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 Second Injury Board

<b>Workers Compensation Medical Treatment Guidelines and Utilization Review Rules</b>	<b>Medical Treatment Guideline and Utilization Review Rules - Clarifications</b>
	<b>Date : TBA</b>
<b>Peer-to-Peer Review</b>	<b>OWCA: 10-2012</b>

**Subject: The role of Peer-to-Peer Reviews in the Workers' Compensation Medical Treatment Guidelines and Utilization Review process.**

**This bulletin is for the purpose of clarification of peer-to-peer reviews as they relate to the Medical Treatment Guidelines and Workers' Compensation Utilization Review.**

**Background:** It has come to our attention that providers and carriers are having difficulty successfully performing peer-to-peer review in workers' compensation. This may be due in large part to the misunderstanding of peer-to-peer review and its role in workers' compensation utilization review and the medical treatment guidelines.

**Discussion:** While peer-to-peer is mandatory in group health, it is not in workers' compensation. The utilization review rules that went into effect April 20, 2012 explain the process interested parties must follow in order to seek and approve medical care. While peer-to-peer review is not mandated by the utilization review rules, it can be helpful, if used correctly and efficiently during the "voluntary reconsideration" period.

Once the Provider sends the Carrier the minimum information necessary for a request for authorization found in Title 40:I:2715(C), the Carrier has 5 days to render a decision. It is very difficult to conduct a peer-to-peer review during that 5 day window. Often, the attempts at peer-to-peer review result in a frustrating game of "phone tag" as neither side is able to speak with the other. With this in mind, the drafters of the utilization review rules included Section 2715(I), which allows for a 10 day "voluntary reconsideration" period during which the provider can call the carrier, discuss the decisions and afford the carrier an opportunity to overturn their previous denial or approval with modification. If that occurs, the carrier is deemed to have acted in good faith.

Title 40:I:2715(I)(2) states:

".....the LWC-WC-1010 and the summary of reasons provided by the carrier/self-insured employer with the denial or approved with modification will include a statement that the health care provider is encouraged to contact the carrier/self-insured employer to discuss reconsideration of the denial or approval with modification. The carrier/self-insured employer shall include on the summary of reasons a section labeled "voluntary reconsideration," and include a phone number that will allow the health care provider to speak to a person with the carrier/self-insured employer or its utilization review company with authority to reconsider the previous denial or approval with modification."

We encourage all parties to initiate "voluntary reconsideration", if they deem it necessary, after receipt of the Section 2715(I)(2) notice above. This will lead to a more informed and less rushed process since there is 10 days instead of 5, and all parties know what is being requested and the reason for its denial or approval with modification.

Please note the 10 day window runs consecutive with the 15 day period to appeal a denial or approval with modification by the carrier. If the “voluntary reconsideration” process is attempted, the time period within which a provider must file an appeal is not suspended. For example, if a provider attempts to contact the carrier’s reviewing physician to discuss a voluntary reconsideration and he/she does not receive a response, and doing so takes the full 10 days, the provider only has 5 days in which to file an appeal to the medical director on the form 1009.

**Summary:** In Workers’ Compensation, peer-to-peer review is not mandatory; however the OWCA encourages the exchange of information between the parties in an effort to resolve the issue prior to filing the LWC-WC-1009. If this exchange is conducted within the 10 day window after a decision by the carrier has been made, it may prove to be helpful in reversing a denial or approval with modification. If the issue remains unresolved, the aggrieved party still has the option of timely filing of the Form 1009 appeal with the Medical Director.

Using the peer-to-peer review during the 10 day window does not interrupt the time period by which a provider must file an appeal with the medical director. All parties must be aware of the time delays found in Section 2715 of the Utilization Review Rules.