Workers' Comp

# High-Cost Treatments Demand a Stronger UR Lens

June 12, 2026
4 MIN READ
Author profile image


## Susan Doering

### Senior Director, Clinical Operations


High-cost treatment requests in workers' compensation do not always fit cleanly into a guideline. Claims teams need to understand the clinical facts behind the request, the documentation supporting it and how the decision affects the injured employee's recovery and the claim.

That challenge comes into focus in a recent California Workers' Compensation Institute review of hospital discharge data. CWCI found that inpatient spinal surgeries averaged **$237,554 in hospital charges in 2024**. Yet the number of these procedures has dropped sharply over the last decade, falling from **4,357 cases in 2013 to 1,429 cases in 2024**. That represents a **67.2% decline** and a new post-reform low.

CWCI points to several contributing factors, including reforms that eliminated duplicate payments for spinal surgery hardware and expanded evidence-based guidelines for spinal fusions. For workers' compensation and auto payers, the data tells an important story: clear clinical guardrails, disciplined review and strong oversight can change the trajectory of high-cost treatment categories.

The numbers also point to a harder question for payers.

Evidence-based guidelines establish the clinical foundation for utilization review (UR). The challenge is applying them to the full clinical picture, especially when the request involves surgery, incomplete documentation and/or a long recovery history.

Spinal surgery requests require evaluation of multiple factors: prior conservative care, clinical exam and diagnostic findings, functional limitations, comorbidities, recovery history and documentation gaps. These variables directly impact clinical assessment and determination rationale.

That is where the clinical lens behind utilization review becomes critical.

A strong review process helps claims teams answer practical questions:

- Is the requested treatment medically necessary?
- Is it supported by the injured employee's documented condition?
- Has the appropriate care pathway been followed?
- Does the request align with evidence-based guidelines?
- Is the determination clear and defensible?

For payers, those questions carry real weight. When UR rationales lack thorough clinical reasoning, claims teams are left with unanswered questions, leading to delayed decisions, increased dispute risk and compounded claim complexity.

A strong utilization review program does not treat lower utilization as the only measure of success. It helps determine whether the requested care is appropriate, supported and tied to the injured employee's recovery path.

This is especially important as inpatient care continues to change. CWCI found that while workers' compensation inpatient stays have declined over the last decade, the remaining cases are often more severe, with longer stays and higher charges. Payers may be managing fewer inpatient cases, but the stakes attached to each case are higher.

In that environment, utilization review cannot be treated as a transaction.

A consultative utilization review model combines clinical expertise, evidence-based guidelines, jurisdictional knowledge and clear communication to help claims teams understand request appropriateness and identify when additional information or clinical guidance is needed. When data is analyzed across the entire program, payers can evaluate approval rates, modification trends, appeal outcomes, treatment categories, jurisdictional patterns and peer escalations in context. This model reveals program-level insights that individual reviews cannot, enabling organizations to optimize clinical oversight, calibrate rules by jurisdiction and treatment type, identify emerging cost drivers and improve consistency across the claim journey.

For high-cost treatment categories like spinal surgery, that kind of clinical insight matters. The right review partner helps payers evaluate medical necessity in context, support appropriate care and give claims teams a clearer path forward.

At Enlyte, utilization review combines clinical expertise, consultative engagement, and data-driven insights to help workers' compensation payers assess medical necessity and reasonableness. Our experienced clinical teams apply evidence-based guidelines and deliver clear determination reporting that supports timely, defensible decisions while managing the clinical and regulatory complexity of high-cost treatment requests. Technology enhances this process by reducing manual steps, supporting consistency, and accelerating reviews—but in complex cases, technology strengthens clinical judgment rather than replacing it. The most effective programs recognize when automation can support decisions and when cases require deeper clinical review, peer involvement, or additional consultation.

CWCI's spinal surgery findings show what can happen when a costly treatment category is evaluated through stronger evidence-based guardrails. For payers, the next opportunity is to make sure those guardrails are applied with the right clinical lens.

In claims management, a treatment decision rarely stands alone. It affects recovery, claim direction, medical spend, and the confidence claims teams need to move forward.

High-cost treatment demands more than a checklist.

It demands a stronger UR lens.



©2022 Enlyte Group, LLC.

mitchell | genex | coventry