Utilization Reviews – A Multi Perspective of Employers' Burden and Guide to UR Process

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The Utilization Review Process

Section 306 of the WC Act provides that disputes as to reasonableness and necessity are to be resolved via the Utilization Review (UR) Process set forth in that provision of the statute.

There is no other way to contest the reasonableness and necessity of treatment in a PA WC claim. Some other jurisdictions permit a carrier's internal utilization management determinations to be used for approval or denial of care, but those are primarily jurisdictions where the WC carrier has medical control. In PA, there is no such carrier control and, in any event, the statute specifically states that the UR process must be utilized. Any denial of care for lack of reasonableness and necessity without a favorable UR can lead to imposition of penalties.

UR Form

The form to be utilized is the LIBC-601, entitled Utilization Review Request. The UR Request is also available on WCAIS for electronic filing. The format of the WCAIS request is slightly different, but the information required is substantially the same.

The Medical Treatment Review Section of the Bureau is very particular when it comes to processing UR Requests. The slightest deviation or omission can lead to rejection of the form and possibly missing the time window in which to file the Request. Generally, every field should be filled in and the form should be free from even the smallest typographical error. Lately, the Bureau has been preserving the original filing date for a rejected form for 14 days from the date of notice of rejection, but only with respect to the first rejection. If it is rejected a second time, or if it isn't re-filed within 14 days, the original filing date is lost, and with it potentially the opportunity to file the UR.

The current form promulgated in November 2013 is an improvement over the previous one. Multiple providers may now be included in the same UR Request, which prevents the need to file numerous separate UR Requests when challenging care. This is most helpful with, for example, chiropractic care, where claimants often receive care from multiple providers at the same facility. The new form eliminates the need to file one for each such provider. [In the past, this would often have resulted in multiple conflicting UR Determinations.] As a result, the Bureau sends all of the challenges on the request to the same URO, creating more consistent determinations since the URO will have a complete as opposed to fragmented treatment picture.

Timing

For a retrospective review, in other words a review of treatment which has already occurred, the UR Request must be filed within 30 days of receipt of a properly submitted bill for the treatment. Arguably, there are 30 days from receipt of a clean bill (i.e. HCFA-1500 with LIBC-9) within which to file. Therefore, if a defective bill that doesn't technically trigger a payment obligation is received, the 30 day UR window should not start to run. However, it isn't recommended that this be tested too vigorously. There have been cases holding that even non-clean bills can trigger payment obligation if such incomplete bills have been processed in the past. This, it may only be a matter of time before this is applied to UR proceedings. To be safe, a challenge to treatment as lacking reasonableness and necessity is best done as early as possible.

If litigating a denied Claim Petition where medical liability has not been established, there are 30 days from a WCJ decision granting Claim Petition to file UR challenges to treatment that was provided during the pendency of the Claim, regardless of when the bills were received.

For a prospective review of treatment recommendations, the UR Request should be filed sometime before the treatment actually occurs. This typically arises when a doctor recommends related surgery that the carrier wishes to challenge. A prospective UR Request should be filed as soon as possible, mainly so the doctor can receive a copy of it before the procedure takes place. This may delay the procedure pending the outcome of the UR challenge, as many doctors won't proceed with surgery without a guarantee of payment.

Prospective review often arises when a provider contacts a carrier for pre-authorization of medical care. Strictly speaking, the PA WC Act doesn't require pre-authorization. However, in cases involving a request for pre-authorization of surgery, it is recommended that if pre-authorization is not going to be given then a prospective UR Request be filed. The Courts have held that in today's insurance market refusal to pre-authorize a surgery is tantamount to a denial, and as such penalties can be imposed in the absence of a UR challenge. This has not yet been extended to other types of care.

Lately, we are seeing more prospective UR Requests coming from claimants. This will often arise in the same type of scenario as above involving a recommendation for surgery. If a surgery is recommended, a claimant can file a prospective request. The Bureau will then contact the carrier to ascertain the carrier's position on the surgery. If the carrier advises that it will pay, the UR won't be processed. If the carrier advises that the surgery is being denied on the basis of a lack of causal relationship, the UR won't be processed, as this would then require a different type of litigation to resolve. Only if the carrier says it won't pay because it isn't reasonable and necessary or because pre-authorization isn't required, or if the carrier fails to respond to the

Bureau, will the UR be processed. It is important to note that the carrier pays the cost of the UR regardless of whether it is filed by the claimant or the carrier.

Who to Challenge?

The UR Request must name an individual medical provider. A medical group or hospital cannot be named or the UR Request will be rejected. If a claimant is seeing multiple physicians at the same practice, a separate UR Request must be filed on each one.

PT or OT can be challenged by naming the prescribing provider, without the need to name each therapist separately. Chiropractors should be named individually as they operate under their own license, regardless of whether they are primarily providing PT or OT-type care.

Durable medical goods supply companies are not considered providers. Challenges to prescriptions for durable medical goods are to be made at the level of the prescribing physician.

Prescriptions for medication are challenged at the level of the prescribing physician, not the pharmacy that fills them.

Remember that UR Requests are provider-specific. If something is recommended or performed by one provider and found to lack reasonableness and necessity, and claimant starts getting the same thing from another provider, another UR Request needs to be filed.

Post-Filing Process

The Bureau will assign the UR Request to a Utilization Review Organization (URO). The URO must have the same specialty as the provider whose treatment is under review. The URO will collect medical records from the provider being challenged as well as all of the claimant's other providers named in the UR Request (at the carrier's expense). Thereafter the URO will review all of the care in context in order to render its determination.

The Bureau will circulate a Notice of Assignment which advises all parties as to whom the matter was assigned, and the date by which the UR is to be processed. The URO may contact the claimant and/or the provider for input as to the efficacy of the treatment, but is not required to do so.

The URO then conducts its review. After it is finished, it circulates a written Determination. This document includes a face sheet, giving simple information as to what treatment was reviewed, along with which portions of it were found reasonable or unreasonable, followed by a written opinion explaining what was reviewed as well as how the conclusions were reached.

The URO is required to assume a causal relationship between the treatment and the work injury. However, it can question the causal relationship if, for example, the treatment all pertains to non-accepted body parts. This would later be used as part of its basis for finding a lack of reasonableness and necessity. Reinhardt v. WCAB (Mt. Carmel Nursing Center), 789 A.2d 871 (Pa. Cmwlth. 2002). Reinhardt was procedurally somewhat complicated, involving not only UR litigation, but also Claim/Review Petitions seeking recognition of additional injuries, which were denied.

Automatic Supersedeas

The filing of a UR Request automatically stays (a.k.a. supersedes, hence the term "supersedeas") the obligation to pay for the treatment being challenged.

This was challenged as unconstitutional as a violation of due process in the case of American Manufacturers Mutual Ins. Co, v. Sullivan, 526 U.S. 40 (1999), however the U.S. Supreme Court held that there was no constitutional violation.

If the UR results in a determination that the treatment is not reasonable and necessary, then payment for the treatment is not required unless the claimant or the provider files the next level challenge and prevails.

If the UR results in a determination that the treatment is reasonable and necessary, then payment for the treatment must be paid within 30 days of the URO's Determination. The language of the statute gives a good argument that the treatment shouldn't be paid until all challenges at all levels have been exhausted by the carrier. Nevertheless the PA Commonwealth Court in Scranton School District v. WCAB (Carden), 994 A.2d 1162 (Pa. Cmwlth. 2010) held that the current regulation in place (Section 127.208(g)) did require payment and was consistent with the Act, and that penalties can be imposed for failure to pay even if a further challenge is filed.

Petition for Review of Utilization Review Determination

Any party to a UR Request, namely the carrier, the claimant, or the medical provider whose treatment was under review, may file a challenge to the UR Determination by completing and submitting LIBC-603, Petition for Review of Utilization Review Determination to the Bureau. This must be done within 30 days of the date of the UR Determination or it will be considered untimely. If it is timely, this gets assigned to a Workers' Compensation Judge (WCJ) and listed for hearings on the merits.

The case before the WCJ will be a *de novo* proceeding, meaning that the URO's Determination doesn't create any presumptions and isn't given any special weight. The carrier has the burden of proof in all Petitions for Review of UR Determination, regardless of who prevailed at the URO level. Topps Chewing Gum v. WCAB (Wickizer), 710 A.2d 1256 (Pa. Cmwlth. 1998).

The carrier also has the burden to establish a reasonable contest, meaning that if a UR Request results in an unfavorable determination for the carrier, and the carrier wishes to appeal to the WCJ level proceedings, the carrier must have in its possession, at the time of filing the Petition some evidence in support of the proposition that the treatment is not reasonable and necessary. Otherwise, unreasonable contest counsel fees can be imposed. An IME obtained after the fact will not by itself provide reasonableness of contest. U.S. Steel Corp. v. WCAB (Luczki), 887 A.2d 817 (Pa. Cmwlth. 2005). However, a WCJ can consider an after-acquired IME as evidence on the merits. Road Toad, Inc. v. WCAB (McLean), 8 A.3d 922 (Pa. Cmwlth. 2010). Essentially, if a carrier wants to rely on an after-acquired IME, it is taking its chances that, if it loses before the WCJ, counsel fees will be imposed.

Though the original UR Determination isn't accorded any special weight and doesn't create any presumptions or affect the burden of proof, it must be considered by the WCJ and, automatically, becomes part of the record in the litigation. Any party to the proceedings may introduce additional evidence in support of its position and the matter will proceed to decision by the WCJ based on such evidence.

How to Meet the Burden of Proof?

Pre-UR Preparation

It is necessary to secure an IME, or independent records review, before the UR Request is filed. If it provides an opinion that the treatment you wish to challenge lacks reasonableness and necessity, then proceed forward with the filing of the UR Request. You are now in a position to file further challenge to the WCJ-level proceedings if the UR Determination is unfavorable to you. Carrier also now has evidence corroborative of a favorable UR Determination in the event the claimant or the provider challenges the results. Without a pre-UR opinion supporting your position, you may be precluded from filing further challenge to an unfavorable result. You will also be in a significantly weaker position in trying to hold on to a favorable result. However, you could obtain a post-UR IME or records review in this circumstance, using the original UR determination in your favor to provide your reasonable basis for contest, but you might run the risk of receiving an unfavorable IME or records review which may cut against your case. In an abundance of caution, obtain it first instead.

Choice of Expert

When practical, engage an expert for the pre-UR exam or records review who has a specialty relevant to the treatment in question. While a medical expert in WCJ-level proceedings is not required to be in the same field of specialization as the provider whose treatment is under review (Leca v. WCAB (Philadelphia School District), 39 A.3d 631 (Pa. Cmwlth. 2012)), it will add to the weight of your evidentiary presentation if he/she has some specific expertise in the area. A physical medicine and rehabilitation physician whose inclination may be to continue conservative measures may not be the most credible expert with respect to the issue of reasonableness of surgery. Likewise, a "cut first, ask questions later" orthopedic surgeon may not be the best to comment on continued PT, OT, or chiropractic care. One should also inquire into the areas of the body on which your chosen expert will focus, as a doctor specializing in hips and knees may not carry much weight in a carpal tunnel case.

However, this doesn't mean you are "locked in" to the same type of provider under review. Sometimes, family physicians prescribe excessive amounts and types of medications. In those cases, you may want to choose someone with "better" expertise as to such medications, namely an anesthesiologist or pain management physician.

Cross-examination

There is opportunity for cross examination of the claimant, and often of the provider under review, during WCJ-level proceedings. Maximize the opportunity.

For the claimant in a PT, OT or chiropractic case, focus on how the treatment affects him/her, and what ongoing assessments as to the treatment's efficacy are administered by the physician. While palliative care is not *per se* unreasonable (Glick v. WCAB (Concord Beverage Co.), 750 A.2d 919 (Pa. Cmwlth. 2000)), neither is it reasonable just because it is palliative. In Womack v. WCAB (School District of Philadelphia), 83 A.3d 1139 (Pa. Cmwlth. 2014), the Commonwealth Court affirmed a WCJ in finding care to lack reasonableness based on a number of factors including that the treatment proved relief only for the remainder of the day on which it was rendered, that claimant could do the same exercises and get the same results at home, and the lack of established clinical outcome objectives and specific therapeutic goals in the doctor's records.

For the provider under review, the same type of questions can be asked to bolster the claimant's admissions. Focus on the rationale of the original UR Determination (if it was favorable to you) as to why the treatment lacked reasonableness and necessity and confirm that the URO had the facts right to buttress its opinion. If you had a pre-UR records review or IME, use the rationale

of that expert in your cross-examination as well so all of the evidence comes together in a logical way.

How much money is the doctor making from the continued care of the claimant? While not directly relevant to the reasonableness of the treatment by itself, (some care is just expensive), it can go to show pecuniary motivation on the part of the provider to continue the care beyond just the well-being of the claimant, especially when coupled with a claimant's admission as to minimal or temporary results. At least one federal court has held that evidence submitted by a witness whose self interest may well have dictated its content should not constitute competent evidence. Cullinane v. Sec'y of the Dep't of Human Services of the US, 728 F.2d 137 (2nd Cir. 1984). While PA courts have held that testimony of the provider under review is indeed competent (Acme Markets, Inc. v. WCAB (Johnson & Peterson), 725 A.2d 863 (Pa. Cmwlth. 1999), this type of evidence can nevertheless go to the weight and credibility of the provider's testimony.

In a similar vein, is there an alternative treatment that would net the doctor less money that hasn't been tried? Did the physician jump straight to the $6,000/month compound cream before trying Motrin? Does provider sell that cream out of his office at a profit? These types of questions won't be appropriate in every case, but there are particularly egregious cases where they can be appropriate. Evidence of alternative care options was held to be relevant in Bedford Somerset MHMR v. WCAB (Turner), 51 A.3d 267 (Pa. Cmwlth. 2012), where the care being utilized was highly addictive and other options did exist.

Surveillance

As in any case, the claimant's condition is always relevant. Hypothetically, if a physician stopped care after a UR request was filed because it wouldn't be paid and the claimant testifies that cessation of care had a severe impact on his/her condition, surveillance evidence belying that testimony can be very relevant to whether or not the claimant is credible as to the effect of withdrawal and therefore the efficacy of continued care.

Evidence that a claimant isn't going to scheduled appointments being billed by the doctor is even more convincing.

Prior UR Determinations/Decisions

As per Brookside Family Practice v. WCAB (Heacock), 897 A.2d 539 (Pa. Cmwlth. 2006), medical evidence must address the specific treatment currently under review. Evidence that earlier similar treatment was not reasonable and necessary will not, by itself, sustain an employer's burden on proof. Nevertheless, it has been held to be relevant (Leca v. WCAB

(Philadelphia School District), 39 A.3d 631 (Pa. Cmwlth. 2012)) and, as a practical matter, consider the impact on the fact finder if multiple prior UR challenges resulted in opinions that ongoing chiropractic care or PT wasn't reasonable or necessary and the only thing that has changed since then is the doctor prescribing it.

Tactical Considerations…When NOT to UR

Sometimes you may have a medical opinion that would support a UR challenge to ongoing care. Consider the big picture in the case you are handling. What if you are in the process of completing a labor market survey that's going to take more time to finalize and get ready to litigate and the same IME physician is going to be your expert? Or what if your IME doctor said he expects a full recovery within 6 months, and you plan to have a re-evaluation after that time period expires? Do you want that physician subjected to credibility determinations right now? Do you risk handing the claimant the argument that your doctor's testimony has already been found to lack credibility over a few prescriptions or 4 more weeks of PT? Consider holding off on that UR Request until you are ready to pursue the bigger issue.

Managing Expectations a.k.a. Defining Victory Conditions

Not every UR Request will be successful. However, even a partial victory can result in significant reduction in exposure. Utilization Review is not an all or nothing proposition. It can limit the frequency of treatment. Snyder v. WCAB (International Staple & Machinery), 857 A.2d 202 (Ps. Cmwlth. 2004). With expensive types of care such as injection therapy, PENS, separately-billed PT modalities, etc., even a reduction in frequency can be very important. At a minimum, it may reduce settlement value, or the amount of a Medicare Set Aside, and thus facilitate resolution.