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Chapter 27. Utilization Review Procedures

§2701. Statement of Policy

A. It is the intent of this rule to establish procedures and policies appropriate to the fulfillment of the powers, duties, and functions of the director of the Office of Workers' Compensation as set forth in R.S. 23:1291 (Act 938 of the 1988 Regular Session). R.S. 23:1291 empowers the director of the Office of Workers' Compensation:

1. "to resolve disputes over the necessity, advisability, and cost of proposed or already performed hospital care or services, medical or surgical treatment, or any nonmedical treatment recognized by the laws of this state as legal."; and

2. "to audit the specific medical records of the patient under treatment by any health care provider who has furnished services or treatment to a person covered by this Chapter, or the records of any person or entity rendering care, services, or treatment or furnishing drugs or supplies for the purpose of determining whether an inappropriate reimbursement has been made."

B. The law provides that after the promulgation of the medical treatment schedule, medical care, services, and treatment due, pursuant to R.S. 23:1203 et seq., by the employer to the employee incurred in the treatment of work-related injuries or occupational diseases [hereinafter referred to as "illness(es)"] shall mean care, services, and treatment in accordance with the medical treatment schedule.

1. It is therefore the policy of the Office of Workers' Compensation that medical bills for services should be sent to the carrier/self-insured employer for payment. Fees for covered services in excess of the amounts allowable under the terms of this schedule are not recoverable from the employer, insurer, or employee.

2. It is also deemed to be in the best interest of all of the parties in the system that fees for services reasonably performed and billed in accordance with the reimbursement schedule should be promptly paid. Not paying or formally contesting such bills by filing LWC-WC-1008 (disputed claim for compensation), with the Office of Workers' Compensation within 60 days of the date of receipt of the bill may subject the carrier/self-insured employer to penalties and attorneys fees. Additionally, frivolous contesting of the bill may subject the carrier/self-insured employer to penalties and attorneys fees.

3. If claimant is receiving treatment for both compensable and noncompensable medical conditions, only those services provided in treatment of compensable conditions should be listed on invoices submitted to the carrier/self-insured employer unless the noncompensable condition (e.g., hypertension, diabetes) has a direct bearing on the treatment of the compensable condition. In addition, payments from private payers for noncompensable conditions should not be listed on invoices submitted to the carrier/self-insured employer. If a provider reasonably doesn't know the workers' compensation status, or the workers' compensation insurer has denied coverage, the provider won't be penalized for not complying with this rule. Upon notification or knowledge of workers' compensation eligibility, the provider will comply with these regulations prospectively.

4. Statements of charges shall be made in accordance with standard coding methodology as established by these rules, ICD-9-CM, HCPCS, and CPT-4 coding manuals. Unbundling or fragmenting charges, duplicating or over-itemizing coding, or engaging in any other practice for the purpose of inflating bills or reimbursement is strictly prohibited. Services must be coded and charged in the manner guaranteeing the lowest charge applicable. Knowingly and willfully misrepresenting services provided to workers' compensation claimants is strictly prohibited.

5. Providers should take reasonable steps to ensure that only those services provided are billed to the carrier/self-insured employer. Violation of this provision may subject provider/practitioner to mandatory audit of all charges.
6. Bills for a particular charge item may not be included in subsequent billings without clear indication that they have been previously billed.
7. These rules must be used in addition to all the reimbursement rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:263 (March 1991), repromulgated LR 17:653 (July 1991), amended by the Louisiana Workforce Commission, Office of Workers' Compensation, LR 38:1030 (April 2012), amended by the Louisiana Workforce Commission, Office of Workers' Compensation, LR 38:1030 (April 2012).

§2703. Introduction

A. Managed care activities are defined as a set of coordinated cost and utilization management activities by the carrier/self-insured employer to assure appropriate payment for health care services rendered to employees eligible for workers' compensation benefits in the state of Louisiana.

1. Pre-admission certification review is the cornerstone of utilization management. The pre-admission certification review notice (i.e., telephone call or written notification) is the claimant's entry into the benefits management system and triggers other utilization management functions. During pre-admission certification review, all utilization management activities can be coordinated. When cases are reviewed before hospitalization, this activity works to promote appropriate lengths of stay, discharge planning, and ambulatory care. The pre-admission certification program reviews and certifies, before hospitalization, that a proposed hospital admission is both medically necessary and appropriate. It is not a process of substituting judgement for that of the physician, but rather making a determination of what level of care is to be reasonable and necessary under the provisions of the Louisiana Workers' Compensation Act.

2. The following managed care activities required by the Louisiana Workers' Compensation Act are described: pre-admission certification, admission certification, continued stay review (including length of stay assignment), discharge planning, reporting standards and dispute resolution, ambulatory surgery, and second surgical opinion.

B. Definitions

Admission Review—the review of the medical necessity and appropriateness of hospital admissions. The review takes place after the admission, but within a stated time frame.

Ambulatory Review—the review of the medical necessity and appropriateness of services rendered to claimants in out-of-hospital settings (e.g., skilled nursing facility, home health services, physician's office, and outpatient ancillary services).

Appeals Process—a physician, hospital, or a claimant may appeal to the carrier/self-insured employer to change its decision regarding payment for an inpatient admission, an extension of a length of stay, a specific treatment or for a claim for medical services. The appeals process is formally written and includes specific time frames, how the process works and who makes the final decision. The final step in the appeals process is a review by the Office of Workers' Compensation Administration.

Continued Stay Review—the review of an ongoing inpatient hospitalization to assure that it remains the most appropriate setting for the care being rendered.

Discharge Planning—the process of assessing a claimant's need for medically appropriate treatment after hospitalization to effect an appropriate and timely discharge. The hospital and attending physician have major responsibility for this function with the carrier/self-insured employer promoting, monitoring, and assisting the hospital.

Pre-Admission Certification Review—the review and assessment of the medical necessity and appropriateness of hospital admissions before hospitalization occurs. The appropriateness of the site or level of care is assessed along with the timing and duration of the proposed hospitalization.

Second Surgical Opinion—second surgical opinion programs enable claimants to receive a consultation from a second physician before undergoing specified surgical procedures. The consulting opinion does not have to confirm the original recommendation for surgery, however, the decision to have or not to have the surgery remains with the claimant.

Utilization Management Program—a comprehensive set of integrated utilization management components including: pre-admission certification review, admission review, second surgical opinion, continued stay review, and discharge planning.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

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§2705. Pre-Admission Certification

Editor's Note: The telephone number for the Office of Workers' Compensation has been changed to (225) 342-9836.**

A. Pre-admission certification is the review and assessment of the medical necessity and appropriateness of non-emergency hospital admissions before hospitalization has occurred. The appropriateness of the site and the level of care is assessed along with the timing of the proposed admission. Actual payment for services is also contingent upon the carrier/self-insured employer's verification of:

1. claimant's entitlement to benefits at the time hospitalization actually occurs; and
2. statutory coverage for the care that is actually provided.

B. Application for pre-admission certification should be made prior to admission to the hospital unless the admission to the hospital is for a compensable illness or bodily injury that occurs without warning and requires immediate inpatient treatment to prevent death, disability or serious impairment of patient function. In the event an inpatient admission is for treatment of such a medical emergency, notification must be made to the carrier/self-insured employer within 48 hours of admission.

C. The pre-admission certification process follows the sequence below.

1. The physician, hospital, or claimant must initiate the pre-admission certification process by calling the carrier/self-insured employer. The reviewer will request the following information:

- a. claimant name;
- b. Social Security number;
- c. date of injury;
- d. claimant's address;
- e. sex;
- f. claimant's date of birth;
- g. name of hospital;
- h. hospital address;
- i. anticipated admission date;
- j. admitting diagnosis (to include ICD-9 codes);*
- k. expected length of stay;
- l. major procedures and related CPT codes;*
- m. plan of treatment;
- n. complications or other factors requiring the inpatient setting;
- o. medical justification for inpatient admission;
- p. is surgery anticipated? If yes, procedure;
- q. is general anesthesia required;
- r. admitting physician's name;
- s. admitting physician's address;
- t. admitting physician's phone number;
- u. admitting physician's Tax ID or Social Security number; and
- v. caller's name and number.

*The provider will provide descriptive/narrative information and the reviewer, representing the carrier/self insured employer, will provide the ICD-9-CM and/or CPT-4 codes.

D. Pre-Admission Review Procedures

1. The carrier/self-insured employer must be able to administer a program where pre-admission certification review is initiated by the physician, hospital or claimant. Once the caller has made the first phone call to notify the carrier/self-insured

employer of proposed hospitalization, the carrier/self-insured employer will follow through with phone calls and written confirmations to the claimant, physician and hospital.

2. Pre-admission certification review is primarily conducted by telephone during normal business hours (8 a.m. to 4:30 p.m. Central Time, Monday through Friday, excluding legal holidays) to assure quick responses. Written requests for pre-admission certification may be processed by the carrier/self-insured employer on a case by case basis.

3. The Office of Workers' Compensation Administration will require annual reports on all workers' compensation medical review activity. Automated software support for the review process is recommended in order to assure timely responses, uniform administration, and complete data gathering.

4. All non-emergency hospital admissions must be reviewed using nationally accepted criteria designed to assess the need for the acute level of care. The Appropriateness Evaluation Protocol (AEP) and the Intensity/Severity/Discharge (ISD) criteria are the two most prominent nationally accepted criteria for admissions.

a. The AEP manual is available from:

Utilization Management Assoc.
888 Worcester Street
Wellesly, MA 02811
Phone: (617) 237-6822

b. The ISD manual is available from:

InterQual
44 Lafayette
North Hampton, NH 03862
Phone: (603) 964-7255

5. When the medical necessity of a proposed hospitalization is approved or certified, an expected length of stay is assigned. The length of stay is based on statistical norms developed by the Professional Activities Study (PAS) of the Commission on Professional and Hospital Activities, Southern Region.

a. The PAS is available from:

CPHA Publications
1968 Green Road
Box 1809
Ann Arbor, MI 48106
Phone: (800) 521-6210

6.a. The carrier/self-insured employer shall use registered nurses for the initial review of recommended hospitalization. Registered nurses will use written criteria provided in Paragraph D.4 above to assess proposed hospitalizations. Physicians must review all questionable cases and make the carrier/self-insured employer decisions on all denials of certifications.

b. Within five calendar days of receipt of the request, a response must be generated in writing as to whether or not the admission is approved or denied. Verbal response will be given within two working days from the time of the request followed by the written response. Copies of the written response will be sent to the attending physician, the hospital, and the claimant and must notify the parties of the right to appeal and the appeal process. Sample letters are enclosed as Clauses E.1.b.iii and iv.

7.a. An appeals process must be available for reconsideration of any denial decisions. If the admitting physician, hospital, or claimant desires to appeal a denial of an admission or continued stay request, the appeals process is initiated by contacting the carrier/self-insured employer by telephone or other immediate means following receipt of the denial. After the appeal request is received, it will be referred to the carrier/self-insured employer medical director or physician consultant in the appropriate specialty if required. The carrier/self-insured employer medical director or physician consultant will review the available information regarding the request and make a decision concerning the appeal within 48 hours of receipt/communication of the appeal.

b. If the carrier/self-insured employer medical director decision is an approval of the appeal the admitting physician and hospital will be immediately notified via telephone and follow up by letter will be sent to the physician, claimant, and hospital.

c. If the carrier/self-insured employer medical director's decision is a denial the carrier/self-insured employer will notify the admitting physician and hospital and will immediately submit in writing the denial and case documentation by fax to the director of the Office of Workers' Compensation for review at (225) 342-6556.** The material should be clearly identified as a denial of hospital admission and should be addressed "Attention: Medical Manager, Office of Workers' Compensation." The director will immediately review the case and will notify the carrier/self-insured employer, admitting physician, and hospital by telephone of his agreement or disagreement with the denial decision. Follow-up notification will be sent to the claimant,

carrier/self-insured employer, hospital, and admitting physician by certified mail return receipt requested. Any party who disagrees with the director's resolution may file a Disputed Claim for Compensation Form (LDOL-WC-1008), available from the Office of Workers' Compensation Administration as otherwise provided by law.

8. Review nurses should coordinate related managed care activities with the pre-admission certification request. For example, compliance with a second surgical opinion component should be checked during the physician's initial call.

9. The review process is also used to identify and refer cases for discharge planning.

10. The carrier/self-insured employer will provide written notification of the review decision to the claimant, attending physician and the hospital.

11.a. The carrier/self-insured employer must maintain appropriate internal documentation of each request for pre-admission certification to verify the process and the decision for claims processing and reporting purposes.

b. If a patient does not enter the hospital on the proposed date of admission (or within 15 days following that date) re-certification is required. In such cases the caller should contact the carrier/self-insured employer to re-affirm the previously submitted pre-certification data and have the admission re-certified.

E. Pre-Admission Review Preparation

1. Preparation

a. Educational Program for Providers. The carrier/self-insured employer will develop and distribute provider notices announcing the pre-admission certification program, describing the reasons for implementation and operation, including an explanation of the appeals process. This notice of the pre-admission certification program may be included in local carrier/self-insured employer provider newsletters.

b. Pre-Admission Review Forms. The carrier/self-insured employer may use the samples attached (Exhibit 1 and 2) or develop forms to capture pertinent patient and provider information during the pre-admission certification activity. These forms may be identical to those used by the carrier/self-insured employer for their other business. However, they should capture the statistical data elements required by the Office of Workers' Compensation Administration.

i. Exhibit 1, Pre-Certification Activity Sheet

EXHIBIT 1 PRE-CERT ACTIVITY SHEET					
NAME OF CLAIMANT		SOCIAL SECURITY NUMBER		DATE OF INJURY	
ADDRESS OF CLAIMANT		CITY	STATE	ZIP CODE	
SEX	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	CLAIMANT'S DATE OF BIRTH		
NAME OF HOSPITAL					
ADDRESS		CITY	STATE	ZIP CODE	
PROPOSED DATE OF ADMISSION		DIAGNOSIS AND/OR ICDA & CM		EXPECTED LENGTH OF STAY	
MAJOR PROCEDURE		PLAN OF TREATMENT		COMPLICATIONS	
MEDICAL JUSTIFICATION					
PROVIDER NUMBER		PRIMARY PHYSICIAN		CALLERS NAME AND NUMBER	
ATTENDING PHYSICIAN'S NAME				PHONE NUMBER	
ADDRESS		CITY	STATE	ZIP CODE	
IS SURGERY ANTICIPATED? IF YES, PROCEDURES			IS GENERAL ANESTHESIA REQUIRED?		
<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO		
_____ DATE		75% ()	90% ()	_____ DAYS	_____ PAST 75%
APPEAL		OUT PT.	MMC/SNF	RECERT	CERTIFICATGION NO. _____
RECERTS 1. NO. OF RECERT DAYS _____ NO. OF RECERT DAYS TO SHOW _____ FILE D C ACTUVE _____ DATE _____ 2. NO. OF RECERT DAYS _____ NO. OF RECERT DAYS TO SHOW _____ FILE D C ACTUVE _____ DATE _____ 3. NO. OF RECERT DAYS _____ NO. OF RECERT DAYS TO SHOW _____ FILE D C ACTUVE _____ DATE _____ 4. NO. OF RECERT DAYS _____ NO. OF RECERT DAYS TO SHOW _____ FILE D C ACTUVE _____ DATE _____ 5. NO. OF RECERT DAYS _____ NO. OF RECERT DAYS TO SHOW _____ FILE D C ACTUVE _____ DATE _____			CHANGES DATE OF SERVICE _____ CHANGE		

ii. Exhibit 3, Pre-Admission Approval Letter

Re: Patient:
Pre-Admission Certification No.:
Claimant No.:
Date of Service:
Hospital:

The admission to the hospital referenced above has been initially approved for (number of days) days.

IT IS IMPORTANT FOR YOU TO KNOW THAT.....

this approval of the inpatient hospital setting is based on information provided by the above listed hospital and/or physician.

THE DETERMINATION OF ACTUAL BENEFITS.....

can only be made upon receipt of the completed claim. Payment for the services received is subject to statutory limitations. Eligibility is dependent upon:

1. the medical necessity for the services provided; and
2. the work-relatedness of the illness or injury.

IF THE CLAIMANT REQUIRES CONTINUED HOSPITALIZATION BEYOND THE NUMBER OF DAYS APPROVED.....

the admitting physician or authorized hospital representative should contact the carrier/self-insured employer at (phone number) on or before the above days expire.

BENEFITS FOR SERVICES RENDERED DURING ADDITIONAL HOSPITAL DAYS NOT CERTIFIED MAY BE DENIED.

iii. Exhibit 3-B, Pre-Admission Denial Letter

Re: Patient:
Pre-Certification No.:
Contract No.:
Date of Service:
Hospital:

Dear (claimant/physician/provider)

The medical director for (carrier/self-insured employer) has carefully reviewed the pre-certification request for admission to the hospital referenced above.

Based upon information obtained, it has been determined that the medical necessity of the admission has not been documented.

As a result of the findings, this letter is to notify you that (carrier/self-insured employer) will not consider payment for the requested admission.

If you disagree with this decision, you may appeal in accordance with the guidelines attached.

Sincerely,

2. Implementation

a. Telephone Inquiry Service. Telephone numbers should be published in educational materials and standardized form letters to the physicians, hospitals, and claimants. This telephone service allows for prompt response to requests for review and to general inquiries about the review process.

b. Appropriate Staff and Documentation for Program Management of Certified, Denied and Appealed Admissions. Registered nurses and physicians are the recommended staff for processing of pre-admission certification requests and inquires. Procedures must be available for timely review of appealed or denied admissions by a physician (a psychiatrist for mental illness or substance abuse admissions). Program procedures should be routine and documented.

3. Evaluation

a. Data Collection. Pre-admission certification documentation should be linked to the payment system to properly process inpatient claims. The pre-admission certification documentation should be retrievable on a claim-by-claim basis for compilation and classification of activity performance.

b. Carrier/Self-Insured Employer Data Reporting. Carrier/self-insured employer will be required to collect the following data according to the Office of Workers' Compensation Administration requirements.

Information	Positions	Type
ICD-9 Diagnosis Code	5	Numeric
Provider Name	30	Alpha
Provider Street Address	30	Alpha Numeric
Parish Code for Provider of Service (Use Standard FIPS code, see Exhibit 5)	3	Numeric
Place of Treatment	1	Alpha Numeric
Type of Facility*	6	Numeric
Type of Service: Medical vs. Surgical	1	Alpha Numeric
Claimant Name	30	Alpha
Claimant Social Security Number	9	Numeric
Length of Stay	4	Numeric
*See "Type Facility Codes" in Exhibit 6.		

c. Exhibit 5

F.I.P.S. Area Codes		
001 Acadia	045 Iberia	089 St. Charles
003 Allen	047 Iberville	091 St. Helena
005 Ascension	049 Jackson	093 St. James
007 Assumption	051 Jefferson	095 St. John the Baptist
009 Avoyelles	053 Jefferson Davis	097 St. Landry
011 Beauregard	055 Lafayette	099 St. Martin
013 Bienville	057 Lafourche	101 St. Mary
015 Bossier	059 La Salle	103 St. Tammany
017 Caddo	061 Lincoln	105 Tangipahoa
019 Calcasieu	063 Livingston	107 Tensas
021 Caldwell	065 Madison	109 Terrebonne
023 Cameron	067 Morehouse	111 Union
025 Catahoula	069 Natchitoches	113 Vermillion
027 Claiborne	071 Orleans	115 Vernon
029 Concordia	073 Ouachita	117 Washington
031 DeSoto	075 Plaquemines	119 Webster
033 East Baton Rouge	077 Pointe Coupee	121 West Baton Rouge
035 East Carroll	079 Rapides	123 West Carroll
037 East Feliciana	081 Red River	125 West Feliciana
039 Evangeline	083 Richland	127 Winn
041 Franklin	085 Sabine	
043 Grant	087 St. Bernard	998 Out-of-State

d. Exhibit 6a

Type Of Facility Code General Type Provider (Position 1 and 2)			
00	Not Licensed	36	Alcohol/Drug Rehab Center (CDU)
01	Hospital*	37	Special Care Unit-Behavior Modification
02	Skilled Nursing Facility*	38	Outpatient Surgical Unit (Hospital Based)
03	Custodial Nursing/Rehab Facility	39	Hospice
04	Physician (M.D.)	40	Licensed Massage Therapist (MA)
05	Home Health Agency*	41	Doctor of Education (EdD)
06	Dentist (D.M.D.-D.D.S.)	42	Lithotripter Facility
07	Pharmacy (not hospital)	43	Master of Science (M.S.)
10	Ambulance (non-hospital)	44	Certified Substance Abuse Counselor (CSAC)
11	Podiatrist (D.P.M.)	45	Counseling and Biofeedback Therapy
12	Psychologist (Ph.D.)	46	Family Counseling, Pastoral Counseling
13	Chiropractor	47	Oriental Medical Doctor (O.M.D.)
14	Osteopath (D.O.)	48	Certified Surgical Technician (C.S.T.)
15	Registered Nurse (R.N.)	49	Doctor of Divinity (D.D.)
16	Surgical Center (free standing)	50	Private Duty Nursing
17	Radiation Center (free standing)	51	Multiple Specialties
18	Renal Dialysis Center (free standing)	52	Radiology (Non-Hospital)
19	Certified Registered Nurse Anesthetist (CRNA)	53	VA/Military Hospital/ Acute Care
20	Physical Therapist	54	VA/Military Hospital/ Psychiatric
21	Optometrist	55	VA/Military Hospital/CDU
22	Registered Sitter	56	VA/Military Hospital/SNF
23	Optical Dispensary	57	VA/Military Hospital/HHA
24	Medical/Surgical Supply Organization	58	VA/Military Hospital/ Ambulatory Surgery
25	Other Para-Medical	59	Registered Dietitian (R.D.)
26	Hearing Aid Dealers	60	Cardiac Catherization Facility
27	Audiologist	61	Residential Treatment Center
28	Speech Pathologist	62	Eating Disorder Treatment Facilities
28	Social Worker	63	Physician's Assistant
30	Licensed Practical Nurse	64	Third Party Liability
31	Public Conveyance	65	Emergency Room Physicians
32	Rehabilitation Center	66	Medical Staff Services
33	Pre-admit Testing Facility	67	Mental Health Clinic
34	Alcohol/Drug Rehabilitation Center (CDU) Detox Services Only	68	Sperm Banks
35	Psychiatric Hospitals- Inpatient and Outpatient	69	Home Infusion Therapy
*If position 1 and 2 are 01, 02, or 05, use the additional codes on the next page, otherwise, the remaining four positions of the Type Facility Code may be filled with zeros (0's).			

e. Exhibit 6b

Type of Facility Code			
Specific Type Provider (Position 3 and 4)			
If General Type (Position 1 and 2) is 01:			
01	General Short Term	03	Official Health Agency
02	General Long Term	04	Rehab. Facility Based Program
03	TB	05	Hospital Based Program
04	Psychiatric	06	S.N.F. Based Program
05	Chronic Disease	07	Proprietary
06	Specialty Short Term	08	Other
07	Specialty Long Term	Ownership/Management (Position 5 and 6)	
08	Christian Science	If General Type (Position 1 and 2) is 01 or 02 or 05:	
09	All Others	01	Church
If General Type (Position 1 and 2) is 02:		02	Other Than Church
01	Skilled Nursing Facility	03	Proprietary
02	E.C. Unit of Hospital	04	State
03	E.C. Unit of Rehabilitation Center	05	Parish (County)
04	E.C. Unit of Domiciliary Institution	06	City
05	Distinct part of S.N.F.	07	City-Parish (County)
06	Christian Science	08	Hospital District
07	Combined with Intermediate Care	09	P.H.S. (Fed. Gov't.)
08	Intermediate Care Facility Only	10	Other than P.H.S. (Fed Gov't.)
09	Other	11	All Other
If General Type (Position 1 and 2) is 05:		12	Nonprofit
01	Visiting Nurse Association		
02	Combined Govt. and Vol. Agency		

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:263 (March 1991), repromulgated LR 17:653 (July 1991).

§2707. Admission and Continued Stay Review

Editor's Note: The telephone number for the Office of Workers' Compensation has been changed to (225) 342-9836.**

A. In those instances when an emergency hospital admission is involved, an admission review is conducted. Admission review determines the medical appropriateness of the admission and utilizes the same techniques employed in pre-admission certification review such as reviewing all pertinent medical information against a set of accepted medical criteria to evaluate the need for hospital level of care. Non-emergency admissions that have not been pre-certified by pre-admission certification review are also monitored through admission review. If the admission is considered appropriate, a reasonable length of stay is assigned using a set of standard criteria. The admission review and continued stay review follow the sequence below.

B. Continued stay review is the review of the appropriateness and necessity of continued hospitalization while the patient is still in the hospital. The review is conducted using acceptable medical criteria to evaluate the appropriateness of continued hospital level of care. The same criteria used in pre-admission certification review are used during continued stay review. The day before the expected discharge date, the case is reviewed to determine if hospital level of care is still needed. If additional inpatient care is necessary, review personnel will authorize an extension of the length of stay.

C. Continued stay review is an integral part of managed care. During continued stay review, review personnel can identify cases that will benefit from individual case management. Continued stay review permits the review personnel to become aware of changes in a patient's condition or slow recovery which may necessitate a longer hospital stay.

D. Admission and Continued Stay Review Procedures

1. The carrier/self-insured employer will automatically review the necessity for continued hospitalization the day before the initial length of stay assigned expires without claimant initiation responsibility. The responsibility to request an extension may be

delegated to the hospital if requested by the hospital and agreed to in writing by the carrier/self-insured employer. If the party who has the responsibility for initiating the continued stay review fails to do so, they will be responsible for the cost of any subsequent care provided.

2. Continued stay review will include telephone discussions with the hospital or physician if the information required is not available from the hospital. All pertinent information necessary to determine if continued hospitalization is medically necessary and appropriate will be gathered (i.e., current medications and methods of administration used, frequency, lab values, and results of diagnostic tests). If re-certification is appropriate, additional days are assigned based upon statistical norms indicated in the PAS manual using the next higher percentile adjusted by the medical judgement of the reviewer, if applicable. This process will continue until the patient is discharged or until documentation no longer supports the medical necessity for inpatient services. If re-certification is not medically necessary or appropriate based upon documentation reviewed, the medical director will issue a denial to the physician, claimant, and hospital by the close of business (4:30 p.m. Central Time) on the day of the review.

3. All nonelective acute care hospital admissions including emergencies, psychiatric admissions, and all extended hospitalizations are reviewed using nationally accepted criteria designed to assess the need for hospital level of care. The Appropriateness Evaluation Protocol (AEP) and the Intensity/Severity/Discharge (ISD) criteria are the two most prominent nationally accepted criteria for admissions.

4. Automated software support for the review process is recommended in order to assure timely responses, uniform administration and complete data gathering. Computer prompts may be especially important in following up on length of stay assignments and assuring timely continued stay review.

5. Registered nurses use written criteria to assess the need for continued stays in the hospital. Physicians review all questionable cases and will make the final carrier/self-insured employer decisions on all denials of certification.

6.a. An appeals process must be available for reconsideration of any denial decisions. If the admitting/treating physician, hospital, or claimant desires to appeal a denial of an admission or continued stay request, the appeals process is initiated by contacting the carrier/self-insured employer by telephone or other immediate means following receipt of the denial. After the appeal request is received, it will be referred to the carrier/self-insured employer medical director or physician consultant. The carrier/self-insured employer medical director or physician consultant will review the available information regarding the request and make a decision concerning the appeal within 48 hours of receipt/communication of the appeal.

b. If the carrier/self-insured employer medical director's decision is an approval of the appeal the admitting/treating physician and hospital will be immediately notified via telephone and follow up by letter will be sent to the physician, claimant, and hospital.

c. If the carrier/self-insured employer medical director's decision is a denial the carrier/self-insured employer will notify the admitting/treating physician and hospital and will immediately submit in writing the denial and case documentation by fax to the director of the Office of Workers' Compensation for review at (225) 342-6556.** The material should be clearly identified as a denial of an admission or continued hospital stay request and should be addressed "Attention: Medical Manager, Office of Workers' Compensation." The director will immediately review the case and will notify the carrier/self-insured employer, the admitting/treating physician, and hospital by telephone of his agreement or disagreement with the denial decision. Follow-up notification will be sent to the claimant, carrier/self-insured employer, hospital, and admitting/treating physician by certified mail return receipt requested. Any party who disagrees with the director's resolution may file a Disputed Claim for Compensation Form (LDOL-WC-1008), available from the Office of Workers' Compensation Administration as otherwise provided by law.

7. The review process is also used to identify and refer cases for discharge planning.

8. The program includes written notification of the continued stay review decision to the claimant, physician and the hospital.

9. The carrier/self-insured employer maintains appropriate internal documentation of each request for continued stay review to verify the process and the decision for claims processing and reporting purposes.

E. Admission And Continued Stay Review Preparation

1. Preparation

a. Educational Program for Providers. The carrier/self-insured employer will maintain and make available to the provider information regarding the admission and continued stay review certification program, describing the reasons for implementation and operation, including an explanation of the appeals process. This notice of the admission and continued stay review program may be included in local carrier/self-insured employer provider newsletters.

b. Admission and Continued Stay Review Forms. The carrier/self-insured employer may use samples (Exhibit 1 and 2, Clauses E.1.d.i and ii) or develop forms to capture pertinent patient and provider information during the admission and continued

stay review activity. These forms may be identical to those used by the carrier/self-insured employer for their other business, however, they should capture the statistical data elements required by the Office of Workers' Compensation Administration.

c. Standardized Form Letters. The carrier/self-insured employer will develop letters announcing the results of the admission and continued stay review process to:

- i. claimant;
- ii. the admitting/treating physician; and
- iii. the hospital, with appeals process information where necessary.

d. Exhibits of Form Letters

i. Exhibit 3-A—Continued Stay Approval Letter

Re: Patient:

Pre-Admission Certification No.:

Claimant No.:

Date of Service:

Hospital:

Additional days to the hospital referenced above have been approved based upon a determination of medical necessity for continued inpatient care. A total of (indicate number of days) days is available for this hospital stay.

IT IS IMPORTANT FOR YOU TO KNOW THAT ...

This approval of the inpatient hospital setting is based on information provided by the above listed hospital and/or physician.

THE DETERMINATION OF ACTUAL BENEFITS ...

Can only be made upon receipt of completed claim. Payment for the services received is subject to statutory limitations. Eligibility is dependent upon:

1. the medical necessity for the services provided; and
2. the work-relatedness of the illness or injury.

IF THE CLAIMANT REQUIRES CONTINUED HOSPITALIZATION BEYOND THE NUMBER OF DAYS APPROVED ...

The admitting physician or authorized hospital representative should contact the carrier/self-insured employer at (phone number) on or before the above days expire.

BENEFITS FOR SERVICES RENDERED DURING ADDITIONAL HOSPITAL DAYS NOT CERTIFIED MAY BE DENIED.

ii. Exhibit 3-C—Continued Stay Denial Letter

Re: Patient:

Pre-Certification No.:

Contract No.:

Date of Service:

Hospital:

Dear (claimant/physician/provider)

The medical director has reviewed carefully your current medical status and, based upon the information obtained, has determined that the medical necessity of further hospitalization has not been documented.

Charges for inpatient services after (date), at the hospital referenced above will not be considered for payment.

If you disagree with this decision, you may appeal in accordance with the guidelines attached.

Sincerely,

2. Implementation

a. Telephone Inquiry Service. Telephone numbers should be published in educational materials and standardized form letters to the physicians, hospitals, and claimants. This telephone service allows for prompt response to requests for review and to general inquires about the review process.

b. Appropriate Staff and Documentation for Program Management of Certified, Denied, and Appealed Admissions. Registered nurses and physicians are the recommended staff for processing of admission and continued stay review requests and inquires. Procedures must be available for timely review of appealed or denied admissions by a physician (a psychiatrist for mental illness or substance abuse admissions). Program procedures should be routine and documented.

3. Evaluation

a. Data Collection. Admission and continued stay review documentation should be linked to the claims system to properly process inpatient claims. The admission and continued stay review documentation should be retrievable on a claim-by-claim basis for compilation and classification of activity performance.

b. Carrier/Self-Insured Employer Data Reporting. Carrier/self-insured employer will be required to collect data according to the Office of Workers' Compensation Administration requirements:

Information	Positions	Type
ICD-9 Diagnosis Code	5	Numeric
Provider Name	30	Alpha
Provider Street Address	30	Alpha Numeric
Parish Code for Provider of Service (Use Standard FIPS code, see Exhibit 5)	3	Numeric
Place of Treatment	1	Alpha Numeric
Type of Facility*	6	Numeric
Type of Service: Medical vs. Surgical	1	Alpha Numeric
Claimant Name	30	Alpha
Claimant Social Security Number	9	Numeric
Length of Stay	4	Numeric
* See "Type Facility Codes" in Exhibit 6.		

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:263 (March 1991), repromulgated LR 17:653 (July 1991).

§2709. Discharge Planning

Discharge planning is the process of assessing a patient's need for treatment after hospitalization and effecting an appropriate and timely discharge. The hospital has major responsibility for this function with the carrier/self-insured employer promoting, monitoring, and assisting the hospital.

A. Discharge Planning Procedures

1. Discharge planning is primarily the responsibility of the hospital.

2. The carrier/self-insured employer supports discharge planning by identifying and referring patients who may need discharge planning, by assisting the hospital with information on statutory coverage and alternative providers, and by monitoring hospitals to assure that appropriate discharge planning services are provided.

3. Discharge planning cases are identified primarily by the hospital. These services may not be duplicated by the carrier/self-insured employer if they are provided by the hospital. However, in addition, the carrier/self-insured employer identifies cases through pre-admission certification, admission review, continued stay review, and other managed care activities.

4. The carrier/self-insured employer requires appropriate hospital documentation on cases processed through discharge planning.

B. Discharge Planning Preparation

1. Preparation

a. Discharge Planning Information. The carrier/self-insured employer will capture pertinent patient and provider data during the discharge planning activity. This information may be identical to that used by the carrier/self-insured employer for their other business, however it should include the statistical data elements required by the Office of Workers' Compensation Administration.

b. Screening for Cases. The carrier/self-insured employer should identify the cases that are most likely to require discharge planning. This process can be initiated during the pre-admission certification activity to identify cases and to notify the hospital to begin discharge planning as soon as possible. The sooner the hospital discharge planner knows the patient's needs, the more likely it is that unnecessary days will be avoided.

2. Implementation

a. Telephone Inquiry Service. Telephone numbers should be published in educational materials and standard form letters to hospitals and claimants. This telephone service should provide for prompt response to general inquiries about the discharge planning process.

b. Monitoring the Hospital. The carrier/self-insured employer should monitor the hospital's discharge planning activity on a case-by-case basis and an aggregate basis at regular intervals. Monitoring ensures that Louisiana workers' compensation claimants receive quality care. As part of the monitoring effort, the carrier/self-insured employer may require documentation from the medical records or abstract material on patients. Documentation should include information on the cases the hospital has seen, the discharge planning activity, the results of the activity and the problems encountered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

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§2711. Second Surgical Opinion

A. When surgery has been recommended by the treating physician, the carrier/self-insured employer is entitled to obtain a second professional opinion from a physician chosen by the carrier/self-insured employer. Regardless of the second surgical opinion outcome, the claimant remains free to elect not to undergo surgery after the consultation. The carrier/self-insured employer is responsible for informing the claimant when a second surgical opinion is required and for referring the claimant to a second surgical opinion physician. This Program is designed to reduce unnecessary surgeries and to provide the claimant with possible alternate courses of treatment so that he or she can make an informed decision.

B. Second Surgical Opinion Procedures

1. The following is a list of surgical procedures that usually require a second opinion.

Spinal Surgery	Foot Surgery
Gastrectomy	Hemorrhoidectomy
Coronary Artery Bypass	Varicose Vein Surgery
Knee Surgery	Traumatic Cataract Surgery
Nasal Surgery	Joint Replacement

2. The carrier/self-insured employer should have in place a process to waive second surgical opinions on the basis of defined criteria.

3. The carrier/self-insured employer shall develop manual procedures or develop an automated system for administering program requirements, selecting consultants, documenting claimant compliance with the program, and efficiently handling claimant and physician contacts.

4. The second surgical opinion consultation and any tests necessary for the second surgical opinion consultant to render an opinion on the proposed surgery are to be paid by carrier/self-insured employer.

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§2713. Ambulatory Surgery

A. Ambulatory surgery refers to a program which recommends that specified surgical procedures be performed on an outpatient basis. The program is designed to reduce unnecessary hospitalizations and to shift care to less costly settings if medically appropriate. The surgeon is responsible for following the specified guidelines for procedures which should be performed in an outpatient setting.

B. Ambulatory Surgery Procedures

1. The following is a list of surgical procedures and tests that are classified as primarily outpatient procedures not requiring hospitalization under normal circumstances.

Arthroscopy	Brush Biopsy of Stomach
Blood Transfusions	Carpal Tunnel Release
Closed Reduction Nasal Fracture	Cystoscopy
Closed Reduction of Dislocation or Fracture	Dx Radiological Procedures in Absence of Acute Admittable Illness
Dx Ultrasound	Esophagoscopy
Exploration Tendon Sheath—Hand	Excision Lesion Tendon Sheath—Hand
Excision Lesion Tendon Sheath	Fiberoptic Bronchoscopy
Flex Fiberoptic Colonoscopy	Gastroscopy
Lid Reconstruction	Laryngoscopy/ Tracheoscopy
Large Bowel Endoscopy	Laparoscopy
Other Larynx Diagnostic Procedures	Other Fusion of Toe
Other Skin and Subcutaneous Incision/Drainage	Other Local Destruction of Skin
Peripheral Nerve Biopsy	Plastic Repair External Ear
Partial Osteotomy	Sinus Puncture for Lavage
Surgical Tooth Extraction	Small Bowel Endoscopy—via existing surgical ostomy
Skin Incision and Foreign Body Removal	Skin and Subcutaneous Biopsy
Skin Suture	Tooth Extraction
Turbinate Fracture	Tenotomy of Hand
Total Osteotomy—Digit	Turbinectomy by Diathermy/Cryosurgery
The Office of Workers' Compensation may expand this list pursuant to its rulemaking authority.	

2. The carrier/self-insured employer should not waive ambulatory surgeries except on the basis of defined criteria, which must include at least the following:

- a. presence of other documented medical problems that make prolonged pre-operative or post-operative observation medically necessary;
- b. inability to provide proper post-operative care at home; and
- c. likelihood that another major surgical procedure might follow the initial procedure.

3. The carrier/self-insured employer should have an automated system for administering program requirements and documenting provider compliance with the program.

C. Ambulatory Surgery Preparation

1. Preparation

a. It is important to stress to the provider that the intent of the program is not to reduce the quality of care and to explain that carrier/self-insured employer consultant physicians are available to discuss cases for which the attending physician feels the surgery must be performed on an inpatient basis.

b. Drawing on the strength of existing physician relations, the carrier/self-insured employer needs to stress continued cooperation between the carrier/self-insured employer physician consultant and the attending physician. In addition, the carrier/self-insured employer should develop ongoing physician communications, such as newsletters and attendance at community physician gatherings.

2. Implementation

a. Telephone Inquiry Service. Telephone numbers should be published in educational materials and standard form letters to physicians and claimants. This telephone service should provide for prompt response to inquiries regarding ambulatory surgery.

b. Appropriate Staff and Documentation. Registered nurses and physicians are the recommended staff for processing of ambulatory surgery requests and inquiries. Procedures must be available for timely review of cases which providers believe cannot be safely performed in an outpatient setting. Program procedures should be routine and documented.

3. Evaluation

a. Data Collection. Ambulatory surgery information should be linked to the claims system to properly process surgical claims. Ambulatory surgery elements should be retrievable on a claim-by-claim basis for compilation and classification of activity performance.

b. Plan Data Reporting. Carriers will be required to collect data for report preparation as outlined in the billing and maintenance section of the Office of Workers' Compensation Reimbursement Manual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

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§2715. Medical Treatment Schedule Authorization and Dispute Resolution

A. Purpose. It is the purpose of this Section to facilitate the management of medical care delivery, assure an orderly and timely process in the resolution of care-related disputes; identify the required medical documentation to be provided to the carrier/self-insured employer to initiate a request for authorization as provided in R.S. 23:1203.1(J); and provide for uniform forms, timeframes, and terms for suspension of prior authorization process, withdrawal of request for authorization, authorization, denial, and dispute resolution in accordance with R.S. 23:1203.1.

B. Statutory Provisions

1. Emergency Care

a. In addition to all other utilization review rules and procedures, R.S. 23:1142 provides that no prior consent by the carrier/self-insured employer is required for any emergency medical procedure or treatment deemed immediately necessary by the treating health care provider. Any health care provider who authorizes or orders diagnostic testing or treatment subsequently held not to have been of an emergency nature shall be responsible for all of the charges incurred in such testing or treatment. Such health care provider shall bear the burden of proving the emergency nature of the diagnostic testing or treatment.

b. Fees for those services of the health care provider held not to have been of an emergency nature shall not be an enforceable obligation against the employee or the employer or the employer's workers' compensation insurer unless the employee and the payor have agreed upon the treatment or diagnostic testing by the health care provider.

2. Non-Emergency Care. In addition to all other utilization review rules and procedures, the law (R.S. 23:1142) establishes a monetary limit for non-emergency medical care. No health care provider shall incur more than a total of \$750 in non-emergency diagnostic testing or treatment without the mutual consent of the carrier/self-insured employer and the employee. The statute further provides significant penalties for a carrier's/self-insured employer's arbitrary and capricious refusal to approve necessary care beyond that limit.

3. Medical Treatment Schedule

a. In addition to all other utilization review rules and procedures, R.S. 23:1203.1 provides that after the promulgation of the medical treatment schedule, medical care, services, and treatment due, pursuant to R.S. 23:1203

et seq., by the employer to the employee shall mean care, services, and treatment in accordance with the medical treatment schedule.

b. Pursuant to R.S. 23:1203.1(I), medical care, services, and treatment that varies from the promulgated medical treatment schedule shall also be due by the employer when it is demonstrated to the medical director of the Office of Workers' Compensation by a preponderance of the scientific medical evidence, that a variance from the medical treatment schedule is reasonably required to cure or relieve the injured worker from the effects of the injury or occupational disease given the circumstances.

c. Pursuant to R.S. 23:1203.1(M), with regard to all treatment not covered by the medical treatment schedule, all medical care, services, and treatment shall be in accordance with Subsection D of R.S. 23:1203.1.

d. All requests for authorization of care beyond the statutory non-emergency monetary limit of \$750 are to be presented to the carrier/self-insured employer. In accordance with these Utilization Review Rules, the carrier/self-insured employer or a utilization review company acting on its behalf shall determine if such request is in accordance with the medical treatment schedule. If the request is denied or approved with modification and the health care provider determines to request a variance from the medical director, then a LWC-WC-1009 shall be filed as provided in Subsection G of this Section.

e. Disputes shall be filed by any aggrieved party on a LWC-WC-1009 within 15 calendar days of receipt of the denial or approval with modification of a request for authorization. The medical director shall render a decision as soon as practicable, but in no event later than 30 calendar days from the date of filing. The decision shall determine whether:

- i. the recommended care, services, or treatment is in accordance with the medical treatment schedule; or
- ii. a variance from the medical treatment schedule is reasonably required; or
- iii. the recommended care, services, or treatment that is not covered by the medical treatment schedule is in accordance with another state's adopted guideline pursuant to Subsection D of R.S. 23:1203.1.

f. In accordance with LAC 40:1.5507.C, any party feeling aggrieved by the R.S. 23:1203.1(J) determination of the medical director shall seek a judicial review by filing a Form LWC-WC-1008 in a workers' compensation district office within 15 calendar days of the date said determination is mailed to the parties. A party filing such appeal must simultaneously notify the other party that an appeal of the medical director's decision has been filed. Upon receipt of the appeal, the workers' compensation judge shall immediately set the matter for an expedited hearing to be held not less than 15 days nor more than 30 calendar days after the receipt of the appeal by the office. The workers' compensation judge shall provide notice of the hearing date to the parties at the same time and in the same manner.

g. R.S. 23:1203.1(J) provides that after a health care provider has submitted to the carrier/self-insured employer the request for authorization and the information required pursuant to this Section, the carrier/self-insured employer shall notify the health care provider of their action on the request within five business days of receipt of the request.

C. Minimum Information for Request of Authorization

1. Initial Request for Authorization. The following criteria are the minimum submission by a health care provider requesting care beyond the statutory non-emergency medical care monetary limit of \$750 and will accompany the LWC-WC-1010:

- a. history provided to the level of the condition and as provided in the medical treatment schedule;
- b. physical findings/clinical tests;
- c. documented functional improvements from prior treatment, if applicable;
- d. test/imaging results; and
- e. treatment plan including services being requested along with the frequency and duration.

2. To make certain that the request for authorization meets the requirements of this Subsection, the health care provider should review the medical treatment schedule for each area(s) of the body to obtain specific detailed information related to the specific services or diagnostic testing that is included in the request. Each section of the

medical treatment schedule contains specific recommendations for clinical evaluation, treatment and imaging/testing requirements. The medical treatment guidelines can be viewed on Louisiana's Workforce Commission website. The specific URL is http://www.laworks.net/WorkersComp/OWC_MedicalGuidelines.asp.

3. Subsequent Request for Authorizations. After the initial request for authorization, subsequent requests for additional diagnostic testing or treatment does not require that the healthcare provider meet all of the initial minimum requirements listed above. Subsequent requests require only updates to the information of Subparagraph 1.a-e above. However such updates must demonstrate the patient's current status to document the need for diagnostic testing or additional treatment. A brief history, changes in clinical findings such as orthopedic and neurological tests, and measurements of function with emphasis on the current, specific physical limitations will be important when seeking approval of future care. The general principles of the medical treatment schedule are:

- a. the determination of the need to continue treatment is based on functional improvement; and
- b. the patient's ability (current capacity) to return to work is needed to assist in disability management.

D. Submission and Process for Request for Authorization

1. To initiate the request for authorization of care beyond the statutory non-emergency medical care monetary limit of \$750 per health care provider, the health care provider shall submit LWC-WC-1010 along with the required information of this Section by fax or email to the carrier/self insured employer.

2. The carrier/self-insured employer shall provide to the OWC a fax number and/or email address to be used for purposes of these rules and particularly for LWC-WC-1010 and 1010A. If the fax number and/or email address provided is for a utilization review company contracted with the carrier/self-insured employer, then the carrier/self-insured employer shall provide the name of the utilization review company to the OWC. All carrier/self-insured employer fax numbers and/or email addresses provided to the OWC will be posted on the office's website at www.laworks.net. If the fax number or e-mail address is for a contracted utilization review company, then the OWC will also post on the web the name of the utilization review company. When requesting authorization and sending the LWC-WC-1010 and 1010A, the health care provider shall use the fax number and/or email address found on the OWC website.

3. Pursuant to R.S. 23:1203.1, the five business days to act on the request for authorization does not begin for the carrier/self-insured employer until the information of Subsection C and LWC-WC-1010 is received. In the absence of the submission of such information, any denial of further non-emergency care by the carrier/self-insured employer is prima facie, not arbitrary and capricious.

E. First Request

1. If a carrier/self-insured employer determines that the information required in Subsection C of this Section has not been provided, then the carrier/self-insured employer shall, within five business days of receipt of LWC-WC-1010, notify the health care provider of its determination. Notice shall be by fax or e-mail to the healthcare provider and shall include the provider-submitted LWC-WC-1010 with the "first request" section completed to indicate a delay due to lack of information and LWC-WC-1010A identifying the information that was not provided. A copy of the LWC-WC-1010 and all information faxed or emailed to the health care provider shall also be faxed or emailed to the claimant attorney, if any. On the same business day, a copy of the LWC-WC-1010 and all information faxed or emailed to the health care provider shall also be sent by regular mail to the claimant's last known address.

a. The health care provider must respond by fax or e-mail to the carrier/self-insured employer's request for additional information within 10 business days of receipt of the request.

b. If the health care provider agrees that the additional information from the first request is due, then such information shall be provided along with LWC-WC-1010 and 1010A.

c. If the health care provider disagrees that the additional information in the first request is due, then the health care provider shall return the LWC-WC-1010 and 1010A with an explanation describing why the health care provider believes all required information has been previously provided.

d. If the health care provider fails to respond to the first request within 10 business days of receipt, then such failure to respond shall result in a withdrawal of the request for authorization without further action by the OWC or the carrier/self-insured employer. In order to obtain authorization for care the health care provider will be required to initiate a new request for authorization with a new LWC-WC-1010 pursuant to this Section.

e. The carrier/self-insured employer must respond by fax or e-mail within five business days of receipt of a timely submitted response from the health care provider:

i. if the health care provider responds timely with additional information and the carrier/self-insured employer determines that the requested information has been provided, then the carrier/self-insured employer has five business days to act on the request for authorization pursuant to R.S. 23:1203.1(J) and these rules. Subsection G of this Section provides the rules regarding whether a request for authorization is approved, approved with modification, or denied;

ii. if the health care provider responds timely with additional information but the carrier/self-insured employer determines that the requested information has again not been provided, then the carrier/self-insured employer shall return LWC-WC-1010 to the health care provider, and indicate suspension of prior authorization process due to lack of information;

iii. if the health care provider responds timely with the appropriate forms and an explanation as to why no additional information is necessary; and

iv. the carrier/self-insured employer determines that the request for information has been satisfied, then the carrier/self-insured employer has five business days to act on the request for authorization pursuant to R.S. 23:1203.1(J) and these rules. Subsection G of this Section provides the rules regarding whether a request for authorization is approved, approved with modification, or denied;

v. the carrier/self-insured employer determines that the requested information has still not been provided, then the carrier/self-insured employer shall return to the health care provider the LWC-WC-1010 indicating suspension of prior authorization process due to lack of information.

2.a. A carrier/self-insured employer who fails to return LWC-WC-1010 within the five business days as provided in this Subsection is deemed to have denied such request for authorization. A health care provider, claimant, or claimant's attorney if represented who chooses to appeal a denial pursuant to this Subsection shall file a LWC-WC-1009 pursuant to Subsection J of this Section.

b. A request for authorization that is deemed denied pursuant to this Subparagraph may be approved by the carrier/self-insured employer within 10 calendar days of being deemed denied. The approval will be indicated in section 3 of LWC-WC-1010. The medical director shall dismiss any appeal that may have been filed by a LWC-WC-1009. The carrier/self-insured employer shall be given a presumption of good faith regarding the decision to change the denial to an approval provided that the LWC-WC-1010 which indicates "approved" in section 3 is faxed or emailed within the 10 calendar days.

F. Appeal of Suspension of Prior Authorization Process

1. If the health care provider disagrees with the suspension of prior authorization process, the provider, within five business days of receipt of the suspension, shall file an appeal with the medical services section of the OWC. The appeal shall include:

a. a copy of the LWC-WC-1010 submitted to the carrier/self-insured employer. The health care provider should complete the appropriate section of the form indicating that an appeal is being requested; and

b. a copy of LWC-WC-1010A; and

c. a copy of all information previously submitted to the carrier/self-insured employer.

2. The medical services section shall, within 10 business days of receipt of the filed LWC-WC-1010:

a. determine whether the information provided satisfied the provisions of Subsection C of this Section; and

b. issue a written determination to the health care provider, claimant and carrier/self-insured employer.

3. If the medical services section determines that the requested information was not provided, then the health care provider will be required to submit the information to the carrier/self-insured employer within five business days of receipt of the decision of the medical services section.

a. If the information is provided as required by decision of the medical services section, the carrier/self-insured employer shall have five business days to act on the request for authorization pursuant to R.S. 23:1203.1(J)

and these rules. Subsection G of this Section provides the rules regarding a request for authorization being approved, approved with modification, or denied.

b. Failure of the health care provider to provide the information within five business days of receipt of the decision of the medical services section shall result in a withdrawal of the request for authorization without further action by the OWC or the carrier/self-insured employer. In order to obtain authorization, the medical provider will be required to initiate a new request for authorization pursuant to this Section.

4. If the medical services section determines that the requested information was provided, then within five business days of receipt of the decision of the medical services section decision, the carrier/self-insured employer shall act on the request for authorization pursuant to R.S. 23:1203.1(J) and these rules with the information as previously provided. Subsection G of this Section provides the rules regarding a request for authorization being approved, approved with modification, or denied.

5. Failure of the carrier/self-insured employer to act on the request within the five business days will be deemed a denial of the request for authorization. A health care provider, claimant, or claimant's attorney if represented who chooses to appeal a denial pursuant to this subparagraph shall file a LWC-WC-1009 pursuant to Subsection J of this Section.

6. A request for authorization that is deemed denied pursuant to this subparagraph may be approved by the carrier/self-insured employer within 10 calendar days of being deemed denied. The approval will be indicated in section 3 of LWC-WC-1010. The medical director shall dismiss any appeal that may have been filed by a LWC-WC-1009. The carrier/self-insured employer shall be given a presumption of good faith regarding the decision to change the denial to an approval provided that the LWC-WC-1010 which indicates "approved" in section 3 is faxed or emailed within the 10 calendar days.

G. Approval or Denial of Authorization for Care

1. Request for authorization covered by the medical treatment schedule. Upon receipt of the LWC-WC-1010 and the required medical information in accordance with this Section, the carrier/self-insured employer shall have five business days to notify the health care provider of the carrier/self-insured employer's action on the request. Based upon the medical information provided pursuant to this Section the carrier/self-insured employer will determine whether the request for authorization is in accordance with the medical treatment schedule:

a. the carrier/self-insured employer will return to the health care provider Form 1010, and indicate in the appropriate section on the form that "The requested treatment or testing is approved" if the request is in accordance with the medical treatment schedule; or

b. the carrier/self-insured employer will return to the health care provider, claimant, and the claimant's attorney if one exists, the LWC-WC-1010, and indicate in the appropriate section on the form "The requested treatment or testing is approved with modification" if the carrier/self-insured employer determines that modifications are necessary in order for the request for authorization to be in accordance with the medical treatment schedule, or that a portion of the request for authorization is denied because it is not in accordance with the medical treatment schedule. The carrier/self-insured employer shall include with the LWC-WC-1010 a summary of reasons why a part of the request for authorization is not in accordance with the medical treatment schedule and explain any modification to the request for authorization. The LWC-WC-1010 and the summary of reasons shall be faxed or emailed to the health care provider and to the claimant attorney, if any. On the same business day, a copy of the LWC-WC-1010 and the summary of reasons shall also be sent by regular mail to the claimant's last known address; or

c. the carrier/self-insured employer will return to the health care provider, the claimant, and the claimant's attorney if one exists, the LWC-WC-1010, and indicate in the appropriate section on the form "the requested treatment or testing is denied" if the carrier/self-insured employer determines that the request for authorization is not in accordance with the medical treatment schedule. The carrier/self-insured employer shall include with the LWC-WC-1010 a summary of reasons why the request for authorization is not in accordance with the medical treatment schedule. The LWC-WC-1010 and the summary of reasons shall be faxed or mailed to the health care provider and to the claimant attorney, if any. On the same business day, a copy of the LWC-WC-1010 and the summary of reasons shall also be sent by regular mail to the claimant's last known address.

2. Request for Authorization not Covered by the Medical Treatment Schedule. Requests for authorization of medical care, services, and treatment that are not covered by the medical treatment schedule in accordance to R.S.

23:1203.1(M), must follow the same prior authorization process established for all other requests for medical care, services, and treatment. A request for authorization that is not covered by the medical treatment schedule exists when the requested care, services, or treatment are for a diagnosis not addressed by the medical treatment schedule. The health care Provider requesting care, services, or treatment that is not covered by the medical treatment schedule may submit documentation sufficient to establish that the request is in accordance with R.S. 23:1203.1(D). After timely receipt of the LWC-WC-1010, the submitted documentation if any, and the required medical information in accordance with this Section, the carrier/self-insured employer shall determine whether the request for authorization is in accordance with R.S. 23:1203.1(D). In making this determination, the carrier/self-insured employer shall review the submitted documentation, but may apply another guideline that meets the criteria of R.S. 23:1203.1(D). The carrier/self-insured employer has five business days to notify the health care provider of the carrier/self-insured employer's action on the request:

a. the carrier/self-insured employer will return to the health care provider the LWC-WC-1010, and indicate in the appropriate section on the form that "The requested treatment or testing is approved" if the request is in accordance with R.S. 23:1203.1(D); or

b. the carrier/self-insured employer will return to the health care provider, claimant, and the claimant's attorney if one exists, the LWC-WC-1010, and indicate in the appropriate section on the form "The requested treatment or testing is approved with modification" if the carrier/self-insured employer determines that modifications are necessary in order for the request for authorization to be in accordance with R.S. 23:1203.1(D), or that a portion of the request for authorization is denied because it is not in accordance with R.S.23:1203.1(D). The carrier/self insured employer shall include with the LWC-WC-1010 a summary of reasons why a part of the request for authorization is not in accordance with R.S. 23:1203.1(D). The LWC-WC-1010 and the summary of reasons shall be faxed or emailed to the health care provider and to the claimant attorney, if any. On the same business day a copy of the LWC-WC-1010 and the summary of reasons shall also be sent by regular mail to the claimant's last known address; or

c. the carrier/self-insured employer will return to the health care provider, the claimant, and the claimant's attorney if one exists, the LWC-WC-1010, and indicate in the appropriate section on the form "the requested treatment or testing is denied" if the carrier/self-insured employer determines that the request for authorization is not in accordance with R.S. 23:1203.1(D). The carrier/self-insured employer shall include with the LWC-WC-1010 a summary of reasons why the request for authorization is not in accordance with R.S. 23:1203.1(D). The LWC-WC-1010 and the summary of reasons shall be faxed or emailed to the health care provider and to the claimant attorney, if any. On the same business day a copy of the LWC-WC-1010 and the summary of reasons shall also be sent by regular mail to the claimant's last known address.

3. Summary of Reasons. The summary of reasons provided by the carrier/self-insured employer with the approval with modification or denial shall include:

- i. the name of the employee;
- ii. the date of accident;
- iii. the name of the health care provider requesting authorization;
- iv. the decision (approved with modification, denied);
- v. the clinical rationale to include a brief summary of the medical information reviewed;
- vi. the criteria applied to include specific references to the medical treatment schedule, or to the guidelines adopted in another state if the requested care, services or treatment is not covered by the medical treatment schedule; and

vii. a Section labeled "Voluntary Reconsideration" pursuant to Paragraph I.2 of this Section that includes 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 a denial or approval with modification.

4. Upon receipt of the LWC-WC-1010 and the required medical information in accordance with this Section, the carrier/self-insured employer shall have five business days to notify the health care provider of the carrier/self-insured employer's action on the request. Based upon the medical information provided pursuant to this Section, and other information known to the carrier/self-insured employer at the time of the request for authorization, the carrier

will return to the health care provider, claimant, and claimant's attorney if one exists, the LWC-WC-1010 and indicate in the appropriate section on the form "the requested treatment or testing is denied because:

- a. "the request for authorization or a portion thereof is not related to the on-the-job injury;" or
- b. "the claim is non-compensable;" or
- c. "other" and provide a brief explanation for the basis of denial.

5. The LWC-WC-1010 and the summary of reasons shall be faxed or emailed to the health care provider and the claimant attorney, if any. On the same business day a copy of the LWC-WC-1010 and the summary of reasons shall also be sent by regular mail to the claimant's last known address.

H. Failure to respond by carrier/self-insured employer. A carrier/self-insured employer who fails to return LWC-WC-1010 with section 3 completed within the five business days to act on a request for authorization as provided in this Section is deemed to have denied such request for authorization. A health care provider, claimant, or claimant's attorney if represented who chooses to appeal a denial pursuant to this Subparagraph shall file a LWC-WC-1009 pursuant to Subsection J of this Section.

I. Reconsideration Prior to LWC-WC-1009 Decision

1. R.S. 23:1203.1(L) provides that it is the intent of the legislature that, with establishment of the medical treatment schedule, medical and surgical treatment, hospital care, and other health care provider services shall be delivered in an efficient and timely manner to injured employees.

2. In furtherance of that goal, 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.

3. Reconsideration after denied or approved with modification. If the carrier/self-insured employer determines that the requested care should now be approved, it will return to the health care provider, the claimant, and the claimant's attorney if one exists within 10 calendar days of the denial or approval with modification, the LWC-WC-1010, and in the appropriate section on the form indicate "the prior denied or approved with modification request is now approved." Such approval ends the utilization review process as it relates to the request. A LWC-WC-1009 or 1008 shall not be filed regarding such request. The carrier/self-insured employer shall be given a presumption of good faith regarding the decision to change its decision of denied or approved with modification to approved after discussing the request with the health care provider.

4. Reconsideration after deemed denied due to failure to respond. A request for authorization that is deemed denied pursuant to Subsection H of this Section may be approved by the carrier/self-insured employer within 10 calendar days of the request for authorization as indicated on the LWC-WC-1010. The approval will be indicated in Section 3 of LWC-WC-1010. The medical director shall dismiss any appeal that may have been filed by a LWC-WC-1009. The carrier/self-insured employer shall be given a presumption of good faith regarding the decision to change the denial to an approval provided that the LWC-WC-1010 which indicates "approved" in Section 3 is faxed or emailed within 10 calendar days of the request for authorization.

J. Review of denial, approved with modification, deemed denied, or variance by LWC-WC-1009.

1. Any aggrieved party who disagrees with a request for authorization that is denied, approved with modification, deemed denied pursuant to Paragraphs E.2, F.5, and Subsection H, or who seeks a determination from the medical director with respect to medical care, services, and treatment that varies from the medical treatment schedule shall file a request for review with the OWC. The request for review shall be filed within 15 calendar days of:

- a. receipt of the LWC-WC-1010 by the health care provider indicating that care has been denied or approved with modification; or
- b. the expiration of the fifth business day without response by the carrier/self-insured employer pursuant to Paragraphs E.2, F.5, and Subsection H of this Section.

2. The request for review shall include:

- a. LWC-WC-1009 which shall state the reason for review is either;
 - i. a request for authorization that is denied; or
 - ii. a request for authorization that is approved with modification; or
 - iii. a request for authorization that is deemed denied pursuant to Paragraphs, E.2, F.5, and Subsection H; or
 - iv. a variance from the medical treatment schedule is warranted; and
- b. a copy of LWC-WC-1010 which shows the history of communications between the health care provider and the carrier/self-insured employer that finally resulted in the request being denied or approved with modification; and
- c. all of the information previously submitted to the carrier/self-insured employer; and
- d. in cases where a variance has been requested, the health care provider or claimant shall also provide any other evidence supporting the position of the health care provider or the claimant including scientific medical evidence demonstrating that a variance from the medical treatment schedule is reasonably required to cure or relieve the claimant from the effects of the injury or occupational disease given the circumstances.

3. In cases where the requested care, services, or treatment are not covered by the medical treatment schedule pursuant to R.S. 23:1203.1(M):

- i. the health care provider may also submit with the LWC-WC-1009 the documentation provided to the carrier/self-insured employer pursuant to Paragraph G.2 of this Section; and
- ii. the carrier/self-insured employer may submit to the medical director within five business days of receipt of the LWC-WC-1009 from the health care provider or claimant the documentation used to deny or approve with modification the request for authorization pursuant to R.S. 23:1203.1(D). A copy of the information being submitted to the medical director must be provided by fax or email to the health care provider and claimant attorney, if any, and on the same business day to the claimant by regular mail at his last known address.

4. The health care provider or claimant filing the LWC-WC-1009 shall certify that such form and all supporting documentation has been sent to the carrier/self-insured employer by email or fax. The OWC shall notify all parties of receipt of a LWC-WC-1009.

5.a. Within five business days of receipt of the LWC-WC-1009 from the health care provider or claimant, the carrier/self-insured employer shall provide to the medical director, with a copy going to the health care provider or claimant attorney, if any, via fax or email and on the same business day to the claimant via regular mail at his last known address, any evidence it thinks pertinent to the decision regarding the request being denied, approved with modification, deemed denied, or that a variance from the medical treatment schedule is warranted.

b. The medical director shall within 30 calendar days of receipt of the LWC-WC-1009, and consideration of any medical evidence from the carrier/self-insured employer if provided within such five business days, render a decision as to whether the request for authorization is medically necessary and is:

- i. in accordance with the medical treatment schedule: or
- ii. in accordance with R.S. 23:1203.1(D) if such request is not covered by the medical treatment schedule,
or
- iii. whether the health care provider or claimant demonstrates by a preponderance of the scientific medical evidence that a variance from the medical treatment schedule is reasonably required. The decision of the medical director shall be provided in writing to the health care provider, claimant, claimant's attorney if one exists, and Carrier/ Self-Insured Employer.

c. The decision of the medical director shall include:

- i. the date the decision is mailed; and
- ii. the name of the employee; and
- iii. the date of accident; and

- iv. the decision of the medical director; and
- v. the clinical rationale to include a summary of the medical information reviewed; and
- vi. the criteria applied to make the LWC-WC-1009 decision.

K. Appeal of 1009 Decision by Filing 1008

1. In accordance with LAC 40:I.5507.C, any party feeling aggrieved by the R.S. 23:1203.1(J) determination of the medical director shall seek a judicial review by filing a Form LWC-WC-1008 in a workers' compensation district office within 15 calendar days of the date said determination is mailed to the parties. The filed LWC-WC-1008 shall include a copy of the LWC-WC-1009 and the decision of the medical director. A party filing such appeal must simultaneously notify the other party that an appeal of the medical director's decision has been filed. Upon receipt of the appeal, the workers' compensation judge shall immediately set the matter for an expedited hearing to be held not less than 15 calendar days nor more than 30 calendar days after the receipt of the appeal by the office. The workers' compensation judge shall provide notice of the hearing date to the parties at the same time and in the same manner. The decision of the medical director may only be overturned when it is shown, by clear and convincing evidence that the decision was not in accordance with the provisions of R.S. 23:1203.1.

L. Variance to Medical Treatment Schedule

1. Requests for authorization of medical care, services, and treatment that may vary from the medical treatment schedule must follow the same prior authorization process established for all other requests for medical care, services, and treatment that require prior authorization. If a request is denied or approved with modification, and the health care provider or claimant determines to seek a variance from the medical director, then a LWC-WC-1009 shall be filed as provided in Subsection J of this Section. The health care provider, claimant, or claimant's attorney filing the LWC-WC-1009 shall submit with such form the scientific medical literature that is higher ranking and more current than the scientific medical literature contained in the medical treatment schedule, and which supports approval of the variance.

2. A variance exists in the following situations.

a. The requested care, services, or treatment is not recommended by the medical treatment schedule although the diagnosis is covered by the medical treatment schedule.

b. The requested care, services, or treatment is recommended by the medical treatment schedule, but for a different diagnosis or body part.

c. The requested care, services, or treatment involves a medical condition of the claimant that complicates recovery of the claimant that is not addressed by the medical treatment schedule.

M. Emergency Care. In addition to all other rules and procedures, the health care provider who provides care under the "medical emergency" exception must demonstrate that it was a "medical emergency" in the following manner:

a. by demonstrating that the illness or condition presents one or more of the following findings:

i. Severity of Illness Criteria:

(a). Sudden Onset of Unconsciousness or Disorientation (coma or unresponsiveness);

(b). Pulse Rate:

(i). less than 50 per minute;

(ii). greater than 140 per minute;

(c). Blood Pressure:

(i). systolic less than 90 or greater than 200 mm Hg.;

(ii). diastolic less than 60 or greater than 120 mm Hg.;

(d). acute loss of sight or hearing;

(e). acute loss of ability to move body part;

- (f). persistent fever equal to or greater than 100 (p.o.) or greater than 101(r) for more than five days;
- (g). active bleeding;
- (h). severe electrolyte/blood gas abnormality (any of the following:
 - (i). Na < 124 mEq/L, or Na > 156 mEq/L;
 - (ii). K < 2.5 mEq/L, or K > 6.0 mEq/L;
 - (iii). CO₂ combining power [unless chronically abnormal] < 20 mEq/L, or CO₂ combining power [unless chronically abnormal] > 36 mEq/L;
 - (iv). blood ph < 7.30, or blood ph > 7.45);
- (i). acute or progressive sensory, motor, circulatory or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, breathe, etc.).

NOTE: Must also meet Intensity of Service criterion simultaneously in order to certify. Do not use for back pain.

- (j). EKG evidence of acute ischemia; must be suspicion of a new MI;
 - (k). wound dehiscence or evisceration.
- ii. Intensity of Service Criteria
- (a). Intravenous medications and/or fluid replacement (does not include tube feedings);
 - (b). surgery or procedure scheduled within 24 hours requiring:
 - (i). general or regional anesthesia; or
 - (ii). use of equipment, facilities, procedure available only in a hospital;
 - (c). vital sign monitoring every two hours or more often (may include telemetry or bedside cardiac monitor);
 - (d). chemotherapeutic agents that require continuous observation for life threatening toxic reaction;
 - (e). treatment in an I.C.U.;
 - (f). intramuscular antibiotics at least every eight hours;
 - (g). intermittent or continuous respirator use at least every eight hours;

NOTE: If at least one criterion is satisfied from both the severity of illness criteria and the intensity of service criteria, the service is considered to be emergency.

b. by demonstrating by other objective criteria that the treatment was necessary to prevent death, or serious permanent impairment to the patient.

N. Change of Physician

1. Requests for change of treating physician within one field or specialty shall be made in writing to the carrier/self-insured employer and shall contain a clear statement of the reason for the requested change. Having exhausted the monetary limit for non-emergency treatment is insufficient justification, without other reasons. The carrier/self-insured employer shall notify all parties of the request, and of their action on the request, within five calendar days of date of receipt of the request. Failure to timely respond may result in assessment of penalties by the hearing officer.

2. Disputes over change of physician will be resolved in accordance with R.S. 23:1142(B).

O. Opposing Medical Opinions. In the event that there are opposing medical opinions regarding claimant's condition or capacity to work, the Office of Workers' Compensation Administration will appoint an independent medical examiner of the appropriate licensure class to examine the claimant, or review the medical records at issue. The expense of this examination will be set by the director and will be borne by the carrier/self-insured employer.

AUTHORITY NOTE: Promulgated in accordance with RS 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:263 (March 1991), repromulgated LR 17:653 (July 1991), repromulgated LR 18:257 (March 1992), amended by the Louisiana Workforce Commission, Office of Workers' Compensation, LR 38:1030 (April 2012), repromulgated LR 38:1287 (May 2012).

§2717. Medical Review Guidelines

A. Workers' Compensation is designed to provide indemnity and medical care benefits for workers who sustain injuries or illnesses arising out of and in the course and scope of employment. The following instructions give some general guidelines for medical review of workers' compensation claims.

B. Technical Considerations for Review of Claims

1. Prior to a detailed medical review, a cursory review of the claim should be accomplished and should include at least the following.

- a. Job related illness/injury must be identified.
- b. Each service/item billed must be identifiable.
- c. Billing period must be identified.
- d. Appropriate forms must be used and filled out completely.

2. If the cursory review indicates that sufficient information is present, processing of the claim can proceed. If the review indicates information is lacking, the carrier/self-insured employer must take immediate and appropriate action to obtain the information required. The "timely payment" provision contained in the statement of policy in this manual will not apply until the required information is obtained. However, absence of nonessential information is not justification for delay in claim processing.

C. Functions of Medical Review. The carrier/self-insured employer should use a program of prevention and detection to guarantee the most appropriate and economical use of health care resources for claimants.

1. Prevention through Education. Informing physicians and other health care providers about workers' compensation programs, policies and statutory provisions that deal with claim submission is the key to ensuring the appropriate billing of covered services. As part of that educational focus, the following are some of the administrative policies encountered in the review process:

- a. quality of care;
- b. medical necessity;
- c. screening tests;
- d. confidentiality;
- e. general documentation requirements.

2. Quality of Care. Quality care should:

- a. be provided in a timely manner, without inappropriate delay, interruption, premature termination or prolongation of treatment, and emphasize an early, safe return to work;
- b. seek the patient's cooperation and participation in the decisions and process of his or her treatment;
- c. be based on accepted principles of evidence based practice as established in R.S. 23:1203.1 and the skillful and appropriate use of other health professionals and technology;
- d. be provided with sensitivity to the stress and anxiety that illness can cause, and with concern for the patient's and family's overall welfare and should focus on improvement in function related to the physical demands of the injured workers' job;
- e. use technology and other resources efficiently to achieve the treatment goal;
- f. be sufficiently documented in the patient's medical record to allow continuity of care and peer evaluation.

3. Medical Necessity

a. The workers' compensation law provides benefits only for services that are medically necessary for the diagnosis or treatment of a claimant's work related illness, injury, symptom or complaint. *Medically necessary* or *medical necessity* shall mean health care services that are:

i. clinically appropriate, in terms of type, frequency, extent, site, and duration, and effective for the patient's illness, injury, or disease; and

ii. in accordance with the medical treatment schedule and the provisions of R.S. 23:1203.1.

b. To be medically necessary, a service must be:

i. consistent with the diagnosis and treatment of a condition or complaint; and

ii. in accordance with the Louisiana medical treatment schedule; and

iii. not solely for the convenience of the patient, family, hospital or physician; and

iv. furnished in the most appropriate and least intensive type of medical care setting required by the patient's condition.

c. Services not related to the diagnosis or treatment of a work related illness or injury are not payable under the workers' compensation laws and shall be the financial responsibility of the claimant, and in appropriate cases, his health insurance carrier. A.

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- c. be based on accepted principles of evidence based practice as established in R.S. 23:1203.1 and the skillful and appropriate use of other health professionals and technology;
- d. be provided with sensitivity to the stress and anxiety that illness can cause, and with concern for the patient's and family's overall welfare and should focus on improvement in function related to the physical demands of the injured workers' job;
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a. The workers' compensation law provides benefits only for services that are medically necessary for the diagnosis or treatment of a claimant's work related illness, injury, symptom or complaint. *Medically necessary* or *medical necessity* shall mean health care services that are:

- i. clinically appropriate, in terms of type, frequency, extent, site, and duration, and effective for the patient's illness, injury, or disease; and
 - ii. in accordance with the medical treatment schedule and the provisions of R.S. 23:1203.1.
- b. To be medically necessary, a service must be:
- i. consistent with the diagnosis and treatment of a condition or complaint; and
 - ii. in accordance with the Louisiana medical treatment schedule; and
 - iii. not solely for the convenience of the patient, family, hospital or physician; and
 - iv. furnished in the most appropriate and least intensive type of medical care setting required by the patient's condition.
- c. Services not related to the diagnosis or treatment of a work related illness or injury are not payable under the workers' compensation laws and shall be the financial responsibility of the claimant, and in appropriate cases, his health insurance carrier.

4. Screening Tests

- a. A screening test not related to the on-the-job illness or injury is not covered under the workers' compensation law.
- b. A screening test may be defined as a diagnostic procedure or test which is performed for a claimant in the absence of, or regardless of, his/her presenting sign(s), complaint(s), or symptom(s).
- c. Although screening tests may reflect good medical practice, such tests are not covered under the Workers' Compensation Program if not specifically related to the on-the-job illness or injury. For example, a standard battery of laboratory tests ordered without regard to a specific symptom or diagnosis consistent with the reported on-the-job illness or injury, is considered nonpayable screening.
- d. Payment for such test(s) shall be an enforceable obligation against the claimant and, in appropriate cases, his health insurance carrier, but shall not be an enforceable obligation against the employer or insurer.

5. Confidentiality. When it is necessary to request additional information to clarify the need for services or substantiate coverage for a claim being reviewed, the carrier/self-insured employer must take particular care to ensure that all of its employees adhere to strict policy guidelines regarding claimant privacy. The carrier/self-insured employer shall require only sufficient information to allow a reviewer to make an independent judgement regarding diagnosis and treatment. Intimate details in a claimant's records are neither necessary nor desired, and are specifically protected by law.

6. General Documentation Requirements. The determination of appropriate reimbursement requires adequate documentation of services. The following items establish the minimum documentation requirements prior to payment.

a. Documentation for all services must be legible and signed by the health care provider, i.e., date(s) of service, type of surgery where applicable, diagnosis (not a list of symptoms).

b. Submitted documentation must contain sufficient data to substantiate the diagnosis and need for treatment on each date of service.

c. To substantiate medical necessity:

i. it is essential to report the most complete and precise diagnosis(es) on the claim form;

ii. service(s) billed should be appropriate for the diagnosis;

iii. documentation in the clinical record (i.e., physical findings and historical data) should confirm the diagnosis and support the medical necessity and appropriateness of the service billed; and

iv. documentation should be available for each service billed.

d. The maintenance of adequate and accurate clinical records is a requirement for all physicians and hospitals. Documentation should be complete, including positive as well as negative findings, and should be recorded in a timely manner.

7. Detection. The carrier/self-insured employer detects the misuse of benefits through routine claims review, computer analysis, claims audit and the investigation of complaints. The carrier shall conduct such reviews and analysis on an ongoing basis and shall investigate all complaints in a timely manner. Referrals of appropriate cases may be made to the Office of Workers' Compensation Medical Review staff.

8. Prepayment and Postpayment Claim Review. A practitioner's or provider's claims may be selected for review by the Office of Workers' Compensation if utilization review procedures detect a pattern of over-utilization of services. If a review indicates a possible overuse or misuse of services, the practitioner or provider will be notified in writing that he or she will receive a request for additional information on a sampling of submitted claims.

9. Referrals. The Office of Workers' Compensation medical review staff will investigate complaints from claimants, carriers, employers, physicians, other practitioners, and health care facilities, inquiries from the press or government agencies, referrals from other internal areas of the Office of Workers' Compensation, and even leads from various media sources (e.g., newspapers) if in the judgement of the medical manager such investigation is warranted. In appropriate cases, the Office of Workers' Compensation will refer evidence of over-utilization to the various licensing authorities.

D. Professional Justification

1. Medical Necessity. All claims submitted for payment to the carrier/self-insured employer must be reviewed for medical necessity and for compliance with the medical treatment schedule and the provisions of R.S. 23:1201.1. Medical necessity implies the use of technologies* services, or supplies provided by a hospital, physician, or other provider that is determined to be:

a. medically appropriate for the symptoms and diagnosis or treatment of the work-related illness or injury;

b. provided for the diagnosis or the direct care and treatment of the patient's illness or injury;

c. in accordance with the medical treatment schedule and the provisions of R.S. 23:1203.1; and

d. not primarily for the convenience of the patient, patient's family, practitioner or provider; and

e. the most appropriate level of service that can be provided to the patient.

2. Additional Medical Record Information. It is the responsibility of the claimant and provider to furnish all medical documentation needed by the carrier/self-insured employer to determine if the injury or illness is job related and if the services are medically necessary for the condition of the claimant (e.g., physician office record, hospital medical record, doctor's orders, treatment plan, vital signs, lab data, test results, nurses' notes, progress notes).

*The term *technology* refers to any medical or surgical treatment, medical or surgical device, therapeutic or diagnostic procedure, drug, biological, or therapeutic or diagnostic agent.

AUTHORITY NOTE: Promulgated in accordance with RS 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:263 (March 1991), repromulgated LR 17:653 (July 1991), amended by the Louisiana Workforce Commission, Office of Workers' Compensation, LR 38:1036 (April 2012), repromulgated LR 38:1293 (May 2012).

§2718. Utilization Review Forms

A. LWC Form 1010—Request of Authorization/Carrier or Self Insured Employer Response

LWC FORM 1010 - REQUEST OF AUTHORIZATION/CARRIER OR SELF INSURED EMPLOYER RESPONSE
PLEASE PRINT OR TYPE

SECTION 1. IDENTIFYING INFORMATION - To Be Filled Out By Health Care Provider			
Last Name: First: Middle:		Street Address, City, State, Zip:	
Social Security Number:	Date of Birth:	Phone Number:	Date of Injury:
Employers Name:		Street Address, City, State, Zip:	
Name:		Adjuster:	Claim Number (if known):
Street Address, City, State Zip:	Email Address:	Phone Number:	Fax Number:
SECTION 2. REQUEST FOR AUTHORIZATION - To Be Filled Out By Health Care Provider			
Requesting Health Care Provider		Phone Number:	Fax Number:
Street Address, City, State Zip:		Email:	
Diagnosis:		CPT/DRG Code:	ICD-9/DMS-4 Code:
Requested Treatment or Testing (Attach Supplement If Needed):			
Reason for Treatment or Testing (Attach Supplement If Needed):			
INFORMATION REQUIRED BY RULE TO BE INCLUDED WITH REQUEST FOR AUTHORIZATION - To Be Filled Out By Health Care Provider			
(Following is the required minimum information for Request of Authorization (LAC 40:2715 (C))			
<input type="checkbox"/> History provided to the level of condition and as provided by Medical Treatment Schedule <input type="checkbox"/> Physical Findings/Clinical Tests <input type="checkbox"/> Documented functional improvements from prior treatment <input type="checkbox"/> Test/imaging results <input type="checkbox"/> Treatment Plan including services being requested along with the frequency and duration			
I hereby certify that this completed form and above required information was <input type="checkbox"/> Faxed to the Carrier/Self Insured Employer on this the _____ day of _____ (month) (year)			
Signature of Health Care Provider: _____ Printed Name: _____			
SECTION 3. RESPONSE OF CARRIER/SELF INSURED EMPLOYER FOR AUTHORIZATION			
(Check appropriate box below and return to requesting Health Care Provider, Claimant and Claimant Attorney as provided by rule)			
<input type="checkbox"/> The requested Treatment or Testing is approved <input type="checkbox"/> The requested Treatment or Testing is approved with modifications (Attach summary of reasons and explanation of any modifications) <input type="checkbox"/> The requested Treatment or Testing is denied because			
<input type="checkbox"/> Not in accordance with Medical Treatment Schedule or R.S.23:1203.1(D) (Attach summary of reasons) <input type="checkbox"/> The request, or a portion thereof, is not related to the on-the-job injury <input type="checkbox"/> The claim is being denied as non-compensable <input type="checkbox"/> Other (Attach brief explanation)			
I hereby certify that this response of Carrier/Self Insured Employer for Authorization was <input type="checkbox"/> Faxed to the Health Care Provider (and to the Attorney of Claimant if one exists, if denied or approved with modification) on this the _____ day of _____ (month) (year)			
Signature of Carrier/Self Insured Employer: _____ Printed Name: _____			
<input type="checkbox"/> The prior denied or approved with modification request is now approved			
I hereby certify that this response of Carrier/Self Insured Employer for Authorization was <input type="checkbox"/> Faxed to the Health Care Provider and Attorney of Claimant if one exists on this the _____ day of _____ (month) (year)			
Signature of Carrier/Self Insured Employer: _____ Printed Name: _____			

Signature of Carrier/Self Insured Employer:		Printed Name:	
SECTION 4. FIRST REQUEST (Form 1010A is required to be filled out by Carrier/Self Insured Employer and Health Care Provider)			
<input type="checkbox"/> The requested Treatment or Testing is delayed because minimum information required by rule was not provided			
I hereby certify that this First Request and accompanying Form 1010A was		<input type="checkbox"/> Faxed to the Health Care Provider on this the _____ day of _____, _____	
Signature of Carrier/Self Insured Employer:		<input type="checkbox"/> Emailed (day) (month) (year)	
I hereby certify that a response to the First Request and accompanying Form 1010A was		<input type="checkbox"/> Faxed to the Carrier/Self Insured Employer on this the _____ day of _____, _____	
Signature of Health Care Provider:		<input type="checkbox"/> Emailed (day) (month) (year)	
SECTION 5. SUSPENSION OF PRIOR AUTHORIZATION DUE TO LACK OF INFORMATION Suspension of Prior Authorization Process due to Lack of Information			
<input type="checkbox"/> The requested Treatment or Testing is delayed due to a Suspension of Prior Authorization Due to Lack of Information			
I hereby certify that this Suspension of Prior Authorization was		<input type="checkbox"/> Faxed to the Health Care Provider on this the _____ day of _____, _____	
Signature of Carrier/Self Insured Employer:		<input type="checkbox"/> Emailed (day) (month) (year)	
Appeal of Suspension to Medical Services Section by Health Care Provider			
I hereby certify that this form and all information previously submitted to Carrier/Self Insured Employer was faxed to OWCA Medical Services (Fax Number: 225-XXX-XXXX) this _____ day of _____, _____.			
I hereby certify that this Appeal of Suspension of Prior Authorization was		<input type="checkbox"/> Faxed to the Carrier/Self Insured Employer on this the _____ day of _____, _____	
Signature of Health Care Provider:		<input type="checkbox"/> Emailed (day) (month) (year)	
SECTION 6. DETERMINATION OF MEDICAL SERVICES SECTION			
<input type="checkbox"/> The required information of LAC40:2715(C) was not provided			
<input type="checkbox"/> The required information of LAC40:2715(C) was provided			
I hereby certify that a written determination was		<input type="checkbox"/> Faxed to the Health Care Provider & Carrier/Self Insured Employer on this the _____ day of _____, _____	
Signature:		<input type="checkbox"/> Emailed (day) (month) (year)	
SECTION 7. HEALTH CARE PROVIDER RESPONSE TO MEDICAL SERVICES DETERMINATION			
I hereby certify that additional information, pursuant to the determination of Medical Services Section, was		<input type="checkbox"/> Faxed to the Carrier/Self Insured Employer on this the _____ day of _____, _____	
Signature of Health Care Provider:		<input type="checkbox"/> Emailed (day) (month) (year)	

B. LWC Form 1010A—First Request

LWC FORM 1010A - FIRST REQUEST
PLEASE PRINT OR TYPE

P A T I E N T	SECTION 1. IDENTIFYING INFORMATION		
	Last Name: First: Middle:	Social Security Number:	
C A R R I E R	Employers Name:		Claim Number (if known):
	SECTION 2. CARRIER/SELF INSURED EMPLOYER'S FIRST REQUEST FOR REQUIRED MINIMUM INFORMATION		
P R O V I D E R	I have received a request for authorization for the above referenced matter and have determined it lacks the required minimum information of 40:2715(C) - Please check all that apply		
	<input type="checkbox"/> History provided to the level of condition and as provided by Medical Treatment Schedule		
	<input type="checkbox"/> Physical Findings/Clinical Tests		
	<input type="checkbox"/> Documented functional improvements from prior treatment		
	<input type="checkbox"/> Test/imaging results		
	<input type="checkbox"/> Treatment Plan including services being requested along with the frequency and duration		
COMMENTS (Please provide a detailed explanation in support of your First Request)			
SECTION 3. HEALTH CARE PROVIDER RESPONSE TO FIRST REQUEST			
<input type="checkbox"/> Additional information has been provided - Attach Supporting Documentation			
<input type="checkbox"/> Additional information has not been provided - Provide explanation below			
EXPLANATION			

AUTHORITY NOTE: Promulgated in accordance with RS 23:1291.

HISTORICAL NOTE: Promulgated by the Louisiana Workforce Commission, Office of Workers' Compensation, LR 38:1037 (April 2012).

§2719. Instructions for On-Site Audit of Hospital Charges by Workers' Compensation Carrier

A. The carrier is authorized to conduct an on-site audit of hospital services related to a compensable injury or illness. This is accomplished by a line-by-line examination of billed charges, comparing the doctor's orders with supporting medical documentation in the patient's chart and the corresponding departmental records.

B. The following audit guidelines will be followed by hospitals and carrier/self-insured employer. Disputes between the carrier/self-insured employer and hospitals will be referred to the Office of Workers Compensation for final resolution.

1. Carrier/Self-Insured Employer Responsibilities

a. The claims to be audited should be identified as quickly as possible after the carrier/self-insured employer receives the claim.

b. The carrier/self-insured employer or its audit agency should give 10 calendar days advance notice to the hospital of its desire to perform an audit. The carrier/self-insured employer or its audit agency should make an appointment to do the audit at the time that is mutually agreed to by both parties. At the time the appointment is made, the hospital shall be informed of:

- i. the name(s) of patient(s) whose records are to be audited;
- ii. the admission and discharge dates for each case;
- iii. the medical record numbers and billing numbers of the claims to be audited, as assigned by the hospital, if those appear on the claim;
- iv. the name(s) of the auditor(s) who will conduct the audit, if available, and the name of the audit firm if the carrier/self-insured employer is contracting for auditing services;
- v. the portion of the bill to be audited (i.e., drugs, respiratory therapy, etc.) if the entire bill is not to be audited.

c. Qualified individuals familiar with hospital billing practices, medical terminology and medical record charting must be used to perform the billing audit.

d. Auditors must be properly authorized and identified as representatives of the carrier/self-insured employer or its audit agency.

e.i. Recognizing that no single standard exists for the payment of hospital bills prior to audit, or for audit fees charged by hospitals, the Office of Workers' Compensation recommends the following guidelines.

(a). The carrier/self-insured employer should pay at least 80 percent of billed charges prior to the audit. If an audit fee is charged by the provider, it should not exceed \$50 per patient record plus copy charges as provided below.

(b). The carrier/self-insured employer will reimburse the hospital for copies of medical records at the following rates: Fees will not exceed \$15 per record for 1-20 pages, and \$0.30 per page for records in excess of 20 pages. Microfilm copies will not exceed \$0.50 per page.

ii. Should the carrier/self-insured employer and hospital not be able to agree to this standard or some other standard, either party may submit the dispute to the Office of Workers' Compensation Administration in the same manner and subject to the same procedures as established for dispute resolution of claims for workers' compensation benefits.

f. Auditors should itemize specific unsupported charges and unbilled charges found on hospital bills. The final audit findings will offset unbilled charges against unsupported charges in a reconciliation process to be completed by the carrier/self-insured employer after receiving the audit report which should include a listing of all unbilled charges and unsupported billings.

g. Auditors should conduct exit interviews with a hospital's audit coordinator and/or other appropriate hospital personnel prior to leaving to permit the review of the preliminary audit results before issuing a final report. If the exit interview is waived by the hospital, this fact should be indicated in writing.

h. A written report of the final audit results should be sent to all interested parties in a timely fashion.

2. Hospital Responsibilities

a. Hospitals must schedule an appointment to audit a bill promptly upon the receipt of a request for such an appointment, at a time mutually agreed upon by the hospital and the carrier/self-insured employer or its audit agency no later than 10 days from receipt of request.

b. Hospitals should respond promptly to a request for an itemized bill from the carrier/self-insured employer or its agent.

c. Hospitals should respond promptly to requests for additional information on the period of hospitalization, including information from the medical record and from the billing office.

d. Hospitals should designate one individual to be responsible for coordinating all hospital audit activities, and act as a liaison between provider personnel and the carrier/self-insured employer. This would include informing appropriate hospital departments of pending audits and audit results, answering carrier/self-insured employer questions, insuring that a late charge bill is sent to the patient or carrier/self-insured employer, issuing a refund to the appropriate party, etc. After notice of a proposed audit has been received by the hospital, this individual should coordinate between the medical records department and the billing office to insure that medical records, financial records, and any other documentation needed to substantiate charges are provided and available for the audit.

e. The hospital liaison shall acquaint the carrier/self-insured employer representative or audit agent with its record system and charging practices.

f. All substances administered to the patient in any form, as well as all treatments or medical services, must be specifically and accurately documented.

g. The hospital's representative will be available to the carrier/self-insured employer to conduct an exit interview. Discrepancies will be reviewed, resolved, and agreed upon by both parties. This will be done by written confirmation of the unbilled and/or undocumented charges identified during the audit and signed by both parties. In the event that same day resolution is not possible, the hospital, in a timely manner, should resolve differences in any unsupported or unbilled amounts resulting from the audit.

h. The hospital should issue refunds promptly if overcharges and/or undocumented charges exceeding the balance of the carrier/self-insured employer liability are discovered during the audit.

i. Hospitals may not bill for undocumented charges discovered during the bill audit process. However, hospitals may bill for documented and previously unbilled charges discovered during the bill audit process, for charges in excess of the audit fee charged by the hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:263 (March 1991), repromulgated LR 17:653 (July 1991).