

TO: Workers' Compensation Practitioners
(Adjusters, Attorneys, Health Care Providers, V.R. Counselors)

FROM: J. Stephen Monahan, Director
Workers' Compensation & Safety Division

DATE: October 17, 2011

RE: Preauthorization -- Guidance Concerning Recently Enacted Statute

The Vermont Legislature passed Act 50 in its last legislative session. Section 3 of the Act created specific statutory procedures governing a health care provider's request that a Workers' Compensation Insurer preauthorize proposed medical treatment. (*A copy of section 3 is provided at the end of this Memorandum.*) The provision became effective on July 1, 2011. It is now clear that Workers' compensation practitioners would benefit from additional guidance concerning this new statute.

1. *What is a preauthorization request for Workers' compensation purposes?*

A preauthorization request is a request made to a Workers' compensation **insurer by an injured Workers' health care provider**, for approval to pay for health care diagnostics, or treatment proposed by the provider. **The statute requires that the request for preauthorization be accompanied by medical evidence supporting the request.** The preauthorization request and accompanying documentation must be in writing. Normally the request would be made directly by claimant's treating health care provider to the W.C. insurer, but the department will permit the claimant or the claimant's legal representative to forward the request on behalf of the provider. (Medical evidence supporting the request, still must be submitted).

The following are not considered preauthorization requests:

- a. a complaint that a bill for a diagnostic procedure or treatment already provided has not been paid.
- b. a request for reimbursement for medical supplies; including special clothing, footwear, or equipment, or for prescriptions already purchased or provided.

Complaints or requests of this type are governed by the provisions of 21 VSA §640a and not the preauthorization section.

2. *The statute provides a 14 day time period in which an insurer must respond to a preauthorization request. When does that time period begin to run?*

The 14 day time period starts when the insurer has received **both** the preauthorization request and the medical evidence supporting that request. A request, unaccompanied by supporting documentation, does not start the 14 day response period. Since the statute anticipates that a healthcare provider is to file the request, and the health care provider is unlikely to know whether an insurer is represented, we are starting the calculation from the moment either the insurer or its attorney is notified. The insurer should promptly notify its legal representative if it is represented.

3. *If the W.C. insurer receives a preauthorization request without any supporting documentation, what should it do?*

The insurer may deny the request with an explanation that no supporting medical evidence was provided.

4. *When the W.C. insurer receives a preauthorization request with supporting medical evidence, what action is required within 14 days?*

The statute provides the W.C. insurer with 3 options: authorize the requested health care, deny the requested health care, or notify the injured worker, department, and physician that it has scheduled/ordered an independent medical review.

Authorizing treatment

If the W.C. insurer agrees that the requested treatment is reasonable and necessary treatment of a work related injury, it shall authorize treatment. The W.C. insurer shall send a written notice to the injured worker, the health care provider and the department, indicating that it is authorizing the treatment. Provide the Department of Labor with a copy of the preauthorization request, supporting medical documentation provided, and the written notice authorizing the treatment.

Denying Treatment

The statute recognizes two bases for denying the requested preauthorization treatment:

A. The W.C. insurer may deny the preauthorization request because it is disputing the entire W.C. claim, and no interim order has been issued by the department. In this circumstance the adjuster shall file a Form 2 denial, indicating that the entire claim is disputed and attach or specifically refer to the original Form 2 denial filed to dispute the entire claim and the evidence supporting that denial. Provide the Department of Labor with a copy of the preauthorization request, supporting medical documentation provided. This must be filed within 14 days of receiving the request.

If a preauthorization request is made at the time an initial claim is made, or during the statutory 21 day period the W.C. insurer has to investigate and accept or deny the claim,

as soon as practicable, but within 14 days, the W.C. insurer shall notify the Department, the claimant and the health care provider that the claim was filed within the 21 day investigation period, and that the preauthorization request will be considered after the 21 day investigation period has run.

Note: if an Interim order has been issued, the reasonableness of the requested treatment must be considered, and addressed by the insurer.

B. The W.C. insurer may deny the preauthorization request because it has evidence indicating that the requested treatment is not reasonable and necessary treatment of the work related injury. In this circumstance the adjuster shall file a Form 2 denial with the supporting medical evidence specifically addressing the proposed treatment and why it is unreasonable or unnecessary treatment or treatment unrelated to the work injury. The Form 2 denying preauthorization and the supporting medical evidence must be filed within 14 days of receiving the request.

Requesting an Independent Medical Review/Examination

If the WC insurer does not have sufficient information to accept or deny a preauthorization request it should order a medical record review or schedule an independent medical exam. The WC insurer must notify the injured worker, the department, and the health care provider that it has ordered a medical record review, or scheduled an independent medical examination within the initial 14 day period. Provide the Department of Labor with a copy of the preauthorization request, supporting medical documentation provided.

A notice of “*intent to order or schedule*” will not suffice – the review must be ordered, or the exam scheduled within the 14 day period. The notice should identify the health care provider/practice that will perform the review, or the date the independent examination is scheduled. (The actual review or examination does not have to occur within the 14 day period; it just must be ordered or scheduled within the time frame.)

Making a decision based on the review or the medical examination

If a review is ordered, or a medical examination scheduled, the WC insurer has **45** days in which to notify the claimant, the claimant’s health care provider, and the department of whether it will authorize treatment or deny treatment.

Calculating the 45 days

The 45 day period is calculated **from the date the WC insurer received the request** for preauthorization and supporting documentation. It does **not** run from the date the exam is ordered or scheduled. For this reason the WC insurer would be wise to order a review, or schedule an exam, as soon after receipt of the preauthorization request as possible.

What about an extension?

The statute does provide that, in her discretion, the Commissioner may grant an extension of up to 10 days. However, both Legislative committees specifically advised the Commissioner that they expected that extensions should be rarely granted.

It is highly unlikely that the department will grant an extension before a medical review is ordered, or an examination is scheduled. The insurer would have to be able to demonstrate extreme circumstances that prohibited it from ordering a review or scheduling an examination within the first 14 days. An example of such circumstances might be evidence that a natural disaster knocked out power and communications for the first 14 days.

An extension request will be considered when the health care provider or practice performing the review or examination experiences emergency circumstances that prevent completing a review and reporting to the insurer within the 45 day period. In that event the extension request should be made as soon as practicable after learning of the emergency circumstances.

If the parties notify the department in writing, signed by both parties, that they have agreed to additional time to complete the review, and the amount of additional time is clearly specified, the department will accept that agreement of the parties.

What if the WC insurer fails to act within 14 days?

If the WC insurer does not accept or deny the preauthorization request within 14 days, or does not provide notice that it has scheduled an examination or ordered a medical record review within 14 days, the claimant, or the claimant's health care provider, may request that the department issue an interim order authorizing treatment. The claimant shall provide the Department of Labor with a copy of the preauthorization request, supporting medical documentation provided to the W.C. insurer. Upon receipt of the request for an interim order, the department shall notify the insurer that it has five days from the date of the department's notice to respond. The Commissioner may issue an interim order between the fifth and the tenth day after giving the insurer notice.

The Commissioner is required to issue an interim order authorizing treatment unless the WC insurer is able to demonstrate that the entire claim (or if the requested treatment involves a different body part than that originally accepted – for example low back is the accepted injury and request is for shoulder surgery) has been disputed. (I.e. Arguments that the treatment is not reasonable or necessary will not prevent an order from being issued if the 14 day period has lapsed.)

What if the WC insurer after requesting a medical record review or scheduling a medical examination fails to issue a determination within 45 (or if extension granted, 55) days?

If the WC insurer fails to issue a determination within 45 (or if extension granted, 55) days, the claimant, or the claimant's health care provider, may request that the department issue an interim order authorizing treatment. The claimant shall provide the Department of Labor with a copy of the preauthorization request, supporting medical documentation provided to the W.C. insurer. The Commissioner shall issue an interim order.

What if the insurer denies the preauthorization request, either within the first 14 days or within the 45 day medical review/independent examination period?

The statute authorizes the department (WC Specialist), on its own initiative, or at the request of the claimant, to review the evidence supporting the denial. Because of the large work load at the department, it is less likely that the department will review on its own initiative, but will promptly respond to requests to review. If the department concludes, after reviewing all of the evidence in the file, that the requested treatment is reasonable, necessary, and related to the work injury, an interim order authorizing treatment may be issued. Since a preauthorization request involves medical treatment not previously provided or accepted by the W.C. insurer, the claimant has the burden of proving the reasonableness and necessity of the treatment (in absence of a procedural violation by the W.C. insurer). The Commissioner shall review the evidence upon which a denial is based and if that evidence does not reasonably support the denial (i.e. in light of all other relevant evidence in the file) the Commissioner shall issue an interim order.

/JSM

cc: VDOL Workers' Compensation Staff

- Sec. 3. 21 V.S.A. § 640b is added to read:
- § 640b. REQUEST FOR PREAUTHORIZATION TO DETERMINE IF PROPOSED
 TREATMENT IS NECESSARY
- (a) Within 14 days of receiving a request for preauthorization for a proposed medical treatment and medical evidence supporting the requested treatment, a workers' compensation insurer shall:
- (1) authorize the treatment and notify the health care provider, the injured worker, and the department; or
- (2) (A) deny the treatment because the entire claim is disputed and the commissioner has not issued an interim order to pay benefits; or
- (B) deny the treatment if, based on a preponderance of credible medical evidence specifically addressing the proposed treatment, it is unreasonable or unnecessary. The insurer shall notify the health care provider, the injured worker, and the department of the decision to deny treatment; or
- (3) notify the health care provider, the injured worker, and the department that the insurer has scheduled an examination of the employee or ordered a medical record review pursuant to section 655 of this title. Based on the examination or review, the insurer shall authorize or deny the treatment and notify the department and the injured worker of the decision within 45 days of a request for preauthorization. The commissioner may in his or her sole discretion grant a 10-day extension to the insurer to authorize or deny treatment, and such an extension shall not be subject to appeal.
- (b) If the insurer fails to authorize or deny the treatment pursuant to subsection (a) of this section within 14 days of receiving a request, the claimant or health care provider may request that the department issue an order authorizing treatment. After receipt of the request, the department shall issue an interim order within five days after notice to the insurer, and five days in which to respond, absent evidence that the entire claim is disputed. Upon request of a party, the commissioner shall notify the parties that the treatment has been authorized by operation of law.
- (c) If the insurer denies the preauthorization of the treatment pursuant to subdivision (a)(2) or (3) of this section, the commissioner may on his or her own initiative or upon a request by the claimant issue an order authorizing the treatment if he or she finds that the evidence shows that the treatment is reasonable, necessary, and related to the work injury.