from the payer.

- Deadline to notify employee and ATP:
  Within three days of receiving the determination, the payer must notify the employee and ATP as to whether it will authorize any of the treatments that were not certified by UR.

-- Tenn. Comp. R. & Regs. 0800-02-06-.06

Important Timeframes: Concurrent Review

- ER Admissions
  "[U]tilization review… shall begin within one (1) working day of all emergency hospital admissions."

  -- T. C. A. § 50-6-124(b) (claims with DOI on or after 7/1/2014)

The ODG Treatment Guidelines and Formulary

Treatment Guidelines

- Eff. 1/1/2016, BWC adopted the ODG treatment guidelines.
- UR of treatment in TN claims must apply ODG guidelines.
- If the treatment is:
  - **Explicitly supported by or "reasonably derived" from ODG:** it is presumed to be medically necessary, for UR purposes.
  - Explicitly not recommended by ODG: reviewer must apply ODG; however, they must also determine whether exceptions are warranted, based on the documentation provided.
  - Not addressed by ODG: that, by itself, is not a sufficient basis for denial; denial must be supported by documented, evidence-based medicine.

Drug Formulary

- ODG Appendix A formulary (published by MCG Health)
  - with some TN-specific provisions.
- Came into effect: 8/28/2016.
  - Initially only applied to newer fills.
- Fills subject to the formulary:
  - As of 2/28/2017, all fills (including refills in older claims) are subject to the formulary.
- Formulary is updated by MCG Health; those updates are subject to review by the Bureau's Administrator and are posted for free in Excel format on the Bureau's webpage.

ODG Workers' Compensation Drug Formulary - April 2023

Drug Class	Generic Name	Brand Name	Gener Equiv	Status	Notes
Anthelmintics	Ivermectin	Stromectol	Yes	N	Oral
Anticoagulants	Apixaban	Eliquis	No	Y	
Anticoagulants	Dabigatran	Pradaxa	No	Y	
Anticoagulants	Enoxaparin	Lovenox	Yes	Y	
Anticoagulants	Rivaroxaban	Xarelto	No	Y	
Antidepressants	Amitriptyline	Elavil	Yes	Y	For mental health conditions
Antidepressants	Bupropion	Wellbutrin	Yes	Y	For mental health conditions
Antidepressants	Bupropion	Wellbutrin	Yes	N	For pain treatment
Antidepressants	Citalopram	Celexa	Yes	N	For mental health conditions
Antidepressants	Desvenlafaxine	Pristiq	Yes	Y	For mental health conditions
Antidepressants	Duloxetine	Cymbalta	Yes	Y	For mental disorders

Drug Formulary

- How it works:
  - ODG classifies drugs as "N" (not preferred as a first-line drug) and "Y" (preferred as a first-line drug).
  - **"N" drugs** require prior authorization, as do some other types of drugs defined by regulation.
  - **"Y" drugs** are generally not subject to prior authorization, but are subject to retrospective UR (with some limits)*.

Drug Formulary

- Other drugs that require prior authorization:
  - **"Compounds,"** as defined by regulation;
  - **"Topicals,"** as defined by regulation;
  - *"Any investigational or experimental drug that has not yet been identified as a "Y" or "N" drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet accepted as the prevailing standard of care."*

  -- Tenn. Comp. R. & Regs. 0800-02-25-.04(11)(a)

Drug Formulary

What is a "compound"?

- A drug that was subject to "*preparing, mixing, assembling, packaging, or labeling….*"

  -- Tenn. Comp. R. & Regs. 0800-02-25-.04(11)(b)

Drug Formulary

What is a "topical"?

"'Topical' means a prescription substance or substances, not injected or ingested, that are used on the skin or other membranes, or are applied to exterior or exposed surfaces. This category includes 'inhalers.'"

-- Tenn. Comp. R. & Regs. 0800-02-25-.04(11)(l)

Drug Formulary

What is a "topical"?

- Examples of "topicals" per regulatory definition:
  - Traditional topical medications (applied on skin);
  - Inhalers;
  - Sublingual medications (absorbed under the tongue);
  - Buccal medications (absorbed in the cheek);
  - Suppositories.

Drug Formulary – Limits on UR

Good Faith Dispensing Rule

"Retrospective review of medications will be allowed only for drugs that are not appropriate for the injured worker's diagnosis. Only the next refill prescribed by the authorized treating physician can be denied."

-- Tenn. Comp. R. & Regs. 0800-02-06-.04(10)

Drug Formulary – Limits on UR

Good Faith Dispensing Rule

Ensures that:

- Pharmacy is not punished for dispensing an appropriate "Y" drug.
- Prescriber has a reason to either (i) appeal document basis for prescribing or (ii) modify treatment plan.
- Payer is not forced to submit repeated UR referrals for the same "Y" drug.

Penalties & Common Mistakes

Penalties -- Generally

- Penalties may be applied to any of the following:
  - employer,
  - insurer,
  - TPA;
  - URO.
- Investigations may be initiated:
  - Following a complaint;
  - Following detection of a potential violation in the UR Appeal process;
  - By referral from a Workers' Compensation Judge.

Penalties -- Generally

- Range from $50 to $5,000 per violation, generally.
- Additionally:
  - $25 per 15 calendar days: untimely filing of Form C-35 or Form C-36/C-37.
  - $25 per 15 calendar days: Untimely filing of annual UR report by URO.
- Additional measures if Administrator determines that there is a pattern of violations.
  - May temporarily or permanently suspend right to perform UR.

Penalties – Bad Faith UR

"Use of utilization review… in an excessive or punitive manner, including but not limited to unjustified, repetitive, or poorly-supported utilization review activity as determined by the Administrator, where there has been a documented pattern… , including attempts to force closure or alteration in a claim status, shall subject such party to a penalty of not less than fifty dollars ($50.00) nor more than five thousand dollars ($5,000.00) per violation at the discretion of the Administrator."

-- Tenn. Comp. R. & Regs. 0800-02-06-.04(10)

Penalties – New Considerations Reporting

- UROs are now required to submit annual reports to the Bureau.
  - Number of reviews;
  - Number of denials, modifications, and approvals;
  - Names of physician reviewers; number of reviews performed by each;
  - Number of peer-to-peer discussions:
    - Requested
    - Completed (in total; by each reviewer)
    - Resulting in approval
    - Resulting in modification
    - Resulting in overturn.

Penalties – New Considerations Peer-to-Peer Conferences

Regulations define the reconsideration/peer-to-peer process.

- Must take place within ten (10) days of request for peer-to-peer.
- If phone conference is requested, requesting provider must provide:
  - Telephone number
  - Name of physician or designee
  - Date for conference not less than 2 business days nor more than 7 business days from the date of receipt of the request by the URO;
  - Three 2-hr periods during which the requesting medial provider or designee will be available to participate
    - Mon-Fri (excluding holidays)
    - 8:00 – 5:00 (Central)

Penalties – New Considerations Peer-to-Peer Conferences

- If ATP/designee fails to attend, requested treatment may be denied unless good cause excuses the failure.
  - If good cause: provider must reschedule the conference no later than 2 business days following the original conference date.
- If reviewer (or alternate reviewer) fails to attend, request must be approved unless good cause excuses the failure.
  - If good cause: reviewer must reschedule the conference no later than 2 business days following the original conference date.
  - Invasive procedures: reviewer not permitted to reschedule.

Penalties – New Considerations Peer-to-Peer Conferences

" A verifiable, complete, and accurate electronic record of all peer-to-peer telephonic contacts and interactive electronic communications, if any, shall be saved by the utilization review organization for a period of two (2) years from the date of receipt of the reconsideration request and shall be made available to the Bureau upon request. The authorized treating physician or their designee shall note in the medical records the outcome of all peer-to-peer communications. Once in the medical records, the communication becomes a permanent record. Such information shall be available to the Bureau upon request."

See Tenn. Comp. R. & Regs. 0800-02-06-.14(8)

Common Mistakes

1.) URO issues a denial without allowing opportunity for peer-to-peer discussion.

- Ask if the URO:
  - Actively seeks discussion (vs waiting on provider to initiate);
  - Attempts to schedule a date/time for discussion;
  - Has a process for non-responsive providers;
  - Makes multiple contact attempts;
  - Documents attempts in the report.
- Make sure that referrals are sent to UR with sufficient time to allow for discussion.

Common Mistakes

2.) Failure to organize/format/limit medical records.

- Records must:
  - Contain all pertinent medical records corresponding to test and treatments paid for by payor in the past 12 months
  - Contain any communications necessary for URO to evaluate the treatment;
  - Be in chronological or reverse-chronological order;
  - Contain no duplicates, fax sheets, or billing records;
  - One-sided (no double-sided printing).
- UROs often have the ability to handle these sorting requirements (if provided with all required information).

Common Mistakes

3.) Adjuster fails to provide medical records for UR Appeal

- Within 5 business days receipt of notice of appeal, adjuster must send records to the Bureau.

- Records must:
  - Contain all pertinent medical records corresponding to test and treatments paid for by payor in the past 12 months
  - Contain any communications necessary for URO to evaluate the treatment;
  - Be in chronological or reverse-chronological order;
  - Contain no duplicates, fax sheets, or billing records;
  - One-sided (no double-sided printing).

Common Mistakes

4.) Incomplete/outdated information on the Form C-35A

- Be sure to include current information for:
  - Carrier/TPA/Self-insured
    - Including current adjuster, adjuster's supervisor, and compliance contact.
  - Employee;
  - Employer;
  - Physician;
  - URO;
  - Attorneys (if applicable)

Common Mistakes

5.) URO used wrong diagnosis/guideline.

- Be sure that URO understands which conditions are being treated as part of the claim.
- Be sure that URO has a quality assurance process.

Common Mistakes

6.) URO issues late determination, or adjuster issues late response.

- Be sure that URO receives referral with sufficient time to perform the review and still allow for completion of the C-35A.
- Be sure that URO is aware of timeframes.
  - Tracking from when adjuster received the request – not just when URO received it.
- Note that adjuster has 3 business days (following receipt of UR report) to notify employee and physician as to whether any reviewed treatments will be approved.

Common Mistakes

7.) Failure to request additional records

- If the denial is based on lack of supporting records, additional records should be requested.
- Adjuster/URO may request additional information from provider; review deadline is tolled for up to 5 business days.
- Failure to request or to provide information may result in penalties.

See Tenn. Comp. R. & Regs. 0800-02-06-.06(7)

Metrics for Successful UR

Metrics

Quality of UR

1. Discussion rate: How often is the reviewer successfully obtaining discussion?

   (Related: How many documented attempts are made? How is discussion scheduled?)

2. Appeal overturn rate: What % of denials/modifications are overturned on appeal?

   How does that compare to the statewide appeal overturn rate?

3. Penalties incurred: This number should be zero.

   Note: Larger programs have larger risk.

Metrics

Quality of UR

4. Approval/denial/modification rates.
   Many states require that this information be reported by the URO.

5. Peer-to-peer/reconsideration overturn rate:
   What % of denials are overturned (pre-appeal) following a peer-to-peer discussion?

Metrics

Timeliness

1. Average turnaround time: How long does it typically take to complete a review once all information is obtained?

2. Longest turnaround time: This should never exceed the state deadline.

3. Requests for additional information: If additional information is required, how long does it typically take the reviewer to identify and request that information?

Alternative Approaches

Alternative Approaches

Review w/Collegial (Peer-to-Peer) Discussion

- Performed by clinician.
- Goal is twofold:
  - In-depth review to determine best outcome for the patient.
  - Collegial discussion to ensure that provider has access to all necessary resources. (Ex: weaning resources).
- Not a basis for denial. Not UR.
- Not a means of directing care/substituting provider's medical judgment.

Alternative Approaches

Case Management

- Performed by certified case manager.
- Goal is:
  - To evaluate current treatment plan;
  - To assess whether alternative medical care services are appropriate;
  - To evaluate how the employee is following the prescribed medical care plan.
- Not a basis for denial.
- May find barriers to recovery that are not evident in the medical record.

Best Practices

Best Practices

1.) Set clear expectations; ensure ATP has all necessary resources.

- Version of the ODG formulary adopted by the Bureau is available for free on the Bureau's website.
- The Bureau's website contains additional FAQs and resources, including a free webinar on use of odgbymcg.com to access treatment guidelines.

Best Practices

2.) Engage UR only when there is a good-faith objection to medical necessity.

- Where approval is appropriate, UR is not required.
- Where the dispute pertains to cost, compensability, etc., UR is not the appropriate tool.
- If the problem is lack of information, better tools are available.

Best Practices

3.) Assume that every UR referral will go to appeal.

- Is the treatment subject to UR?
- Were all relevant documents submitted to UR? In correct order/format?
- Is the URO facilitating communication with the provider?
- If UR recommends denial, what is the plan?

Best Practices

For UROs: Build a pro-communication program

- Set expectations when contracting reviewers; if they won't commit to discussion, they don't belong in your network.
- Provide administrative support for reviewers to facilitate discussion.
  - Utilize an outbound calls team.
  - Collect treating physician's availability; be clear about the issues to be discussed.
  - Directly connect the treating physician and reviewing physician on the call.
- Have the physician reviewer's questions ready and available to help him/her recall the case quickly.
  - If missing details on previous treatment, ask the MA or nurse if there are additional records that the physician reviewer can see to answer those questions.

Best Practices

<u>If peer-to-peer discussion is not possible:</u>

- Provide alternative methods such as:
  - Encrypted email
  - Secure web forms that provide the opportunity for electronic responses.

    (Treating physician should be able to complete these from a mobile device.)

New Considerations

New Considerations

3.) Assume that every UR referral will go to appeal.

- Is the treatment subject to UR?
- Were all relevant documents submitted to UR? In correct order/format?
- Is the URO facilitating communication with the provider?
- If UR recommends denial, what is the plan?

BWC Programs

BWC Programs

Certified Physician Program (CPP)*

- For employers:
  - Will provide a registry of certified physicians who have completed the program.

BWC Programs

Certified Physician Program (CPP)*

- For physicians:
  - Will provide educational resources pertaining to TN's workers' compensation system (including guidelines, formulary, UR, and appeals).
  - Will provide CME credits.
  - Will allow for enhanced fees.

Questions?

Resources

- Best Practices for Treating and Evaluating Injured Workers https://www.tn.gov/content/dam/tn/workforce/documents/injuries/reward/CPP_Best_Practices.pdf
- Information re: Access to ODG Guidelines https://www.tn.gov/workforce/injuries-at-work/bureau-services/bureau-services/medical-programs-redirect/medical-treatment-guidelines.html
- ODG by MCG On-Demand Webinar https://info.mcg.com/odg-webinar-on-demand-training-tennessee.html?utm_medium=partner&utm_source=state-agency-outreach&utm_campaign=wbr-odg-trn-tn
- ODG Drug Formulary (as adopted by BWC) https://www.tn.gov/content/tn/workforce/injuries-at-work/bureau-services/bureau-services/medical-programs-redirect/medical-treatment-guidelines/drug-formulary.html

We hope you enjoyed this session. Please enjoy a 15-minute Networking Break. Coming up next:

"TODAY in Tennessee (part 2): The Workers' Compensation Review: Negotiating and Settling the Claim"

Agenda

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