UTILIZATION REVIEW DECISIONS ISSUED PRIOR TO JULY 1, 2013 FOR INJURIES OCCURRING PRIOR TO JANUARY 1, 2013

GOALS

- Assure injured workers receive timely and appropriate care in the appropriate setting.
- Monitor quality and cost effectiveness of 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.
- Identify long term, costly disabilities and rehabilitation needs
- Provision of 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, and prior to, retrospectively, or concurrent with the provision of medical treatment pursuant to Labor Code section 4600.
- Utilization review is limited to a review based on medical necessity and does not include determinations of the work-relatedness of the injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed.
- Compliance with 8 CCR § 9792.6 et seq.

Bunch CareSolutions performs utilization review in the state of California as a service to our managed care clients. The services performed are based upon account protocols and the delegation of specific claims and services. Our clients and their Third Party Administrators may utilize an approval and/or prior authorization program for certain treatment requests based on the client's established criteria. Bunch CareSolutions acts upon treatment requests within the statutory requirements when received by the claim payor or by Bunch, whichever is sooner.

I. OVERVIEW

The following plan outlines the processes to be followed for either an occupational injury or illness occurring prior to January 1, 2013 if the decision or the request is communicated to the requesting physician prior to July 1, 2013.

In conducting utilization review the following definition for authorization will be utilized:

> *"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.*

1) A Nurse Reviewer reviews all available medical information and applies appropriate guidelines.

2) If a treatment request fails to meet or exceeds stated guidelines, the request will be assigned to a Physician Advisor.
3) The Nurse Reviewer may also discuss the applicable criteria with the requesting physician and request an amendment of the original request. Any requesting physician who agrees to an amended request will forward a signed document outlining the change in the requested treatment/service.
4) A Nurse Reviewer may issue a request for information letter within 5 business days of receipt of the request for authorization, thus extending the utilization review process not to exceed 14 days from receipt of request for treatment.
5) Any decision to deny, delay or modify a request for medical treatment will be conducted by a Physician Advisor who is competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the scope of the physician's practice.
6) Bunch CareSolutions has a process in place to accommodate any treatment requests identified as requiring expedited review according to the provisions of §9792.9
7) Our internal appeals process affords the injured worker and his attorney, if represented and requesting provider the opportunity to appeal all decisions made by a Physician Advisor as well as meet regulatory timeframes and requirements.
8) Bunch CareSolutions utilizes Medical Treatment Utilization Schedule (MTUS) as the primary guideline and if MTUS is silent, other evidence based guidelines as defined by the California Code of Regulations.
9) A utilization review decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

II. FIRST LEVEL REVIEW

Upon receipt of a valid treatment request, the Nurse Reviewer verifies that all pertinent information necessary to complete the review is available. This information includes identifying information about the injured worker, the treating healthcare provider and the facilities rendering care. In addition, clinical information regarding the diagnosis and the medical history of the injured worker relevant to the diagnosis of the compensable injury, and the treatment plan prescribed by the treating health care provider should be available.

If information necessary to complete the review and render a decision is not provided with the original request for certification, such information may be requested via a request for information letter within five (5) working days from the date of receipt of the written request for certification.

If the information is not received by the end of the 11th calendar day from the date of receipt of the original request, the review will be sent to a Physician Advisor to make a determination based on the information at hand. The Nurse Reviewer will document all attempts to obtain the information from the physician. A determination will be given no later than 14 days from the date of receipt of the request.

If additional information is received, the review will continue. The Nurse Reviewer applies the state mandated guidelines and criteria to the requested treatment. If the treatment or service meets the stated guidelines, the Nurse Reviewer certifies the service and notifies the requesting physician, the injured worker and the claims examiner no later than 14 days from the date of receipt of the request. Those services which do not meet the stated guidelines are referred to a Physician Advisor.

If a treatment request does not meet applicable criteria or the Nurse Reviewer and requesting physician have agreed upon a modified or amended treatment request, the requesting physician may voluntarily withdraw and/or modify all or part of the request and submit either a signed and completed notice of withdraw/modify request form or an amended request.

III. SECOND LEVEL REVIEW

Should requested medical treatment or service fail to meet treatment guidelines, a second level review is performed by a Physician Advisor. Any decision to deny, delay or modify a request for medical treatment will be conducted by a physician who is competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the scope of the physician's practice.

The Physician Advisor assigned to the case reviews the documentation and attempts to contact the ordering physician, as necessary, in order to make a determination. The Physician Advisor will attempt to contact the requesting physician to discuss the request at least two (2) times during the window of opportunity provided by the Nurse Reviewer. If contact is made, the Physician Advisor will notify the requesting provider of the determination or if contact is not successful, leave the determination with the office staff. All contact attempts will be documented on their report.

The Nurse Reviewer will send written notification via fax or letter to the affected parties within 24 hours for a concurrent review and within two (2) business days for a prospective review after the verbal notification has occurred. (See the section "Contents of Written Notifications" for details.)

IV. DELAYED DETERMINATIONS

A Physician Advisor may extend the determination under the following conditions:

1) all reasonably necessary information has not been received but has been requested;
2) the Physician Advisor has asked that an additional examination or test be performed that is reasonable and consistent with professional recognized standards of medical practice;
3) the claims administrator needs a specialized consultation and review of medical information by an expert reviewer. 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 and where these services are within the individual's scope of practice, who has been consulted by the reviewer to provide specialized review of medical information.

If the request is delayed, the requesting physician, injured worker and if represented, the injured worker's attorney will be notified and the notification will include their right to file a dispute.

V. TIMEFRAMES FOR DECISIONS

Prospective Review
Prospective Review means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to delivery of the requested medical services.

All prospective review decisions shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) working days from the date of receipt of the written request for certification. Within twenty-four (24) hours after a decision is made it will be communicated to the requesting provider by phone or fax. The verbal decision is followed by written documentation to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within two (2) business days of the decision. The written notification to the non-physician provider of goods will not include the rationale, criteria or guidelines used for the decision.

Concurrent Review
Concurrent review means utilization review conducted during an inpatient stay.

The Nurse Reviewer will conduct the review in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) working days from the date of receipt of the written request for certification or prior to the end of their previously authorized confinement.

Notification of the decision will be given to the requesting physician within twenty-four (24) hours by phone or fax. The communication by telephone shall be followed by written notice to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within twenty-four (24) hours.

Medical care will not be discontinued until the treating physician has been notified of the decision and a care plan has been agreed upon by the treating physician that is appropriate for the medical needs of the injured worker. The treating physician is afforded the opportunity to discuss the determination with the clinical review staff in the case of an adverse determination and may request an internal appeal process.

Expedited Review
Upon notice from the provider that there is need for an expedited review because the injured worker's condition is such that he/she 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.

The Nurse or Physician Reviewer makes a determination in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination.

Emergency Healthcare Services

Any emergency healthcare service is defined as a healthcare service 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 will not require prior certification through utilization review.

Failure to obtain prior certification for emergency healthcare services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services.

Retrospective Review

Retrospective review means utilization review conducted after medical services have been provided and for which approval has not already been given.

If a retrospective review requires the review by a physician advisor, they are performed by Physician Advisors/ Reviewers, who are competent to evaluate the specific clinical issues and where services requested, are within the scope of the physician's practice.

Retrospective review determinations are communicated to the physician, injured worker, and if the injured worker is represented, to the attorney within thirty (30) calendar days of receipt of the medical information that is reasonably necessary to make this determination.

VI. INTERNAL APPEALS

Participation in the internal appeals process is on a voluntary basis. This process is available to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. All appeal requests must be received within twenty (20) days of receipt of the determination. The request must include pertinent clinical information to support the request. The appeal review will be conducted by a Physician Advisor other than the one involved in the initial determination and who is competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the scope of the physician's practice.

All internal appeals will be completed within five (5) business days of the receipt of the request or within 72 hours if the requesting physician determines the need for an expedited appeal.

When a request for an appeal is made, the Nurse Reviewer will:

- Document the name and phone number of the person making the appeal request;
- Document the stated reason for the appeal;
- Review the case information for any supporting information;
- Refer to a Physician Advisor not involved in the initial denial.

The Physician Advisor must respond to an appeal request by:

- Reviewing the rationale and information from the original decision, if necessary;
- Consider new information that has become available since the initial decision;
- Make reasonable attempts to contact the requesting physician;
- Make a final determination per regulatory requirements.

If the Physician Advisor agrees with the initial denial, he will notify the requesting physician by telephone of his/her determination. The Physician Advisor notifies the Nurse Reviewer of the determination and rationale for upholding the denial. The Nurse Reviewer will send the letter "CA UR Final Appeal Upheld" within 24 hours to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.

If the Physician Advisor overturns the denial he will provide the Nurse Reviewer with the determination and the rationale for reversing the denial. The Nurse Reviewer immediately notifies the requesting physician if the advisor has not verbally notified the requesting physician, that the determination was overturned and proceeds with certification of the requested procedure and sends written notice of the approval to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.

VII. DISPUTE PROCESS

An adverse treatment request decision may also be disputed by an injured worker and if the injured worker is represented by counsel, the injured worker's attorney, through the Division of Workers' Compensation dispute resolution process. The dispute may be for any health care service. The following mandatory language in accordance with §9792.9 b (1) (E) will be included on our letters:

> "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me at (INSERT NURSE PHONE #). However, if you are represented by an attorney, please contact your attorney instead of me.

Also included is this mandatory language from section 9792.9(k)(7):

A clear statement that any dispute shall be resolved in accordance with the provisions of Labor Code section 4062, and: "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 the receipt of the utilization review decision. You must meet this deadline even if you are participating in our internal utilization review appeal process. The time limited may be extended for good cause or by mutual agreement of the parties."

"For information about the workers' compensation claims process and your rights and obligations go to http://www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

"The injured worker or injured worker's attorney may file an Application for Adjudication of Claim Form WCAB 1, and a Declaration of Readiness to Proceed (expedited trial), DWC-CA form 10208.3

VIII. CONTENTS OF WRITTEN NOTIFICATIONS

All written notifications of approvals shall specify the medical treatment service approved.

Written notifications will be sent within two (2) business days of receipt of the decision for prospective and retrospective review and within twenty-four (24) hours for concurrent review.

All written notifications modifying, delaying or denying treatment certification will be provided to the physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information.

- The date on which the decision is made;
- A description of the specific course of proposed medical treatment for which certification was requested;
- A clear and concise explanation of the reasons for the utilization review decision;
- A description of the medical criteria or guidelines used pursuant to section 9792.8, subdivision (a)(3)(B);
- The clinical reasons regarding medical necessity;
- The appeals process and dispute resolution process and to whom they are available;
- The name and specialty of the physician reviewer, and a telephone number by which a discussion can be scheduled with the reviewer, expert reviewer or medical director. The Nurse Reviewer will coordinate the conversation and all physician reviewers will be available for at least 4 hours per week during business hours (9:00 AM to 5:30 PM, Pacific Time.)

Non-physician providers of goods identified in the request for authorization, and for whom contact information has been included, shall also be notified in writing but shall not include the rationale, criteria or guidelines used for the decision.

The written notification will also include a description of the Division of Workers' Compensation dispute resolution process (see the section for Dispute Resolution).

Please see the enclosed "sample" CA UR letters.

IX. TREATMENT GUIDELINES AND CRITERIA

Bunch CareSolutions utilizes the Medical Treatment Utilization Schedule (MTUS) as the primary guideline and if MTUS is silent, other nationally-accepted guidelines and evidence-based literature in our utilization review program such as the Official Disability Guidelines and other state-adopted guidelines.. When the Medical Treatment Utilization Schedule (MTUS) is updated, Bunch CareSolutions will accept and utilize that schedule.

Our Physician Advisors utilize MTUS as the primary guideline and if MTUS is silent, other nationally recognized guidelines, evidence based literature and the "Standard of Care" criteria during the physician advisor process as well as the Official Disability Guidelines and other state-adopted guidelines.

Bunch CareSolutions Quality Management Committee undergoes a review and update of policies and procedures and treatment guidelines each year. All nurses undergo an individualized training course in the use of the treatment guidelines in addition to their twelve (12) week orientation training period.

Bunch CareSolutions will disclose the criteria or guidelines utilized for the specific procedures or conditions in our determination letters (except for letters to non-physician providers).

X. PERSONNEL QUALIFICATIONS AND TYPE

Medical Director

Gary Rischitelli, MD, JD, MPH, FACOEM, serves as our Medical Director. Dr. Rischitelli has almost 25 years of experience in occupational medicine and workers' compensation. He is a graduate of the Baylor College of Medicine in Houston, TX, and received his MPH from the Medical College of Wisconsin. He is board certified in Occupational Medicine by the American Board of Preventive Medicine and is a Fellow of the American College of Occupational and Environmental Medicine. Dr. Rischitelli was Chair of the Board of Fellowship Examiners, and has served as a member of the Board of Directors of the Occupational Physician Scholarship Fund and the American College of Occupational and Environmental Medicine.

Dr. Rischitelli is responsible for reviewing all commercial criteria used during the utilization review process (ACOEM and MDA) as well as oversight of the California utilization management program at Bunch CareSolutions. He is responsible for all decisions made in the utilization review process, including approvals, modifications, delays, or denials of requests by

physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, and complies with the state regulations.

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Nursing Staff

Bunch CareSolutions' Nursing Staff are licensed and many hold additional credentials such as CVN, CCM, CDMS, or CRRN. The Nurse Reviewers possess clinical nursing experience and are knowledgeable in medical management as well as workers' compensation.

Physician Staff

Our Physician Advisors hold current, unrestricted professional licenses by any state or the District of Columbia, hold board certification in their specialty and are in active practice.

XI. ACCESSIBILITY

Nurse Reviewers are accessible via a toll-free telephone number, 1-(866) 298-3126 between the hours of 8:00 am to 5:30 pm Pacific Time, Monday through Friday, excluding holidays. All Nurses have voicemail and will return all incoming telephone calls within one business day. Outside of normal business hours, we offer nurse availability twenty-four (24) hours per day, seven (7) days per week by calling 1-888-853-4735. Upon dialing this number the caller will get an after hour mailbox, where they will be instructed to leave a message and the call will be returned. A facsimile line is also available 24 hours per day at 1-(863) 669-2082.

A request for authorization transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day.

XII. REQUESTS FOR UR PLAN

Upon request by the public, Bunch CareSolutions will make available the complete utilization review plan through electronic means. If a member of the public requests a hard copy of the utilization review plan, Bunch may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed $0.25 per page plus actual postage costs.

UTILIZATION REVIEW DECISIONS FOR DATES OF INJURY ON OR AFTER JANUARY 1, 2013

GOALS

- Assure injured workers receive timely and appropriate care in the appropriate setting.
- Monitor quality and cost effectiveness of 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.
- Identify long term, costly disabilities and rehabilitation needs
- Provision of 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 pursuant to Labor Code section 4600.
- Utilization review is limited to a review based on medical necessity and does not include determinations of the work-relatedness of the injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed.
- Compliance with 8 CCR § 9792.6.1 et seq.

Bunch CareSolutions performs utilization review in the state of California as a service to our managed care clients. The services performed are based upon account protocols and the delegation of specific claims and services. Our clients and their Third Party Administrators may utilize an approval and/or prior authorization program for certain treatment requests based on the client's established criteria. Bunch CareSolutions acts upon treatment requests within the statutory requirements when received by the claim payor or by Bunch, whichever is sooner.

I. OVERVIEW

The following plan outlines the processes to be followed for either an occupational injury or illness occurring on or after January 1, 2013 or where the decision on the request is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

In conducting utilization review the following definition for authorization will be utilized:

> *"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 a completed "Request for Authorization for Medical Treatment," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, that has been transmitted by the treating physician to the claims administrator. Authorization*

shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the Request for Authorization for Medical Treatment," DWC Form RFA.

1) A Nurse Reviewer is responsible for the first level review of all medical information and for the certification of any treatment or procedure requested by the treating physician based on clinical information and guidelines.
2) If a treatment request fails to meet or exceeds stated guidelines, the request will be assigned to a Physician Advisor.
3) The Nurse Reviewer may also discuss the applicable criteria with the requesting physician and request a modification of the original request. Any requesting physician who agrees to an amended request will forward a signed document outlining the change in the requested treatment/service.
4) A Nurse Reviewer may issue a request for information letter within 5 business days of receipt of the request for authorization, thus extending the utilization review process not to exceed 14 days from receipt of request for treatment.
5) Any decision to deny, delay or modify a request for medical treatment will be conducted by a Physician Advisor who is competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the scope of the physician's practice.
6) Bunch CareSolutions has a process in place to accommodate any treatment requests identified as requiring expedited review according to the provisions of §9792.9.1(c)(3)(A).
7) Our internal appeals process affords the injured worker and his attorney, if represented and requesting provider the opportunity to appeal all decisions made by a Physician Advisor as well as meet regulatory timeframes and requirements.
8) Bunch CareSolutions utilizes Medical Treatment Utilization Schedule (MTUS) as a primary guideline, but if MTUS is silent, then Bunch will use other evidence based guidelines as defined by the California Code of Regulations.
9) A utilization review decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

I. FIRST LEVEL REVIEW

Upon receipt of a DWC Form RFA, the Nurse Reviewer verifies that all pertinent information necessary to complete the review is available. This information includes identifying information about the injured worker, the treating healthcare provider and the facilities rendering care. In addition, clinical information regarding the diagnosis and the medical history of the injured worker relevant to the diagnosis of the compensable injury, and the treatment plan prescribed by the treating physician should be available. Based on what information is available to us and what information may be missing on the RFA, the Nurse Reviewer will either mark it as "not complete" and return it to the requesting physician no later than five (5) business days from receipt or they may accept it as complete and continue with the processing. If the RFA is

returned as "Not Complete", the timeframe for the decision will begin once the RFA is completed and returned.

If information necessary to complete the review and render a decision is not provided with the original RFA, such information may be requested via a request for information letter within five (5) working days from the date of receipt of the written request for certification.

The Nurse Reviewer will document all attempts to obtain the information from the requesting physician. If the required information is not received by the end of the 11th calendar day from the date of receipt of the original request, the RFA will be sent to a Physician Advisor to make a determination based on the information provided. A determination will be given no later than 14 calendar days from the date of receipt of the RFA.

If the additional information is received, the review will continue. The Nurse Reviewer applies the state mandated guidelines and criteria to the requested treatment. If the treatment or service meets the stated guidelines, the Nurse Reviewer approves the service and notifies the ordering physician and the claims examiner within five (5) working days of receipt of the information. Those services which do not meet the stated guidelines are referred to a Physician Advisor.

If a RFA does not meet applicable criteria or the Nurse Reviewer and requesting physician have agreed upon a modified treatment request, the requesting physician may voluntarily withdraw and/or modify all or part of the request and submit either a signed and completed notice of withdraw/modify request form or an amended RFA.

II. SECOND LEVEL REVIEW

Should requested medical treatment or service fail to meet treatment guidelines, a second level review is performed by a Physician Advisor.

The Physician Advisor assigned to the case reviews the documentation and attempts to contact the ordering physician in order to make a determination.

Any decision to deny, delay or modify a request for medical treatment will be conducted by a physician who is competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the scope of the physician's practice.

The Physician Advisor will attempt to contact the requesting physician to discuss the request at least two (2) times during the window of opportunity provided by the Nurse Reviewer. If contact is made, the Physician Advisor will notify the requesting provider of the determination or if contact is not successful, leave the determination with the office staff. All contact attempts will be documented on their report. For all decision types; for prospective, concurrent, or expedited review, a decision to modify, delay, or deny shall be communicated to the requesting physician **within 24 hours of the decision**, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The Nurse Reviewer will send written notification via fax or letter to the affected parties within 24 hours for a concurrent review and within two (2)

business days for a prospective review after the verbal notification has occurred. (See the section "Contents of Written Notifications" for details.)

III. DELAYED DETERMINATIONS

A Physician Advisor may delay the determination under the following conditions:

1) all reasonably necessary information has not been received but has been requested;
2) the Physician Advisor has asked that an additional examination or test be performed that is reasonable and consistent with professional recognized standards of medical practice;
3) the claims administrator needs a specialized consultation and review of medical information by an expert reviewer. 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 and where these services are within the individual's scope of practice, who has been consulted by the reviewer to provide specialized review of medical information.

If the request is delayed, the requesting physician, injured worker and if represented, the injured worker's attorney, will be notified and the notification will include their right to file a dispute.

IV. TIMEFRAMES FOR DECISIONS

Prospective Review
Prospective Review means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to delivery of the requested medical services.

All prospective review decisions shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) working days from the date of receipt of the RFA. Within twenty-four (24) hours after a decision is made it will be communicated to the requesting provider by phone or fax or electronic mail. The verbal decision is followed by written documentation to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within two (2) business days of the decision.

Concurrent Review
Concurrent review means utilization review conducted during an inpatient stay.

The Nurse Reviewer will conduct the review in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) working days from the date of receipt of the RFA or prior to the end of their previously authorized confinement.

Notification of the decision will be given to the requesting physician within twenty-four (24) hours by phone or fax or electronic mail. The communication by telephone shall be followed by

written notice to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within twenty-four (24) hours.

Medical care will not be discontinued until the treating physician has been notified of the decision and a care plan has been agreed upon by the treating physician that is appropriate for the medical needs of the injured worker. The treating physician is afforded the opportunity to discuss the determination with the clinical review staff in the case of an adverse determination and may request reconsideration or follow the appeals process.

Expedited Review

The requesting provider must indicate on the RFA that there is need for an expedited review because the injured worker's condition is such that he/she 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.

The Nurse Reviewer / Physician Reviewer makes a determination in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination.

Emergency Healthcare Services

Any emergency healthcare service is defined as a healthcare service 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. These emergency services will not require prior certification through utilization review.

Failure to obtain prior certification for emergency healthcare services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services.

Retrospective Review

Retrospective review means utilization review conducted after medical services have been provided and for which approval has not already been given.

If a retrospective review requires the review by a physician advisor, they are performed by Physician Advisors/ Reviewers, who are competent to evaluate the specific clinical issues and where services requested, are within the scope of the physician's practice.

Retrospective review determinations are communicated to the physician, injured worker, and if the injured worker is represented, to the attorney within thirty (30) calendar days of receipt of the medical information that is reasonably necessary to make this determination.

V. INTERNAL APPEALS

This process is available to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. The decision to pursue the internal appeal process is voluntary and optional and neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6.

All internal appeal requests must be received within five (5) business days of receipt of the determination to initiate an appeal. The appeal review will be conducted by a Physician Advisor other than the one involved in the initial determination. All internal appeals will be completed within 15 days for a standard appeal or 72 hours for an expedited appeal from the date of receipt of the determination.

When a request for an appeal is made, the Nurse Reviewer will:

- Document the name and phone number of the person making the appeal request;
- Document the stated reason for the appeal;
- Review the case information for any supporting information;
- Refer to a Physician Advisor not involved in the initial denial.

The Physician Advisor must respond to an appeal request by:

- Reviewing the rationale and information from the original decision, if necessary;
- Consider new information that has become available since the initial decision;
- Make reasonable attempts to contact the requesting physician;
- Make a final determination per regulatory requirements.

If the Physician Advisor agrees with the initial denial, he will notify the requesting physician by telephone. The Advisor notifies the Nurse Reviewer of the determination and rationale for upholding the denial. The Nurse Reviewer will send the letter "CA UR Final Appeal Upheld" within 24 hours to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.

If the Physician Advisor overturns the denial he will provide the Nurse Reviewer with the determination and the rationale for reversing the denial. The Nurse Reviewer immediately notifies the provider, if the advisor has not verbally notified the requesting physician, that the determination was overturned and proceeds with certification of the requested procedure and sends written notice of the approval to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.

VI. DISPUTE PROCESS

An adverse treatment request decision may also be disputed by an injured worker and if the injured worker is represented by counsel, the injured worker's attorney, through the Division of Workers' Compensation dispute resolution process. The dispute may be for any health care service. The following mandatory language in accordance with §9792.9.1 (e) 5 (I) is included on our letters:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me at the number below. However, if you are represented by an attorney, please contact your attorney instead of me.

For information about the workers' compensation claims process and your rights and obligations, go to http://www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

All disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days of receipt of the decision. This deadline must be adhered to even if the internal appeal process outlined above is used. Complete instructions are given on the second page of the form. We have enclosed a pre-addressed envelope for your convenience in returning the form.

VII. CONTENTS OF WRITTEN NOTIFICATIONS

All written notifications of approvals shall specify the medical treatment service approved.

Written notifications will be sent within two (2) business days of receipt of the decision for prospective and retrospective review and within twenty-four (24) hours for concurrent review.

All written notifications modifying, delaying or denying treatment certification will be provided to the physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information.

- The date on which the RFA was first received;
- The date on which the decision is made;
- A description of the specific course of proposed medical treatment for which certification was requested;
- A list of all medical records reviewed;
- A clear, concise and appropriate explanation of the reasons for the utilization review decision including the clinical reasons regarding medical necessity and a description of the medical criteria or guidelines used (if due to incomplete or insufficient info, must specify the reason and specific info needed);
- IMR application with all fields completed except the IW signature and an addressed envelope to the Administrative Director or his designee (the IMR application and envelope will be sent only to the injured worker and to the attorney and only on the initial adverse determination – not with an appeal determination letter);
- Information regarding the internal appeal process;

- The name and specialty of the physician reviewer, and a telephone number by which a discussion can be scheduled with the reviewer, expert reviewer or medical director. The Nurse Reviewer will coordinate the conversation and all physician reviewers will be available for at least 4 hours per week during business hours (9:00 AM to 5:30 PM, Pacific Time.)

Non-physician providers of goods identified in the request for authorization, and for whom contact information has been included, shall also be notified in writing but shall not include the rationale, criteria or guidelines used for the decision.

The written notification will also include a description of the Division of Workers' Compensation dispute resolution process (see the section for Dispute Resolution). Please see the enclosed "sample" CA UR letters.

VIII. TREATMENT GUIDELINES AND CRITERIA

Bunch CareSolutions utilizes the Medical Treatment Utilization Schedule (MTUS) as the primary guideline and if MTUS is silent, other nationally-accepted guidelines and evidence-based literature in our utilization review program such as the Official Disability Guidelines and other state-adopted guidelines. When the Medical Treatment Utilization Schedule (MTUS) is updated, Bunch CareSolutions will accept and utilize that schedule.

Our Physician Advisors utilize MTUS as the primary guideline and if MTUS is silent, other nationally recognized guidelines, evidence based literature and the "Standard of Care" criteria during the physician advisor process as well as the Official Disability Guidelines and other state-adopted guidelines..

Bunch CareSolutions Quality Management Committee undergoes a review and update of policies and procedures and treatment guidelines each year. All nurses undergo an individualized training course in the use of the treatment guidelines in addition to their twelve (12) week orientation training period.

Bunch CareSolutions will disclose the criteria or guidelines utilized for the specific procedures or conditions in our determination letters (except for letters to non-physician providers).

IX. PERSONNEL QUALIFICATIONS AND TYPE

Medical Director

Gary Rischitelli, MD, JD, MPH, FACOEM, serves as our Medical Director. Dr. Rischitelli has almost 25 years of experience in occupational medicine and workers' compensation. He is a graduate of the Baylor College of Medicine in Houston, TX, and received his MPH from the Medical College of Wisconsin. He is board certified in Occupational Medicine by the American Board of Preventive Medicine and is a Fellow of the American College of Occupational and

Environmental Medicine. Dr. Rischitelli was Chair of the Board of Fellowship Examiners, and has served as a member of the Board of Directors of the Occupational Physician Scholarship Fund and the American College of Occupational and Environmental Medicine.

Dr. Rischitelli is responsible for reviewing all commercial criteria used during the utilization review process (ACOEM and MDA) as well as oversight of the California utilization management program at Bunch CareSolutions. He is responsible for all decisions made in the utilization review process, including approvals, modifications, delays, or denials of requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, and complies with the state regulations.

Gary Rischitelli, MD, JD, MPH, FACOEM
California License No. C55926
9370 SW Greenberg Road
Suite 101
Portland, OR 97223
(503) 246-7030 (office)
(503) 267-1541 (cell)
E-Mai: gary.rischitelli@bunchcare.com

Nursing Staff

Bunch CareSolutions' Nursing Staff are licensed and many hold additional credentials such as CVN, CCM, CDMS, or CRRN. Nurse Reviewers possess clinical nursing experience and are knowledgeable in medical management as well as workers' compensation.

Physician Staff

Our Physician Advisors hold current, unrestricted professional licenses by any state or the District of Columbia, hold board certification in their specialty and are in active practice.

X. ACCESSIBILITY

Nurse Reviewers are accessible via a toll-free telephone number, 1-(866) 298-3126, between the hours of 8:00 am to 5:30 pm Pacific Time, Monday through Friday, excluding holidays. All Nurses have voicemail and will return all incoming telephone calls within one business day. Outside of normal business hours, we offer nurse availability twenty-four (24) hours per day, seven (7) days per week by calling 1-888-853-4735. Upon dialing this number the caller will get an after hour mailbox, where they will be instructed to leave a message and the call will be returned. A facsimile line is also available 24 hours per day at 1-(863) 669-2082.

A request for authorization transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day.

XI. REQUESTS FOR UR PLAN

Upon request by the public, Bunch CareSolutions will make available the complete utilization review plan through electronic means. If a member of the public requests a hard copy of the utilization review plan, Bunch may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed $0.25 per page plus actual postage costs.

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www.bunchcare.com

«Date»

«Patient Name»
«Patient Address»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker: «Patient Name»
Date of Birth: «DOB»
Employer Name: «Employer»
Carrier Case ID: «Carrier Case ID»
Date of Injury: «DOI»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. The claims administrator has instructed us to issue an administrative certification for the services/treatments listed below.

Services	Description	Start Date	End Date	Qty.	Precert No.	Decision Date
«Item/Service»		«Certification Begin DOS»	«Certification End DOS»		«Treatment ID»	«Certification Date»
«Item/Service»		«Certification Begin DOS»	«Certification End DOS»		«Treatment ID»	«Certification Date»
«Item/Service»		«Certification Begin DOS»	«Certification End DOS»		«Treatment ID»	«Certification Date»

The Administrative Director of the State of California Division of Workers' Compensation has adopted regulations setting forth utilization review (UR) standards applicable to workers' compensation insurers and self-insured employers. Insurers and self-insured employers may engage in a case-by-case review of the medical treatment provided injured workers in order to improve care and manage costs.

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If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks or contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc.

This administrative certification is valid for 60 days. Extension or changes in the treatment plan will require additional certifications. Questions can be directed to either the claims adjuster at «Adjuster Phone» or the Bunch CareSolutions UR Team at 1-888-853-4735.

«Nurse Signature»

cc: «Adjuster Name», Claims Examiner
«Attorney Name», Attorney

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«Date»

«Patient Name»
«Patient Address»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker:	«Patient Name»
Date of Birth:	«DOB»
Employer Name:	«Employer»
Carrier Case ID:	«Carrier Case ID»
Date of Injury:	«DOI»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request for utilization review of the following treatment(s) or procedure(s) for the injured worker listed above.

Date request received:	(INSERT DATE OF KNOWLEDGE)
Service(s) Requested:	«Item/Service»
Diagnosis:	«ICD9», «ICD9 Desc»
Date of Decision:	«Certification Date»

This approval is limited to this specific treatment and/or procedure requested and does not require utilization review pursuant to the «Employer» Approval Program and only pertains to accepted body parts.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or the Bunch CareSolutions UR Team at 1-888-853-4735.

Sincerely,

«Nurse Signature»

cc: «Adjuster Name», Claims Examiner
«Attorney Name», Attorney

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«Date»

«Patient Name»
«Patient Address»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker:	«Patient Name»
Date of Birth:	«DOB»
Employer Name:	«Employer»
Date of Injury:	«DOI»
Carrier Case ID:	«Carrier Case ID»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request for an extension for the following treatment(s) or procedures(s) on the employee listed above.

Date of Knowledge:	(INSERT EARLIEST DATE OF RECEIPT)
Service(s) Requested:	«Item/Service»
Diagnosis:	«ICD9», «ICD9 Desc»
Precert #:	«Treatment ID»
Date of Verbal Notification:	«Certification Date»
Procedure and/or CPT Code:	«Item/Service»
Original Begin Service Date:	(INSERT ORIGINAL BEGIN SERVICE DATE)
Original End Service Date:	(INSERT ORIGINAL END SERVICE DATE)
Extended Begin Service Date:	(INSERT EXTENDED BEGIN SERVICE DATE)
Extended End Service Date:	(INSERT EXTENDED BEGIN SERVICE DATE)
# of Visits/Service:	(ENTER # OF VISITS)

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/.

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This recommendation is based on medical necessity. If you have any questions regarding this determination, please contact the Bunch CareSolutions UR Team at 1-888-853-4735 between the hours of 9:00 am and 5:30 pm PST.

«Nurse Signature»

cc: «Adjuster Name», Adjuster
«Attorney Name», Attorney

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«Date»

«Patient Name»
«Patient Address»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker:	«Patient Name»
Date of Birth:	«DOB»
Employer Name:	«Employer»
Date of Injury:	«DOI»
Carrier Case ID:	«Carrier Case ID»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request for an extension for the following treatment(s) or procedures(s) on the employee listed above.

Date of Knowledge:	(INSERT EARLIEST DATE OF RECEIPT)
Service(s) Requested:	«Item/Service»
Diagnosis:	«ICD9», «ICD9 Desc»
Precert #:	«Treatment ID»
Date of Verbal Notification:	«Certification Date»
Procedure and/or CPT Code:	«Item/Service»
Original Begin Service Date:	(INSERT ORIGINAL BEGIN SERVICE DATE)
Original End Service Date:	(INSERT ORIGINAL END SERVICE DATE)
Extended Begin Service Date:	(INSERT EXTENDED BEGIN SERVICE DATE)
Extended End Service Date:	(INSERT EXTENDED BEGIN SERVICE DATE)
# of Visits/Service:	(ENTER # OF VISITS)

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/.

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This recommendation is based on medical necessity. If you have any questions regarding this determination, please contact the Bunch CareSolutions UR Team at 1-888-853-4735 between the hours of 9:00 am and 5:30 pm PST.

«Nurse Signature»

cc: «Adjuster Name», Adjuster
«Attorney Name», Attorney

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«Date»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker: «Patient Name»
Date of Birth: «DOB»
Employer Name: «Employer»
Date of Injury: «DOI»
Carrier Case ID: «Carrier Case ID»

Bunch CareSolutions, as the designed Utilization Review agent for «Account Name», received a request to certify the following treatment(s)/procedure(s) for the employee listed above.

Date of Knowledge: (INSERT EARLIEST DATE OF RECEIPT)
Service(s) Requested: «Item/Service»
Diagnosis: «ICD9», «ICD9 Desc»

(INSERT REVIEWER'S NAME), who is licensed in (INSERT STATE), (INSERT LICENSE #) performed the clinical review of the proposed treatment listed above. A determination has been made to issue a denial.

Date of determination: (INSERT DATE)
Date of verbal notification: (INSERT DATE OF VERBAL NOTIFICATION)

This notification is being sent to you as a provider of treatment and/or services.

«Nurse Signature»

cc: «Attorney Name», Attorney
«Adjuster Name», Adjuster
«Patient Name», Injured Worker

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«Date»

«Patient Name»
«Patient Address»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker:	«Patient Name»
Date of Birth:	«DOB»
Employer Name:	«Employer»
Date of Injury:	«DOI»
Carrier Case ID:	«Carrier Case ID»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request for certification and/or to address an appeal for the following treatment(s) or procedure(s) on the employee listed above.

Date of Knowledge:	(INSERT EARLIEST DATE OF RECEIPT)
Service(s) Requested:	«Item/Service»
Diagnosis:	«ICD9», «ICD9 Desc»

This letter serves as notification that we have certified the requested treatment.

Precert #:	«Treatment ID»
Date of Verbal Notification:	(INSERT DATE OF VERBAL NOTIFICATION)
Procedure and/or CPT Code:	«Item/Service»
Begin Service Date:	«Certification Begin DOS»
End Service Date:	«Certification End DOS»
# of Visits/Service:	(ENTER # OF VISITS)

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/.

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This recommendation is based on medical necessity. If you have any questions regarding this determination, please contact the Bunch CareSolutions UR Team at 1-888-853-4735 between the hours of 9:00 am and 5:30 pm PST.

«Nurse Signature»

cc: «Adjuster Name», Adjuster
«Attorney Name», Attorney

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«Date»

«Patient Name»
«Patient Address»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker:	«Patient Name»
Date of Birth:	«DOB»
Employer:	«Employer»
Date of Injury:	«DOI»
Carrier Case ID:	«Carrier Case ID»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request to certify the following treatment(s) or procedure(s) for the employee listed above.

Date of Knowledge:	(INSERT EARLIEST DATE OF RECEIPT)
Service(s) Requested:	«Item/Service»
Diagnosis:	«ICD9», «ICD9 Desc»

At this time we are unable to make a medical necessity determination for the procedure(s) for the following reason(s):

_____The claims administrator has requested a specialized consultation and review of medical information by an expert reviewer. Upon receipt of the report, the medical necessity decision will be completed within five (5) days for prospective and thirty (30) days for retrospective requests.

_____ The physician advisor who reviewed the procedure(s) has requested (INSERT THE TEST OR EXAMINATION REQUESTED) before making a decision on the medical necessity of the procedure. Upon receipt of the results, the medical necessity decision will be completed within five (5) days for prospective and thirty (30) days for retrospective requests.

DIVISION OF WORKERS' COMPENSATION DISPUTE PROCESS FOR INJURED WORKERS

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call us. However, if you are represented by an attorney, please contact your attorney instead.

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If you have any questions or the physician would like to speak with the Physician Reviewer, please contact the Bunch CareSolutions UR Team at 1-888-853-4735 between the hours of 9:00 AM and 5:30 PM PST.

«Nurse Signature»

cc: «Adjuster Name», Adjuster

«Attorney Name», Attorney
«Attorney Address»
DELIVERED BY MAIL

Enclosures: Physician Advisor Report

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«Date»

«Patient Name»
«Patient Address»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker:	«Patient Name»
Date of Birth:	«DOB»
Employer Name:	«Employer»
Date of Injury:	«DOI»
Carrier Case ID:	«Carrier Case ID»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request to certify the following treatment(s) or procedure(s) for the employee listed above.

Date of Knowledge:	(INSERT EARLIEST DATE OF RECEIPT)
Service(s) Requested:	«Item/Service»
Diagnosis:	«ICD9», «ICD9 Desc»

At this time we are unable to make a medical necessity determination for the procedure(s) for the following reason(s): (CHOOSE ONE)

_____ The claims administrator has requested a specialized consultation and review of medical information by an expert reviewer. Upon receipt of the report, the medical necessity decision will be completed within five (5) days for prospective and thirty (30) days for retrospective requests.

_____ The physician advisor who reviewed the procedure(s) has requested (INSERT THE TEST OR EXAMINATION REQUESTED) before making a decision on the medical necessity of the procedure. Upon receipt of the results, the medical necessity decision will be completed within five (5) days for prospective and thirty (30) days for retrospective requests.

DIVISION OF WORKERS' COMPENSATION DISPUTE PROCESS FOR INJURED WORKERS

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You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call us. However, if you are represented by an attorney, please contact your attorney instead.

For information about the workers' compensation claims process and your rights and obligations, go to http://www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

If you have any questions regarding this determination or the physician would like to speak with the Physician Reviewer, please contact the Bunch CareSolutions UR Team at 1-888-853-4735 between the hours of 9:00 am and 5:30 pm PST.

«Nurse Signature»

cc: «Adjuster Name», Adjuster
«Attorney Name», Attorney

Enclosure: Physician Advisor Report

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«Date»

«Patient Name»
«Patient Address»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker:	«Patient Name»
Date of Birth:	«DOB»
Employer Name:	«Account Name»
Carrier Case ID:	«Carrier Case ID»
Date of Injury:	«DOI»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request to certify the following treatment(s) or procedure(s) for the employee listed above.

Date of Knowledge:	(INSERT EARLIEST DATE OF RECEIPT)
Service(s) Requested:	«Item/Service»
Diagnosis:	«ICD9», «ICD9 Desc»

(INSERT REVIEWER'S NAME), (INSERT SPECIALTY), who is licensed in (INSERT STATE), (INSERT LICENSE #) performed the clinical review of the proposed treatment listed above. A determination has been made to issue a denial based upon the following reasons:

Date of determination: «Certification Date» Date of verbal notification: (INSERT DATE OF VERBAL NOTIFICATION)
Treatment Guideline used: «Treatment Guidelines»
Principal reason: Refer to enclosed Physician Advisor Report
Clinical rationale: Refer to enclosed Physician Advisor Report

This recommendation is based on medical necessity.

INTERNAL UTILIZATION REVIEW APPEAL PROCESS FOR INJURED WORKERS
If you disagree with this determination you are entitled to an appeal review. This process is available to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. Your decision to pursue the internal appeal process is voluntary and optional and neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6.

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All appeal requests must be received within five (5) business days of receipt of the determination to initiate an appeal. You must be prepared to present pertinent clinical information in support of your request. The appeal review will be conducted by a Physician Advisor other than the one involved in the initial determination. All internal appeals will be completed within 15 days for a standard appeal or 72 hours for an expedited appeal from the date of receipt of the determination.

DIVISION OF WORKERS' COMPENSATION DISPUTE PROCESS FOR INJURED WORKERS

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call us. However, if you are represented by an attorney, please contact your attorney instead.

For information about the workers' compensation claims process and your rights and obligations, go to http://www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

All disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days of receipt of the decision. This deadline must be adhered to even if the internal appeal process outlined above is used. Complete instructions are given on the second page of the form. We have enclosed a pre-addressed envelope for your convenience in returning the form.

A decision to modify, delay or deny a request for authorization will remain in effect for twelve (12) months from the date of the decision without further action by the claims administration or utilization review agent with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

If you have any questions regarding this determination or the physician would like to speak with the Physician Reviewer, please contact the Bunch CareSolutions UR Team at 1-888-853-4735 between the hours of 9:00 am and 5:30 pm PST.

«Nurse Signature»

cc: «Adjuster Name», Adjuster

«Attorney Name», Attorney
«Attorney Address»
DELIVERED BY MAIL

Enclosures: Physician Advisor Report
Application for Independent Medical Review, DWC form IMR

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Pre-Addressed Envelope

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«Date»

«Patient Name»
«Patient Address»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker:	«Patient Name»
Date of Birth:	«DOB»
Employer Name:	«Account Name»
Carrier Case ID:	«Carrier Case ID»
Date of Injury:	«DOI»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request to certify the following treatment(s) or procedure(s) for the employee listed above.

Date of Knowledge:	(INSERT EARLIEST DATE OF RECEIPT)
Service(s) Requested:	«Item/Service»
Diagnosis:	«ICD9», «ICD9 Desc»

(INSERT REVIEWER'S NAME), (INSERT SPECIALTY), who is licensed in (INSERT STATE), (INSERT LICENSE #) performed the clinical review of the proposed treatment listed above. A determination has been made to issue a denial based upon the following reasons:

Date of determination:	«Certification Date»
Date of verbal notification:	(INSERT DATE OF VERBAL NOTIFICATION)
Treatment Guideline used:	«Treatment Guidelines»
Principal reason:	Refer to enclosed Physician Advisor Report
Clinical rationale:	Refer to enclosed Physician Advisor Report

This recommendation is based on medical necessity.

INTERNAL UTILIZATION REVIEW APPEAL PROCESS FOR INJURED WORKERS
If you disagree with this determination you are entitled to an appeal review. This process is available to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. Your decision to pursue the internal appeal process is voluntary.

P.O. Box 32037, Lakeland, FL 33802
Tel: (888) 853-4735 • Fax: (863) 668-9553
www.bunchcare.com

All appeal requests must be received within twenty (20) days of receipt of the determination. The request must include pertinent clinical information to support the request. The appeal review will be conducted by a Physician Advisor other than the one involved in the initial determination. All internal appeals will be completed within five (5) business days of the receipt of the request or within 72 hours if the requesting physician determines the need for an expedited appeal.

DIVISION OF WORKERS' COMPENSATION DISPUTE PROCESS FOR INJURED WORKERS

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call us. However, if you are represented by an attorney, please contact your attorney instead.

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 the receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in our internal utilization review appeal process. The time limit may be extended for good cause or by mutual agreement of the parties.

For information about the workers' compensation claims process and your rights and obligations, go to http://www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

The injured worker or injured worker's attorney may file an Application for Adjudication of Claim Form WCAB 1, and a Declaration of Readiness to Proceed (expedited trial), DWC-CA form 10208.3.

A decision to modify, delay or deny a request for authorization will remain in effect for twelve (12) months from the date of the decision without further action by the claims administration or utilization review agent with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

If you have any questions regarding this determination or the physician would like to speak with the Physician Reviewer, please contact the Bunch CareSolutions UR Team at 1-888-853-4735 between the hours of 9:00 am and 5:30 pm PST.

«Nurse Signature»

cc: «Adjuster Name», Adjuster
«Attorney Name», Attorney

Enclosure: Physician Advisor Report

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«Date»

«Patient Name»
«Patient Address»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address»

Injured Worker:	«Patient Name»
Date of Birth:	«DOB»
Employer Name:	«Account Name»
Carrier Case ID:	«Carrier Case ID»
Date of Injury:	«DOI»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request to appeal the denial of the following treatment(s) or procedure(s) for the employee listed above.

Date of Knowledge:	(INSERT EARLIEST DATE OF RECEIPT)
Service(s) Requested:	«Item/Service»
Diagnosis:	«ICD9», «ICD9 Desc»

(INSERT REVIEWER'S NAME), (INSERT SPECIALTY), who is licensed in (INSERT STATE), (INSERT LICENSE #) performed the clinical review of this final internal appeal and additional supporting documentation. A determination has been made to uphold the denial based upon the following reasons:

Date of Determination:	(INSERT DATE)
Date of Verbal Notification:	(INSERT DATE OF VERBAL NOTIFICATION)
Treatment Guideline Used:	«Treatment Guidelines»
Principal Reason:	Refer to enclosed Physician Advisor Report
Clinical Rationale:	Refer to enclosed Physician Advisor Report

This recommendation is based on medical necessity.

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DIVISION OF WORKERS' COMPENSATION DISPUTE PROCESS FOR INJURED WORKERS
You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call us. However, if you are represented by an attorney, please contact your attorney instead.

For information about the workers' compensation claims process and your rights and obligations, go to http://www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

All disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker.

A decision to modify, delay or deny a request for authorization will remain in effect for twelve (12) months from the date of the decision without further action by the claims administration or utilization review agent with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

If you have any questions regarding this determination or if the physician would like to speak to the Physician Reviewer, please contact the Bunch CareSolutions UR Team at 1-888-853-4735 between the hours of 9:00 am and 5:30 pm PST.

Sincerely,

«Nurse Signature»

Enclosure(s): Physician Advisor Report

cc: «Adjuster Name», Claims Adjuster

Delivered by Mail: «Attorney Name», Attorney
«Attorney Address»

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«Date»

«Patient Name»
«Patient Address»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address»

Injured Worker:	«Patient Name»
Date of Birth:	«DOB»
Employer:	«Employer»
Carrier Case ID:	«Carrier Case ID»
Date of Injury:	«DOI»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request to appeal the denial of the following treatment(s) or procedure(s) for the employee listed above.

Date Appeal Received:	(INSERT DATE OF RECEIPT)
Service(s) Requested:	«Item/Service»
Diagnosis:	«ICD9», «ICD9 Desc»

(INSERT REVIEWER'S NAME), (INSERT SPECIALTY), who is licensed in (INSERT STATE), (INSERT LICENSE #) performed the clinical review of this final internal appeal and additional supporting documentation. A determination has been made to uphold the denial based upon the following reasons:

Date of Determination:	(INSERT DATE)
Date of Verbal Notification:	(INSERT DATE OF VERBAL NOTIFICATION)
Treatment Guideline Used:	«Treatment Guidelines»
Principal Reason:	Refer to enclosed Physician Advisor Report
Clinical Rationale:	Refer to enclosed Physician Advisor Report

This recommendation is based on medical necessity.

DIVISION OF WORKERS' COMPENSATION DISPUTE PROCESS FOR INJURED WORKERS
You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call us. However, if you are represented by an attorney, please contact your attorney instead.

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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 the receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in our internal utilization review appeal process. The time limit may be extended for good cause or by mutual agreement of the parties.

For information about the workers' compensation claims process and your rights and obligations, go to http://www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

The injured worker or injured worker's attorney may file an Application for Adjudication of Claim Form WCAB 1, and a Declaration of Readiness to Proceed (expedited trial), DWC-CA form 10252.1.

A decision to modify, delay or deny a request for authorization will remain in effect for twelve (12) months from the date of the decision without further action by the claims administration or utilization review agent with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

If you have any questions regarding this determination or the physician would like to speak with the Physician Reviewer, please contact the Bunch CareSolutions UR Team at 1-888-853-4735 between the hours of 9:00 am and 5:30 pm PST.

Sincerely,

«Nurse Signature»

Enclosure(s): Physician Advisor Report

cc: «Adjuster Name», Claims Adjuster
«Attorney Name», Attorney

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«Date»

«Patient Name»
«Patient Address»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker:	«Patient Name»
Date of Birth:	«DOB»
Employer Name:	«Employer»
Carrier Case ID:	«Carrier Case ID»
Date of Injury:	«DOI»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request to certify the following treatment(s) or procedure(s) for the employee listed above.

Date of Knowledge:	(INSERT EARLIEST DATE OF RECEIPT)
Service(s) Requested:	«Item/Service»
Diagnosis:	«ICD9», «ICD9 Desc»

(INSERT REVIEWER'S NAME), (INSERT SPECIALTY), who is licensed in (INSERT STATE), (INSERT LICENSE #) performed the clinical review of the proposed treatment. The Physician Advisor recommended a modification of the original request to the following:

Date of Determination:	«Certification Date»
Date of Verbal Notification:	(INSERT DATE OF VERBAL NOTIFICATION)
Treatment/Service Being Certified:	(INSERT MODIFIED TREATMENT)
Treatment Guideline Used:	«Treatment Guidelines»
Principal Reason:	Refer to enclosed Physician Advisor Report
Clinical Rationale:	Refer to enclosed Physician Advisor Report
Begin Service Date:	«Certification Begin DOS»
End Service Date:	«Certification End DOS»
Number of Visits/Service:	(INSERT # OF VISITS/SERVICE)
Certification Number:	«Treatment ID»

This recommendation is based on medical necessity.

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If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/.

INTERNAL UTILIZATION REVIEW APPEAL PROCESS FOR INJURED WORKERS

If you disagree with this determination you are entitled to an appeal review. This process is available to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. Your decision to pursue the internal appeal process is voluntary and optional and neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6.

All appeal requests must be received within five (5) business days of receipt of the determination to initiate an appeal. You must be prepared to present pertinent clinical information in support of your request. The appeal review will be conducted by a Physician Advisor other than the one involved in the initial determination. All internal appeals will be completed within 15 days for a standard appeal or 72 hours for an expedited appeal from the date of receipt of the determination.

DIVISION OF WORKERS' COMPENSATION DISPUTE PROCESS FOR INJURED WORKERS

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call us. However, if you are represented by an attorney, please contact your attorney instead.

For information about the workers' compensation claims process and your rights and obligations, go to http://www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

All disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days of receipt of the decision. This deadline must be adhered to even if the internal appeal process outlined above is used. Complete instructions are given on the second page of the form. We have enclosed a pre-addressed envelope for your convenience in returning the form.

A decision to modify, delay or deny a request for authorization will remain in effect for twelve (12) months from the date of the decision without further action by the claims administration or utilization review agent with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

If you have any questions regarding this determination or the physician would like to speak with the Physician Reviewer, please contact the Bunch CareSolutions UR Team at 1-888-853-4735 between the hours of 9:00 am and 5:30 pm PST.

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Fax: 863.668.9553
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Sincerely,

«Nurse Signature»

cc: «Adjuster Name», Adjuster

«Attorney Name», Attorney
«Attorney Address»
DELIVERED BY MAIL

Enclosures (3): Physician Advisor Report
Application for Independent Medical Review, DWC Form IMR
Pre-Addressed Envelope

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Fax: 863.668.9553
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«Date»

«Patient Name»
«Patient Address»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker's Name:	«Patient Name»
Date of Birth:	«DOB»
Employer's Name:	«Employer»
Carrier Case ID:	«Carrier Case ID»
Date of Injury:	«DOI»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request to certify the following treatment(s) or procedure(s) for the employee listed above.

Date of Knowledge:	(INSERT EARLIEST DATE OF RECEIPT)
Service(s) Requested:	«Item/Service»
Diagnosis:	«ICD9», «ICD9 Desc»

(INSERT REVIEWER'S NAME), (INSERT SPECIALTY), who is licensed in (INSERT STATE), (INSERT LICENSE #) performed the clinical review of the proposed treatment. The Physician Advisor recommended a modification of the original request to the following:

Date of Determination:	«Certification Date»
Date of Verbal Notification:	(INSERT DATE OF VERBAL NOTIFICATION)
Treatment/Service being Certified:	(INSERT MODIFIED TREATMENT)
Treatment Guideline Used:	«Treatment Guidelines»
Principal Reason:	Refer to enclosed Physician Advisor Report
Clinical Rationale:	Refer to enclosed Physician Advisor Report
Begin Service Date:	«Certification Begin DOS»
End Service Date:	«Certification End DOS»
Number of Visits/Service:	(INSERT # OF VISITS/SERVICE)
Certification Number:	«Treatment ID»

This recommendation is based on medical necessity.

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If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/.

INTERNAL UTILIZATION REVIEW APPEAL PROCESS FOR INJURED WORKERS

If you disagree with this determination you are entitled to an appeal review. This process is available to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. Your decision to pursue the internal appeal process is voluntary.

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DIVISION OF WORKERS' COMPENSATION DISPUTE PROCESS FOR INJURED WORKERS

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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 the receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in our internal utilization review appeal process. The time limit may be extended for good cause or by mutual agreement of the parties.

For information about the workers' compensation claims process and your rights and obligations, go to http://www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

The injured worker or injured worker's attorney may file an Application for Adjudication of Claim Form WCAB 1, and a Declaration of Readiness to Proceed (expedited trial), DWC-CA form 10208.3.

A decision to modify, delay or deny a request for authorization will remain in effect for twelve (12) months from the date of the decision without further action by the claims administration or utilization review agent with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

If you have any questions regarding this determination or the physician would like to speak to the Physician Reviewer, please contact the Bunch CareSolutions UR Team at 1-888-853-4735 between the hours of 9:00 am and 5:30 pm PST.

Sincerely,

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«Nurse Signature»

cc: «Adjuster Name», Claims Adjuster
«Attorney Name», Attorney

Enclosure: Physician Advisor Report

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«Date»

«Patient Name»
«Patient Address»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker: «Patient Name»
Date of Birth: «DOB»
Employer: «Employer»
Date of Injury: «DOI»
Carrier Case ID: «Carrier Case ID»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request for certification and/or to address an appeal for the following treatment(s) or procedure(s) on the employee listed above.

Date of Knowledge: (INSERT EARLIEST DATE OF RECEIPT)
Service(s) Requested: «Item/Service»
Diagnosis: «ICD9», «ICD9 Desc»

At this time we are unable to make a medical necessity determination due to lack of sufficient medical documentation for the procedure(s). In order to continue this review, we will need the following information: (INSERT REQUIRED DOCUMENTATION)

We have contacted your office by phone/fax on (ENTER DATE) and (ENTER DATE). Please be advised there may be a delay in the determination regarding medical necessity for the services requested above since the Utilization Review process cannot continue until the requested information is received. Please fax the information to my attention at (INSERT FAX #) so the process can be completed within 14 days of receipt of your original request and a decision rendered. If the requested information is not received by (INSERT DATE INFO REQUIRED), this request will be sent to a physician reviewer for further determination.

If you have any questions, please contact the Bunch CareSolutions UR Team at 1-888-853-4735 between the hours of 9:00 am and 5:30 pm PST.

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«Nurse Signature»

cc: «Adjuster Name», Adjuster
«Attorney Name», Attorney

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NOTICE OF "NOT COMPLETE" REQUEST FOR AUTHORIZATION (RFA)

«Date»

«Adjuster Name», Adjuster
OR
Provider Name: «Provider Name»
Fax #: «Provider Fax»

Injured Worker: «Employee»
Date of Birth: «DOB»
Employer Name: «Employer»
Date of Injury: «DOI»
Carrier Case ID: «Carrier Case ID»

Bunch CareSolutions (Bunch) is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. We received a request for certification of treatment(s) or procedure(s) on the employee listed above.

On (INSERT DATE RFA WAS RECEIVED) we received a RFA that was **"NOT COMPLETE"** according to 8 C.C.R. 9792.6.1(t):

"Request for authorization" means a written request for a specific course of proposed medical treatment. A request for authorization must be set forth on a "Request for Authorization for Medical Treatment (DWC Form RFA)," completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5. "Completed", for the purpose of this section and for purposes of investigations and penalties, means that information specific to the request has been provided by the requesting treating physician for all mandatory fields indicated on the DWC Form RFA. The form must be signed by the physician and may be mailed, faxed or e-mailed."

The following information was missing or incomplete:

Upon receipt of a completed DWC Form RFA, we will begin processing your request based upon the date of receipt of the completed form.

Thank you,

«Nurse Signature»

cc: «Employee», Injured Worker
«Attorney Name», Attorney
«Adjuster Name», Adjuster OR «Provider Name», Requesting Provider

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«Date»

«Provider Name»
«Provider Address»
DELIVERED VIA FAX

Injured Worker: «Patient Name»
Date of Birth: «DOB»
Employer Name: «Employer»
Date of Injury: «DOI»
Carrier Case ID: «Carrier Case ID»

Per our conversation on «Date», this letter confirms the discussion whereby you have agreed to withdraw the following request:

Date of Knowledge: (INSERT EARLIEST DATE REQUEST WAS RECEIVED)
Service(s) Requested: «Item/Service»
Diagnosis: «ICD9», «ICD9» Desc

Please complete if applicable: I am submitting a new request for: _____

_____

By completing and signing this letter, we will be able to process your new request for utilization review.

********TO BE COMPLETED BY THE PHYSICIAN/MEDICAL PROVIDER********

Signature: _____

Print name: _____ Date: _____

Please complete today and return via fax to «Bunch Fax Number».

«Nurse Signature»

cc: «Adjuster Name», Adjuster
«Attorney Name», Attorney
«Employee», Injured Worker