WORKERS' COMP UPDATE

CALIFORNIA

VOLUME 8 NUMBER 11 NOVEMBER 2004

Properly Implementing Utilization Review

For many insurance companies, third party administrators, and self-insured employers, the new Labor Code Section 4610 became yet another burden to bear because it introduced new requirements for their Utilization Review (UR) programs. As most know by now, these new requirements include shorter time frames to operate within, mandate the use of a California-licensed medical director, and require the use of particular guidelines.

Some entities have started using the new law, but have done so incompletely or incorrectly. For those who have correctly applied this new law, it has been used both to improve their own financial bottom line and to provide better care for the injured employees they cover – a win-win situation.

Complying with the language of Section 4610 includes adherence to strict time frames. It states that, "decisions shall be made in a timely fashion…not to exceed five working days from the receipt of the information reasonably necessary to make the determination…, but in no event more than 14 days from the date of the medical treatment recommendation by the physician." While there is debate as to the interpretation of this language, a conservative approach would mean that after a request is received, a decision to approve, modify, delay pending further information, or deny a request must be rendered in 5 days. This is troublesome for many companies, as mail is not opened sometimes for weeks. The easiest solution is to inform requesting parties to direct all requests to the Utilization Review department of the company. That, however, is not easy given that some companies have one single company fax number and mailing address. If this is the case, the importance of the mailroom and fax machine become much higher than before.

As highlighted in recent seminars on this issue, utilization review can be thought of as a pyramid that starts from the mailroom and ends with the medical director. All the components need to have seamless communications and work well with one another. However contested and debated these time frames are, the conservative approach is to ensure that they are adhered to as best as possible – not only to comply with the law but also to help speed up the process of care delivery.

The delivery of quality health care to the injured worker is, from the ethical perspective, the greatest asset to utilizing utilization review. Conflicting with this intent, however, is the fact that certain practices in medicine are more financially rewarding than others.

Unfortunately, whether consciously, unconsciously, or simply stemming from poor or outdated professional training, providers sometimes deliver care that is more expensive than that which is best for their patients. For example, most know that time spent performing a procedure is more lucrative than intellectual time spent simply seeing a patient. However, pathways derived from evidence-based medical literature often show that a step-wise clinical investigation that eventually leads to a procedure is better for patients. This is because the routine clinical investigation may save the patient from a risky procedure by treating their ailment conservatively. Yet, some clinicians bypass essential steps in the clinical investigation of routine ailments and jump straight to a procedure.

…WHETHER CONSCIOUSLY, UNCONSCIOUSLY, OR SIMPLY STEMMING FROM POOR OR OUTDATED PROFESSIONAL TRAINING, PROVIDERS SOMETIMES DELIVER CARE THAT IS MORE EXPENSIVE THAN THAT WHICH IS BEST FOR THEIR PATIENTS.

It is important to remember, however, that the financial gains of the individual provider are not always the culprit in the decision to curtail proven clinical pathways. As shown in numerous scientific studies, clinicians, as humans, are vulnerable to suggestion and are regrettably far too often influenced by advertisements and other incentives to chose treatment options that are poor choices for their patients. They may be poor choices economically, as in the choice of an equally effective brand name medication over a generic label, or more tragically, in the choice of unproven, ineffective treatment modalities that unnecessarily prolong the treatment phase of an ailment.

Currently, the law calls for adherence to the guidelines published by the American College of Occupational and Environmental Medicine (ACOEM) whenever possible and to other evidence-based medical literature for topics not discussed by the ACOEM Guidelines. This directive may change – even by the time this article is printed. Either way, medical technology will advance and scientific knowledge will increase and all guidelines should evolve with time. For the correct application of the ACOEM Guidelines and other evidence-based medical guidelines, the law mandates the use of a California-licensed M.D. or D.O.

While the state legislature did introduce numerous new criteria for using utilization review, this is actually a gift of diamond in coal for all of us. Despite the successful use of utilization review by the managed care industry since the early 1980s, previous technical legalities made it next to impossible for the California workers' compensation system to do the same for literally over a decade. Now is finally the time to responsibly apply utilization review for the health of our state's employees and for the economic betterment of our state's businesses. ■

Dr. Matian is President and Medical Director of Matian Medical Corp., providing utilization review services for workers' compensation claims in California. He can be contacted at 213-386-7282.