Utilization Review Agent Plan-Based Audit

November 20, 2020

Section I: General Statement and Overview

Texas Department of Insurance, Division of Workers' Compensation (DWC) is required by Texas Labor Code §413.002 to "monitor health care providers, insurance carriers, independent review organizations, and workers' compensation claimants who receive medical services to ensure the compliance of those persons with rules adopted by the commissioner relating to health care, including medical policies and fee guidelines." Texas Labor Code §413.0512 requires the Medical Quality Review Panel (MQRP) to recommend to the medical advisor "appropriate action regarding doctors, other health care providers, insurance carriers, utilization review agents, and independent review organizations."

DWC will manage the Medical Quality Review Process in a manner that is fair to all workers' compensation system participants, open, and transparent to the extent consistent with state confidentiality laws and provide the subject of a review the opportunity to participate throughout the Medical Quality Review Process.

Medical quality reviews help DWC monitor compliance with the Texas Labor Code and DWC rules. They also ensure that injured employees in the workers' compensation system receive reasonable and medically necessary health care that is timely, cost-effective, and facilitates functional recovery and appropriate return-to-work outcomes. Under Texas Labor Code §408.023(l)(3), DWC shall collect information regarding cost and utilization of health care provided or authorized by a treating doctor.

Utilization Review Agents (URAs) are registered or licensed entities that review requests for health care services being provided (concurrent), proposed to be provided (prospective), or already provided (retrospective). URAs determine whether services are medically necessary and appropriate and may also determine if services are experimental and investigational. The Managed Care Quality Assurance Office processes applications for entities seeking registration, licensure or licensure renewal as a URA within the state of Texas.

Preauthorization is a form of prospective review of health care services to be provided to an injured employee. The insurance carrier is liable for all reasonable and necessary medical costs relating to the preauthorization of health care. All requests for preauthorization must go through utilization review under 28 Texas Administrative Code (TAC) Chapter 19, Subchapter U, and 28 TAC Chapters 133 and 180. Under Labor Code §§408.026 and 413.014, and TAC §134.600, non-emergency health care requiring preauthorization includes spinal surgeries. Spinal lumbar fusion is not a recommended surgical procedure by the *Official Disability Guidelines* (ODG) "in workers' compensation patients for degenerative disc disease, disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or nonspecific low back pain, due to lack of evidence or risk exceeding benefit." Reviewing the appropriateness of approvals for spinal lumbar fusions approved through the preauthorization process is necessary to ensure the delivery of quality health care in a cost-effective manner, including protecting the safety of injured employees.

Section II: Purpose

- Promote the delivery of quality health care in a cost-effective manner, including protecting the safety of injured employees.
- Ensure that insurance carriers or URAs adhere to the ODG and medically accepted standards of care for conducting utilization review, including the appropriate selection of reviewing health care providers.

Section III: Scope and Methodology

- Includes insurance carriers or URAs who have prospectively approved spinal lumbar fusions for injured employees:
    - Where the spinal lumbar fusion was billed with Current Procedural Terminology (CPT) codes 22533, 22558, 22586, 22612, 22630, or 22633;
    - Where the spinal lumbar fusion was billed with ICD-10 diagnosis code of M48.061, M48.062, M54.5, M51.36, or M51.9;
    - Where the spinal lumbar fusion was no earlier than 180 days from date of injury; and
    - Where the spinal lumbar fusion was not denied for lack of preauthorization by the insurance carrier.
- Procedures for determining the reasonableness of a doctor's decision and recordkeeping regarding return to work are set forth in Section II of the Medical Quality Review Process, specifically, the adopted return to work guidelines. See also Texas Labor Code §§413.002, 413.013, and 413.05115.

Section IV: Selection Criteria

- Time frame to select data:
    - Insurance carriers will be identified through the medical bill and payment data.
    - URAs will be identified from medical records provided by the selected insurance carriers.
    - Cases will be identified through medical bill and payment data submitted to DWC with dates of service on or after January 1, 2018, through June 30, 2020, which contain CPT codes 22533, 22558, 22586, 22612, 22630, or 22633;
- Case selection:
    - Identify bills where the injured employee had a spinal lumbar fusion:
        - billed with CPT codes 22533, 22558, 22586, 22612, 22630, or 22633;
        - billed with ICD-10 diagnosis code of M48.061, M48.062, M54.5, M51.36, or M51.9;
        - was no earlier than 180 days from date of injury; and
        - was not denied for lack of preauthorization by the insurance carrier.
    - Include only one bill per each unique surgical event.
    - Randomly select 30 bills.

Section V: Roles and Responsibilities

Information Management Services (IMS)

- Provides a list of cases based on the scope, methodology, and selection criteria.
- Coordinates code review of programming used to meet the scope, methodology, and selection criteria as outlined in Sections III and IV.
- Selects the case files for medical quality review based on selection criteria.

Health Care Quality Review (HCQR)

- Notifies insurance carriers identified through the chosen cases for medical quality review and requests documents.
    - Upon receipt of documents, HCQR identifies the URAs associated with the selected cases and notifies those URAs of the medical quality review.
    - URAs notified of the medical quality reviews will be the subjects of this plan-based audit.
- Requests another subject or case from IMS if the nurse investigator verifies in writing that a subject or case did not meet the approved plan-based audit criteria.
- Selects MQRP members to perform a review in accordance with 28 TAC §§19.2006, 180.22, 180.66, and 180.68.
- Provides an executive summary to the commissioner of workers' compensation upon conclusion of the plan-based audit.

Medical Advisor

- Develops questions for MQRP experts. The questions will be approved by the commissioner of workers' compensation prior to records being sent to MQRP experts.

Section VI: Conflicts

This plan-based audit complies with the approved medical quality review process. However, if a specific conflict exists between this plan-based audit and the medical quality review process, this plan-based audit prevails.

Section VII: Approvals

Submitted by:

11/20/20

Graves Owen, M.D. Date
Medical Advisor

Approved by:

November 23, 2020

Cassie Brown Date
Commissioner of Workers' Compensation