



# Utilization Review Plan

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# I. Introduction

## Mission Statement

The State Fund's Utilization Review (UR) Program is founded on the principle that appropriate medical care for a work-related injury or illness improves medical outcomes while containing costs. Quality medical care for injured employees is enhanced through education and timely communication between State Fund and the medical provider. The Utilization Review Program ensures that medical care is consistent with evidence-based practice and meets current peer-reviewed medical standards and guidelines.

Working in conjunction with the UR Program, State Fund's Return to Work (RTW) Program promotes early intervention and injury/illness management in order to expedite the opportunity for injured employees to return to work. We believe these programs will improve the overall quality of care and reduce unnecessary costs.

## Objectives

1. Eliminate unnecessary and inappropriate treatment thus reducing medical costs.
2. Deliver timely responses to physician requests for treatment.
3. Reduce temporary disability costs by promoting return to work and use of transitional duty for the injured employee.
4. Improve communication between the medical community and State Fund.

## Scope

This document describes State Fund's Utilization Review Program. The utilization review process applies only to accepted body parts on accepted claims and claimed body parts on delayed claims.

# II. Definitions

## Utilization Review

"ACOEM Practice Guidelines" means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition.

"Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code.

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

"Emergency health care services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of

immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

"Expedited review" means utilization review conducted when the injured employee's condition is such that the injured employee 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 employee's life or health or could jeopardize the injured employee's permanent ability to regain maximum function.

"Expert reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice.

"Immediately" means within 24 hours after learning the circumstances that would require an extension of the timeframe for decisions.

"MTUS" means the Medical Treatment Utilization Schedule set forth in 8 CCR 9792.20 through 9792.23.

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

"Request for authorization" means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) or a written request for a specific course of proposed medical treatment. An oral request for authorization must be followed by a written confirmation of the request within 72 hours. Both the written confirmation of an oral request and the written request must be set forth on the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Reports, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization.

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

"Reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice.

"Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by

physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600.

"Written" includes a facsimile as well as communications in paper form.

### **Medical Necessity**

The following themes describe what is considered 'medically necessary', 'reasonable and necessary,' or 'medically appropriate'. The procedure, test, or service:

- Is necessary to cure or relieve the effects of the injury
- Is safe and effective
- Is consistent with the recipient's symptoms, diagnoses, condition, or injury
- Is likely to provide a clinically meaningful benefit
- Is likely to produce the intended health result
- Is likely more effective than more conservative or less costly services
- Is not provided simply as a convenience to the patient or the provider
- Represents a benefit that outweighs any risk
- Is reasonably expected to diagnose, correct, cure, alleviate or prevent worsening of illnesses or injuries, and
- Enables a patient to make reasonable progress in treatment
- Meets the prevailing standard for medical care, as outlined in the MTUS or other accepted evidenced-based guidelines [unless the treating physician has presented reasonable information to explain why the particular patient does need atypical, unexpected treatment]

### **III. Program Requirements**

State Fund provides telephone and facsimile access for physicians to request authorization for health care services 24 hours per day. State Fund processes these requests between the hours of 9:00 a.m. and 5:30 p.m., Pacific Time, Monday through Friday, except State Holidays.

The UR Program is:

- Evaluated at least annually, and updated if necessary
- Developed with involvement from actively practicing physicians
- Disclosed by the employer to employees, physicians, and the public upon request and is publicly available on the State Fund website at [www.scif.com](http://www.scif.com)
- Disclosed to the physician and the injured employee, if used as the basis of a decision to modify, delay, or deny services

## IV. Program Structure

### Medical Director

The State Fund Medical Director is:

Gideon Letz, M.D., M.P.H.  
California License Number G-035503  
1275 Market St., San Francisco, CA 94103  
(415) 565-1677

The State Fund Medical Director is responsible for oversight of all utilization review activities, ensures that the utilization review process is in accordance with this document, and is responsible for all UR decisions for both on-site and off-site contracted UR service providers. The Medical Director is a board-certified occupational medicine physician who holds an unrestricted license to practice in California. In addition, a staff of three masters-prepared occupational health nurses provide consultation to the UR Program.

The State Fund Medical Director:

1. Develops and disseminates the overall policy and philosophy of the UR Program.
  - a) Participates in teleconferences with in-house reviewers and provides guidance for the utilization review process. Holds periodic meetings with Medical Directors from each UR service provider to discuss use of guidelines and other UR policies and procedures.
  - b) Evaluates, prepares, and distributes policy memos to UR service providers. Some examples include:
    - The relationship between utilization review and disability management,
    - Utilization review decision statements related to chronic pain services,
    - Identification of claims at risk for delayed recovery – the use of predictors and early interventions to facilitate return to work.
2. Provides periodic review of the UR database:

Monitors and identifies trends and opportunities for educational interventions to improve quality and ensure consistency of UR decision-making.
3. Oversees selection of clinical guidelines to be used in addition to the MTUS, such as McKesson InterQual® Clinical Decision Support Criteria (McKesson InterQual Criteria) and the Work Loss Data Institute's Official Disability Guidelines (ODG).
4. Oversees State Fund technology assessment activities.

State Fund, in conjunction with ECRI Institute, an outside health technology assessment information service, reviews the current medical evidence for new

technologies or new or problematic applications for existing technology that are commonly seen. The Medical Director provides final review on any technology assessment position statements.

### **Utilization Review Unit**

Within the Medical Director's Office, State Fund has a dedicated unit to assist adjusting locations in the implementation of their utilization review processes and understanding of requirements for compliance with statutory regulations regarding utilization review. Each adjusting location has an assigned representative to answer questions and provide support for utilization review issues.

### **UR Coordinators**

Each adjusting location or claims department has one or more UR Coordinators who are responsible for overseeing the utilization review process in their location. The UR Coordinators will ensure timely authorization and act as resources for adjusting location staff regarding the UR process.

### **UR Service Providers**

State Fund uses on-site and off-site contracted service providers to conduct UR services for State Fund. *All on-site and off-site UR services are in strict compliance with California law and meet the highest standards of quality in decision-making.*

Each physician reviewer, whether on-site or off-site, will make available a minimum of four (4) hours of availability to discuss decisions with requesting providers. The UR physician reviewers' hours of availability will be clearly outlined on the provider notification letters or on the Health Assessments outlining clinical issues.

### **On-Site Service Providers**

On-site UR service providers conduct utilization review and utilization management services in accordance with MTUS. The following California-licensed medical professionals conduct UR at State Fund's adjusting locations:

#### **Health Consultants (HCs)**

- Nurse Consultant (NC), Registered Nurse
- Physical Therapy Consultant (PTC), Registered Physical Therapist
- Chiropractic Consultant (CC), Doctor of Chiropractic
- Medical Consultant (MC), Medical Doctor, M.D. or Doctor of Osteopathy, D.O

### **Off-Site Service Providers**

Off-site UR service providers provide utilization review and utilization management services in accordance with MTUS. Utilization review requests along with appropriate

medical records may be electronically transmitted to some UR service providers for processing. UR service provider may accept requests and supporting documentation directly from providers for processing.

### **Medical Specialty Panel**

The Medical Specialty Panel consists of Board-certified specialists to review requests for treatment. The specialty panel ensures that a wide range of complex medical issues can be addressed by the State Fund UR program. The MC/CC shall review the claim before making a referral.

## **V. Utilization Review Process**

### **Initial Review of the Treatment Plan**

Effective medical management begins with the injured employee's first visit for treatment of an injury. An appropriate initial evaluation, diagnosis, and the setting of treatment goals and treatment plan with the injured employee promotes early return to work and functional recovery.

### **Identification of UR Requests**

All requests for authorization must be in writing and must specify the course of the proposed medical treatment. Any oral request for authorization must be followed by a written confirmation of the request within 72 hours. The written request must be set forth in the Form DLSR 5021 (Doctor's First Report) or in the Primary Treating Physician's progress report (PR2). The PR2 may be in a narrative format; however it must contain the same information as required in the PR-2 form and the document shall be clearly marked at the top that it is a request for authorization.

### **Referral for Utilization Review**

The claims adjuster or UR technician may authorize limited procedures for common conditions in accordance with the Medical Director's instructions. All other treatment requests must be referred for utilization review. The adjuster or UR technician shall assess the medical information for completeness and request any additional information needed to make a decision within the appropriate timeframes.

If the claims adjuster or UR technician can not authorize a treatment request, the request will be triaged to an on-site or off-site contractor for further review.

### **On-Site Referral for Utilization Review**

#### **First Level Consultant Assessment- NC/PTC**

The Nurse Consultant (NC) or the Physical Therapist Consultant (PTC) performs the first level medical assessment for UR services provided on-site.

The NC or PTC provides a recommendation based on his or her assessment of the clinical information and possible discussion with the provider.

The first level assessment is completed within the appropriate timeframe in the event that further review is necessary. The NC/PTC assesses the medical information and requests any additional information needed to make a decision within the appropriate timeframes.

The NC or PTC may authorize the request for medical treatment on the basis of the clinical information. The NC or PTC shall not delay, deny, or reduce the services. If the NC or PT is unable to authorization based on the available clinical information, the request is forwarded to the MC for further review.

### **Physician Consultant Assessment- MC/CC**

Only a physician competent to evaluate the specific clinical issues, which are within the scope of the physician's practice, may modify, delay, or deny treatment requests. The MC or CC may contact the provider to discuss the case. The MC or CC will refer cases requiring UR review by a specialist from the specialty panel as appropriate.

Medical Consultants (MCs) and Chiropractic Consultants (CCs) are contracted with EK Health Services, Inc. All physician Consultants perform utilization review in accordance with State Fund's Utilization Review Plan.

### **Documentation of Decisions**

All HCs shall clearly and concisely document their activities and decisions in writing on the appropriate State Fund forms or in software designed for that purpose.

### **Decisions to Delay, Modify, or Deny Treatment**

All MCs and CCs shall include their license number, specialty, contact information, and hours of availability on the assessment form. Documentation shall also include:

- The date on which the decision is made
- A description of the specific course of proposed medical treatment for which authorization was requested
- A specific description of the medical treatment service approved, if any
- A clear and concise explanation of the reasons for the UR decision including the clinical rationale regarding medical necessity
- A citation of the medical criteria or guidelines used
- A minimum of four (4) hours per week the reviewer is available to discuss the decision

### **Off-Site Referral for Utilization Review**

The adjuster or UR technician may triage requests for treatment to off-site UR service providers. All UR decisions made by off-site service providers shall clearly and concisely document their activities and decisions in writing.

Off-site UR service providers include Anthem Blue Cross and CompPartners. All UR service providers shall conduct utilization review in accordance with State Fund's UR Plan.

Any decisions to delay, modify, or deny treatment shall include the physician reviewer's license number, contact information, and hours of availability on the assessment form. Documentation shall also include:

- The date on which the decision is made
- A description of the specific course of proposed medical treatment for which authorization was requested
- A specific description of the medical treatment service approved, if any
- A clear and concise explanation of the reasons for the UR decision including the clinical rationale regarding medical necessity
- A description of the medical criteria or guidelines used

### **Catastrophic Cases**

Requests for treatment authorization on accepted or delayed cases designated as catastrophic (including spinal cord injuries, multiple amputations, head traumas), or other medically complex cases, will be reviewed initially by the assigned State Fund catastrophic case manager (CCM). In no event shall a CCM delay, deny or modify a request for treatment authorization. Requests which cannot be authorized by a State Fund CCM will be referred to an off-site UR service provider for review.

### **Home Health and Attendant Care Services**

Physician requests for authorization for psychiatric attendant care services on accepted or delayed claims are subject to UR. Physician requests for home health care or attendant care services on non-catastrophic, non-psychiatric accepted or delayed claims shall also be reviewed by an off-site UR service provider.

### **Spine Surgery -Mandatory Review**

Requests for spinal surgery shall be referred to off-site UR service provider, Anthem Blue Cross (Anthem BC), for utilization review. Anthem BC will conduct utilization review in accordance with all regulatory requirements.

Disputes regarding any utilization review decision for spinal surgery may be subject to the Spinal Surgery Second Opinion Procedure pursuant to 8 Cal C Reg 9788.01-9788.91 and Labor Code §4062(b) and/or informal provisions that are decided upon by the WCAB pertaining to the Spinal Surgery Second Opinion Process.

### **Decision Timeframes**

All decisions must be made in a timely fashion after receipt of the information reasonably necessary to make the determination, in accordance with 8 Cal C Reg 9792.9 (b) through (g). Decision timeframes depend upon the type of utilization review conducted, as described below.

When a provider sends a request that requires additional information, the non-physician reviewer may telephone the provider to request the additional information, within 5

working days of the initial request for authorization. This request must be followed by a written confirmation of the request that clearly indicates what additional information is needed.

If the provider fails to submit the requested information, the request may be denied within 14 days from the date of the original request for treatment. Once the requested additional information is received, the treatment request will be re-reviewed for reconsideration of the original decision.

### **Prospective or Concurrent Reviews**

For prospective or concurrent reviews, a decision must be made in a timely fashion that is appropriate for the nature of the employee's condition. The decision must not exceed 5 working days from the date of receipt of the written request for authorization.

If appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) working days from the date of the written request for authorization to make the proper determination. In no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization by the health care provider.

When treatment is denied during a concurrent review, that treatment will continue until the treating physician is notified of the denial, and an alternate care plan is agreed on, which is appropriate for the injured employee.

### **Expedited Reviews**

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

The requesting physician will indicate the need for an expedited review upon submission of the request. In this event, the UR request will be sent to the first level reviewer for immediate evaluation and processing.

Services provided on an emergency basis, without a request for authorization, will be subject to retrospective review. Services will not be denied because pre-authorization was not obtained.

### **Retrospective Reviews**

For retrospective reviews, a decision must be communicated within 30 days of receipt of information that is reasonably necessary to make the determination.

### **UR Letters & Notification Requirements**

When decisions are made by on-site UR service providers, statutory notification letters will be completed by State Fund personnel.

When decisions are made by off-site UR service providers, statutory notification letters will be completed by the off-site UR service provider. A copy of the UR notification and the clinical assessment will be provided to State Fund.

Decisions to approve, modify, delay, or deny treatment recommendations by a physician must be communicated as follows for both the on-site and off-site program:

### **Approval**

Decisions to approve a physician's request for treatment shall be communicated to the requesting physician within 24 hours of the decision by telephone or facsimile. The phone call shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two business days for prospective review.

### **Withdrawal**

If a treatment request does not meet applicable criteria, the requesting physician may voluntarily withdraw all or part of the request, and submit either a signed and completed "Notice of Withdrawal/Change of Request for Treatment" form or an amended request.

### **Delay**

The physician reviewer must complete a clinical assessment that includes:

- the procedures or services being delayed
- a citation of the criteria or guidelines used
- the clinical rationale for the decision
- the consultation, diagnostic test, or specialty review needed

A written notice must advise the treating physician and employee, and the employee's representative, if any, of the reason for the delay and the estimated date that a final decision will be reached.

A decision to delay shall be communicated to the requesting physician within 24 hours of the decision by telephone or facsimile. The phone call shall be followed by written notice to the requesting physician, employee, and the employee's representative, if any, within 24 hours of the decision for concurrent review and within two business days for prospective review.

Non-physician providers of goods or services for whom contact information has been included, shall be notified in writing of any decision to delay but shall not be entitled to the clinical assessment which includes rationale, criteria, or guidelines used to make the decision.

### **Denial**

The physician reviewer must complete a clinical assessment that includes all of the following:

- The procedure(s) being denied

- A citation of the criteria or guidelines used
- The clinical rationale for the decision

The UR response letter and clinical assessment shall be sent to the requesting physician, injured employee, and injured employee's representative, if any within statutory timeframes.

Non-physician providers of goods or services for whom contact information has been included, shall be notified in writing of any decision to deny authorization but shall not be entitled to the clinical assessment which includes rationale, criteria, or guidelines used to make the decision.

Decisions to deny a physician's request shall be communicated to the requesting physician within 24 hours of the decision by telephone or facsimile. The phone call shall be followed by written notice to the requesting physician, employee, and the employee's representative, if any, within 24 hours of the decision for concurrent review and within two business days for prospective review.

When a provider sends a request for treatment that requires additional information, the non-physician reviewer may telephone the provider to request the additional information, within 5 working days of the initial request for authorization. This request must be followed by a written confirmation of the request that clearly indicates what additional information is needed.

If the provider fails to submit the requested information, the treatment request may be denied on a conditional basis within 14 days from the date of the original request. Once the additional information is received, the treatment request will be re-reviewed for reconsideration of the original decision.

### **Modification**

Modification refers to a change made in the treatment plan, based upon medical necessity. It does not refer to negotiated changes that are agreed upon. If the physician reviewer modifies the treatment request, he or she must complete a clinical assessment that includes all of the following:

- the procedure(s) requested
- the modified procedure(s) authorized,
- a citation of the criteria or guidelines used
- the clinical rationale for the decision.

The UR response letter and clinical assessment shall be sent to the requesting physician, injured employee, and injured employee's representative, if any.

Decisions to modify a physician's request for treatment shall be communicated to the requesting physician within 24 hours of the decision by telephone or facsimile. The phone call shall be followed by written notice to the requesting physician, employee, and the employee's representative, if any, within 24 hours of the decision for concurrent review and within two business days for prospective review.

Non-physician providers of goods or services for whom contact information has been included, shall be notified in writing of any decision to modify authorization but shall not be entitled to the clinical assessment which includes rationale, criteria, or guidelines used to make the decision.

### **Pharmacy Benefit Management Program**

State Fund uses a pharmacy benefit management (PBM) program for the provision of pharmaceuticals for injured employees. When prescriptions are electronically adjudicated through network pharmacies, it ensures an expedited authorization process.

The PBM program has a formulary that includes the authorization of medications for common industrial injuries and illnesses. The adjuster also has the ability to pre-authorize medications as indicated in the approved treatment plan.

Requests for authorization for prescriptions that fall outside the formulary are forwarded to State Fund via email notification by the PBM vendor. These prescriptions may be submitted for utilization review. If medications are authorized, notification will be submitted to the PBM. If medications are not authorized notification of the UR decision is provided to the appropriate parties.

### **Medical Provider Network Treatment Authorization Program (TAP)**

On October 1, 2007 State Fund implemented the TAP program. TAP allows physicians in the State Fund's Medical Provider Network (MPN) to provide evidence-based medical treatment on selected services without the need for prior authorization. TAP only applies to accepted claims and body parts. All treatment must follow the Title 8 CCR § 9792.20 -9792.22 MTUS criteria.

All services performed under this program must be reported on a special form, which is to be included with either the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Reports, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. As outlined in the program, physician notification letters will not be provided for these covered services.

### **UR Passport Program**

In 2009 State Fund initiated a program to provide MPN physicians authority to perform routine medical procedures on accepted and delayed claims without utilization review based on a their adherence to the MTUS and evidence-based medicine. Passport participants shall provide treatment consistent with the MTUS found in Title 8 CCR §9792.20 - 9792.22. No provider notification letters will be sent by State Fund for those procedures which fall under this program.

## **MPN Economic Profiling Policy**

Labor Code §4616.1 allows a claims administrator to evaluate the quality of physicians within the Medical Provider Network. Treatment outcomes will continue to be assessed using incurred data to evaluate physician performance and continued participation in the UR Passport program. Random audits of physicians participating in the UR Passport program will be conducted to ensure compliance with MTUS and evidence-based medicine.

## **Treatment Guidelines**

The UR process requires objective medical evidence-based guidelines to evaluate medical treatment requests. In accordance with sections 9792.20 - 9792.23, the Medical Treatment Utilization Schedule (MTUS), shall be used for initial review of treatment requests.

If the MTUS is not applicable, other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community shall be used as in accordance with section 9792.22.

The State Fund is continually expanding reference resources for use by claims personnel and on-site UR Health Consultants. To supplement the MTUS, State Fund routinely uses the McKesson Criteria and/or Official Disability Guidelines (ODG) to evaluate requests for treatment. The State Fund Medical Director's Office acts as a clearinghouse for treatment methodologies and other references providing reliable, valid, current information.

## **UR Appeals and Reconsiderations**

Only the requesting physician may appeal a utilization review decision. The appeal must be in writing, and must be received within 10 days of the date of the UR decision. Participation in the appeals process is voluntary. The 10-day timeframe for appeals does not extend or alter the statutory 20-day timeframe for dispute resolution outlined in Labor Code §4062.

In cases where the requesting physician appeals a UR decision, and the original decision was made by an on-site UR physician, the UR coordinator will initiate contact with a board certified specialist from the specialty panel established for this purpose.

In cases where the requesting physician appeals a decision of an off-site UR service provider, the requesting physician must submit their appeal to the off-site service provider.

A reconsideration, or re-review, is handled differently than an appeal. A reconsideration is when the requesting physician provides additional information for review to substantiate a request for authorization. A reconsideration may be handled by the same physician who reviewed the original request. Reconsiderations may be made on the basis of additional information from the treating physician.

Parties are notified of the appeals process in our utilization review response letters. Response letters include the following language:

***“Any appeal of this particular UR decision must be made by the requesting physician within 10 days of the date of the UR decision. The appeal must be submitted in writing or via FAX to the following phone number:***

Fax Number: **(Insert dedicated adjusting location UR Fax Number here.)**

This written request for appeal should be prominently identified as a "UR Appeal" at the top of the page and include a copy of the specific UR Decision which you are appealing. Your appeal will be re-reviewed in accordance with State Fund's internal utilization review appeals process. *Participation in this process is entirely on a voluntary basis.*"

A written decision will be sent to appropriate parties when a decision is made on an appeal or reconsideration.

### **UR Dispute Resolution**

When a medical treatment decision is disputed, the issue will be resolved through Labor Code §4062 per statutory requirements.

When treatment requests are modified, delayed, or denied; notification letters shall include the following language:

#### **NOTICE TO INJURED EMPLOYEE**

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

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

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

*If you want further information, you may contact the local state Information and Assistance office by calling (LOCAL I&A) or you may receive recorded information by calling 1-800-736-7401. You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.”*

If the employee is subject to the Medical Provider Network (MPN) and he or she disputes the **diagnosis or treatment** of the primary treating physician, the dispute will be resolved in accordance with Labor Code §4616.3(c). These disputes are not considered UR disputes.

### Summary

The UR Program provides timely review of proposed treatment and ongoing care, consistent with the MTUS and other evidenced-based treatment guidelines. It also enhances communication with the provider and facilitates transitional duty and return to work arrangements to achieve optimal outcomes of quality and cost-efficiency.

## VI Exhibits

### Provider Notification Letter Template - Authorization



#### Date

Prescribing Physician  
Address  
City, State, Zip

Claim Number:  
Employee:  
Tracking #:  
Date of Injury:  
Date of Birth:  
Adjuster Name:  
Medical ID #:

Dear Medical Provider:

Your request for medical treatment dated **Report Date** for **Employee** was received on **written request received date** and has been reviewed in accordance with State Fund's Utilization Review Program:

<i>Medical Treatment</i>	<i>Treatment ID</i>	<i>Req Qty.</i>	<i>Auth Qty.</i>	<i>Interval (Freq)</i>	<i>Per Period</i>	<i>Decision</i>	<i>Decision Date</i>
(Procedure)	(ID #)	(#)	(#)	(#)	(Period)	Authorized	(Date)

Please note: If the treatment decision is "Referred", we are still evaluating the request and you will be notified when a decision has been made. "Interval" in the above column describes number of treatments authorized per period.

{MAY CHOOSE ONE OR MORE OPTIONAL TEXTS}

**(Option 1A - Inpatient Only)** The following procedure/s: **(Describe procedure)** is/are authorized at a Blue Cross hospital (inpatient only). The request has been forwarded to Blue Cross for in-patient length of stay and discharge planning. Blue Cross may contact you with further specifics.

**(Option 1B - Outpatient Only)**  The following procedure/s: **(Describe procedure)** is/are authorized at a Blue Cross network outpatient surgery facility.

**(Option 1C)** UR Medical Consultant(s), **Name of Medical Consultant(s)**, has/have reviewed the request. Attached is his/her/their explanation of the reason(s) for the decision, including the criteria or guidelines used and the clinical reason(s) regarding medical necessity.

**(Option 1D) FREEFORM TEXT**

**Certifications are valid for 60 days from the date of this notice.**

Any payments made will be reimbursement per the prevailing California Official Medical Fee Schedule (OMFS), or Contractual Agreement whichever is less. Payment is subject to applicable statutes and regulations, including, but not limited to, Labor Code §139.3 and 139.31 and California Business and Professions codes.

For claims on *delayed status*, payment may also be limited to the criteria as mentioned in Labor Code 5402(c), subject to the \$10,000 cap.

Please be advised that non-physician **providers of goods or services** identified in the request for authorization, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization, but shall **not** receive the rationale, criteria or guidelines used for the decision as per Title 8, CCR § 9792.9 (b)(4)

**Any appeal of this particular UR decision must be made by the requesting physician within 10 days of the date of the UR decision. The appeal must be submitted in writing or via FAX to the following phone number:**

FAX Number: **(Insert URC Fax Number)**

This written request for appeal should be prominently identified as a “UR Appeal” at the top of the page and include a copy of the specific UR Decision which you are appealing. Your appeal will be re-reviewed in accordance with State Fund’s internal utilization review appeals process. *Participation in this process is entirely on a voluntary basis.*

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

Sincerely,

**Adjuster Name**

Workers’ Compensation Insurance Specialist

**PHONE #**

cc: **Applicant Attorney (if represented)**  
**Employee**  
**PTP**

## NOTICE TO INJURED EMPLOYEE

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

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

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

The 20-day time limit may be extended for good cause or by mutual agreement of the parties. You also have the right to file a Grievance through the Alternative Dispute Resolution (ADR) System, showing a bona fide dispute as to entitlement to medical treatment in accordance with Title 8, CCR sections 10136(b)(1), 10400, and 10408.

If you want further information, you may contact the local state Information and Assistance office by calling **LOCAL I&A PHONE NUMBER** or you may receive recorded information by calling 1-800-736-7401.

If you want further information, you may contact the program's Ombudsman by calling **Ombudsman's phone number**. (Please insert the ECF Union dropdown box for user's viewing reference here.)

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

**Provider Notification Letter Template - Denial**

**Date**

**Prescribing Physician  
Address  
City, State, Zip**

**Claim Number:  
Employee:  
Tracking #:  
Date of Injury:  
Date of Birth:  
Adjuster Name:  
Medical ID #:**

Dear Medical Provider:

Your request for medical treatment dated **Report Date** for **Employee** was received on **written request received date** and has been reviewed in accordance with State Fund's Utilization Review Program:

<b>Medical Treatment</b>	<b>Treatment ID</b>	<b>Req Qty.</b>	<b>Auth Qty.</b>	<b>Interval (Freq)</b>	<b>Per Period</b>	<b>Decision</b>	<b>Decision Date</b>
(Procedure)	(ID #)	(#)	(#)	(#)	(Interval)	Denied	(Date)

Please note: If the treatment decision is "Referred", we are still evaluating the request and you will be notified when a decision has been made. "Interval" in the above column describes number of treatments authorized per period.

{MAY CHOOSE ONE OR MORE OPTIONAL TEXTS}

**(Option 1C)** UR Medical Consultant(s), **Name of Medical Consultant(s)**, has/have reviewed the request. Attached is his/her/their explanation of the reason(s) for the decision, including the criteria or guidelines used and the clinical reason(s) regarding medical necessity.

**(Option 1D) FREEFORM**

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

Sincerely,

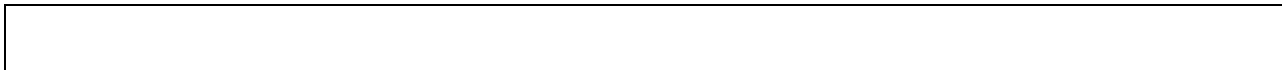
**Adjuster Name**

Workers’ Compensation Insurance Specialist

**PHONE #**

Enc: **Health Consultant Assessment**

cc: **Applicant Attorney (if represented)**  
**Employee**  
**PTP**



## NOTICE TO INJURED EMPLOYEE

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If you want further information, you may contact the program's Ombudsman by calling **Ombudsman's phone number**. **(Please insert the ECF Union dropdown box for user's viewing reference here.)**

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

**Provider Notification Letter Template - Modification**

**Date**

**Prescribing Physician  
Address  
City, State, Zip**

**Claim Number:  
Employee:  
Tracking #:  
Date of Injury:  
Date of Birth:  
Adjuster Name:  
Medical ID #:**

Dear Medical Provider:

Your request for medical treatment dated **Report Date** for **Employee** was received on **written request received date** and has been reviewed in accordance with State Fund's Utilization Review Program:

<b>Medical Treatment</b>	<b>Treatment ID</b>	<b>Req Qty.</b>	<b>Auth Qty.</b>	<b>Interval (Freq)</b>	<b>Per Period</b>	<b>Decision</b>	<b>Decision Date</b>
<b>(Procedure)</b>	<b>(ID #)</b>	<b>(#)</b>	<b>(#)</b>	<b>(#)</b>	<b>(Interval)</b>	<b>Modified</b>	<b>(Date)</b>

Please note: If the treatment decision is "Referred", we are still evaluating the request and you will be notified when a decision has been made. "Interval" in the above column describes number of treatments authorized per period.

{MAY CHOOSE ONE OR MORE OPTIONAL TEXTS}

**(Option 1C)** UR Medical Consultant(s), **Name of Medical Consultant(s)**, has/have reviewed the request. Attached is his/her/their explanation of the reason(s) for the decision, including the criteria or guidelines used and the clinical reason(s) regarding medical necessity.

**(Option 1D) FREEFORM**

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FAX Number: **(Insert URC Fax Number)**

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

Sincerely,

**Adjuster Name**

Workers’ Compensation Insurance Specialist

**PHONE #**

Enc: **Health Consultant Assessment**

cc: **Applicant Attorney (if represented)**  
**Employee**  
**PTP**

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

**Provider Notification Letter Template - Delay**

**Date**

**Prescribing Physician  
Address**

**City, State, Zip**

**Claim Number  
Employee**

**Date of Injury**

**Date of Birth  
Medical ID #:**

Dear Medical Provider:

The **[REQUEST DATE]** request for medical treatment for **(EMPLOYEE)** was received on **(REQUEST RECEIVED DATE)** and a decision was made on **(DECISION DATE)**. The request of the following services has been reviewed in accordance with State Fund's Utilization Review Program:

**(List CPT codes+ Requested Procedure + Total #)**

{MAY CHOOSE ONE OR MORE DELAY REASON(S) from 1A-1E}

**(Option 1A-Need Examination)** Our medical consultant, has delayed the request for authorization of the following service(s)/item(s):

**(List CPT codes+ Delayed Procedure + Total #by [Medical Consultant & phone#])**

At the advice of our medical consultant, we will schedule **(EMPLOYEE)** for **a/an (TYPE OF EXAMINATION)** examination. Until we receive the results of the examination, we are unable to authorize the proposed treatment. A final determination is anticipated within five (5) working days after receipt of this report, which we anticipate will be available on **(DATE)**.

**(Option 1B-Need Testing)** Our medical consultant, has delayed your request for authorization of the following service(s)/item(s):

**(List CPT codes+ Delayed Procedure + Total #by [Medical Consultant & phone#])**

At the advice of our medical consultant, we will schedule **(EMPLOYEE)** for the following test(s):

**(SPECIFY TEST OR PROCEDURE.)**

Until we receive the results of the test, we are unable to authorize the proposed treatment. A final determination is anticipated within five (5) working days after receipt of the test results, which we anticipate will be available on **(DATE)**.

**(Option 1C-Need Expert Reviewer)** Our medical consultant, has delayed the request for authorization of the following service(s)/item(s):

**(List CPT codes+ Delayed Procedure + Total #by [Medical Consultant & phone#]))**

At the advice of our medical consultant, we have referred the request to a/an **(TYPE OF SPECIALIST)** as an expert reviewer. A final determination is anticipated within five (5) working days after receipt of this assessment, which we anticipate will be available on **(DATE)**.

**(Option 1D) FREEFORM**

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**Any appeal of this particular UR decision must be made by the requesting physician within 10 days of the date of the UR decision. The appeal must be submitted in writing or via FAX to the following fax number: (Insert URC Fax Number)**

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

Sincerely,

**(Adjuster's Full Name)**

**Claims Representative**

**Address**

**PHONE #**

Enc: Health Consultant Assessment

**cc: Applicant Attorney; Address; City, State Zip Code (if represented)**  
**Injured Employee; Address; City, State Zip Code**  
**PTP ; Address; City, State Zip Code**  
**Service provider ( Letter – mandatory, Assessment- Optional)**

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Health Consultant Assessment

<b>STATE</b> COMPENSATION INSURANCE <b>FUND</b>	<b>HEALTH CONSULTANT UTILIZATION REVIEW ASSESSMENT</b>
--	--

**Date:**

**To:**

**Injured Employee Name:**

**DOB:**

**Tracking #:**

**Claim Number:**

**DOI:**

**Treatment Request:** (should include CPT codes when applicable):

**Clinical Summary:** (include response to treatment and *work status*):

**Contact with requesting Provider:**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Results: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Results: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Results: \_\_\_\_\_

**Analysis** (integrate Evidence Based Guidelines with information from provider):

**Decision:**

**Supporting references:**

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title (Specialty), License No & Office hours

\_\_\_\_\_  
Telephone

EK Health Services, Inc. Independently Contracted Utilization Review Physician

Notice of Withdrawal Form

**Notice of Withdrawal/Change of Request for Treatment**

Date  
Prescribing Physician  
Address  
City, State, Zip

Claim Number  
Employee  
Date of Injury

To: \_\_\_\_\_

Fax No. \_\_\_\_\_

**Attention: (INSERT REQUESTING PHYSICIAN'S NAME)**

As a follow up to our conversation on (Insert Date), you had agreed to withdraw/amend your treatment request for your patient.

In order to process your request per regulation 8 Cal. Code of Regs. §9792.7 (b) (3), please **SIGN** and return this form as soon as possible but no later than (insert date and time) via fax to: (Insert Name and Title) at (Insert fax Number)

I hereby withdraw/amend my request for the following treatment for:

Patient \_\_\_\_\_ Claim Number \_\_\_\_\_

Original Request dated \_\_\_\_\_ and received by State Fund on \_\_\_\_\_:

Original Requested Procedure(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Select one of the following options:

Withdrawn \_\_\_\_\_  
(Date)

Or

Instead, I agree to the following amended treatment request:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Requesting Physician Name: \_\_\_\_\_

Requesting Physician Signature: \_\_\_\_\_, MD/DO/DC

Date: \_\_\_\_\_

**Important Note: If this form is not received by the above date the original request will be processed through Utilization Review.**