CHAPTER 5

ALTERNATIVE DISPUTE RESOLUTION (ADR)

All MCOs are required to have an Alternative Dispute Resolution (ADR) process. ADR is intended to handle medical disputes regarding quality assurance, utilization review, medical necessity and other treatment and provider issues. With the implementation of The Health Partnership Program (HPP), it is the first time providers are able to initiate a medical dispute involving a workers' compensation claim. All parties initiating a medical dispute should contact the MCO directly. Parties involved in the dispute include:

- Employer
- Injured Worker
- Provider (except at the IC level of dispute)
- BWC
- MCO (except at the IC level of dispute)

ADR affords due process regarding conflicts in medical treatment issues but **does not** include fee schedule grievances, dismissed C-9's (4123-6-16.2) and reactivation issues. Disputed issues may include:

- Authorization of medical treatment and diagnostic testing
- Request for consultation
- Feasibility of Voc Services/Closure of rehabilitation files
- Authorization of medical equipment, supplies and services
- Nursing services
- Necessity of treatment

GOALS OF ADR

- Facilitate resolution of disputes through negotiation by introduction of objective third party at MCO and BWC level.
- Support and complement medical case management continuum
- Ensure fairness and due process to parties
- Avoid litigation
- Preserve relationships of parties
- Strive for satisfaction of parties
- Improve communications
- Promote lasting outcomes
- Achieve goals of HPP

Appeal Process

Appeal to C-9 Decision

Injured workers (IW) and their representatives (AOR), employers and their representatives (TPA), or providers may initiate the ADR process by contacting the injured worker's MCO on-line or in writing using The Ohio BWC C-11 (*Appeal to the MCO Medical Treatment/Service Decision*) Form.

Although the C-11 will result in improved communications between providers and MCOs and streamline the dispute resolution process, MCO's will continue honoring any claim party generated document, containing the data elements on the C-11, used for initiating ADR. A written request to initiate the alternative dispute resolution process must contain, at a minimum, the following elements:

- Injured worker name.
- Injured worker claim number.
- Date of initial medical treatment reimbursement request (form C-9 or equivalent) in dispute.
- Specific issue(s) in dispute, including description, frequency/duration, beginning/ending dates, and type of treatment/service/body part.
- Name of party making written appeal request.
- Signature of party making written appeal request or their authorized representative.

BWC will also accept signatures from any representative given signature authority.

Note: If an online C-86 motion with an electronic signature is being utilized as an appeal the MCO may accept and process this appeal, providing the form has a www.ohiobwc.com footer.

Appeal Dismissal Criteria

- The MCO will make three attempts to contact the appellant to receive the missing elements before dismissing the dispute. These contact attempts must be documented in the claim record. The appellant will be afforded one business day to provide the missing element(s).
- The MCO's timeframe is not extended to accommodate this one day requirement.
- If the appellant does not respond with the requested missing element(s) after one business day the appeal can be dismissed without predjudice.

- There is no time frame specific to the amount of time for the 3 attempts to be made, i.e., the 3 attempts could be 2 phone calls and one e-mail, all done in one day.

Appeal Withdrawal Criteria

- Signed and dated appellant withdraw letter or C-11.
- The MCO must attempt to contact the IW and these attempts must be documented in the claim file. Withdrawals must be sent to BWC to be imaged separately.

Timeline for appeal to C-9 decision:

According to Rule 4123-6-16(B), parties have 14 days upon receipt of the initial decision to file a medical treatment dispute. **These are guidelines not deadlines.** Neither the ADR Rule nor case law provides any consequence if an ADR appeal is filed untimely.

Note: Due to the Ohio Supreme Court decision in State ex rel. Haylett v. Ohio Bur. of Workers' Comp., 87 Ohio St. 3d 325 (1999), these timeframes cannot be strictly enforced and the MCOs must accept untimely appeals. The Court in Haylett was asked to decide whether the delegation of medical management to the MCOs and the ADR process as set up by the HPP were unconstitutional. The Supreme Court rejected both arguments, and ultimately found both the MCOs' medical management and the ADR process to be constitutional. In doing so, the Court placed great emphasis on the fact that the MCOs' treatment decisions were "*non-binding*," were not "*quasi-judicial*" in nature, and were subject to further review by BWC and the IC.

In the event that the IC receives an untimely filed appeal, to an MCO decision, the IC will issue an *ex parte* order returning the appeal (motion) to the CSS. The CSS will return the motion to the MCO to continue with the ADR process. Original MCO ADR 21-day and 7-day time frames will apply; The MCO must process any appeal it receives and**,** except as provided immediately below, does not have the jurisdiction to state that it has not received an appealable issue. The MCO shall respond to the appeal regardless of whether or not medical documentation was received with the appeal. An ADR appeal letter does **NOT** have to contain the word "appeal" in order for the MCO to accept the appeal letter.

Non-appealable Issues

Any services that are never reimbursed by BWC should not be processed through ADR. Some examples include:

- **Home furniture** including, but not limited to: reclining chairs, non-hospital beds, water beds, lounge beds (such as Adjust-A-Sleep Adjustable Bed, Craftmatic Adjustable Bed, Electropedic Adjustable Bed, Simmons Beautyrest Adjustable Bed);
- **A mattress** for a non-hospital bed;
- **Home exercise equipment** including but not limited to such equipment as treadmills and exercise bikes, are not considered to be durable medical equipment

and shall not be authorized or paid by for BWC/MCO, except when the criteria has been met for an IW who is participating in a vocational rehab program;

- **Home whirlpools** including built-in whirlpools and pumps, portable hydrotherapy pools, Jacuzzi tubs, portable saunas and spas, and TheraSaunas are not considered to be medically necessary. This includes non-portable hot tubs/whirlpools billed as E1310**.** When a request is received for a built in hot tub/whirlpool, the MCO must call the provider to advise that BWC covers the "over tub whirlpool" (E1300) if determined to be medically necessary and appropriate to the industrial injury.
- **Hot and cold packs**.

ADR should not be initiated prior to a final (no pending appeals) administrative or judicial order allowing the claim. Once an allowance determination has been made at the SHO level (or higher) medical can be reimbursed, and the ADR appeal can be heard. Once a final determination has been made, as described above, the MCO should contact the appellant and receive a new appeal that is dated after the determination of the allowance of the claim.

A physician does not have to be BWC certified in order to appeal; however, they must be enrolled. Enrollment allows the physician to receive reimbursement.

Medical Treatment Decision Appealed

MCO Responsibilities

According to Rule 4123-6-16(C), upon receipt of a written medical dispute, the MCO shall initiate the ADR process. The MCO's ADR process shall consist of one independent level of professional review as follows:

(1) *If an individual health care provider eligible to be physician of record would be providing the services requested in the dispute, the independent level of professional review shall consist of a peer review conducted by an individual or individuals licensed pursuant to the same section of the Revised Code as the health care provider who would be providing the services requested.*

While MDs and DOs are both licensed by the Ohio State Medical Board and much of the medical and osteopathic school training is similar, rarely does medical school training provide instruction on the use of manipulation. Therefore, MCOs must use osteopathic trained physicians to provide reviews in ADR cases that pertain to osteopathic manipulation issues. This applies only to osteopathic manipulation. MDs and DOs may continue to opine on other requests that apply to both professions. Chiropractic treatment must be reviewed by a chiropractic physician.

(2) Notwithstanding paragraph (C) (1) of this rule, if the MCO has already obtained one or more peer reviews during previous disputes involving the same or

similar treatment, the MCO may obtain a different perspective review from a licensed physician who falls outside the peer review criteria set forth above.

A Different Perspective reviewer is defined as; a licensed physician that falls outside the criteria of peer-to-peer reviewer. This includes specialists that practice in one specific branch of medicine. Examples of these reviewers include, but are not limited to: spine surgeons, chiropractic specialists, pain management, hand surgeons, joint replacement orthopedists, and physical medicine & rehabilitation physicians.

The criteria for determining if a different perspective review (file review or IME) is indicated includes, but are not limited to, the following:

- There must be at least 1 peer-to-peer review on file
- Complex cases (e.g. multiple ICD-9 codes, multiple treating providers, pain management, etc.)
- Multiple provider types to perform treatment (e.g. TPI's, ESI's, Physical Modalities, etc...)
- Duration and/or complexity of C-9 requests
- Specialty service/procedure has been requested (e.g. repeat surgery, invasive procedures, long term clinic placement, etc.)
- *Excessive* treatment that significantly exceeds evidence based/nationally recognized treatment pathways. For example, chronic pain cases where the IW has reached a treatment plateau.

(3) If an individual health care provider not eligible to be physician of record would be providing the services requested in the dispute, the independent level of professional review shall consist of a provider review conducted by an individual or individuals eligible to be physician of record whose scope of practice includes the services requested.

According to Rule 4123-6-16(E) The MCO may recommend that the employee be scheduled for an independent medical examination. This recommendation shall toll the MCO's time frame for completing the ADR process, and in such cases the MCO shall submit its recommended ADR decision to the bureau electronically within seven days after receipt of the independent medical examination report
If a file review has been performed as part of the current workers' compensation claim for the IW, employer, employer's representatives, MCO, or BWC in the past 12 months, the same reviewer may not be used. **If 12 months has elapsed, the same reviewer may be utilized again in that claim.**

If a peer-to-peer or different perspective Independent Medical Examination (IME), is completed in lieu of a file review, reports must be sent to all parties. This includes original reports and addendums.

BWC will reimburse for the ADR IME ordered by the MCO. The IME must take place within the ADR process in order for BWC to reimburse for the IME. See "MCO Scheduled/BWC Reimbursement IME Policy" below.

For file reviews and/or IME's refer to Chapter 2 of the BWC DEP Evaluator Handbook for information regarding a list of potential conflicts of interest.

Denials cannot be based on lack of medical to support the request. The peer reviewer must document in his/her review all allowed and disallowed conditions in the claim.

- The ***Miller*** **Criteria** (Rule 4123-6-16.2(B)(1) through (B)(3); see **Legal Considerations** below) must be applied to all requests of workers' compensation medical services.

MCO SHALL NOT ADDRESS CAUSALITY IN MCO ADR FILE REVIEWS - Causality must be addressed in the claim determination process by BWC through BWC file review or BWC IME. Addressing causality in reviews by MCO ADR reviewers is not appropriate. To avoid confusion, refrain from using terminology such as, causality, causal, and causal relationship in final reports.

MCO SHALL NOT ADDRESS MAXIMUM MEDICAL IMPROVEMENT. Determination of maximum medical improvement and additional claim allowance are the responsibility of the BWC. The BWC addresses maximum medical improvement through either the 90 day examination or IME. This process may utilize BWC medical file review or BWC IME to obtain appropriate expert medical opinion. Therefore, refrain from asking these questions when obtaining MCO ADR file reviews or MCO ordered IME's.

A peer reviewer and IME physician may review and opine on multiple C9s for the same injured worker, as long as the report is individualized and addresses only the issues in a given appeal.

MCO Responsibilities

The MCO QA's the independent report to ensure that it meets the basic requirements of an ADR IME or file review which must also include a medically reasonable and evidence base decision.
The basic requirements include (must address all):

1. The reviewer's decision is consistent with Official Disability Guidelines (ODG) and/or other evidence based guidelines adopted by the Bureau per Rule 4123-6-16.1.
2. The decision is individualized to the IW's current symptoms and objective signs.

3. The report reflects an accurate interpretation of all medical on file.
4. All pertinent medical is considered in the final report and opinion.
5. The *Miller* Criteria are considered and applied appropriately.
6. The reviewer *did not* address causality or maximum medical improvement (MMI) status.
7. All allowed and disallowed conditions are considered.
8. The report is signed and dated.
9. The IME report is time stamped with date of receipt.

If the final report meets the basic requirements of an ADR IME or file review and a medically reasonable evidence based decision, the MCO will proceed with drafting a recommended ADR decision, in the form of a draft order, based on the physician reviewer's recommendations.

If the final report **does not** meet the basic requirements of an ADR IME or file review and a medically reasonable evidence based decision, the MCO is directed to obtain an addendum to the file review or IME until all decision criteria are met. The recommendation should be processed within one business day of receipt of an acceptable addendum.

The injured worker, employer and their representatives must always receive a copy of the IME report. Results of a file review must be shared upon request by a party to the claim.

There are four instances in which disputes can be referred to the BWC ADR review staff for a final recommendation:

- Treatment is not reimbursable by the BWC
- Treatment is potentially harmful or contraindicated for the IW's condition
- Excessive costs

  The final report *does* meet the basic requirements of an ADR IME or file review but the MCO disagrees with the reviewer's findings

BWC referrals must be faxed to the BWC ADR department at 614-621-2542. The packet must include:

- Completed ADR Info Guide which includes reason for referral
- C-11 or equivalent
- File review, and/or IME report
- Initial decision letter (if MCO does not use the C-9)
- Initial review
- Initial request or C-9

MCO referrals will be reviewed by BWC ADR Staff who will also apply the same basic requirements for an acceptable ADR IME or file review listed above. After the review process is completed, the BWC IRN will make a final recommendation in accordance

with results of the final IME or file review. This recommendation will be emailed (password protected document) to the assigned MCO ADR Department within 72 hours of receipt at the BWC. The MCO will then draft recommended ADR decision, in the form of a draft order, which is electronically sent to the BWC.

The MCO must send a separate copy of the file review report/IME to the BWC Service Office assigned to the claim to be imaged into the claim file.

Dispute Timeline:

- Day one of the dispute occurs the date the MCO receives signed written notice of appeal to a medical treatment decision from a provider or legal party to the claim.
- All documents received by the MCO related to the dispute, regardless of the mechanism of transmission, must be date stamped with the receipt date **(**as defined in Appendix G of the MCO contract**)** and the name of the MCO.
- Per Rule 4123-6-16 (E): Unless the MCO reverses the decision under dispute pursuant to paragraph (D) of this rule, the MCO shall complete the ADR process and submit its recommended ADR decision to the bureau electronically within twenty-one days of the MCO's receipt of the written medical dispute. The MCO may recommend that the employee be scheduled for an independent medical examination. This recommendation shall toll the MCO's time frame for completing the ADR process, and in such cases the MCO shall submit its recommended ADR decision to the bureau electronically within seven days after receipt of the independent medical examination report.

The MCO shall be clear in all communication to parties to the dispute. For example, abbreviations must never be used unless they are also spelled out. All CPT codes must be defined in all communication to parties to the dispute and on the ADR Information Guide.

The MCO is responsible for reviewing the BWC Medical Repository and determining if there are new and changed circumstances which impact the initial treatment decision or the previous peer review. Examples of new and changed circumstances which may impact treatment include, but are not limited to, additional allowances, change in compensation, additional medical evidence and overturned decisions at the IC. If upon consideration of additional evidence, the MCO reverses their decision to the satisfaction of all parties, the MCO may issue a new determination and dismiss the dispute without prejudice.

The appeal period for BWC ADR Orders is 14 days from ***receipt of the order***. For parties to the claim other than BWC, 3 days are added to the 14 for mailing. (17 days total for the appeal period process: 14 days to appeal from date of receipt + 3 mailing days). A Modified ADR Order may be issued within 14 days of the original issuance of the ADR Order if no appeal has been filed. The appeal period for BWC ADR Orders is 14 days. Modified ADR Orders may be issued when the MCO has received new medical evidence that changes the initial determination issued and/or to correct clear clerical errors in the initial determination.

The MCO will review the new medical evidence received and determine if the evidence changes the initial determination issued in the BWC ADR Order. If the new medical evidence is submitted within the appeal period and no appeal has been filed, the BWC ADR Order can be vacated and a Modified ADR Order issued within the timeframe outlined above.

If new medical evidence is submitted after an appeal is filed BWC and the MCO no longer have jurisdiction. The documentation will be imaged and the IC will obtain all claim information though a systematic transfer of information prior to the IC hearing.

If the MCO has determined that a Modified ADR Order may be issued, the MCO shall complete a new Order with all the corrected information. Vacating nullifies the original Order; therefore, the Modified ADR Order shall cite all issues that were correctly addressed on the original Order, specific changes to the previous Order, and include the new information or evidence that was received which changed the previous decision, using the modified order inserts on the ADR Order template:

> "This order replaces the BWC Order dated **<user enters date that appears on order, not date which appears in V3 correspondence history >,** which has been vacated for the following reason:
>
> **<<2 lines of additional text >>**
>
> The decision to vacate the previous order is based on:
>
> **<<3 lines of additional text>>**

ADR Mini-Packet Submission Requirements:

At the time of draft order submission, all disputes processed by the MCO must accompany a dispute Mini-Packet which is faxed immediately to the BWC Scan Zone at 1-866-336-8352.

ADR Standard Mini-Packet contents (*must be included in this order*):

1. Fax coversheet with IW's name, claim number, dispute number and clearly marked **ADR Mini-Packet**.
2. Unaltered BWC ADR Information guide
3. C-11 or equivalent
4. File review, Vocational File review (when applicable) and/or IME report
5. Initial decision letter (if MCO does not use the C-9)
6. Initial review
7. Initial request or C-9

Disputes with multiple C-9s can be combined into one packet (Max 20). This option can only be utilized when:

1. Appeal dates are the same
2. Appellant is the same
3. No overlapping dates of service unless clarified and documented in V-3 ADR notes

When applicable, the MCO must obtain beginning and ending dates for the following, but not limited to, all P.T., O.T., chiropractic treatment and injections.

If unable to obtain the dates from the provider, MCOs may use the date that the MCO decision was made as the beginning date then assign the ending date. For services such as but not limited to**,** a one-time consult, diagnostic studies or surgery, it is NOT necessary to obtain the beginning and ending dates.

Specialized Circumstances for Dispute Processing per ADR Rule 4123-6-16

Paragraph (G)(1):

If the MCO receives a written medical dispute involving a medical treatment reimbursement request that appears to be the same as or similar to a previous treatment request for which the MCO conducted a provider review, and the previous treatment request is pending before the bureau or industrial commission, the MCO may pend the new dispute until the previous treatment request has been resolved. Once the previous treatment request has been resolved, the MCO shall resume the ADR process, and may proceed in accordance with paragraph (C)(4) of this rule if appropriate.

The MCO ADR timeframe begins with the receipt of the appeal. If the issue is pended, days during the pend period do not count toward the MCO's ADR timeframe; however, on the day the dispute that was in hearing has been adjudicated completely, the MCO's ADR timeframe resumes where it left off per rule 4123-6-16.

For example, if an MCO pends an ADR on day 7 of the ADR period, once the previous dispute has been adjudicated, the MCO has 14 days remaining to process the appeal. The ADR timeframe is not reset back to 21 days.

Paragraph (G)(1) Criteria

- MCO has previously conducted a peer-to-peer review or an ADR IME for services that are same or similar to the current C-9 received.
- The previous peer-to-peer review or an ADR IME must be within 12 months of the current C-9 decision.
- The previous treatment request must have been **ultimately denied** based on the peer-to-peer review or an ADR IME.

Paragraph (G) (1) Packet Timeline

- Once the Industrial Commission makes a determination in the previous dispute, **under O.R. C. 4123.511 (l) medical benefits are payable as soon as the SHO order allowing the claim/condition is issued; the MCO may process the dispute, and does not have to wait until the SHO appeal period expires.**
- The MCO shall count 14 days then add an additional 3 days for mailing = 17 days.
- The MCO must check on the 17th day from the BWC or IC determination "date mailed" to see whether an appeal has been filed.
- As stated above, once the previous treatment request has been resolved, the MCO shall resume the ADR process, and may proceed in accordance with paragraph (C)(4) of this rule if appropriate

Paragraph (G)(2)

If the MCO receives a written medical dispute involving a medical treatment reimbursement request relating to the delivery of medical services for a condition that is not allowed in the claim, and the issue of the allowance of the additional condition is pending before the bureau or industrial commission, the MCO may pend the dispute until the bureau or industrial commission has made a decision on the allowance of the additional condition. Once the bureau or industrial commission has made a decision on the allowance of the additional condition, the MCO shall resume the ADR process.

The MCO ADR timeframe begins with the receipt of the appeal. If the issue is pended, days during the pend period do not count toward the MCO's ADR timeframe; however, once a decision has been made on the additional condition, the MCO's ADR timeframe resumes where it left off per rule 4123-6-16.

For example, if an MCO pends an ADR on day 7 of the ADR period, once a decision has been made on the additional condition, the MCO has 14 days remaining to process the appeal. The ADR timeframe is not reset back to 21 days.

Paragraph (H)(2)

(H) Notwithstanding paragraph (C) of this rule, an MCO may submit it's recommended ADR decision to the bureau electronically without obtaining an independent level of professional review under the following circumstances:

* * *

(2) The MCO receives a written medical dispute involving a medical treatment reimbursement request relating to the delivery of medical services for a condition that is not allowed in the claim, and the issue of the allowance of the additional condition is not pending before the bureau or industrial commission.

Paragraph (H)(2) Criteria

The MCO submits its recommended ADR decision to the bureau electronically via BWC's secure web offering if a dispute is filed (by a provider, injured worker, employer, or their representative) after the MCO has made an initial determination on a request for treatment of a condition that is not allowed in the claim, and one of the two following conditions is present:

- the injured worker has not filed a motion for an additional allowance, or;
- the provider has recommended an additional allowance which BWC has not allowed.

Paragraph (H)(2) ADR Mini-Packet Submission

1. Fax coversheet with IW's name, claim number, dispute number and clearly marked **ADR Mini-Packet**.
2. Unaltered BWC ADR Information guide
3. C-11 or equivalent
4. MCO C-9 physician review. Documentation must include:
    - MCO C-9 physician review documenting specific condition being treated unless psychiatric treatment request and no psychiatric conditions are allowed in the claim.
    - Reference to medical report documenting treatment of non-allowed condition.
    - Demonstrate *Miller* criteria was applied.
5. Initial decision letter (if MCO does not use the C-9)
6. Initial request or C-9

Senate Bill 7

Per Senate Bill 7 and Rule 4123-6-16(H)(1), the ADR process shall NOT be used to resolve disputes concerning medical services rendered that have been **approved** through standard treatment guidelines, pathways, or presumptive authorization guidelines.

This means, all Employer/TPA appeals of approved authorizations will be exempt from the dispute resolution process if the requested services fall within presumptive authorization, nationally recognized treatment pathways and/or evidenced based guidelines.

Paragraph (H)(1)

(H) Notwithstanding paragraph (C) of this rule, an MCO may submit its recommended ADR decision to the bureau electronically without obtaining an independent level of professional review under the following circumstances:

(1) The MCO receives a written medical dispute involving a medical treatment reimbursement request relating to the delivery of medical services that have been approved by the MCO pursuant to standard treatment guidelines pathways, or presumptive authorization guidelines.

Paragraph (H)(1) ADR Mini-Packet Submission:

1. Fax coversheet with IW's name, claim number, dispute number and clearly marked **ADR Mini-Packet**.
2. Unaltered BWC ADR Information guide
3. C-11 or equivalent
4. Initial decision letter (if MCO does not use the C-9)
5. Initial review
6. Initial request or C-9
7. Reference to Standard Prior Authorization Policy: i.e. Chapter 3 of the MCO Policy Reference Guide pages 18-19

ADR Exams

Beginning 7/1/10 ADR exams are scheduled on behalf of BWC directly by the MCO through BWC's scheduling system on screens on the BWC's web site. This process tolls the MCO's time frame for completing the ADR process and in such cases the MCO will reach their recommended decision and submit it to BWC to publish an order within 7 days after receipt of the ADR IME report. The MCO will place notes in the claim file documenting their decision.

The MCO may select the BWC Certified Provider for ADR exams from the DEP list of doctors identified for ADR exam types in the MCO Update Folder in the MCO portal or the MCO may use their own panel physicians. ADR exams are to be "stand alone" exams; ADR questions should not be included with any BWC scheduled exam.

Exam Scheduling Preparation

Prior to scheduling the ADR exam the MCO must:

Contact the IW to ensure that he/she is aware of his/her obligations to attend the BWC schedule. Explain the reasons for the exam and verify that the address is current. If unable to contact the IW on the first try, attempt to contact them two more times and document in the claim notes each time you are unable to reach the injured worker. The contact to the IW on the second and third times must be on different days and times and the results must be documented.

When scheduling both an in-state and out-of-state ADR IME contact the injured worker to ensure that the injured worker is aware of the obligation to attend the BWC scheduled exam. As part of this contact:

- Explain the reason for the IME;

- Determine times when the injured worker is not available to attend the IME (does not apply to out-of-state exams);
- Verify the injured worker's name and address;
- Inform the injured worker it is necessary to reschedule the exam, the assigned CSS must be contacted as well as the administrative agent for out-of –state exams;
- Explain to the injured worker that benefits may be suspended for failing to appear for cancelling, or requesting to reschedule the exam without good cause;
- Document the conversation when it occurred and its results in the claims notes.

Physician Selection

When scheduling the IME for the injured worker the MCO must exercise care in selection of a respected independent provider, and formulate individualized questions plus the standard Miller questions to insure the best outcome possible from the examination. If necessary, the MCO may request relevant medical documentation from the Customer Service Office. In all claims the selection of the appropriate physician is based on the following:

- Physician specialty-Prefer Board Specialist with Board Certification. If chiropractic IME, recommend "Diplomate Status". For example, if primary issue is rehabilitation or continuation of therapy, specialist such as Physical Medicine and Rehabilitation most likely appropriate. If primary issue is consideration of surgery, appropriate specialty surgeon would be appropriate.
- IW availability
- Physician location the closest to the inured worker's home address. Reasonable proximity to the injured worker considering population density of the injured worker's residence.
- Physician availability-Schedules the exam within 7 days of the MCO's request
- Timeliness-Returns the exam report within or review to the MCO within 48
- Thoroughness of the report in response to the issues to be addressed;
- Remove from selection physicians who have a conflict of interest
    - Evaluator shall not be the POR or be a member or affiliate of the POR's group practice;
    - Evaluator shall not have performed a prior examination on the injured worker as part of the current workers' compensation claim for the injured worker, the employer, or the employer's representative, the MCO, or BWC;

- Evaluator shall not have performed a file review as part of the current workers' compensation claim for the injured worker, the employer, or the employer's representative, the MCO, or BWC in the past 12 months;
- Evaluator shall not be the MCO Medical Director, have ownership interest in the MCO, or be a member of the MCO Medical Director's group practice managing the claim.

  The Evaluator or any facility in which the evaluator has a direct financial interest should not provide medical services to the injured worker at a later date.

Although BWC will supply MCOs with its list of Disability Evaluator Panel providers (DEP), the MCO is not required to use these providers for the exams they schedule. BWC has designated a specific billing code and fee that the MCO's physician evaluators will use for these exams. The MCO physician evaluators will directly bill the MCO for these exams that the MCO schedules with them. The MCO will bill BWC through CAMBRIDGE.

MCO Administrative Agents

MCOs may enter into agreements with administrative agents to schedule, coordinate, and bill MCO ordered ADR IMEs. However, MCOs are strictly forbidden from having any financial relationship with or ownership interest in the administrative agent. The following procedures and guidelines were developed to enable BWC to enroll administrative agents for the purposes of BWC and MCO scheduled IMEs:

- Administrative agents **will not** be enrolled for any purpose other than IMEs.
- Administrative agents will be required to have agreements with each physician for whom they will act as an administrative agent.
- Administrative agents will be required to enroll with BWC by completing an HPP provider application and signing a BWC provider agreement. Any questions regarding the enrollment process should be directed to Tammie Mihaly at (614) 728-5726.
- Administrative agents will be assigned a BWC provider number.
- Administrative agents must bill using the provider number of the physician as the servicing provider and the administrative agent's provider number as the pay to provider.
- MCOs may have no financial relationship with or ownership interest in the administrative agents.
- Despite the delegation of certain IME administrative activities from the MCO to the administrative agent, the MCO is held ultimately responsible for the quality, appropriateness and timeliness of the IME performed.

Standard ADR Questions

The examination and the report may address a wide variety of issues with multiple questions for the evaluation. The issues to be addressed should be explicitly stated in a letter sent with the medial records by the MCO to the examiner prior to the date of the examination. In the requested IME, the MCO shall not request the examining physician to address the issue of MMI. The examiner must provide a clear and concise opinion to establish the clinical rationale for his/her conclusion with specific details and medical data related solely to this claim. An addendum will be requested if information not provided.

This report MUST address the *Miller* criteria for issues of medical necessity:

- Is the current treatment necessary and appropriate for the allowed condition(s) in the claim according to nationally accepted treatment guidelines? If so, please detail the frequency and duration of the recommended supportive treatment.
- Is there additional diagnostic/treatment services consistent with nationally accepted treatment guidelines that should be considered that would be reasonably expected to improve the treatment outcomes of the allowed condition(s)? If so, what are the diagnostic/treatments that should be considered and what may be the expected outcome in most cases if provided?
- Are specialty consults reasonably necessary for clinical insight and appropriate management of the allowed conditions in this claim?
- Are the medical services reasonably related to the industrial injury?
- Are the services reasonably necessary for treatment of the industrial injury?
- Are the costs for the services medically reasonable, or is there a medically supported alternative treatment available for this condition?

The ADR evaluation report should focus on the allowed conditions and the issues in dispute. Reports for ADR evaluations should be submitted **within two business days** of the evaluation.

Exam Packet Content

The packet is created by the MCO and should include all dispute information and the following (but not limited to):

- Cover letter listing the name of the injured worker, all claim allowances, conditions specifically disallowed, date of injury, specific issues to be addressed, and to whom to send the report;
- FROI, accident report, incident report, etc.;
- Disputed C-9;
- Peer to peer review;
- Drug reviews, pain management (as indicated);

- Relevant diagnostic exams and tests including x-rays, MRIs, CT Scans, EMGs, or laboratory studies;
- Due process responses (e.g. rebuttal letters);
- Consultation reports;
- Functional capacity evaluation reports;
- Operative reports and/or hospital discharge summaries;
- Office/progress notes last 6-12 months if available;
- Treatment summaries and progress notes (i.e. PT, OT Chiro., etc.);
- Recent BWC Exam reports;
- Employment status;
- Recent Vocational Rehabilitation results.
- Other pertinent information.

It is recommended to ask the injured worker to bring to the examination any x-rays or diagnostic studies they have had performed as well as any medications they are currently taking.

Out of State Exams

Exams are only referred to BWC's out of state vendor when the IW lives more than 50 miles from the Ohio border. All contact is through the vendor and not the examining physician. Out of state exams are currently exempted from the Failure To Appear Policy.

Injured Worker Attends ADR Exam

The injured worker attends the ADR exam and submits a travel reimbursement request (when appropriate) to the CSS assigned to the claim. The CCT verifies the exam attendance with the MCO authorizes the travel reimbursement and updates V3 notes.

Addendum

When the MCO reviews the IME report and determines that the ADR IME evaluator did not address their issues, the MCO will:

- Request an addendum to the report from the IME evaluator; and
- Forward a copy of the report and his/her concerns to BWC's ADR department for further review.

If an addendum is necessary the MCO will forward the appropriate questions directly to the examining provider. The MCO is to process the addendum request following the same procedures as required for other IMEs. However, timeframes for ADR exams require that an amended report must be received by the MCO within 24-48 hours of the request. When an amended report is received the MCO must send a copy to BWC's imaging and send copies to all parties to the claim.

Failing to Appear for, Canceling or Rescheduling ADR Exams

Injured workers are expected to appear for any examination scheduled by BWC, the Industrial Commission of Ohio (IC) or their employers. Pursuant to R.C. 4123.53(C), applications or motions can be suspended when an injured worker does not appear for (i.e., the injured worker is a "no show"), cancels, or requests to reschedule a scheduled examination without "good cause." In addition, failure to appear for an ADR exam may result in suspension of all medical benefits in the source claim with the exception of medications and emergency or life sustaining treatment.

Determining Good Cause

For purposes of this policy, good cause for failing to appear for, canceling, or requesting to reschedule an examination must result from "unforeseen extraordinary circumstances" including, but not limited to:

- Death of an immediate family member
- Hospitalizations or medical emergencies
- Auto accidents
- Notice of the exam was not received due to an incorrect address
- Proper notice of the exam was not provided to the injured worker
- Weather emergencies

Providing Due Process

Applications or motions are not suspended without providing the injured worker with due process. Immediately upon learning that an injured worker did not appear for, is requesting to reschedule, or has canceled the scheduled examination, an investigation is conducted to establish if the reason is for unforeseen extraordinary circumstances. As part of this investigation, the MCO will:

- Telephone the injured worker's authorized representative to determine the reason for the request, cancellation or missed examination. (**IMPORTANT:** If the injured worker does not have an authorized representative, the injured worker is contacted. If the injured worker does not have a telephone, attempt to establish contact through the claim's other parties. If contact cannot be established, send the injured worker a certified letter asking that the MCO be contacted and that benefits could be suspended.
- Allow **3 business days** for the authorized representative (or injured worker) to provide relevant information once contact is made via personal phone contact or voice message.
- Document the telephone call in claims notes if contact is attempted but the MCO is unable to make personal contact or leave a voice message. Three attempts on

three different days and times are made, and if these are unsuccessful, the MCO moves forward with the suspension of the application or motion. For ADR exams the MCO will notify the CCT they were unable to make contact and BWC and MCO will staff the suspension. BWC sends suspension letter when appropriate. If contact is made, the CCT determines and documents the injured worker's availability, then coordinates with the MCO to reschedule the examination.

- Gather all relevant information. (**IMPORTANT:** If the injured worker has not previously failed to appear for, canceled or requested to reschedule an examination, the MCO should request (but not require) supporting documentation, i.e., death certificates, accident reports, etc. However, if the injured worker cites unforeseen, extraordinary circumstances as a reason for failing to appear for, canceling or requesting to reschedule a previously rescheduled examination, supporting documentation is required to avoid suspension of the application or motion.
- Use its best judgment to determine if unforeseen extraordinary circumstances exist. When there are questions about the existence of unforeseen extraordinary circumstances, the CCT staffs the claim with its Injury Management Supervisor (IMS).
- Continue to process the injured worker's request until it is determined if unforeseen extraordinary circumstances exist.
- Document all of its actions in claim notes.

Note: The MCO may make the determination that IW failed to appear for good cause. Failure to Appear Without Good Cause continues to be determined by the CCT.

Unforeseen Extraordinary Circumstances Exist

For ADR exams, if the MCO determines the IW failed to appear for good cause they will reschedule the exam. If the MCO determines the IW's failure to appear does not meet the "good cause" criteria they must contact the BWC CSS. The CCT then determines if failure to appear applies and medical treatment can be suspended. If BWC determines the IW's failure to appear was with good cause, the MCO will reschedule the exam. If the injured worker contacts the CSS with notification that they have not, or intend not to appear, the CSS is to phone or email the MCO. If the injured worker contacts the MCO, the MCO is to phone or email the CSS.

Unforeseen Extraordinary Circumstances Do Not Exist

When the CCT determines that unforeseen extraordinary circumstances ***do not exist,*** before suspending the application or motion:

- The CSS advises the party (i.e., the injured worker or authorized representative) that the examination will be rescheduled at the earliest possible date. If the exam can be rescheduled within 45 calendar days, the request and/or application are not suspended. This only applies to non-EOD exams. However, if the exam cannot be rescheduled within this period, the request and/or application are suspended until the injured worker appears for the examination.
- The matter is referred to the IMS to determine if the Failure to Appear(FTA) policy applies and medical treatment can be suspended.. The IMS contacts the authorized representative to discuss the issue and decide if the request and/or application should be suspended (If the injured worker does not have an authorized representative, the injured worker is contacted).
- Benefits are not suspended unless approved by the IMS. The IMS will document decision in V3 notes.

In all cases, the CCT documents all of the facts considered, actions taken and reasons for its decisions in V3 Notes.

Supporting Evidence

When suspending the medical treatment, the CCT ensures that all events and actions are clearly documented. Therefore, all decisions regarding exam scheduling, the reasons for suspending the application, motion, or medical treatment, and any other factors the CCT took into consideration in making its decision are documented in V3 Notes.

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Suspension of Benefits

Should the IW fail to attend a BWC scheduled exam, benefits may be suspended according to R.C. 4123.53. The MCO and CST shall collaborate and communicate by e-mail, telephone, etc. to suspend benefits if it has been determined that an injured worker failed (without good cause) to attend a scheduled BWC exam.

If the CCT determines treatment should be suspended the CSS shall update the ADR Exam screen status to SUSPEND MEDICAL, enters detail of the suspension in V3 notes, issues a suspension letter to the IW notifying them that benefits are suspended, and mails a copy of the letter to all parties.

The CSS shall send notification of benefit suspension to the HPP System Support Unit mailbox to stop payment of benefits and authorization of treatment.

HPP Systems Support shall send an e-mail to Medical Billing and Adjustments (MB&A) to place the claim ON REVIEW in Cambridge.

The SUSPEND MEDICAL information will be automatically communicated to the MCO the next day via the ADR FTP file.The MCO is required to use this information to flag the claim for special processing. The MCO shall cease processing of all C-9s and ADR appeals, from the date of the suspension letter to date of the reinstatement letter.
Bill payment is pended for services rendered during the suspension period .
Benefits not suspended : Compensation, medications and life sustaining treatment in the ER.

Except when the MCO determines that treatment is for an emergency situation or is considered life-sustaining, the MCO will use EOB code 744 to authorize payment of emergency or life-sustaining treatment. For incoming bills and C9s for non-emergency or non-life sustaining treatment, the MCO shall pend the bills and C9s until the date benefits are reinstated.

NOTE: If an injured worker does not receive notification of an ADR exam due to an incorrect address, the MCO and the CCT should always conduct an investigation to obtain the correct address and re-schedule the examination.

Reinstating Suspended Benefits

If the IW contacts the CSS with a promise to appear at the exam, the CSS shall contact the MCO to re-schedule the exam. The MCO reschedules the exam.

After the injured worker appears for the examination, and the physician sends the ADR Report to the MCO, the MCO shall update the status to REINSTATE: ADR RPT RCVD and enter the date the report was reveived.

A new DIARY 231-ADR REPORT RECVD PROCESS REINSTATEMENT is posted to the assigned CSS work list with the current date. The CSS shall immediately reinstate the injured worker's benefits by:

- Sending a Reinstatement Letter to the IW (with a copy to the parties to the claim) to notify them benefits are reinstated.
- Documenting all the actions and decisions in V3.
- Notifying the HPP System Support by e-mail to update the bill review system so that bills are no longer denied.
- MB&A shall then take the claim off REVIEW in Cambridge.

The MCO shall then:

- Review all treatment authorization requests in its possession as outlined by the C-9 authorization guidelines. Providers do not need to re-submit C-9s to the MCO that they submitted to the MCO during the suspension of benefits.
- The MCO shall notify the treating provider(s) that authorization of treatment suspension is lifted and C-9 authorization requests will again be considered.
- The MCO shall process pended bills. Providers do not need to re-submit bills to the MCO that they submitted to the MCO during the suspension of benefits.

Reimbursement

ADR IMEs are to be billed through an EDI 837 transaction using procedure code Z1600; for an out-of-state ADR IME use procedure code Z9600. An administrative time and letter fee may be billed for non-compliant injured workers using procedure code Z1601; for out of state administrative time and letter fees, use Z9601. Injured worker travel reimbursement forms, if applicable, are to be sent directly to the CCT. The CSS will coordinate with the MCO in providing forms to the injured worker.

Both MCOs and BWC's DEP physicians receive an "Adminitrative Time and Letter" fee for injured workers' "**no show**" at an ADR exam.

Note: IME fees differ due to the shortened timeframes mandated for the ADR process.

Injured Worker Travel Reimbursement for BWC/IC or ADR IME
Refer to BWC form C-60A

Legal Considerations

***Zamora* Decision**

In ***State ex rel. Zamora v. Industrial Comm. of Ohio***, 45 Ohio State 3rd. 17 (1989), the Ohio Supreme Court held that it would be "inconsistent" for the IC to reject a medical report at one level and later rely on it at another. Therefore, under Zamora, once a decision which relies on, or cites as support, a specific medical report(s) [e.g. a peer review, ADR IME, etc.] has been overturned in a final BWC or IC order, the medical report(s) relied on by the overturned decision cannot be cited to or used by the MCO to support a later decision.

***Reno* Decision**

BWC often sees treatment reimbursement denials based on an ADR physician's review that indicates "*no lasting benefit*" or "*no lasting therapeutic benefit*" as the reason for denial. BWC statutes and rules do not require that a standard of "*lasting benefit*" be met in order for treatment to be reimbursed. Instead, in determining whether reimbursement

for treatment should be authorized or denied, physician reviewers must use, as a standard, the criteria listed in the *Miller* Decision (below).

Miller Decision

One of the most significant requirements affecting medical decision making has been imposed by the case of ***State, ex rel. Miller v. Indus. Comm.****, 71 Ohio St. 3d 229 (1994).*

The *Miller* case mandates that a three-part test be applied when considering requests for authorization of workers' compensation medical services. Requests are evaluated using a three-part test (now contained in Rule 4123-6-16.2(B)(1) through (B)(3)) composed of the following (all of which must be met to allow treatment authorizations):

- The requested medical services are reasonably related to the industrial injury (allowed conditions);
- The requested services are reasonably necessary for treatment of the industrial injury (allowed conditions);
- The costs of the services are medically reasonable.

Peer reviewers may NOT use the terms "possibly", "partially" or "maybe" when addressing *Miller*. "Possibly," "partially" or "maybe" are equivocal terms and such statements are not sufficient to support an MCO, BWC or IC decision. While a definitive "yes" or "no" is stronger evidence and is preferred, a "probable" or "not probable" opinion from a reviewer also constitutes medical evidence which may be relied upon to support a determination. "Probable" when used as equating to "more likely than not" or "greater than 50%" meets the "preponderance of the evidence" standard.

In the *Miller* case, the Ohio Supreme Court expressly stated that these requests cannot be denied because the conditions to be treated are not allowed in the claim. The Supreme Court's decision does not mean, however, that all requests for medical services must be authorized.

Note: The *Miller* criteria do not sanction approval of psychological treatment requests when there is not a psychological condition allowed in the claim. For psychological reviews, the reviewer should state they addressed *Miller* but it does not pertain to psychological treatment requests, as stated above.

Ramifications

Clearly, the application of the *Miller* case must be done on a claim-by-claim basis, which has two (2) distinct ramifications:

- When making decisions on requests for medical services, all medical evidence gathered as part of this process must clearly demonstrate through medical documentation that *Miller* was applied. Those decisions not thoroughly documented are potentially more likely to be challenged, especially at an Industrial Commission (IC) hearing or in court.

- Policies pertaining to medical services cannot stipulate that certain conditions either is present or absent as part of determining an injured worker's eligibility for those services. Instead, eligibility must be evaluated solely upon meeting the three-prong test required by *Miller*.

MCO MEDICAL DIRECTOR'S ROLE IN ADR

1. **Needs for the Process**
   - Reviewers who have an understanding of the system
   - Expert Reviewers who provide unbiased opinions
   - Justified opinions with legally sufficient reports

2. **MCO Medical Director and Associate Medical Director's Roles**
   - Recommendation (decision) to approve or deny authorization (initial or pre-ADR)
   - For ADR process
     - Oversight/consultant of ADR process in MCO
     - Create and maintain ADR file review panel
     - Create and maintain ADR IME panel
     - Oversight/handle complaints to process
   - Once a specific issue in ADR,
     - Oversight of process including recommendations based on ADR file reviews
     - May continue to provide recommendations/opinions on other medical management issues in the claim
     - **May not perform the ADR File Review (which means once the MCO has received an appeal to the initial MCO decision)**

3. **Reports**
   - Address all issues that are at least pertinent to the reviewer's specialty
   - Consider all allowed conditions
   - Address the necessary issues contained in the *Miller* criteria
   - Legally sufficient
   - Conclusions justified with use of nationally accepted treatment guidelines or rationale explained
   - Avoid giving opinions that claim needs updated for additional conditions
   - Legible (preferably typed)
   - Signed