

Conduent Care Solutions, LLC

# North Carolina Preauthorization Program

2017

Rule 1001 Medical Practice Guidelines

**Contents**

Goals ..... 2

Requirements ..... 2

Accessibility ..... 2

Treatment Guidelines and Criteria ..... 2

Personnel Qualifications and Type..... 2

Initial Review Process..... 3

Second Level Review Process..... 4

Appeals Process..... 4

Contents of Written Notifications ..... 4

Timeframes for Decisions ..... 5

## Goals

Conduent Care Solutions' mission is to ensure all injured employees receive timely and appropriate medical care in the most cost effective manner and to integrate all employer resources to prevent injuries and mitigate consequences of injuries.

- Assure that injured employees receive timely and appropriate care in the appropriate setting.
- Monitor the quality and cost effectiveness of delivered medical care by assessing the level of service provided, the duration of care, and the continuing medical necessity of the treatment and any potential alternatives.
- Provide an opportunity for the Nurse to discuss treatment plans with the provider and negotiate alternative delivery settings if appropriate.
- Identify long term, costly disabilities and rehabilitation needs.

## Requirements

Preauthorization is required and can be made by the treating health care provider, unrepresented claimant or the claimant's attorney for all inpatient admissions to a hospital, all inpatient admissions to a treatment center, and all inpatient or outpatient surgical procedures utilizing the North Carolina Industrial Commission's (NCIC) [Form 25PR](#) (Request for Preauthorization of Medical Treatment, in accordance with 04 NCAC 10A.101).

If a request for inpatient admissions to a hospital, inpatient admissions to a treatment center and all inpatient or outpatient surgical procedures is not on the required [Form 25PR](#), the request will be returned to the requester with a copy of the required form.

## Accessibility

Conduent Care Solutions is available on normal business days between 8:00 a.m. and 8:00 p.m. Eastern Standard Time. A nurse is always on call twenty-four (24) hours/day, seven (7) days/week and available to assist in urgent utilization management functions after hours. Contact information is listed below:

Conduent Care Solutions, LLC  
P.O. Box 32037  
Lakeland, FL 33802

Toll Free: 800-853-4735  
Phone: 863-669-0861  
Fax: 863-668-9553  
Email: [WCCS.UR.Referral@conduent.com](mailto:WCCS.UR.Referral@conduent.com)

## Treatment Guidelines and Criteria

Conduent Care Solutions utilizes as the primary source for guidelines and criteria the guidelines adopted by the state of jurisdiction. Commercially-developed and nationally-recognized guidelines will also be used by the clinical review team as well as by clinical peer reviewers. All guidelines used in the decision-making process are based on current principles and processes and developed by providers with current knowledge relevant to the criteria under review. The following are the guidelines used, but not necessarily limited to:

- Official Disability Guidelines (ODG)
- American College of Occupational and Environmental Medicine (ACOEM)

Conduent Care Solutions' Quality Management Committee undergoes a review and update of their policies and procedures and treatment guidelines each year in February. All nurses undergo training in the use of the treatment guidelines.

## Personnel Qualifications and Type

### Medical Director

The medical director, a voting member of Conduent Care Solutions Quality Management Committee, is responsible for reviewing all commercial criteria used during the utilization review process, as well as providing guidance for all clinical aspects of the utilization management program.

The medical director ensures the organizational objective to have qualified clinicians accountable to the organization for decisions affecting injured employees and has authority over all decision-making for preauthorization determinations. The medical director is available to clinical staff by phone or email during normal business hours.

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#### Licensure:

California  
MD License #C55926

Oregon  
MD License #15703

Washington  
MD License #37678

#### Board Certifications:

The American Board of Preventive Medicine – Occupational Medicine  
The American Board of Quality Assurance and Utilization Review Physicians

### Clinical Peer Review Staff

Conduent Care Solutions contracts with URAC-accredited peer review organizations for clinical peer reviews. Licensing and credentialing functions are delegated to the peer review organization, ensuring that all URAC and jurisdictional requirements are met through primary source verification of licensure and board certifications.

Individuals who conduct clinical peer reviews hold active, unrestricted licenses or certifications to practice medicine or a health profession in either North Carolina, South Carolina, Georgia, Virginia or Tennessee and hold professional qualifications, certifications and fellowship training in a like specialty that is at least equal to that of the treating provider requesting preauthorization of surgery or inpatient treatment. Clinical peer reviewers are qualified by the medical director or clinical director to render a clinical opinion about the medical condition, procedures and treatment under review.

A list of clinical peer reviewers is attached to this plan separately.

### Nursing Staff

Conduent Care Solutions' nurses have current, unrestricted professional licenses and are RNs or LPNs. Additional credentials, such as CVN, CCM, CDMS, or CRRN, are also present in our nursing staff. The nurses possess clinical nursing experience and are knowledgeable in case management as well as workers' compensation.

### Initial Review Process

The review process begins the business day after the request is received. Within two (2) business days after the receipt, Conduent Care Solutions will send a letter acknowledging receipt of the request to the requesting party which will include:

- Contact information for the claims adjuster; and,
- Contact information for Conduent Care Solutions.

A nurse is responsible for the initial clinical review of all medical information and for the certification of any treatment or procedure requested by the treating physician.

The nurse will review the information provided with the review request. The information required will include identifying information about the injured employee, the treating healthcare provider and facilities rendering care. It will also include clinical information regarding the diagnosis and the medical history of the injured employee relevant to the diagnosis of the compensable injury, the prognosis, and the treatment plan prescribed by the treating health care provider, along with the providers' justification for the treatment plan. It

must include all the medical information needed to substantiate the medical necessity for the specific treatment in review.

If any additional information is needed, the nurse will send a letter to the requestor documenting the additional information needed to complete the review. The requestor will be given 14 calendar days to respond with the additional information. If the information is not received by the end of the 14<sup>th</sup> calendar day, the nurse will send the case to a clinical peer reviewer to make a determination based upon the information available.

The nurse applies the treatment guidelines and criteria (see section 4, Treatment Guidelines) to the requested treatment. If the treatment or service meets the stated guidelines, the nurse will certify the service and notify the requestor via telephone or fax. A complete written notification will be sent within two (2) business days which will include the a description of the service or treatment that was approved, a start and end date, a reference or tracking number and the number of days or units approved.

If the requested treatment does not meet or exceeds the treatment guidelines, the nurse will refer the request to a clinical peer reviewer for second level review.

## Second Level Review Process

Clinical peer reviews will be conducted for all cases where a nurse cannot certify the treatment/service. The clinical peer reviewer assigned to the case will review the documentation and attempt to contact the requesting physician. He/she will make two attempts to speak directly to the requesting physician to afford the him/her an opportunity to discuss the requested treatment or services. Based upon the information provided and the conversation with the requesting physician (if successful contact was made) he/she will make a determination.

If the determination results in a recommendation of the service/treatment, the clinical peer reviewer will verbally notify the requestor by telephone. The nurse will then follow-up the verbal notification with written notification within two (2) business days. The nurse documents all of the information in the case file.

If the determination results in an adverse determination, the clinical peer reviewer will notify the requesting physician and also outline the process in which he/she may appeal the determination. The clinical peer reviewer also notifies the nurse who sends the written notification of an adverse determination to all parties and documents the case file. Clinical review criteria used for an adverse determination will be disclosed to the requestor, injured employee or attending physician in the written notification.

If peer-to-peer contact was not made prior to the determination, the requesting physician is provided the opportunity within one business day to discuss the denial with the original reviewer (or another clinical peer if the original reviewer is not available.) This conversation will not be considered an appeal.

## Appeals Process

The appeals process must be initiated no later than 30 calendar days from the date of receipt of the written notice of an adverse determination. The injured employee, the injured employee's representative or ordering practitioner for whom the treatment/service was denied may request an appeal. Appeals may be requested verbally or in writing. Verbal requests for appeal must be followed by a written request using page two of the [Form 25PR](#) and submitting it to Conduent Care Solutions with any additional necessary medical information.

The appeal will be referred to a clinical peer reviewer not involved in the original adverse determination.

All appeals are considered standard appeals unless the requested treatment/service requires immediate/expedited consideration. See section 10, Timeframes for Decisions for the timeframes for completion.

## Contents of Written Notifications

No later than two (2) business days after the verbal/fax notification, preauthorization determinations will be documented on the [Form 25PR](#) and attached along with a written determination letter that will include:

- the claimants' name, social security number and address, date of injury, date of requested service, procedure requested, name of provider, or facility;

- a tracking number;
- the treatment or service under review;
- clinical peer reviewer's name, credentials and license number;
- the guidelines used as the basis for the determination;
- the clinical rationale used as a basis for the determination;
- the procedures to initiate an appeal of the determination or the name and telephone number of the person to contact with regard to an appeal and,
- a reasonable period within which an appeal must be filed to be considered

The written notifications will be provided to the health care provider, claimant, person, or entity requesting preauthorization.

## Timeframes for Decisions

Conduent Care Solutions will acknowledge the receipt of the NCIC [Form 25PR](#) within two (2) business days. Requests for preauthorization will be completed within seven (7) business days of receipt of the NCIC [Form 25PR](#).

Decisions for cases involving urgent care will be issued as soon as possible based on the clinical situation, but no later than 72 hours of receipt of a request for preauthorization.

Standard appeals will be completed within thirty (30) calendar days from the receipt of the request with verbal and/or faxed notification. The written notification will include (in addition to the information in section 9, Contents of Written Notifications) the requesting physician's right to further appeal with the applicable regulatory agency if the adverse determination is upheld.

Expedited appeals will be completed within seventy-two (72) hours of receipt of the request with verbal and/or faxed notification within seventy-two (72) hours. The written notification will include (in addition to the information in Section 9, Contents of Written Notifications) the requesting physician's right to further appeal with the applicable regulatory agency if the adverse determination is upheld.



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Workers' Compensation  
Utilization Management  
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