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June 27, 2006

I appreciate this opportunity to address the Medical Cost Containment Committee. The following is my personal commentary concerning the proposed changes to 34 PA. CODE CH. 127 both as a health care provider and as a principal in a state certified Utilization Review Organizations (URO).

My experience includes teaching certification courses throughout the country in peer and utilization review on the post-graduate level and the development and implementation of the precertification system utilized by Independence Blue Cross for several years.

Review of the proposed changes in its entirety reveals a fundamental change in the manner in which injured workers will access healthcare and the manner in which treatment for an injured worker will be reviewed. Also, there are proposed changes that may increase bias in the review system.

First, it is apparent that workers' compensation will enter the managed care arena. (*§ 127.822).*

Until now, utilization review under the Act was essentially retrospective in nature. Although there are request to review prospective treatment, due to the requirements of the Act (obtaining records, sending the case to a reviewer, etc.) the review is not done and cannot be done in "real time". Please note that the "prospective" reviews presently performed require retrospective review to determine the reasonableness and necessity of the prospective treatment. At present, the process takes approximately 65 days.

There are proposed changes that will shorten the aforementioned (127.851, 127.862, etc.), but these time frames are clearly too long in a precert/recert scenario.

"The Department proposes adding § 127.822 (relating to precertification--insurer obligations) to provide prerequisites for precertification, including requirements that the employee or provider first request preauthorization from the responsible insurer and that the responsible insurer respond to the employee's or provider's request. The Department proposes this provision to provide a streamlined mechanism for employees and providers to receive preapproval of treatment options."

I am concerned that an injured worker will need to wait a lengthy period of time in order to obtain precertification for a course of treatment.

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For example,

- § 127.824 (relating to precertification--employee-filed requests) to require UROs that receive employee-filed requests for precertification to contact the provider whose potential treatment is the subject of review and to request from that provider the treatment plan, procedure or referral relevant to the treatment under review **within 10 days of the request** (emphasis added).
- § 127.825 (relating to assignment of proper requests for precertification) to permit the Bureau to assign requests for precertification to UROs in accordance with the provisions of this subchapter. *(Presently takes a total of several days for the Bureau to assign the URO and for the URO to begin the review process).*
- § 127.857 (relating to obtaining medical records--other treating providers) to require that UROs request records from all treating providers in writing and eliminating the provision in the prior regulations that permitted records to be requested telephonically. (*This will add more days to the process if used for precert*)

The "streamlined mechanism" is not delineated in 127.822 and this section only requires that the "*insurer respond to the employee's or provider's request.*" If the proposed changes do not delineate exact time frames for a timely response to a request for treatment, I am very concerned that an injured worker will wait an unreasonable period of time before being able to initiate restorative care. By extending the length of time between the injury and the initiation of treatment, inflammation will build up, further injury will occur and the overall duration of treatment will be extended. Clearly, this would not be good for the worker or the carrier.

In my opinion, what would be required to be timely here is for the carriers/third party payors, etc. to develop a precertification system to be used internally to preauthorize/reauthorize treatment plans. When a treatment plan is denied, then referral to the BWC for assignment to the URO would be appropriate. This would be similar, in part, to Act 68's use of the Independent Review Organization (IRO).

In this scenario, the worker would most probably be afforded a reasonable level of initial care.

Secondly, of concern are the changes in the manner in which a review is performed. For example:

§ 127.864 (relating to duties of reviewers--generally) … *that reviewers assume the existence of a causal relationship between the treatment and the work injury.* But 127.805a states *"to provide a means for review of medical treatment prior to formal acceptance of a claim for benefits under the act".*

COMMENTS BY DR. ARMINE ON PROPOSED CHANGES TO 34 PA CODE PAGE 3

127.805a appears to be a mechanism to determine causality when 127.864 appears to expressly forbid determining causality. This apparent dichotomy needs to be clarified, in my opinion.

It is noted that the same requirements for the content of the review reports are restated in the proposed regulation changes (127.864-127.868).

From experience, I would like to share with the committee that the reviewers find the report requirements cumbersome. As we are asking very busy physicians to author exacting reports in a rigid timeframe this has led to a dwindling of the overall pool of reviewers.

It appears that the reviewers will be required to meet the same report writing criteria for the preauthorization/reauthorization section as well as the remainder of the utilization review system (concurrent/prospective review) with a shortened timeframe.

I am concerned that this scenario will further diminish the pool of reviewers, as producing adequate reports in the proposed abbreviated timeframe will be difficult. This may create bias in the system as there will only be a few reviewers handling the bulk of the reviews in the Commonwealth. It is noted that 127.865 will allow reviewers to address treatment upon redetermination or recertification even though they may have previously addressed treatment relating to the same matter. Presently, this is not allowed which affords the injured worker the benefit of not having the same reviewer look at his/her case multiple times.

A reviewer who performs a significant number of these reviews will inherently appear biased.

This can be mitigated by abbreviating the report requirements for precert/recert and only requiring the full report requirements upon retrospective review. This would have the dual effect of a quicker turnaround time for preauthorization and allowing the UROs to expand their reviewer base via easing the burden of the report protocol.

An increase in the reviewer pool will inherently benefit the injured worker by eliminating as much actual or perceived bias as possible.

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The Department proposes adding § 127.1051 (relating to authorization of UROs/PROs) to provide that the Bureau may authorize UROs/PROs through contracts awarded under 62 Pa.C.S. Part I (relating to Commonwealth Procurement Code). The Department further proposes that the Bureau will not be required to award a contract to every offeror that submits a proposal that meets the minimum requirements established by the request for proposal.

I am led to believe that 127.1051 will require the use of a sealed bidding system in the authorization/reauthorization process for UROs/PROs. This concerns me for the following reasons.

- It is my opinion that the BWC should publish the requirements that it desires in a URO (URAC certification, etc.) so that UROs wishing to be certified or wishing to continue in the system can work toward these goals.
- This section may result in a vast reduction in the number of UROs. Couple this with the aforementioned dwindling reviewer pool will geometrically increase the perceived/actual bias in the review system.

Hypothesize that there are only 2-3 URO's that utilize the same two or three D.O./anesthesiologists to perform all the prospective, concurrent and retrospective reviews in the Commonwealth. It is my opinion that, upon appeal of denied care the Workers' Compensation Judges will most likely side with the injured worker due to the perceived bias of the reviewer.

Thank you again for allowing me to present my opinion.

Sincerely,

Jess P. Armine, RN, DC

Gelnett, Wanda B.

From: Wunsch, Eileen [ewunsch@state.pa.us]
Sent: Wednesday, June 28, 2006 12:38 PM
To: Henneman, Karla
Cc: Kupchinsky, John; Kuzma, Thomas J. (GC-LI); Howell, Thomas P. (GC-LI)
Subject: FW: URAC WC Management Standards

Karla,

More from Jesse Armine that needs to be printed and logged in.

Eileen K. Wunsch, MS, CPIW, ARM
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-----Original Message-----
From: Jess Armine [mailto:thebeardoc@hotmail.com]
Sent: Wednesday, June 28, 2006 12:35 PM
To: gveno@pachiropracticassn.org; docengle@dejazzd.com; ewunsch@state.pa.us
Subject: URAC WC Management Standards

Dear Eileen, Walt and Gene,

As a follow-up to my comments/concerns on the proposed rule changes, I have obtained a copy of the 2006 URAC Workers Compensation Utilization Management Standards (see attached). Pages 14 and 15 have the required time frames form prospective, concurrent and retrospective review. You will kindly note that the proposed rule changes do not meet these standards in their present form.

Please add this document as supporting material for my commentary.

Thanks!

Jess

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Workers' Compensation Utilization Management Standards

Version 4.0

URAC, an independent, nonprofit organization, is well-known as a leader in promoting health care quality through its accreditation and certification programs. URAC offers a wide range of quality benchmarking programs and services that keep pace with the rapid changes in the health care system, and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry.

For more information about this accreditation program or URAC's other activities, please visit www.urac.org, or call (202) 216-9010.

Important: To achieve URAC Workers' Compensation UM Accreditation, an organization must comply with both URAC's Core Standards and Workers' Compensation UM Standards. Both sets of standards are included in this document.

Important: This document is intended to provide a basic understanding of the accreditation standards. It does not include interpretive information, scoring information, or other guidance necessary for a detailed understanding of the standards and the accreditation process. This information is contained in the Program Guide for this accreditation program, which may be purchased on URAC's Web site at www.urac.org, or by calling (202) 216-9010.

Note: Defined terms appear in *italics* throughout this document. A definitions section follows the standards.

Core Standards

Version 2.0

Organizational Structure

Core 1 – Organizational Structure

The *organization* has a clearly defined organizational structure outlining direct and indirect oversight responsibility throughout the organization.

Core 2 – Organization Documents

Organization's documents address:

(a) Mission statement;
(b) Organizational framework for program;
(c) A description of the services delivered by the *organization* and how those services are delivered;
(d) The population served; and
(e) Organizational oversight and reporting requirements of the program.

Policies and Procedures

Core 3 – Policy and Procedure Maintenance, Review, and Approval

The *organization*:

(a) Maintains and complies with written policies and procedures that govern all aspects of its operations;
(b) Maintains a master list of all such policies and procedures;
(c) Reviews policies and procedures no less than annually and revises as necessary; and
(d) Includes the following on all policies and procedures:
    (i) Effective dates, review dates, including the date of the most recent revision; and
    (ii) Identification of approval authority.

Staff Qualifications

Core 4 – Job Descriptions

The *organization* has written job descriptions for *staff* that address:

(a) Required education, training, and/or professional experience;
(b) Expected professional competencies;
(c) Appropriate licensure/certification requirements; and
(d) Scope of role and responsibilities.

Core 5 – Staff Qualifications

Staff meets qualifications as outlined in written job descriptions.

Core 6 - Credentialing

The *organization* implements a policy to:

(a) Verify the current licensure and credentials of licensed or certified personnel/consultants upon hire, and thereafter no less than every 3 years;
(b) Require staff to notify organization in a timely manner of an adverse change in licensure or certification status; and
(c) Implement corrective action in response to adverse changes in licensure or certification status.

Staff Management

Core 7 – Staff Training Program

The *organization* has a training program that includes:

(a) Initial orientation and/or training for all *staff* before assuming assigned roles and responsibilities;
(b) Ongoing training, at a minimum annually, to maintain *professional competency*;
(c) Training in URAC Standards as appropriate to job functions;
(d) Training in state and regulatory requirements as related to job functions;
(e) Conflict of interest;
(f) Confidentiality;
(g) *Delegation* oversight, if necessary; and
(h) Documentation of all training provided for *staff*.

Core 8 – Staff Operational Tools and Support

The *organization* provides *staff* with:

(a) Written operational policies and procedures appropriate to their jobs; and
(b) *Clinical decision support tools* as appropriate.

Core 9 – Staff Assessment Program
The *organization* maintains a formal assessment program for individual *staff* members that includes an annual performance appraisal and a review of relevant documentation produced by that individual staff member.

Clinical Oversight

Core 10 – Senior Clinical Staff Requirements
The *organization* designates at least one senior clinical *staff* person who has:
(a) Current, unrestricted clinical *license(s)* (or if the *license* is restricted, the *organization* has a process to ensure job functions do not violate the restrictions imposed by the State Board);
(b) Qualifications to perform clinical oversight for the services provided; and
(c) Post-graduate experience in direct patient care; and
(d) *Board certification* (if the senior clinical *staff* person is an M.D. or D.O.).

Core 11 – Senior Clinical Staff Responsibilities
The senior clinical *staff* person:
(a) Provides guidance for all clinical aspects of program;
(b) Is responsible for clinical aspects of program; and
(c) Has periodic consultation with practitioners in the field.

Inter-Departmental Coordination

Core 12 – Inter-departmental Coordination
The organization establishes and implements mechanisms to promote collaboration, coordination, and communication across disciplines and departments within the organization, with emphasis on integrating administrative activities, quality improvement, and where present, clinical operations.

Information Management

Core 13 - Information Management
The organization implements information system(s) (electronic, paper or both) to collect, maintain, and analyze information necessary for organizational management that:
(a) Provides for data integrity;
(b) Provides for data confidentiality and security;

(c) Includes a disaster recovery plan that;
  (i) Is tested at least every two years; and
  (ii) Addresses identified areas for improvement; and
(d) Includes a plan for storage, maintenance, and destruction.

Business Relationships

Core 14 – Business Relationships
The *organization* maintains signed *written agreements* with all *clients* describing the scope of the business arrangement.

Oversight of Delegated Functions

Core 15 – Delegation Review Criteria
The *organization* establishes and implements criteria and processes for an assessment prior to the *delegation* of functions.

Core 16 – Delegation Review
Prior to *delegating* functions to another entity, the *organization*:
(a) Conducts a review of the potential *contractor*'s policies and procedures and capacity to perform *delegated* functions; and
(b) Outlines and follows criteria and processes for approving *contractors*.

Core 17 – Delegation Contracts
The *organization* enters into *written agreements* with *contractors* that:
(a) Specify those responsibilities *delegated* to the *contractor* and those retained by the *organization*;
(b) Require that services be performed in accordance with the *organization*'s requirements and URAC standards;
(c) Require notification to the *organization* of any material change in the *contractor*'s performance of *delegated* functions;
(d) Specify that the *organization* may conduct surveys of the *contractor*, as needed;
(e) Require that the *contractor* submit periodic reports to the *organization* regarding the performance of its *delegated* responsibilities;
(f) Specify recourse and/or sanctions if the *contractor* does not make corrections to identified problems within a specified period;
(g) Specify the circumstances under which activities may be further *delegated* by the *contractor*, including any requirements for obtaining permission from the *organization* before any further *delegation*; and

(h) Specify that, if the *contractor* further *delegates* organizational functions, those functions shall be subject to the terms of the *written agreement* between the *contractor* and the *organization* and in accordance with URAC standards.

Core 18 – Delegation Oversight

The *organization* implements an oversight mechanism for *delegated* functions that includes:

(a) A periodic review (no less than annually) of the *contractor*'s policies and procedures and documentation of quality activities for related delegated functions;

(b) A process to verify (no less than annually) the *contractor*'s compliance with contractual requirements and policies and procedures; and

(c) A mechanism to monitor financial incentives to ensure that quality of care or service is not compromised.

Regulatory Compliance

Core 19 – Regulatory Compliance

The *organization* implements a regulatory compliance program that:

(a) Tracks applicable laws and regulations in the jurisdictions where the *organization* conducts business; and

(b) Ensures the *organization's* compliance with applicable laws and regulations.

Financial Incentives

Core 20 – Financial Incentive Policy

If the *organization* has a system for reimbursement, bonuses, or incentives to *staff* or health care providers based directly on *consumer* utilization of health care services, then the *organization* implements mechanisms addressing how the *organization* will ensure that *consumer* health care is not compromised.

Communications

Core 21 – Communication Practices

The *organization* follows marketing and communication practices that include:

(a) Mechanisms to clearly and accurately communicate information about services to *consumer* and *clients*;

(b) Safeguards against misrepresentations about the *organization*'s services;

(c) A formal process of inter-departmental review of marketing materials before dissemination; and
(d) Monitoring of existing materials for accuracy.

Core 22 – Consumer Communication Plan
The *organization* documents and has a mechanism for informing *consumers* and *clients* of their rights and responsibilities, including:
(a) How to obtain services; and
(b) How to submit a *complaint* or *appeal*.

Consumer Protection

Core 23 – Consumer Safety Mechanism
The *organization* has a mechanism to respond on an urgent basis to situations that pose an immediate threat to the health and safety of *consumers*.

Core 24 – Confidentiality of Individually-Identifiable Health Information
The *organization* establishes and implements a policy and procedure to protect the confidentiality of *individually-identifiable health information* that:
(a) Identifies how *individually-identifiable health information* will be used;
(b) Specifies that *individually-identifiable health information* is used only for purposes necessary for conducting the business of the organization, including evaluation activities;
(c) Addresses who will have access to *individually-identifiable health information* collected by the *organization*;
(d) Addresses oral, written, or electronic communication and records that are transmitted or stored;
(e) Address the responsibility of *organization* employees, committee members, and board members to preserve the confidentiality of *individually-identifiable health information*; and
(f) Requires employees, committee members, and board members of the *organization* to sign a statement that they understand their responsibility to preserve confidentiality.

Consumer Satisfaction

Core 25 – Consumer Satisfaction
The *organization* implements a mechanism to collect or obtain information about *consumer* satisfaction with services provided by the *organization*.

Access To Services

Core 26 – Access to and Monitoring of Services

The *organization*:

(a) Establishes standards to assure that *consumers* or *clients* have access to services: and

(b) Defines and monitors its performance with respect to the access standards.

Complaints And Appeals

Core 27 – Complaint and Appeal System

The *organization* maintains a system to receive and respond in a timely manner to *complaints* and, when appropriate, inform *consumers* of their rights to submit an *appeal*.

Core 28 – Appeal Process

The *organization* maintains a formal *appeal* resolution process that includes:

(a) Written notice of final determination with an explanation of the reason for the determination;

(b) Notification of the process for seeking further review, if available; and

(c) A reasonable, specified time frame for resolution and response.

Core 29 – Complaint and Appeal Reporting

The *organization* reports analysis of the *complaints* and *appeals* to the quality management committee (see Core 33).

Quality Improvement/Management

Core 30 – Quality Management Program

The *organization* maintains a *quality management program* that promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon the findings.

Core 31 – Quality Management Program Resources

The *organization* employs *staff* and provides resources necessary to support the day-to-day operations of the *quality management program*.

Core 32 – Quality Management Program Requirements

The *organization* has a written description for its *quality management program* that:

(a) Is approved by the *organization's* governing body;

(b) Defines the scope, objectives, activities, and structure of the *quality management program*;

(c) Is reviewed and updated by the quality management committee at least annually;

(d) Defines the roles and responsibilities of the quality management committee; and

(e) Designates a member of senior management with the authority and responsibility for the overall operation of the *quality management program* and who serves on the quality management committee.

Core 33 – Quality Management Committee

The *organization* has a quality management committee that:

(a) Is granted authority for quality management by the *organization*'s governing body;

(b) Provides on-going reporting to the *organization*'s governing body;

(c) Meets at least quarterly;

(d) Maintains approved minutes of all committee meetings;

(e) If applicable, includes at least one participating provider or receives input from a participating provider committee (such as a Physician Advisory Group);

(f) Provides guidance to *staff* on quality management priorities and projects;

(g) Approves the *quality improvement projects* to undertake;

(h) Monitors progress in meeting quality improvement goals; and

(i) Evaluates the effectiveness of the *quality management program* at least annually.

Core 34 – Quality Management Documentation

The *organization*, as part of its *quality management program*, provides written documentation of:

(a) Ongoing monitoring for compliance with URAC Standards;

(b) Objectives and approaches utilized in the monitoring and evaluation of activities;

(c) Identification and tracking and trending of key indicators relevant to the scope of the entire *organization* and related to:

  (i) *Consumer* and health care services; or

  (ii) For *organizations* who do not interact with *consumers, client* services;

(d) The implementation of action plans to improve or correct identified problems;
(e) The mechanisms to communicate the results of such activities to *staff*; and
(f) The mechanisms to communicate the results of such activities to the quality management committee.

Core 35 – Quality Improvement Project Requirements
For each *quality improvement project*, the *organization* utilizes *valid* techniques *comparable* over time to:
(a) Develop quantifiable measures;
(b) Measure baseline level of performance; and re-measure level of performance at least annually; and
(c) Establish measurable goals for quality improvement.

Core 36 – Quality Improvement Project Goals and Measurement
For each *quality improvement project*, the *organization:*
(a) Designs and implements strategies to improve performance;
(b) Establishes projected time frames for meeting goals for quality improvement;
(c) Documents changes or improvements relative to the baseline measurement;
(d) Conducts at least one remeasurement prior to re-accreditation; and
(e) Conducts a *barrier analysis*, if the performance goals are not met.

Core 37 – Clinical, Error Reduction, and Consumer Safety Requirements
At any given time, the *organization* maintains no less than two *quality improvement projects*.
(a) At least one *quality improvement project* that:
  (i) Focuses on *consumers*; **or** for *organizations* who do not interact with *consumers, client* services;
  (ii) Relates to key indicators of quality as described in 34(c); and
  (iii) Involves a senior clinical *staff* person in judgments about clinical aspects of performance, if the *quality improvement project* is clinical in nature; and
(b) At least one *quality improvement project* focuses on *error reduction* and/or *consumer safety*.
  (i) *Consumer safety* QIPs are required of the following programs: HUM, WCUM, HCC, HP, DM, IRO, and CM.
  (ii) *Error reduction* QIPs are required of all accreditation programs that do not conduct *consumer safety* QIPs.

Review Criteria

WC 1 – Review Criteria Requirements

The *organization* utilizes explicit *clinical review criteria* or scripts that are:

(a) Developed with involvement from appropriate *providers* with current knowledge relevant to the criteria or scripts under review;

(b) Based on current clinical principles and processes;

(c) Evaluated at least annually and updated if necessary by:

  (i) the organization itself; and

  (ii) appropriate, actively practicing physicians and other *providers* with current knowledge relevant to the criteria or scripts under review, and;

(d) Approved by the *medical director* (or equivalent designate) or *clinical director* (or equivalent designate).

Accessibility Of Review Services

WC 2 – Access to Review Staff

The *organization* provides access to its review staff by a toll free or collect telephone line at a minimum from 9:00 a.m. to 4:00 p.m. of each normal business day in each time zone where the *organization* conducts at least two percent of its review activities.

WC 3 – Review Service Communication and Timeframes

The *organization* maintains processes to:

(a) Receive communications from *providers* and *workers* during the business day and after business hours;

(b) Respond to communications within one business day; and

(c) Conduct its outgoing communications related to *utilization management* during *providers'* reasonable and normal business hours, unless otherwise mutually agreed.

WC 4 – Review Service Disclosures

The *organization*:

(a) Requires *utilization management* staff to identify themselves by name, title, and *organization* name; and

(b) Upon request, verbally informs *workers;* facility personnel; the *attending physician* and other *ordering providers*; and *health professionals* of specific *utilization management* requirements and procedures.

On-Site Review Services

WC 5 – Onsite Review Requirements

For on-site review services, the *organization*:

(a) Requires on-site reviewers to carry a picture ID with full name and the name of the *organization*;

(b) Schedules reviews at least one business day in advance, unless otherwise agreed; and

(c) Requires the on-site reviewers to follow reasonable hospital or facility procedures, including checking in with designated hospital or facility personnel.

Initiation of Review Process

WC 6 – Initiation of Review Process

The *organization* allows any appropriate person to initiate the *certification* review process, as determined by state law or regulation or by workers' compensation insurer or *claims administrator*. Appropriate persons may include, but are not limited to the *worker* or a representative of the *worker*, the claims adjustor, the *facility rendering service*, the *provider*, or a state regulator.

Initial Screening

WC 7 – Limitations in Use of Non-Clinical Staff

For *initial screening*, the *organization* limits use of *non-clinical administrative staff* to:

(a) [This standard number is reserved to synchronize with URAC's Health Utilization Management Standards];

(b) Collection and transfer of non-clinical data;

(c) Acquisition of *structured clinical data*; and

(d) Activities that do not require evaluation or interpretation of clinical information.

WC 8 – Pre-Review Screening Staff Oversight
The *organization* ensures that *licensed health professionals* are available to *non-clinical administrative staff* while performing *initial screening*.

WC 9 – Pre-Review Screening Non-Certifications
The *organization* does not issue *non-certifications* based on *initial screening.*

Initial Clinical Review

WC 10 – Initial Clinical Reviewer Qualifications
Individuals who conduct *initial clinical review*:
(a) Are appropriate *health professionals*; and
(b) Possess an active professional relevant *license*.

WC 11 – Initial Clinical Reviewer Resources
Individuals who conduct *initial clinical review* have access to consultation with a:
(a) *Licensed* doctor of medicine or doctor of osteopathic medicine; or
(b) *Licensed health professional* in the same licensure category as the *ordering provider*; or
(c) *Health professional* with the same clinical education as the *ordering provider* in clinical specialties where *licensure* is not issued.

WC 12 – Initial Clinical Reviewer Non-Certifications
The *organization* does not issue *non-certifications* based on *initial clinical review.*

Peer Clinical Review

WC 13 - Peer Clinical Review Cases
The *organization* conducts *peer clinical reviews* for all cases where a *certification* is not issued through *initial clinical review* or *initial screening*.

WC 14 – Peer Clinical Reviewer Qualifications
Individuals who conduct *peer clinical review*:
(a) Are appropriate *health professionals*;
(b) Are qualified, as determined by the *medical director* or *clinical director*, to render a clinical opinion about the medical condition, procedures, and treatment under review; and
(c) Hold a current and valid *license*:
    (i) in the same licensure category as the ordering provider; or
    (ii) as a doctor of medicine or doctor of osteopathic medicine.

Peer-To-Peer Conversation

WC 15 – Peer-to-Peer Conversation Availability
Health professionals that conduct *peer clinical review* are available to discuss review determinations with *attending physicians* or other *ordering providers*.

WC 16 – Peer-to-Peer Conversation Alternate
When a determination is made to issue a *non-certification* and no *peer-to-peer conversation* has occurred:

(a) The *organization* provides, within one business day of a request by the *attending physician* or *ordering provider*, the opportunity to discuss the *non-certification* decision:
  (i) With the *clinical peer* reviewer making the initial determination; or
  (ii) With a different *clinical peer*, if the original *clinical peer* reviewer cannot be available within one business day); and

(a) If a *peer-to-peer conversation* or review of additional information does not result in a certification, the *organization* informs the *provider* and *worker* of the right to initiate an *appeal* and the procedure to do so.

Time Frames for Initial UM Decision

WC 17 – Prospective Review Timeframes
For *prospective review*, the *organization* issues a determination:

(a) As soon as possible based on the clinical situation, but in no case later than 72 hours of the receipt of request for a *utilization management* determination, if it is a *case involving urgent care*; or

(b) Within 15 calendar days of the receipt of request for a *utilization management* determination, if it is a non-urgent case.

(c) For non-urgent cases this period may be extended one time by the *organization* for up to 15 calendar days:
  (i) Provided that the *organization* determines that an extension is necessary because of matters beyond the control of the *organization*; and
  (ii) Notifies the *worker*, prior to the expiration of the initial 15 calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision; and

(iii) If a *worker* fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the *worker* must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information.

WC 18 – Retrospective Review Timeframes

For *retrospective review*, the *organization* issues a determination:

(a) Within 30 calendar days of the receipt of request for a *utilization management* determination.

(b) This period may be extended one time by the *organization* for up to 15 calendar days:

(i) Provided that the *organization* determines that an extension is necessary because of matters beyond the control of the *organization*; and

(ii) Notifies the *worker*, prior to the expiration of the initial 30 calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision; and

(iii) If a *worker* fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the *worker* must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information.

WC 19 – Concurrent Review Timeframes

For *concurrent review*, the *organization* adheres to the following time frames::

(a) For reductions or terminations in a previously approved course of treatment, the *organization* issues the determination early enough to allow the patient to request or review and receive a review decision before the reduction or termination occurs: and

(b) For requests to extend a current course of treatment, the *organization* issues the determination within:

(i) 24 hours of the request for a *utilization management* determination, if it is a *case involving urgent care* and the request for extension was received at least 24 hours before the expiration of the currently certified period or treatments; or

(ii) 72 hours of the request for a utilization management determination, if it is a case involving urgent care and the request for extension was received less than 24 hours before the expiration of the currently certified period or treatments.

Notice of Certification Decisions

WC 20 – Certification Decision Notice and Tracking
For *certifications*, the *organization*:

(a) Has a process for notification of the *attending physician* or other *ordering provider*, *facility rendering service,* and *patient:*

(b) Includes tracking information (such as reference number) in the notice of *certification*; and

(c) Upon request from the *attending physician* or other *ordering provider*, *facility rendering service,* or *worker*, provides *written notification* of any *certification.*

WC 21 – Continued Certification Decision Requirements
Confirmation of *certification* for continued hospitalization or services includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

Notice of Non-Certification Decisions

WC 22 – Written Notice of Non-Certification Decisions & Rationale
For *non-certifications*, the *organization* issues *written notification* of the *non-certification* decision to the *worker* and *attending physician* or other *ordering provider* or *facility rendering service* that includes:

(a) The *principal reasons* for the determination not to certify;

(b) A statement that the *clinical rationale* used in making the *non-certification* decision will be provided, in writing, upon request; and

(c) Instructions for:

  (i) Initiating an *appeal* of the *non-certification;* and

  (ii) Requesting a *clinical rationale* for the *non-certification*.

WC 23 – Clinical Rationale for Non-Certification Requirements
Upon request from the *patient, attending physician,* or other *ordering provider* or *facility rendering service*, the *organization* provides specific *clinical review criteria* upon which the *non-certification* was based.

UM Procedures

WC 24 – Reversal of Certification Determinations

The *organization* does not reverse a *certification* determination unless it receives new information that is relevant to the *certification* and that was not available at the time of the original *certification*.

WC 25 – Frequency of Continued Reviews

The *organization* ensures that the frequency of reviews for the extension of initial determinations is based on the severity or complexity of the *worker's* condition or on necessary treatment and *discharge planning* activity (i.e., not routinely conducted on a daily basis).

Information Upon Which Utilization Management Is Conducted

WC 26 – Scope of Review Information

The *organization*, when conducting routine *prospective review*, *concurrent review*, or *retrospective review*:

(a) Accepts information from any reasonably reliable source that will assist in the *certification* process;

(b) Collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services

(c) [This standard number is reserved to synchronize with URAC's Health Utilization Management Standards];

(d) [This standard number is reserved to synchronize with URAC's Health Utilization Management Standards];

(e) Requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; and

(f) Administers a process to share all clinical and demographic information on individual *workers* among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from enrollees or *providers*.

WC 27 – Prospective and Concurrent Review Determinations

For *prospective review* and *concurrent review*, the *organization* bases review determinations solely on the medical information obtained by the *organization* at the time of the review determination.

WC 28 – Retrospective Review Determinations
For *retrospective review*, the *organization* bases review determinations solely on the medical information available to the *attending physician* or *ordering provider* at the time the medical care was provided.

WC 29 – Lack of Information Policy and Procedure
The *organization* implements policies and procedures to address situations in which it has insufficient information to conduct a review. Such policies and procedures provide for:

(a) Procedural time frames that are appropriate to the clinical circumstances of the review (i.e., *prospective*, *concurrent*, *retrospective reviews*);
(b) Resolution of cases in which the necessary information is not provided to the *organization* within specified time frames; and
(c) Processes by which the *organization* issues an administrative non-certification due to lack of information.

WC 27 – Prospective and Concurrent Review Determinations
For *prospective review* and *concurrent review*, the *organization* bases review determinations solely on the medical information obtained by the *organization* at the time of the review determination.

WC 28 – Retrospective Review Determinations
For *retrospective review*, the *organization* bases review determinations solely on the medical information available to the *attending physician* or *ordering provider* at the time the medical care was provided.

Appeals Consideration

WC 30 - Non-Certifications Appeals Process
The *organization* maintains a formal process to consider *appeals* of *non-certifications* that includes:

(a) The availability of *standard appeal* for non-urgent cases and *expedited appeal* for *cases involving urgent care*; and
(b) Written appeals policies and procedures that:
    (i) Clearly describe the *appeal* process, including the right to *appeal* of the *worker*, *provider,* or *facility rendering service*;
    (ii) Provide for explicit time frames for each stage of the *appeal* resolution process; and
    (iii) Are available, upon request, to any *worker, provider, or facility rendering service*.

WC 31 – Appeals Process
When applicable, the *organization* coordinates its *appeal* activities with regulatory appeals processes, which may be available to the *worker*.
[This standard varies from URAC's Health Utilization Management Standards]

WC 32 – Appeal Peer Reviewer Qualifications
Appeals considerations are conducted by *health professionals* who:
(a) Are *clinical peers*;
(b) Hold an active, unrestricted *license* to practice medicine or a health profession;
(c) Are *board-certified* (if applicable) by:
  (i) A specialty board approved by *the American Board of Medical Specialties* (doctors of medicine); or
  (ii) The *Advisory Board of Osteopathic Specialists* from the major areas of clinical services (doctors of osteopathic medicine);
(d) Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; and
(e) Are neither the individual who made the original non-certification, nor the subordinate of such an individual.

WC 33 – Expedited Appeals Process Timeframe
Expedited appeals are completed, with verbal notification of determination within 72 hours of the request followed by a written confirmation of the notification within 3 calendar days.

WC 34 – Standard Appeals Process Timeframe
Standard appeals are completed, and *written notification* of the *appeal* decision issued, within 30 calendar days of the receipt of the request for *appeal*.

WC 35 – Written Notification of Upheld Non-Certifications
For *appeals* determinations, the *organization* issues *written notification* of the adverse *appeal* decision to the *patient* and *attending physician* or other *ordering provider* or *facility rendering service* that includes:
(a) The *principal reasons* for the determination to uphold the *non-certification*;
(b) A statement that the *clinical rationale* used in making the *appeal* decision will be provided, in writing, upon request; and
(c) Information about additional appeal mechanisms available, if any.

WC 36 – Appeal Record Documentation

The *organization* maintains records for each *appeal* that includes:

(a) The name of the *worker, provider,* and/or *facility rendering service*;

(b) Copies of all correspondence from the *worker, provider,* or *facility rendering service* and the *organization* regarding the *appeal*;

(c) Dates of *appeal* reviews, documentation of actions taken, and final resolution;

(d) Minutes or transcripts of *appeal* proceedings (if any); and

(e) Name and credentials of the clinical peer that meets the qualifications in Standard WC 28.

Definitions *(defined terms appear in italics throughout the standards)*

This glossary is a compilation of all defined terms in the following URAC Standards: Core, Health Utilization Management, Workers' Compensation Utilization Management, Case Management, Disease Management, Independent Review Organization, Credentials Verification Organization, Health Plan, Health Network, Health Call Center, and Provider Credentialing. **Not all terms appear in each module.**

In the Standards, defined terms are *italicized*. Being familiar with these definitions is critically important to accurate understanding of URAC Standards. Readers are encouraged to refer to the definitions section each time they encounter an italicized term until they feel they have committed the meaning of that term to memory.

Abandonment Rate	The percentage of calls offered into a communications network or telephone system -- i.e., automatic call distribution (ACD) system of a call center – that are terminated by the persons originating the call before answer by a *staff* person.
Access	The *consumer's* ability to obtain services at the time which they are needed. The ease of *access* is determined by components such as the *availability* of services, their acceptability to the *consumer*, consumer wait time, and the hours of operation.
Adverse Event	An occurrence that is inconsistent with or contrary to the expected outcomes of the *organization's* functions.
Advisory Board of Osteopathic Specialists (ABOS)	American Osteopathic Association (AOA) certification agent organized in 1939 for the purpose of establishing and maintaining standards of osteopathic specialization and pattern of training.
Advocacy	The act of recommending to speak or write in favor of a *consumer* to promote *consumer* autonomy and independence. It involves educating *consumers* about their rights, health care and human services, resources and benefits, and facilitating appropriate and informed decision making and includes considerations for the *consumer's* values, beliefs, and interests.
American Board of Medical Specialties (ABMS)	Organized originally in 1933 as the Advisory Board of Medical Specialties, the ABMS (1970), in collaboration with the American Medical Association (AMA), is the recognized certifying agent for establishing and maintaining standards of medical specialization and pattern of training.

Appeal	Formal request for review of an *organizational* determination (i.e., services have been denied, reduced, etc.)
	Note: Specific terms used to describe *appeals* vary, and are often determined by law or regulation. URAC's UM Standards apply to first-level appeal.
Appeals Consideration	Clinical review conducted by appropriate *clinical peers*, who were not involved in *peer clinical review,* when a decision not to certify a requested admission, procedure, or service has been *appealed*. Sometimes referred to as "third level review."
Assessment	A systematic process of collecting in-depth information about a *consumer's* situation and functioning to identify individual needs in order to develop a comprehensive *case management* plan that will address those needs. In addition to direct *consumer* contact, information should be gathered from other relevant sources (*patient/consumer*, professional caregivers, non-professional caregivers, employers, health records, educational/military records, etc.)
Attending Physician	The doctor of medicine or doctor of osteopathic medicine with primary responsibility for the care provided to a *patient* in a hospital or other health care *facility*.
Attending Provider	The physician or other health care *practitioner* with primary responsibility for the care provided to a *consumer*.
Availability	The extent to which the *organization* has *participating providers* of the appropriate type and number geographically distributed to meet the needs of *consumers*.
Average Speed of Answer	The average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a call center before answer by a *staff* person.
Barrier Analysis	Post-baseline interpretation of performance data that identifies root causes and key improvements and evaluates the effectiveness of improvements by comparing actual to expected results.
Blockage Rate	The percentage of incoming telephone calls "blocked" or not completed because switching or transmission capacity is not available as compared to the total number of calls encountered. Blocked calls usually occur during peak call volume periods and result in *consumers* receiving a busy signal.

Board-Certified	A certification – approved by the American Board of Medical Specialties, the American Osteopathic Association, or another organization as accepted by URAC – that a physician has expertise in a particular specialty or field. To the extent that future URAC standards include other certifications, URAC will specify further approved boards.
	Note: URAC recognizes that ABMS- and AOA-approved board certifications may not be the only certification programs that may be acceptable for *health professionals* in URAC-accredited organizations. For example, non-physician professionals will have appropriate certifications that are not ABMS- of AOA-approved. Any applicant wishing to have URAC recognize another board certification program should notify URAC early in the accreditation process. URAC will then take this recommendation to URAC's Accreditation Committee. The Accreditation Committee will review all requests, and will decide to approve or reject the certification. The Accreditation Committee will consider the following criteria in judging whether a certification is acceptable: • Is the certification accepted within its target community of *health professionals*? • Was the certification developed through an open, collaborative process? • Does the certification reflect accepted standards of practice? • Is the certification administered through an objective process open to all qualified individuals? All approved organizations will be listed in relevant materials provided by URAC. Note also that the term *board certification* appears only once in the Core Standards, in standard 19, which relates to the clinical qualifications of senior clinical *staff* people who are physicians.
Care Plan	The process of determining specific objectives, goals, and actions designed to meet the *consumers'* needs as identified through the *assessment* process. The plan should be action oriented and time-specific.

Case	A specific request for medical or clinical services referred to an *organization* for a determination regarding the medical necessity and medical appropriateness of a health care service or whether a medical service is experimental/investigational or not. It is a non-approval regarding medical necessity and medical appropriateness decisions for services covered under a *health benefits plan*'s terms and conditions or for coverage decisions regarding experimental or investigational therapies that is at issue during the *independent review* process.
Case Involving Urgent Care	Any request for a *utilization management* determination with respect to which the application of the time periods for making non-urgent care determinations a) could seriously jeopardize the life or health of the *consumer* or the ability of the *consumer* to regain maximum function, or b) in the opinion of a physician with knowledge of the *consumer's* medical condition, would subject the *consumer* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case. (**Note:** This definition is derived from the Department of Labor's definition of "claim involving urgent care.")
	Note: While the URAC standards are silent on the methods by which a claim is determined to be a "case involving urgent care," the Department of Labor claims regulation (29 C.F.R. § 2560.503-1(m)(1)) specifies that whether a claim is a "claim involving urgent care" is to be determined by an individual acting on behalf of the *health benefits plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" shall be treated as a "claim involving urgent care. **Note:** The Department of Labor claims regulations do not apply to the URAC Workers' Compensation Utilization Management Standards.
Case Management	A collaborative process of *assessment*, planning, facilitation and advocacy for options and services to meet a *consumer's* health needs through communication and available resources to promote quality cost-effective outcomes.

Certification	A professional credential, granted by a national organization, signifying that an individual has met the qualifications established by that organization. To qualify under these standards, the *certification* program must: • Establish standards through a recognized, validated program; • Be research-based; and • Be based (at least partially) on passing an examination.
Certification (UM)	A determination by an *organization* that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable *health benefits plan*. **Note:** "Determination" may vary depending on context.
Claims Administrator	Any entity that recommends or determines to pay claims to enrollees, physicians, hospitals, or others on behalf of the *health benefits plan*. Such payment determinations are made on the basis of contract provisions. *Claims administrators* may be insurance companies, self-insured employers, third party administrators, or other private contractors.
Client	A business or individual that purchases services from the *organization*. **Note:** Here are some examples of *client* relationships: • If a health plan provides health coverage to an employer, the employer is the client. • If a health plan contracts for *utilization management* or *case management* services from a *utilization management* organization, the health plan is the client. • If a PPO contracts for credentialing services with a CVO, the PPO is the client.
Clinical Activities	Operational processes related to the delivery of *clinical triage* and *health education* services performed by *clinical staff*.
Clinical Decision Support Tools	Protocols, guidelines, or algorithms that assist in the clinical decision-making process.

Clinical Director	A *health professional* who: (1) is duly *licensed* or *certified*; (2) is an employee of, or party to a contract with, an *organization*; and (3) who is responsible for clinical oversight of the *utilization management* program, including the credentialing of professional *staff* and quality assessment and improvement functions.
Clinical Peer	A physician or other *health professional* who holds an unrestricted *license* and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the *ordering provider*.
Clinical Rationale	A statement that provides additional clarification of the clinical basis for a *non-certification* determination. The *clinical rationale* should relate the *non-certification* determination to the *patient*'s condition or treatment plan, and should supply a sufficient basis for a decision to pursue an *appeal*.
Clinical Review Criteria	The written screens, decision rules, medical protocols, or guidelines used by the *organization* as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable *health benefits plan*.
Clinical Staff	Employees or contracted consultants of the health care organization who are clinically qualified to perform *clinical triage* and provide *health education* services.
Clinical Triage	Classifying *consumers* in order of clinical urgency and directing them to appropriate health care resources according to *clinical decision support tools.*
Comparable	Data about performance is compared to an historical baseline (which may be internal) and ongoing progress is recorded in regular intervals (e.g., monthly, quarterly, or annually). External benchmarks also may be used for purposes of comparison.
Complaint	An expression of dissatisfaction regarding the *organization's* products or services. **Note:** This term is sometimes referred to as "grievance." This definition does not include *appeals*.
Concurrent Review	*Utilization management* conducted during a *patient*'s hospital stay or course of treatment (including outpatient procedures and services). Sometimes called "continued stay review."

Condition	A diagnosis, clinical problem or set of indicators such as signs and symptoms a *consumer* may have that define him/her as eligible and appropriate to participate in a *disease management* program.
Conflict of Interest	Any relationship or affiliation on the part of the *organization* or a *reviewer* that could compromise the independence or objectivity of the *independent review* process. Conflict of interest includes, but is not limited to: • An ownership interest of greater than 5% between any affected parties; • A material professional or business relationship; • A direct or indirect financial incentive for a particular determination; • Incentives to promote the use of a certain product or service; • A known familial relationship; • Any prior involvement in the specific *case* under review.
Consumer	An individual person who is the direct or indirect recipient of the services of the *organization*. Depending on the context, consumers may be identified by different names, such as "member," enrollee," "beneficiary," "patient," "injured worker," "claimant," etc. **Note:** A *consumer* relationship may exist even in cases where there is not a direct relationship between the *consumer* and the *organization.* For example, if an individual is a member of a health plan that relies on the services of a *utilization management* organization, then the individual is a *consumer* of the *utilization management* organization. In the case of a *consumer* who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the *consumer* behalf may be a *consumer* for the purposes of these standards.
Consumer Safety	The prevention of harm to *consumers*.
Contractor	A business entity that performs *delegated* functions on behalf of the *organization*.

	Note: For the purposes of these standards, the term "contractor" includes only those contractors that perform functions related to the key processes of the *organization*. It is not URAC's intent to include contractors that provide services unrelated to key processes. For example, a contractor that provides catering services would not fall within the definition of "contractor" in these standards. Conversely, a company that provides specialty physician reviewers to a *utilization management* organization would clearly fall within the definition of "contractor."
Criteria	A broadly applicable set of standards, guidelines, or protocols used by the *organization* to guide the *case management* process. Criteria should be: • Written; • Based on professional practice; • Literature-based; • Applied consistently; and • Reviewed annually.
Credentials Verification	A process of reviewing and verifying specific credentialing criteria of a *practitioner*.
Credentials Verification Organization	An *organization* that gathers data and verifies the credentials of *health care practitioners*.
Delegation	The process by which the *organization* permits another entity to perform functions and assume responsibilities covered under these standards on behalf of the *organization*, while the *organization* retains final authority to provide oversight to the delegate.
Discharge Planning	The process that assesses a *consumer*'s needs in order to help arrange for the necessary services and resources to affect an appropriate and timely discharge.

Disease Management	According to the Disease Management Association of America, "Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management: supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an going basis with the goal of improving overall health. Disease management components include: population identification processes; evidence-based practice guidelines; collaborative practice models to include physician and support-service providers; patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance); process and outcomes measurement, evaluation, and management; routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling."
Disease Management Program	A program or entity that provides the scope of functions and activities necessary to provide *disease management*.
Engagement	Proactive outbound contact with *consumers*, by phone or mail, within some specified time frame of identification of eligible *consumers*, with tracking of interactions.
Error	The failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).
Evidence-Based	Recommendations based on valid scientific outcomes research, preferably research that has been published in peer reviewed scientific journals. Evidence-based information can be used to develop protocols, pathways, standards of care or clinical practice guidelines and related educational materials.
Expedited Appeal	An *appeal* of a *non-certification* in a *case involving urgent care*.
Facility	An institution that provides health care services.

Facility Rendering Service	The institution or organization in or by which the requested admission, procedure, or service is provided. Such *facilities* may include, but are not limited to: hospitals; outpatient surgical facilities; individual *practitioner* offices; rehabilitation centers; residential treatment centers; skilled nursing facilities; laboratories; imaging centers; and other organizational *providers* of direct services to *patients*.
Family	Individuals whom the *consumer* chooses to involve in the decision-making process regarding the *consumer*'s health care. In the case of a *consumer* who is unable to participate in the decision-making process, "family" shall include any individual legally authorized to make health care decisions on the *consumer*'s behalf.
Health Care Team	The *attending physician* and other health care *providers* with primary responsibility for the care provided to a *consumer*.
Health Benefits Plan	An arrangement to pay for medical services provided to a *consumer*. "Health benefits plan" includes (but is not limited to): • HMOs; • PPOs; • Indemnity health insurance programs; • Self-insured plans; • Public programs, such as Medicare and Medicaid; • Workers' Compensation insurance programs; and • Self-directed/consumer directed health plans.
Health-Related Field	A professional discipline that promotes the physical, psychosocial, or vocational well being of individual persons.
Health Education	Educational resources designed to enhance the knowledge and understanding of health topics to promote wellness and self-care.
Health Professional	An individual who: (1) has undergone formal training in a health care field; (2) holds a *license* in a health care field issued by a state and the *license* allows the professional to practice within the scope of the *license* without the supervision of another *licensed* professional; (3) has professional experience in providing direct patient care; and (4) holds a post-secondary degree in health care. A post-secondary degree is defined as any college, university, or nursing school diploma obtained after graduating from high school (nursing diploma or associates, bachelors, masters, or doctorate degree).

Independent Review	A process, independent of all affected parties, to determine if a health care service is medically necessary and medically appropriate or experimental/investigational. *Independent review* typically (but not always) occurs after all *appeal* mechanisms available within the *health benefits plan* have been exhausted. *Independent review* can be voluntary or mandated by law.
Individually-Identifiable Health Information	URAC uses the Health Insurance Portability and Accountability Act (HIPAA) definition of this term.
Initial Clinical Review	Clinical review conducted by appropriate *licensed* or certified *health professionals*. *Initial clinical review staff* may approve requests for admissions, procedures, and services that meet *clinical review criteria*, but must refer requests that do not meet *clinical review criteria* to *peer clinical review* for *certification* or *non-certification*. Sometimes referred to as "first level review."
Initial Screening	Automated or semi-automated screening of requests for authorization that may include: (1) collection of *structured clinical data* (including diagnosis, diagnosis codes, procedures, procedure codes); (2) asking scripted clinical questions; (3) accepting responses to scripted clinical questions; and (4) taking specific action (*certification* and assignment of length of stay explicitly linked to each of the possible responses). It excludes: (1) applying clinical judgment or interpretation; (2) accepting unstructured clinical information; (3) deviating from script; (4) engaging in unscripted clinical dialogue; (5) asking clinical follow-up questions; and (6) issuing *non-certifications*.
Knowledge Domains	Areas of specific expertise.
License	A license or permit (or equivalent) to practice medicine or a health profession that is (1) issued by a state regulatory body or jurisdiction in the United States; and (2) required for the performance of job functions. **Note:** In this definition, the word "equivalent" includes certifications, registrations, permits, etc. Specific terms will vary by state and health profession.

Medical Director	A doctor of medicine or doctor of osteopathic medicine who is duly *licensed* to practice medicine and who is an employee of, or party to a contract with, an *organization*, and who has responsibility for clinical oversight of the *organization's utilization management*, credentialing, quality management, and other clinical functions.
Medical Management	A general term encompassing activities such as *utilization management*, *case management*, and the clinical aspects of quality management.
Non-Certification	A determination by an *organization* that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, does not meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable *health benefits plan*.
Non-Clinical Administrative Staff	*Staff* who do not meet the definition of *health professional* (including intake personnel).
Non-Clinical Staff	Employees or contracted consultants of a health care organization who do not perform clinical assessments or provide *consumers* with clinical advice. They may be responsible for obtaining demographic information, providing benefit information, and re-directing *consumers*.
Opt-In	Affirmative consent actively provided by a *consumer* to participate in an activity or function of the *disease management program*, provided after the *disease management program* has fully disclosed the terms and conditions of participation to the *consumer*, including: • The duration of the *opt-in* (is it indefinite or does it apply for a specified period?); • The type of information to be collected from the user, the purposes for which the information will be used, to whom the information may be disclosed; and • The mechanism by which the user may *opt out*.
Opt-Out	A process by which a *consumer* declines to participate in an activity or function of the *disease management program*.
Ordering Provider	The physician or other *provider* who specifically prescribes the health care service being reviewed.
Organization	A business entity that seeks accreditation under these standards.

Outcome	An outcome is a measure that indicates the result of the performance (or nonperformance) of a program, service, or intervention. The evaluation measures may include: clinical, financial, utilization, economic, quality, and humanistic outcomes (e.g. patient and provider satisfaction).
Participant (participating)	An eligible *consumer* or *treating provider* that has had one or more inbound or outbound contacts with the *disease management program*, and if a *consumer*, has not *opted out* of the program.
Participating Provider	A *provider* that has entered into an agreement with the *organization* to be part of a *provider network*.
Patient	The enrollee, covered person, or *consumer* who requests or for whom a request for *certification* has been filed. The term "patient" may include an agent or representative authorized to act on the *patient's* behalf.
	Note: Try to clarify when the term "patient" includes an agent or representative authorized to act on the *patient's* behalf (sometimes defined in benefit contract or by law).
Peer Clinical Review	Clinical review conducted by an appropriate *clinical peer* when a request for an admission, procedure, or service was not approved during *initial clinical review*. Sometimes referred to as "second level review."
Peer-to-Peer Conversation	A request by telephone for additional review of a *utilization management* determination not to certify, performed by the peer reviewer who reviewed the original decision, based on submission of additional information or a peer-to-peer discussion.
Personally-Identifiable Information	Any information that can be tied to an individual identifier.
Population	Depending on the model of the *disease management program*, the population for which it is responsible may be all of the *consumers* identified with the disease condition, or the *population* may be only those *consumers* identified to the *disease management program* by *client* referral or another mechanism. In some instances the *disease management program* may be responsible for identification of the *population*, and in other instances the *client* may conduct identification (and stratification) activities.
Practitioner	An individual person who is licensed to deliver health care services without supervision.

Primary Physician	The physician who is primarily responsible for the medical treatment and services of a *consumer*.
Primary Source Verification or Primary Source	Verification of a *practitioner's* credentials based upon evidence obtained from the issuing source of the credential.
Principle Reason(s)	A clinical or non-clinical statement describing the general reason(s) for the *non-certification* determination ("lack of medical necessity" is not sufficient to meet this).
Professional Competency	The ability to perform assigned professional responsibilities.
Prospective Review	*Utilization management* conducted prior to a *patient*'s admission, stay, or other service or course of treatment (including outpatient procedures and services). Sometimes it can be called "pre-certification review", "pre-service", or "prior authorization."
Provider	Any person or entity that provides health care services. Includes both *practitioners* and *facilities*.
Provider Network	A group of *providers* with which the *organization* contracts to provide health services to *consumers*.
Provider-Specific Information	Information that is sufficient to allow identification of the individual *provider*.
Quality Improvement Project	A process that documents the variation of performance or variance from baseline standards in order to achieve a better outcome for the *organization's consumers*.
Quality Management Program	A systematic data-driven effort to measure and improve *consumer* and *client* services and/or health care services including *consumer safety*.
Quality Review Study	A scientific and systematic measurement of the effects or results of treatment modalities or practices for a particular disease or condition. The goal of quality measurement is to improve health care services by monitoring and analyzing the data and modifying practices in response to this data.
Rationale	The reason(s) or justification(s) – commonly based on *criteria* – for a specific action or recommendation.
Re-Assessment	Re-evaluation of an individual participating in the *disease management program* on a specified frequency, using the same or similar tools that were used in the initial *assessment*. *Re-assessment* may also include re-stratification.

Referring Entity	The organization or individual that refers a *case* to an *organization*. Referring entities may include insurance regulators, *health benefits plans*, *consumers*, and *attending providers*. Some states may limit by law which individuals or organizations may be a referring entity.
Retrospective Review	Review conducted after services (including outpatient procedures and services) have been provided to the *patient*. This can also be called post-service.
	Note: Retrospective medical necessity determinations are considered *utilization management* (and subject to these standards).
Reviewer(s)	The individual (or individuals) selected by the *organization* to consider a *case*. Selection of the reviewer(s) for a *case* must be conducted in accordance with standards IR 1 and IR 5. All reviewer(s) who are health care *practitioners* must have the following qualifications: • Active licensure; • Recent experience or familiarity with current body of knowledge and medical practice; • At least 5 years experience providing health care; • If the reviewer is an M.D. or D.O., board certification by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association. • If the reviewer is a D.P.M., board certification by the American Board of Podiatric Surgery.
Review of Service Request	Review of information submitted to the *organization* for health care services that do not need medical necessity *certification* nor result in a *non-certification* decision.
Second Opinion	Requirement of some health plans to obtain an opinion about the medical necessity and appropriateness of specified proposed services by a *practitioner* other than the one originally making the recommendation.
Secondary Source Verification or Secondary Source	Verification of a *practitioner's* credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential (e.g., copies of licenses and certifications and data base queries).
Service Requests	Screening inquiries to determine the services that are necessary at the time of the inquiry. This is usually performed by a *non-clinical staff* person to determine if the inquiry is clinical and requires transfer to a *clinical staff* person.

Staff	The *organization*'s employees, including full-time and part-time employees.
Standard Appeal	An *appeal* of a *non-certification* that is not an *expedited appeal.* In most cases, *standard appeals* will not relate to *cases involving urgent care*. However, *standard appeals* may also include secondary *appeals* of *expedited appeals*.
Stratification	A process for sorting a *population* of eligible *consumers* into groups relating to the need for *disease management* interventions. *Stratification* and *assessment* are inter-related, and both provide data used to assign interventions. *Stratification* may use a variety of data sources, including but not limited to claims, pharmacy, laboratory, or *consumer*-reported data.
Structured Clinical Data	Clinical information that is precise and permits exact matching against explicit medical terms, diagnoses or procedure codes, or other explicit choices, without the need for interpretation.
Treating Provider	The treating *provider* is the individual or *provider* group who is primarily managing the treatment for a *consumer* participant in the *disease management program*. The *treating provider* is not necessarily the *consumers' primary physician*. The *consumer* may have a different *treating provider* for different conditions.
Utilization Management	Evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and *facilities* under the provisions of the applicable *health benefits plan*; sometimes called "utilization review."
Valid	Based on accepted principles of study design, research methodology, and statistical analysis.
Worker	An ill or injured individual who is eligible for workers' compensation benefits and who files for, or for whom a workers' compensation claim has been filed.
Written Agreement	A document – including an electronic document – that specifies the terms of a relationship between the *organization* and a *client, consumer*, or *contractor*. This term may include a contract and any attachments or addenda.
Written Notification	Correspondence transmitted by mail, facsimile, or electronic medium.

Gelnett, Wanda B.

From: Wunsch, Eileen [ewunsch@state.pa.us]
Sent: Tuesday, June 27, 2006 11:45 AM
To: Kupchinsky, John; Kuzma, Thomas J. (GC-LI); Howell, Thomas P. (GC-LI)
Subject: FW: Comments on Proposed Rule Changes

Comments from one of the UROs. I am not sure he understands what is already in the statute.

Eileen K. Wunsch, MS, CPIW, ARM
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Department of Labor & Industry
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-----Original Message-----
From: Jess Armine [mailto:thebeardoc@hotmail.com]
Sent: Tuesday, June 27, 2006 11:27 AM
To: gveno@pachiropracticassn.org; ewunsch@state.pa.us; docengle@dejazzd.com
Subject: Comments on Proposed Rule Changes

Dear Eileen, Walt and Gene,

Attached are my comments concerning the proposed rule changes to 34 Pa Code, Chapter 127.

I appreciate the opportunity to submit my opinion.

Please call or e-mail me with any questions.

Jess

PS: Eileen, I am also sending these comments via snail mail. J.

Jess P. Armine, RN, DC

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