



State of Michigan
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PROFESSIONAL REVIEW POLICY

TO: All Carriers, Service Companies, and Review Companies
FROM: Health Care Services Division
DATE: June 10, 2009
SUBJECT: Requirements for Professional Review Certification Methodology

The Health Care Services rules require that the Health Care Services Division of the Workers' Compensation Agency certify the carrier's professional review program. This certification is renewable every three years or whenever a change in the review process occurs. The purpose of professional review is to ensure that services are related to the covered work injury and that the carrier is reimbursing for medically necessary and appropriate medical care in accordance with section 315 of the Workers' Disability Compensation Act and the Health Care Services Rules. The General Provisions of the rules, R418.10101, establish that carriers will review the quality and quantity of medical services, based on accepted medical standards. This rule also allows carriers to dispute services that are not medically appropriate or related to the covered work injury.

The certification process requires that the carrier submit their review methodology to Health Care Services every three years. If in a three-year period there is a change in service company, review company or review process, then a new application, WC-590, is necessary to remain in compliance. The methodology **need not** be included with the application if it is already on file and current with the Health Care Services division.

The methodology should include documentation of compliance with Part 12 and Part 13 of the Health Care Services Rules. Also required is a copy of the EOB (WC-739) sent to providers and the injured worker. The Health Care Services sample of the Carrier's Explanation of Benefits is available on this website. Health Care Services must approve any variance from this form.

Failure to submit methodologies may result in a conditional approval or disapproval for the carrier (R418.101207).

The **elements necessary** to include in the **technical review** section of the methodology (R418.101203) are:

- Determine accuracy of coding. Any reason for recoding a procedure shall be communicated to the provider within 30 days of receipt of the bill under Part 13 of the Health Care Services Rules.
- Determine that the amount paid for a procedure does not exceed the maximum allowable payment established by the rules. The **carrier** is totally responsible for the technical computer review, even if performed by a designated agent, and this review must be performed in accord with the rules. Include the name of the software program used in technical review when appropriate.
- Identify those bills and case records which, under R 418.101205, shall be subject to professional health care review.

Necessary elements to include in the **professional review** section of the methodology (R418.101204) are:

- **Non-clinical Staff:** Non-clinical staff (R 418.101204 (5b)) may be used in the application of criteria (based on sound clinical principles and processes) developed by licensed, registered, or certified health care professionals in the review process. They may not gather data that requires evaluation or interpretation of clinical information. Their duties must have oversight by a licensed health professional. They must be properly trained in the principles and procedures of structured clinical data, scripted clinical screening, and maintenance of confidentiality of patient-specific information. A mechanism to promptly move any call to a licensed health professional must be in place in the event the review cannot be completed based on the outlined criteria.
- **Professional (Utilization) Review:** Outline compliance with R 418.101205. Medical claims review demonstrates that the review is retrospective, and is performed strictly for purposes of reimbursement. The review may include determining medical necessity, appropriateness and efficiency of services, coding accuracy, coverage issues and appropriateness of billing. An RN or other licensed professional with suitable occupational injury and/or disease expertise must perform professional review and be involved in determining the carrier's response to a request by a provider for reconsideration of its bill. There must be support by a doctor of medicine or a doctor of osteopathic medicine in the professional review process.
- **Peer Review:** Peer review may be performed when the claims are initially submitted. Peer clinical review is usually done in cases where clinical determination to approve claim payments cannot be made by initial clinical review. Either a carrier or the physician may request a peer review if the outstanding claim issues are not resolved through the written reconsideration process. Peers must have suitable occupational injury or disease expertise, or both, to render an informed clinical judgment on the medical appropriateness of the services provided. They must be in the same licensure category as the ordering provider or a doctor of medicine or doctor of osteopathic medicine.
- **Licensure:** For each licensed individual doing professional review and peer review for the carrier, submit documentation with the full name, professional license number, state of issue, date of expiration and any restrictions on current licensure. Include the same documentation on the medical/clinical director supporting reviewers. It is encouraged that any certification in bill review, utilization management (e.g., URAC, etc.) or personnel having any utilization management/review credentialing (e.g., CCM, CPUR) be included.
- **Reconsideration/Appeals:** Document the process (with time lines) used when a carrier, or their designated agent, adjusts or rejects a bill or a portion of the bill. Notification shall include an explanation of the appeal process provided under the Health Care Services Rules, including the fact that a magistrate of the Department of Energy, Labor & Economic Growth shall conduct any requested administrative appeal hearing. (R 418.101301-101305).
- **Confidentiality:** Document the process in place that ensures confidentiality of worker-specific and provider-specific information.

REMINDER: Claims may not be denied solely on the basis that no prior authorization was obtained. Michigan law does not mandate case management and does not require prior authorization of services.

IT IS THE CARRIER'S RESPONSIBILITY FOR SIGNING THE APPLICATION FOR CERTIFICATION OF A CARRIER'S PROFESSIONAL HEALTH CARE REVIEW PROGRAM APPLICATION (WC-590).

If you have any questions regarding the above information or requirements please call Billie Newsom in the Health Care Services Division at (313) 456-3659.

Attachment

APPLICATION FOR CERTIFICATION OF A CARRIER'S PROFESSIONAL HEALTH CARE REVIEW PROGRAM

Michigan Department of Energy, Labor & Economic Growth
Workers' Compensation Agency
Health Care Services Division
PO Box 30016, Lansing, Michigan 48909

Date of Application	Initial <input type="checkbox"/>	Renewal <input type="checkbox"/>
Note: A new application must be submitted whenever there is a change in carrier, service company, or review company.		

This form is required in accordance with Part 12, R 418.101206 of the Workers' Compensation Health Care Services Rules to receive certification of a carrier's professional review program.

I. CARRIER

Carrier	Service Company	Review Company
NAIC No., Self-Insured No., or FEIN	Agency Assigned Number	Employer Identification
Name	Name	Name
Address (Street)	Address (Street)	Address (Street)
City, State, Zip Code	City, State, Zip Code	City, State, Zip Code
Telephone No. (Include area code)	Telephone No. (Include area code)	Telephone No. (Include area code)
Contact Person and Email Address	Contact Person and Email Address	Contact Person and Email Address

II. METHODOLOGY/REVIEW STAFF AND CREDENTIALS

Attach methodology, according to the workers' comp agency procedure, used to perform a carrier's professional review.

R 418.101204(5)(a)-(c) requires that medical appropriateness of services shall be determined through one of the following approaches:

- 1) Review by licensed, registered, or certified health care professionals.
- 2) The application by others of criteria developed by licensed, registered, or certified health care professionals.
- 3) A combination of (1) and (2) according to the type of covered injury or illness.

The methodology should include a list of all licensed, registered, or certified health care professionals reviewing case records and medical bills for the above carrier. Provide current licensure information (license #, state of issue, date of expiration and restrictions) and qualifications for medical bill review. In addition, include a list of all peer reviewers with current license information and specialty.

*When a service company submits applications for numerous self-insured employers, and the methodology is identical, it is not necessary to submit the professional review methodology more than once. The Workers' Compensation Agency will maintain on file, the review methodology for each service company.

**Methodology for professional certification must be submitted once every three years or whenever changes occur.

III. AUTHORIZED SIGNATURE

By signing this form, I certify that the information included on this form is correct and complete to the best of my knowledge and that the professional review methodology is attached or has already been submitted by the service company and/or their designated agent. I understand that submitting false information is cause for denial of the application or will subject me to penalties as provided by law.

Authorized Signature (In Ink)	Authorized Name and Email Address (Typed)	Date
Alternate Person Name	Alternate Email Address	Alternate Telephone Number

DELEG is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Copy 1 Provider
 Copy 2 Carrier
 Copy 3 Employee

Carrier's Explanation of Benefits

Michigan Department of Energy, Labor & Economic Growth
 Workers' Compensation Agency
 Health Care Services Division

Date processed
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DIRECT ALL PAYMENT INQUIRIES AND REQUESTS FOR RECONSIDERATION TO THE CARRIER

Carrier Name			Service Company			NAICS/Self-Insured		
Street Address			City	State	Zip Code	Telephone Number		
Employer Name						Claim Number		
Provider Name				Employee Name				
Street Address				Street Address				
City			State	Zip Code	City		State	Zip Code
National Provider Identification Number (NPI)/FEIN Number*				Social Security Number *				
Patient Account Number				Date of Injury	Date of the Provider Bill	Date bill received by Carrier		
PROVIDER: IF YOU INTEND TO SEEK RECONSIDERATION, PLEASE CONTACT THE CARRIER INDICATED ABOVE WITHIN 60 CALENDAR DAYS OF RECEIPT OF THIS NOTICE. IF ADDITIONAL INFORMATION IS REQUESTED, PLEASE FORWARD THE INFORMATION TO THE CARRIER.				EMPLOYEE: FOR INFORMATION ONLY. THIS IS NOT A BILL. IF YOU ARE BILLED FOR ANY SERVICES RELATED TO THIS WORKERS' COMPENSATION CLAIM, DO NOT PAY. DO CALL THE CARRIER LISTED ABOVE.				
Date of Service	Place of Service	Procedure Code and Modifier	Description--If Needed	Diagnosis Code	Days or Units	Charge	Payment	Note
<h1 style="color: gray; opacity: 0.5;">THIS IS NOT A BILL</h1>								
Provider/Employee: R 418.10105 and R 418.101301(3) of the Workers' Compensation Health Care Services Rules require that the carrier notify the employee and the provider that the rules prohibit a provider from billing an employee for any amount for health care services provided for the treatment of a covered work-related injury or illness when that amount is disputed by the carrier pursuant to its utilization review program or when the amount exceeds the maximum allowable payment established by these rules. The carrier shall request the employee to notify the carrier if the provider bills the employee.							Total Charge	Payment

This form is required as set forth in Part 1, R 418.10117 (4), Part 10, R 418.101001 (4) and Part 13, R 418.101301 (1) of the Workers' Compensation Health Care Services Rules.

***PROTECTED INFORMATION TO BE USED FOR IDENTIFICATION PURPOSES**

DELEG is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.