



Utilization Review Plan

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I. UR Standards-Definitions

The CompPartner's Utilization Review Program renders decisions for medical necessity and appropriateness of care for proposed treatment plans while attempting to assure quality of care for injured employees. Quality medical care for injured employees is enhanced through timely communication with the medical community. The Utilization Review Program ensures that medical care is consistent with evidence-based practice and meets current peer-reviewed medical standards and guidelines.

8 CCR § 9792.6 Utilization Review Standards- Definitions

- “ACOEM Practice Guidelines” means the American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines, Second Edition.
- “Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on the Doctor’s First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “Primary Treating Physician’s Progress Report,” DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the DWC Form PR-2.
- "Claims Administrator" is a self-administered workers' compensation insurer, an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610. The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.
- “Concurrent review” means utilization review conducted during an inpatient stay.
- “Course of treatment” means the course of medical treatment set forth in the treatment plan contained on the “Doctor’s First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “Primary Treating Physician’s Progress Report,” DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.
- “Emergency health care services” means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.
- “Expedited review” means utilization review conducted when the injured worker’s condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily

function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

- "Expert reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.
- "Health care provider" means a provider of medical services, as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.
- "Immediately" means within 24 hours after learning the circumstances that would require an extension of the timeframe for decisions specified in subdivisions (b)(1), (b)(2) or (c) and (g)(1) of section 9792.9.
- "Material modification" is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.
- "Medical Director" is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California. The Medical Director is responsible for all decisions made in the utilization review process.
- "Medical services" means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.
- "Prospective review" means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services.
- "Request for authorization" means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) or a written request for a specific course of proposed medical treatment. An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours. Both the written confirmation of an oral request and the written request must be set forth on the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same

information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization.

- “Retrospective review” means utilization review conducted after medical services have been provided and for which approval has not already been given.
- “Reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer’s practice.
- “Utilization review plan” means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.
- "Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. Utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed.
- "Written" includes a facsimile as well as communications in paper form.

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 3209.3, 4062, 4600, 4600.4, 4604.5, and 4610, Labor Code.

II. UR Program Access and Structure

Utilization Review Structure

CompPartners uses on-site and off-site contracted medical professionals to provide Utilization Review Services.

The CompPartners Medical Director is responsible for oversight of all utilization report activities and ensures that the utilization review process is followed in accordance with this utilization review plan and the regulations adopted on September 22, 2005. The Medical Director is board-certified occupational medicine physician who holds an unrestricted license to practice medicine in the State of California. The responsibilities include, but are not limited to:

1. Guideline training
2. Daily file reviews with nurses
3. Participant in UR CQI committee
4. Evaluation of CQI reports

The CompPartners Medical Director is:

Steven Rosen. MD
California License Number G-24823
4 Park Plaza, Suite 750
Irvine, CA 92614
(949) 253-3114

Utilization Review Staff

Utilization Review Nurses are licensed professionals that will review request for authorizations and will apply the Medical Treatment Utilization Schedule (MTUS). If the MTUS is not applicable, other evidence-based medical treatment guidelines generally recognized by the medical community shall be used.

The **Peer Reviewer** will be utilized to render decisions on those requests for authorization that are outside of guidelines or when the utilization review nurse does not have enough medical information to render a decision. A Reviewer will be a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed in the state of California, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice.

CompPartners may use the services of outsourced vendors for utilization review services to supplement the utilization review program. All outsourced utilization review services are in strict compliance with California and are subject to the high quality assurance standards in their decision making.

III. Utilization Review Program Access and Process

Program Access

CompPartners provides telephone and facsimile access for physicians to request authorization for health care services between the hours of 8:00 a.m. and 5:30 p.m., Pacific Time, Monday through Friday. CompPartners has available voicemail and facsimile options for after hour requests for medical treatment or to provide medical information in response to inquiries from CompPartners staff.

CompPartners Utilization Review plan is evaluated at least annually and updated when indicated based upon California regulations. The plan is available upon request to the public.

Authority: Sections 133, 4603.5, and 5307.3, Labor Code. 8 CCR § 9792.9

Reference: Sections 4062, 4600, 4600.4, 4604.5, and 4610, Labor Code.

Utilization Review Process

Referrals

All requests for authorization must be in writing and must specify the course of the proposed medical treatment. Any oral request for authorization must be followed by a written confirmation of the request within 72 hours. The written request must be set forth in the Form DLSR 5021 (Doctor's First Report) or in the Primary Treating Physician's progress report (PR2). The PR2 may be in a narrative format; however it must be clearly marked at the top that it is a request for authorization.

Administrative Authorization

Non-licensed medical personnel will provide certifications for non-complex treatment requests that are within the MTUS guidelines to assist with expediting medical care. This process will be client specific and only performed on cases that are within the first two months of the date of injury.

Clinical Assessment

CompPartners will review all requests for authorization submitted for medical necessity as submitted via client account instructions. The Utilization Review Nurse will assess the medical information for completeness and request any additional information needed to make a decision. The Utilization Review Nurse may certify the request for authorization upon review of the medical information. The Utilization Review Nurse may discuss the applicable criteria with the requesting physician. If the treatment is inconsistent with the criteria, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request which the Utilization Review Nurse can certify. The Utilization Review Nurse may not delay, deny or modify the request for authorization. If the Utilization Review Nurse is not able to certify the request based on the medical information available, the request should be forwarded to the Peer

Reviewer for medical necessity determination. Only a Peer Reviewer competent to evaluate the specific clinical issues, which are within the scope of the physician's practice, may modify, delay or deny request for authorizations.

The Peer Reviewer will document decisions on the request for authorizations. The report that conveys decision to delay, modify or deny treatment will include the following documentation:

- License number, specialty, contact information and hours of availability
- Date on which the decision was made
- Description of the specific course of proposed medical treatment for which authorization was requested
- Description of the medical treatment approved, if any
- Clear and concise explanation of the reason for the decision
- Description of the criteria or guideline used pursuant to section 9792.8 (a) (3)
- Clinical reasons regarding medical necessity

The Peer Review report is considered a part of the decision letter. The decision letter is essentially a cover page to the peer review report. As a package they contain all required regulatory language.

We currently do not issue conditional denials secondary to lack of information. Instead, a peer review process is initiated and denials are based on lack of medical necessity. If a denial occurs without a successful discussion with the requesting physician, a reconsideration process is allowed with the same reviewer, if available. Please refer to the Appeals/Reconsideration section for additional details.

CompPartners will not deny treatment for failure to obtain prior authorization for emergency health care services.

Time Frames

All decisions must be made in a timely fashion after receipt of the information reasonably necessary to make the determination. Decision timeframes depend upon the type of utilization review conducted, as outlined:

- Prospective and Current Reviews- A decision will be provided within 5 business days from when the provider request for treatment was received. When a provider sends a request that requires additional information, the Utilization Review Nurse may telephone the provider to request the additional information, within 5 business days of the receipt of the request for authorization. This request must be followed by a written request for information that clearly indicates what additional information is needed. If the provider fails to submit the requested information within 14 days from the date of the original request, the request will be sent to a Reviewer for a decision to delay, deny or modify the request for authorization.
- Retrospective Reviews – A decision must be communicated within thirty days of receipt of information that is reasonably necessary to make the decision.

- Expedited Reviews - If the injured employee's condition is such that there is an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other major bodily function, a decision must be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of all necessary information.

The Requesting physician will indicate the need for an Expedited Review upon submission of the request. In this event, the request for authorization should be sent to the Utilization Review Nurse for immediate review. Services provided on an emergency basis, without a request for authorization will be subject to retrospective review.

Decision Communications

CompPartners will communicate all decisions by phone call or facsimile and the formal written will be sent to the prescribing physician within twenty four hours of the decision for concurrent review and within two business days for prospective review as outlined below:

- Certification- Decisions to approve a physician's request shall be communicated to the requesting physician within 24 hours of the decision by telephone or facsimile. The phone call shall be followed by written notice to the prescribing physician within twenty four hours of the decision for concurrent review and within two business days for prospective review. CompPartners only certifies treatment as medically necessary.
- Withdrawal-If a request does not meet criteria, the prescribing physician may voluntarily withdraw a portion or all of the requested treatment and submit in writing an amended request or complete the Notification of Withdrawn/Amended Request for Treatment document initiated by the CompPartners staff.
- Delay- The decision shall be communicated by phone or facsimile and shall be followed by written notice to the prescribing physician within twenty four hours of the decision for concurrent review and within two business days for prospective review. A written notification must advise the requesting provider, the injured worker, and the injured worker's attorney if applicable, of the delay and estimated date that a decision will be reached. The Peer Review report shall include the procedures or services being delayed, a description of the criteria or guidelines utilized the clinical reasons for the decision, the information reasonably necessary to make the decision and be attached to the Provider Notification Letter.

Non-physician providers of goods or services and for whom contact information has been included, shall be notified in writing of any decision to delay authorization but shall not be entitled to the rationale, criteria, or guidelines used, or the Peer Review Report.

- Denial- The decision shall be communicated by phone or facsimile and shall be followed by written notice to the prescribing physician within twenty four hours of the decision for concurrent review and within two business days for prospective review. The Peer Review Report will include the procedure(s) being denied, a description of the criteria or guidelines used, and the clinical reasons for the decision. The Peer Review report will be attached to

the Provider Notification Letter. The letter shall be sent to the prescribing physician, injured worker, and injured worker's attorney, if applicable.

Non-physician providers of goods or services, identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of any decision to deny authorization but shall not be entitled to the rationale, criteria, or guidelines used, or the Peer Review Report.

- Modification- The decision shall be communicated by phone or facsimile and shall be followed by written notice to the prescribing physician within twenty four hours of the decision for concurrent review and within two business days for prospective review. A change made in the treatment plan, based upon medical necessity. It does not refer to negotiated changes that are agreed upon by the provider and the nurse. The Peer Reviewer may modify requests pertaining to frequency and/or duration of an intervention, durable medical equipment requests, and rental versus purchase requests. If a discussion occurs with the requester then it must be an agreed modification. If it is not agreed to then it is non-certified. If contact doesn't occur then the reviewer can modify without an agreement.

If the Peer Reviewer modifies the treatment request, the report must include the procedure(s) requested, the modified procedure(s) authorized, a description of the criteria or guidelines used, and the clinical reasons for the decision. The Peer Review Report shall be attached to the Provider Notification Letter. The letter shall be sent to the prescribing physician, injured worker, and injured worker's attorney, if applicable.

Non-physician providers of goods or services and for whom contact information has been included, shall be notified in writing of any decision to modify the authorization but shall not be entitled to the rationale, criteria, or guidelines used, or the Peer Review Report.

As noted in the attached letter templates, our Physician Reviewers and/or Medical Directors are available 8 am to 5pm PST or an agreed upon scheduled time to discuss the decision with the requesting physician. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services. CompPartners provides a telephone number in the letter to designated staff members to facilitate scheduling the discussion.

Specifically in the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker. In addition, the non-physician provider of goods or services identified in the request for authorization, and for who contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

The mandatory language is outlined in all Provider Notifications Letters that require a carbon copy to the injured worker as noted below.

NOTICE TO INJURED EMPLOYEE

All utilization review disputes will be resolved in accordance with Labor Code Section 4062.

If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in the claims administrator's internal utilization review appeals process.

The 20-day time limit may be extended for good cause or by mutual agreement of the parties. You also have the right to file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with Title 8, CCR sections 10136(b)(1), 10400, and 10408.

If you want further information, you may receive recorded information by calling 1-800-736-7401 or you may contact the local state Information and Assistance office. A list of the local office numbers are provided below.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

I&A Office	Phone Numbers
Anaheim	(714) 738-4038
Bakersfield	(661) 395-2514
Eureka	(707) 441-5723
Fresno	(559) 445-5355
Grover Beach	(805) 481-3296
Goleta	(805) 968-4158
Long Beach	(562) 590-5240
Los Angeles	(213) 576-7389
Oakland	(510) 622-2861
Oxnard	(805) 485-3528
Pomona	(909) 623-8568
Redding	(530) 225-2047
Riverside	(951) 782-4347
Sacramento	(916) 263-2741
Salinas	(831) 443-3058
San Bernardino	(909) 383-4522
San Diego	(619) 767-2082
San Francisco	(415) 703-5020
San Jose	(408) 277-1292
Santa Ana	(714) 558-4597
Santa Monica	(310) 452-1188
Santa Rosa	(707) 576-2452
Stockton	(209) 948-7980
Van Nuys	818) 901-5367

Review of requests for authorization (RFA) of Disputed (Non Accepted) Body Parts

If requested by a client, CompPartners will provide a separate handling for disputed body parts certifications. The process will include:

- Verbal decision will contain the following language:
 - *“We found the treatment to be medically necessary, however, we are advised that the claims examiner is not authorizing the treatment due to a legal objection so the RFA is not approved and the reasons will be explained in a letter you will receive shortly.”*
- The letter will be completed by CompPartners staff and forwarded to claims
- Claims will be responsible for submitting the objection letter and the certification letter within the appropriate timeframes and copy all required parties.

Treatment Guidelines

As in accordance with section section9792.20-9792.23, the Medical Treatment Utilization Schedule (MTUS) should be used for initial review of treatment requests. If the MTUS is not

applicable, other evidence-based medical treatment guidelines generally recognized by the medical community shall be used as in accordance with 9792.22. To supplement the MTUS, CompPartners generally uses the Official Disability Guidelines (ODG) to evaluate requests for medical treatment.

Annually, CompPartners CQI committee reviews these guidelines for continued use. All guidelines utilized are disclosed to the prescribing physician and the injured worker and are available to the public.

Reconsideration/Appeals Process

CompPartners maintains a voluntary internal secondary review process. Our internal telephonic peer review process is in addition to the 20 day window allowed under the 4062 rule. We afford the requester a 30 day window to request a reconsideration or an appeal. The former may occur if peer to peer contact was attempted but failed. The latter occurs when the requester had a discussion with the reviewer and continues to disagree with the recommendation and request a different reviewer to evaluate the request. The requests must be in writing from the prescribing physician and can be faxed or mailed to the utilization review nurse to facilitate the reconsideration/appeals process. If it has been greater than thirty days since the peer reviewer's decision, then the request must be submitted as a new request. CompPartners will complete the reconsideration/appeals decision within five business days from date of the request received.

Authority: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, and 4610, Labor Code.

IV. Provider Notification Letters

Provider Certification Letter

Date:
Auth Number:

Prescribing Physician:
Fax number:

Claim Number:
Employee:
Client:
Date of Injury:

Dear Medical Provider:

The **PR2 Report Date** request for medical treatment for _____ was received on _____ and a decision was made on _____. The request of the following services has been reviewed in accordance with CompPartners' Utilization Review Program:

<p>Your request for (_____) is certified. Approved facility: Phone/Fax: TIN#: Units: Dates of Service:</p>

If you need to discuss this certification please call me at the following telephone number:

This certification is valid for 60 days from the date of this notice.

Sincerely,

Utilization Review Nurse

cc:

Provider Notification Letter

Request for Auth #:
Date:

Prescribing physician:
Fax number:

Claim Number:
Employee:
Date of Injury:

Dear Medical Provider:

The PR2 Report Date request for medical treatment for Employee was received on Date adj rcvd written request and a decision was made on mm/dd/yy. The request of the following services has been reviewed in accordance with Comp Partners' Utilization Review Program: List procedure description /frequency of service/.

All available documentation has been reviewed. In an attempt to obtain additional relevant information:

- Nurse attempted to contact your office on mm/dd/yy
- A request for information letter was sent to you on mm/dd/yy and a copy is attached
- The physician reviewer attempted to contact you on mm/dd/yy and the attempt was successful or not successful

Our Physician Reviewer, PA_NAME, has denied the request for authorization of the following service(s)/item(s): List procedure description/frequency of service. Attached is our Physician Reviewer's explanation of the reason(s) for the denial, which includes the criteria or guidelines used in the decision and the clinical reason(s) regarding medical necessity.

Disclaimer: Denial or non-certification for all or part of the requested intervention is in no way intended to absolve the provider from his or her duty to adhere to any applicable practice standards. Medical necessity determinations are based on available information. You are entitled to a voluntary secondary review if the following box is checked:

All requests for a secondary review must be in submitted in writing to the assigned Utilization Review Nurse on this claim by mail or fax @ () . If you wish to speak to the Physician

Reviewer directly, please contact () between the hours of 8am-5pm PST so we may facilitate contact with the Physician Reviewer. The payment decision for the proposed treatment will be made by the insurer or third party administrator, whichever is applicable.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE OR BILLING.

Sincerely,

Utilization Review Nurse

Enc: Physician Peer Review Report (except for provider of service)
Request for Information Letter (if applicable)

cc: **Claims Adjuster**
Applicant Attorney; Address; City, State Zip Code
Injured Employee; Address; City, State Zip Code
Service Provider (if noted on request); Address; City, State Zip Code

NOTICE TO INJURED EMPLOYEE

All utilization review disputes will be resolved in accordance with Labor Code Section 4062.

If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in the claims administrator's internal utilization review appeals process.

The 20-day time limit may be extended for good cause or by mutual agreement of the parties. You also have the right to file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with Title 8, CCR sections 10136(b)(1), 10400, and 10408.

If you want further information, you may receive recorded information by calling 1-800-736-7401 or you may contact the local state Information and Assistance office. A list of the local office numbers are provided below.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

<u>I&A Office</u>	<u>Phone Numbers</u>
Anaheim	(714) 738-4038
Bakersfield	(661) 395-2514
Eureka	(707) 441-5723
Fresno	(559) 445-5355
Grover Beach	(805) 481-3296
Goleta	(805) 968-4158
Long Beach	(562) 590-5240
Los Angeles	(213) 576-7389
Oakland	(510) 622-2861
Oxnard	(805) 485-3528
Pomona	(909) 623-8568
Redding	(530) 225-2047
Riverside	(951) 782-4347
Sacramento	(916) 263-2741
Salinas	(831) 443-3058
San Bernardino	(909) 383-4522
San Diego	(619) 767-2082
San Francisco	(415) 703-5020
San Jose	(408) 277-1292
Santa Ana	(714) 558-4597
Santa Monica	(310) 452-1188
Santa Rosa	(707) 576-2452
Stockton	(209) 948-7980
Van Nuys	(818) 901-5367



**Physician Review Recommendation
Prepared for –**

Patient Name:
CompPartners Case:
Requester:
Adjuster:
State:
Review:

Claim/Policy #:
DOI:
Request #:
Case #:
Date Referred:
Date Completed:

<u>Reason for Referral :</u>	<u>Recommendation:</u>
Determine the medical necessity for:	
1. Request # -	
2. Request # -	

Guideline/Reference Used:

- 1.

Clinical Summary:

Rationale for Recommendation:

1. (DETERMINATION) – Request # –

2. (DETERMINATION) – Request # –

If non-certification is secondary to lack of sufficient information, what information, or test result would be required?

Reviewed Data: All appropriate medicals submitted have been reviewed.

Requesting Provider/Telephone #:

Provider or Designee Contact:

Appeal/reconsideration/disclaimer given:

Date/Time:

Name:

Content of Discussion:

Date/Time:

Name:

Content of Discussion:

Attestation of lack of conflict of interest: Yes.

This reviewer declares, under penalty of perjury, that the information contained in this report and its attachment, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, this report accurately describes the information provided to me.

Peer Reviewer's Name: M.D.

Specialty:

License #:

State:

Signature:

Date:

This recommendation and rationale has been secondarily reviewed by Dr. _____, CA licensed # _____. It has been found to be appropriate given the clinical information available for review.

Provider Notification Letter

Request for Auth #:

Date:

Prescribing physician:

Fax number:

Claim Number:

Employee:

Date of Injury:

Dear Medical Provider:

The PR2 Report Date request for medical treatment for Employee was received on Date adj rcvd written request and a decision was made on mm/dd/yy. The request of the following services has been reviewed in accordance with Comp Partners' Utilization Review Program: List procedure description /frequency of service/.

All available documentation has been reviewed. In an attempt to obtain additional relevant information:

- Nurse attempted to contact your office on mm/dd/yy
- A request for information letter was sent to you on mm/dd/yy and a copy is attached
- The physician reviewer attempted to contact you on mm/dd/yy and the attempt was successful or not successful

Our Physician Reviewer, PA_NAME, has modified the request for authorization and the decision(s) is/are: List procedure description/frequency of service.

Attached is our Physician Reviewer's explanation of the reason(s) for the modification, which includes the criteria or guidelines used in the decision and the clinical reason(s) regarding medical necessity.

Disclaimer: Denial or non-certification for all or part of the requested intervention is in no way intended to absolve the provider from his or her duty to adhere to any applicable practice standards. Medical necessity determinations are based on available information. You are entitled to a voluntary secondary review if the following box is checked:

All requests for a secondary review must be in submitted in writing to the assigned Utilization Review Nurse on this claim by mail or fax @ () . If you wish to speak to the Physician Reviewer directly, please contact () between the hours of 8am-5pm PST so we may facilitate contact with the Physician Reviewer. The payment decision for the proposed treatment will be made by the insurer or third party administrator, whichever is applicable.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE OR BILLING.

Sincerely,

Utilization Review Nurse

Enc: Physician Peer Review Report (except for provider of service)
Request for Information Letter (if applicable)

cc: **Claims Adjuster**
Applicant Attorney; Address; City, State Zip Code
Injured Employee; Address; City, State Zip Code
Service Provider (if noted on request); Address; City, State Zip Code

NOTICE TO INJURED EMPLOYEE

All utilization review disputes will be resolved in accordance with Labor Code Section 4062.

If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in the claims administrator's internal utilization review appeals process.

The 20-day time limit may be extended for good cause or by mutual agreement of the parties. You also have the right to file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with Title 8, CCR sections 10136(b)(1), 10400, and 10408.

If you want further information, you may receive recorded information by calling 1-800-736-7401 or you may contact the local state Information and Assistance office. A list of the local office numbers are provided below.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for

disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

I&A Office	Phone Numbers
Anaheim	(714) 738-4038
Bakersfield	(661) 395-2514
Eureka	(707) 441-5723
Fresno	(559) 445-5355
Grover Beach	(805) 481-3296
Goleta	(805) 968-4158
Long Beach	(562) 590-5240
Los Angeles	(213) 576-7389
Oakland	(510) 622-2861
Oxnard	(805) 485-3528
Pomona	(909) 623-8568
Redding	(530) 225-2047
Riverside	(951) 782-4347
Sacramento	(916) 263-2741
Salinas	(831) 443-3058
San Bernardino	(909) 383-4522
San Diego	(619) 767-2082
San Francisco	(415) 703-5020
San Jose	(408) 277-1292
Santa Ana	(714) 558-4597
Santa Monica	(310) 452-1188
Santa Rosa	(707) 576-2452
Stockton	(209) 948-7980
Van Nuys	(818) 901-5367



**Physician Review Recommendation
Prepared for –**

Patient Name:	Claim/Policy #:
CompPartners Case:	DOI:
Requester:	Request #:
Adjuster:	Case #:
State:	Date Referred:
Review:	Date Completed:

<u>Reason for Referral :</u>	<u>Recommendation:</u>
Determine the medical necessity for:	
1. Request # -	
2. Request # -	

Guideline/Reference Used:

- 1.

Clinical Summary:

Rationale for Recommendation:

1. (DETERMINATION) – Request # –

2. (DETERMINATION) – Request # –

If non-certification is secondary to lack of sufficient information, what information, or test result would be required?

Reviewed Data: All appropriate medicals submitted have been reviewed.

Requesting Provider/Telephone #:

Provider or Designee Contact: **Appeal/reconsideration/disclaimer given:**

Date/Time: **Name:**

Content of Discussion:

Date/Time:

Name:

Content of Discussion:

Attestation of lack of conflict of interest: Yes.

This reviewer declares, under penalty of perjury, that the information contained in this report and its attachment, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, this report accurately describes the information provided to me.

Peer Reviewer's Name: M.D.

Specialty:

License #:

State:

Signature:

Date:

This recommendation and rationale has been secondarily reviewed by Dr. _____, CA licensed # _____ . It has been found to be appropriate given the clinical information available for review.

Notification of Withdrawal/Amended Request for Treatment

Request for Auth #:

Date:

Prescribing Physician:

Fax number:

Claim Number:

Employee:

Date of Injury:

Dear Medical Provider:

Based on our conversation on _____, you have agree to withdraw/amend your treatment request for the above referenced employee.

In order to process your request per Title 8, California Code of Regulations, Section 9792.7 (b) (3), please sign and return this form by _____ via fax to _____.

I agree to withdraw/amend my request for the following treatment:

Original request dated: _____ which was received on _____ regarding requested treatment

Please select one of the following options:

Withdrawn on

I agree to following amended treatment request-

Prescribing Physician name:

Prescribing Physician signature:

Date:

Please note that if this request is not received back by the above due date the original treatment request will be sent for physician review.