InterQual® Workers’ Compensation and Disability Management
Care Management Criteria: REVIEW PROCESS

ORGANIZATION

InterQual Workers’ Compensation and Disability Management (WC&DM) Care Management Criteria are organized according to the following six (6) categories: All Categories, Imaging, Procedures, Rehabilitation Services, Chiropractic Services and Return To Work. These categories provide the criteria for Workers’ Compensation and Disability Management of ill or injured workers over age 17. Some of the categories contain subcategories and all have criteria subsets.

UTILIZATION MANAGEMENT COMPONENTS

Care Folders: Before choosing the subset in the Care Management Criteria, it is recommended that the user creates an Injury Claim Care Folder. The care folder can record and track all the reviews for each claim and contains comprehensive demographic and claims information, provider information, attorney and employer information, and return-to-work (RTW) information including the length of disability (LOD) guideline by diagnosis provided by the Official Disability Guidelines (ODG) from the Work Loss Data Institute (WLDI). The care folder can track case savings, both medical and indemnity savings, and gives an average total case cost for most diagnoses. It can also be used to store letters, case activity, and denials. Initial treatments and interventions can be tracked in the Requested Plan of Care section.

Categories organize specific clinical and work related criteria. In the WC&DM Care Management Criteria there are six (6) categories.

The subcategories are defined by areas of the body (e.g., upper extremity, neck, back, etc). Not all categories have subcategories.

The subset is the procedure, imaging, therapy or work-related criteria that is being reviewed (e.g., MRI, discectomy, fusion, occupational therapy, ergonomic evaluation, etc).

The subset screen includes the definition, ICD-9 and CPT codes, notes and other clinical information. Alternate procedure names are also provided.

The Review Detail screen contains demographic and review information. It allows the user to record requested visits, stop date, target length of stay, and service date. There is a section for comments to be recorded.
Criteria Section:

**Indications** are the reasons an intervention is requested. For example, low back pain is one indication, or reason for requesting physical therapy. Indications cover diagnoses, symptoms, or clinical findings that constitute possible reasons for performing a particular intervention. All indications are denoted with a number that ends in 00.

**Criteria points** are clinical statements that support indications and refer to test results, medications, symptoms, clinical findings, or medical management. A unique number identifies each criteria point and they are organized in a nested decision tree. Criteria points address elements related to the evaluation and management of the patient. They serve to validate the problem identified in the indication or confirm that appropriate diagnostic or therapeutic interventions have been attempted prior to obtaining approval for the requested intervention.

The **criteria rules** show you how many (ONE, BOTH, ALL) of the next level criteria a reviewer must select to fulfill the rule. To meet the criteria and determine that an intervention is appropriate, the reviewer must select criteria points as the rules specify. Rules are presented in upper case letters and bold print.

**Informational Notes** provide reminders of best clinical practice, new clinical knowledge, explanations of criteria rationale, definitions of medical terminology, and current literature references. Except for notes that appear on the criteria subset cover page, notes are numbered to correspond with specific indications or criteria points.

The **Outcome** screen tracks the outcome and reasons, selected CPT codes, the review date and the diary date. In the comment section on the outcome screen, the user can record pertinent patient demographics, state or federal regulations, discussions with caregivers or providers or questions for follow-up review.

The **Review Results** screen includes information related to start and stop dates for the treatment or service.

**Review Summary** includes a summary of all the items selected during the review. It can be printed to provide a hardcopy record of the review.

**Clinical Evidence Summaries** are found on the left navigation pane within a review and/or in Book View and include all the references and clinical explanations to support selected medical conditions.

**State Guidelines** includes a list of all states and the Department of Labor that have some utilization review regulation or medical guidelines. By clicking on the specific state or department, the user can review the regulation to determine appropriateness of the review or specific guidelines by condition for that state.

**PRIMARY REVIEW**
You can apply the criteria to perform a primary review. This first level review usually involves a non-physician reviewer who uses the criteria as a screening tool to determine if the request is appropriate or if the case requires secondary review, peer review or referral to case management.

Primary Review Steps:
- Complete an Injury Claim Care Folder (This step is optional. It is recommended that only one folder be created per patient.)
- Select add a review
- Choose the specific category or subcategory
- Identify the requested criteria subset
- Complete the review detail screen information
- Choose the appropriate indication
- Check the criteria points that reflect the patient’s condition. The user can add a reviewer note at any line of criteria.
- Complete the primary outcome screen information
- Complete the review results screen
- Print the Review Summary if a hardcopy record of the review is required.
- Select the appropriate Clinical Evidence Summary to review additional information on references and the clinical rationale for specific conditions.
- Review the State Guidelines for the appropriate state or Department of Labor for additional information relevant to a specific jurisdiction.
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On the **Primary Outcome** screen, the action that follows depends on whether the review criteria were met, as shown in this table:

<table>
<thead>
<tr>
<th>For these review findings</th>
<th>Do this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary review: Criteria Met, Certified</td>
<td>Approve the request. If the user chooses certified, approve the diagnostic intervention or treatment.</td>
</tr>
</tbody>
</table>
| Primary review: Criteria Not Met, Partially Met, Non-Certified, Partially Certified, Referred for Secondary, Referred for Peer Review, Refer to Case Management | Obtain additional information from the requesting physician to complete the review.  
  - If the additional information *satisfies* the primary review, the request may be approved.  
  - If the additional information *does not satisfy* the review or if no further information is available, refer the case for secondary review, case management or peer review and choose a referral reason. |
| Primary review: Request Canceled                                                         | If the user wants to cancel the current review, select this outcome.                                                                                                                                       |
| Primary review: Next review                                                               | If the user wants to track and select a date for next review, this is the appropriate screen to choose a date.                                                                                              |

**Referral Reasons**

Referral Reasons represent reasons why the proposed request does not meet appropriateness criteria. Referral Reasons vary from product to product. An organization can add their specific referral reasons and create unique outcome groups to delete or hide existing referral reasons.
**Practical Tips**

- If you have trouble finding a procedure in a category, utilize the keyword(s) or medical code(s) search in CareEnhance Review Manager.

- **Mandatory notes** provide information you must read while performing a review. The criteria have two types of mandatory review notes:
  - Medical Review (MDR) Notes—clinical circumstances where secondary medical review is required.
  - Reviewer Instruction Notes (RIN)—special instructions to the reviewer regarding criteria application.

- **Alternate procedure names** are notes located on the criteria subset cover page. These notes provide a list of additional names by which the requested intervention may be referred or the names of different procedures that produce the same result. For example, Angioplasty, Coronary Artery is an alternate name for Percutaneous Coronary Interventions criteria subset. They are different names for the same surgical procedure for patients needing coronary interventions.

- **Inpatient/Outpatient** designations are located on the procedure overview page and provide an inpatient or outpatient setting recommendation. The recommendation of inpatient refers to those procedures most commonly performed in the acute care setting and for which admission to the hospital is indicated. The inpatient setting includes the observation setting level. The outpatient recommendation refers to those procedures performed in the physician’s office or in an ambulatory care setting. The recommended settings are determined by McKesson Health Solutions consultant consensus and are based on best medical practices.

- **Controversial Procedures** (e.g., intradiscal electrothermal therapy (IDET), vertebroplasty) are procedures that require mandatory secondary medical review. A procedure is designated as controversial based on one or more of the following:
  - high risk of morbidity or mortality,
  - conflicting evidence or limited evidence as to its effectiveness or long-term benefits, or
  - procedure is only performed within the confines of a clinical trial.
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#### SECONDARY REVIEW, PEER REVIEW, REFER TO CASE MANAGEMENT

When a case does not meet the criteria, it is referred for a Secondary review. A supervisor, specialist or physician may conduct a secondary review. It is a matter for organizational policy to determine the qualifications of the reviewers as well as the extent to which secondary review is performed in order to render a review outcome. The secondary reviewer determines the medical necessity of the request based on review of the medical record, discussions with the provider or referring physician, and by applying clinical experience.

If the secondary review does not meet criteria, some state jurisdictions mandate that the case be referred for peer review. The case is generally reviewed by a physician or provider with the same qualifications, e.g., orthopedic surgeon to orthopedic surgeon, neurologist to neurologist.

If the ill or injured worker has comorbidities, is a medically complex case, or meets the guidelines for case management, the case is referred to a case manager. This is generally in addition to a secondary or peer review.

**When are a secondary review, peer review, case management appropriate?**

- **Criteria subset or procedure not listed**  
  Only the more common procedures or interventions are included in the criteria. This may not mean that the request is inappropriate, but that the request is rare and requires secondary review.

- **Indications not listed**  
  An indication for performing a procedure or intervention is not listed. Only the more common indications are listed.

- **Medical Review note indicates the need for secondary review**  
  Some indications or the criteria contain Medical Review Notes (MDR) that require, in the presence of certain circumstances, that the request be sent for secondary review.

- **Criteria not met**  
  When the given indication is listed, but the required criteria points are not fulfilled, the case requires secondary review.

- **Patient has comorbid or medically complex conditions**  
  The general state of a patient’s health may influence both the provider and the reviewer regarding the wisdom of performing a procedure or intervention. If there is any question regarding the appropriateness of an intervention because of comorbid conditions, a secondary review is required.

- **Patient choice and preference**  
  The criteria delineate reasonable therapy for the majority of patients. Some patients refuse certain prerequisite therapies or testing; these cases require secondary review.

- **Controversial procedure or indication**  
  Controversial procedures (or indications within procedures) require secondary medical review. These criteria have been developed
to provide reviewers with a basis for proactively gathering and documenting patient-specific clinical information that will facilitate secondary review.

• **Specific employer red flags**

Red flags that may indicate a questionable return to work or interfere with a timely return to work may require secondary review.

**Secondary Review Process, Peer Review Process**

Follow these steps when conducting a secondary review or peer review:

• If the secondary reviewer agrees with the requested procedure or intervention, approve the request.
• If the secondary reviewer does not agree with the request, he or she discusses the optimal alternate management for this patient with the requesting provider.
• If the requesting provider does not agree with the secondary reviewer, a peer review or specialist may become involved in the review process, depending on specific state jurisdictions.

**Secondary Reviewer / Peer Reviewer Decision Reasons**

Secondary or Peer Reviewer Decision reasons represent the decisions of the secondary or peer reviewer.

**IMPORTANT:** The criteria reflect clinical interpretations and analyses and cannot alone either resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions. The criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of health care services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.