Utilization Review
Plan, Process & Investigations
27th Annual DWC Educational Conference (2020)

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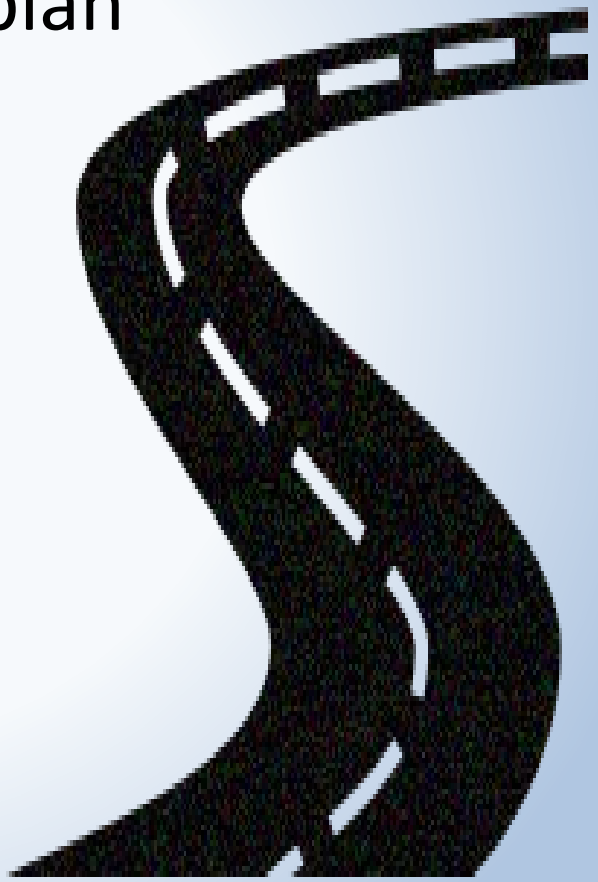
INTRODUCTION

- History of Utilization Review (and related laws).
  - Created in 2003 under SB 228 (Alarcon). Applicable to every employer. MTUS established too, followed closely by creation of MPN. Eventually, creation of IMR (SB 863) effective 2014 for dispute resolution of medical treatment requests.
- AB 1124 – Creation of Formulary (exempt meds)
- SB 1160 (2016) – Creation of 30-day exemption
  - Creation of 30-day exemption
  - Expedited timeframe for formulary exempt meds
  - URAC Accreditation
  - DWC UR Plan Approval Authority
  - Financial Disclosure

ROADMAP

- Added elements of a UR plan
- RFA
- Approvals
- Mods/Denials
- “Working Day”
- UR Investigations



UR Plan – Added Elements

- UR-01 Form for UR Plan Approval
  - Cover page
- URAC Accreditation
  - DWC has authority to obtain all URAC documents pertaining to UR plan *from URAC.*
- Reflect 30-day Exemption
- Reflect MTUS Formulary
- Financial Disclosure

UR Plan Approval Application: DWC UR-01

Application for Approval as Utilization Review Plan (DWC Form UR-01)
Department of Industrial Relations - Division of Workers' Compensation

Submit two copies of the completed, signed application and the complete Utilization Review (UR) Plan in compact discs or flash drives in word-searchable PDF format to: Division of Workers' Compensation, Attn: Medical Unit: Utilization Review Plan Approval, P.O. Box 71010, Oakland, CA 94612.

1. UR Plan Information

Name of UR Plan Applicant:
Address:
City:
State: Zip Code:
Telephone: Fax:
E-mail:
Type of Entity Filing:

2. UR Plan Contact Person Information

Name:
Title:
Address:
City:
State: Zip Code:
Telephone: Fax:
E-mail:

3. Medical Director Information

Name:
Address:
City:
State: Zip Code:
Telephone: Fax:
E-mail:
CA License No.: NPI:
Board Certified Specialty (if any):

4. URAC Accreditation

Accreditation Status:
Original accreditation date:
Most recent accreditation date: Expiration Date:
Comments:

5. UR Plan Client and Vendor Information

List all entities that utilize or contract for UR Plan services. Use additional pages if necessary.

Does the UR Plan delegate any UR functions?
- ○ Yes
- ○ No

If yes, indicate to whom and and which function for each delegation. Use additional pages if necessary.

Signature of authorized individual: "I, the undersigned Medical Director of the UR Plan Applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this application is true and correct."

Name of Medical Director:
Date Signature:

Page 1 - DWC Form UR-01 (1/18)
Page 2 - DWC Form UR-01 (1/18)

Request For Authorization (RFA)

- New Form: PR-1 (§ 9785.6)
- When is it required?
  - Always. (Even for exempt tx? Yes, b/c of potential for retro review, unless CA has an overriding policy)
- "Complete" (9792.6.1(u); 9785(h))
  - IDs employer and requesting provider;
  - IDs with specificity all treatment requests in appropriate section;
  - Accompanied by documentation, *created within 30 days before RFA,* supporting the need for the requested treatment.
- If not "complete" → 9792.9.1

PR-1 Form

Treating Physician's Report (DWC Form PR-1)
Department of Industrial Relations - Division of Workers' Compensation

Check all applicable boxes:

Section A: ☐ Request for Authorization ☐ Expedited Request for Authorization

Section B: ☐ Progress Report ☐ Change in Patient's Condition ☐ Change in Treatment Plan

Section C: ☐ Change in Work Status ☐ Released/Discharged from Care

☐ Response to RFI, as included in: ☐ Section A ☐ Section B ☐ Section C
☐ Other, as included in: ☐ Section A ☐ Section B ☐ Section C

Patient's Name: Last First Middle

Date of Injury: (MM/DD/YYYY) Date of Birth: (MM/DD/YYYY) Claim Number:

Physician Name: Practice Name: Contact Name:

Mailing Address: City:

State: Zip Code: Telephone: Fax:

E-mail: Specialty: State License Numbe

NPI Number: Primary Treating Physician: (if different from above)

Claims Administrator:

Mailing Address: City:

State: Zip Code: Contact Name:

E-mail: Telephone: Fax:

I declare under penalty of perjury that I am the physician who examined the patient, this report is true and correct to the best of my knowledge, and I have not violated Labor Code section 139.3.

Physician Signature: Date:

PRIVACY NOTICE: A statement of current data collection and use policies and certain privacy rights of injured workers can be found at the following website: http://www.dir.ca.gov/od_pub/privacy.html.

Check all applicable boxes:

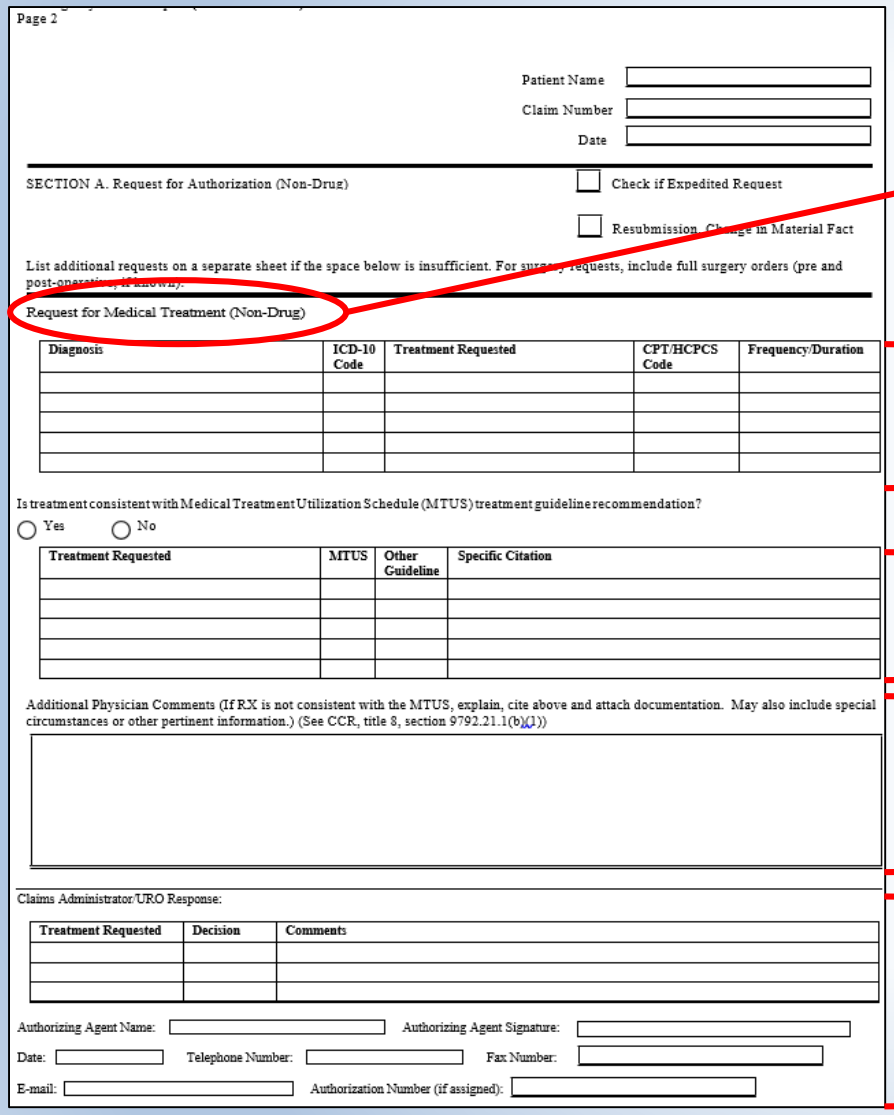
Section A: ☐ Request for Authorization ☐ Expedited Request for Authorization

Section B: ☐ Progress Report ☐ Change in Patient's Condition ☐ Change in Treatment Plan

Section C: ☐ Change in Work Status ☐ Released/Discharged from Care

☐ Response to RFI, as included in: ☐ Section A ☐ Section B ☐ Section C
☐ Other, as included in: ☐ Section A ☐ Section B ☐ Section C

PR-1 Form, RFA (section A)



Page 2

Patient Name

Claim Number

Date

SECTION A. Request for Authorization (Non-Drug)

☐ Check if Expedited Request

☐ Resubmission. Change in Material Fact

List additional requests on a separate sheet if the space below is insufficient. For surgery requests, include full surgery orders (pre and post-operative, if known).

Request for Medical Treatment (Non-Drug)

Diagnosis	ICD-10 Code	Treatment Requested	CPT/HCPCS Code	Frequency/Duration

Is treatment consistent with Medical Treatment Utilization Schedule (MTUS) treatment guideline recommendation?

◯ Yes ◯ No

Treatment Requested	MTUS	Other Guideline	Specific Citation

Additional Physician Comments (If RX is not consistent with the MTUS, explain, cite above and attach documentation. May also include special circumstances or other pertinent information.) (See CCR, title 8, section 9792.21.1(b)(1))

Claims Administrator/URO Response:

Treatment Requested	Decision	Comments

Authorizing Agent Name: Authorizing Agent Signature:

Date: Telephone Number: Fax Number:

E-mail: Authorization Number (if assigned):

Request for Medical Treatment (Non-Drug)

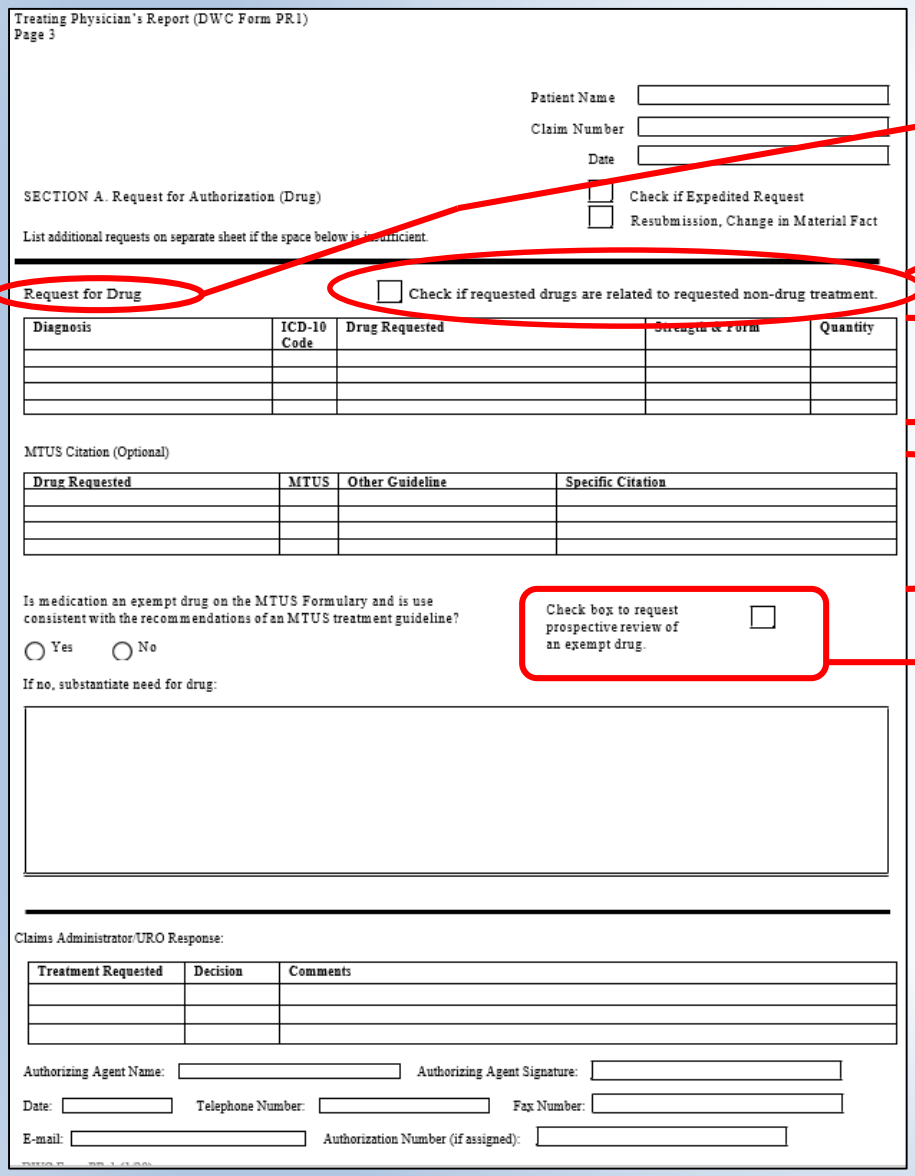
Diagnosis, ICD-10 Code, Treatment Requested, CPT/HCPCS Code, Frequency/Duration

MTUS citation for each treatment request

Additional physician comments, e.g., special circumstances.

CA's/URO's response – similar to old form

PR-1 Form, RFA (section A)



Treating Physician's Report (DWC Form PR1)
Page 3

Patient Name
Claim Number
Date

SECTION A. Request for Authorization (Drug)

☐ Check if Expedited Request
☐ Resubmission, Change in Material Fact

List additional requests on separate sheet if the space below is insufficient.

Request for Drug

☐ Check if requested drugs are related to requested non-drug treatment.

Diagnosis	ICD-10 Code	Drug Requested	Strength & Form	Quantity

MTUS Citation (Optional)

Drug Requested	MTUS	Other Guideline	Specific Citation

Is medication an exempt drug on the MTUS Formulary and is use consistent with the recommendations of an MTUS treatment guideline?

◯ Yes ◯ No

Check box to request prospective review of an exempt drug. ☐

If no, substantiate need for drug:

Claims Administrator/URO Response:

Treatment Requested	Decision	Comments

Authorizing Agent Name: Authorizing Agent Signature:

Date: Telephone Number: Fax Number:

E-mail: Authorization Number (if assigned):

Request for Drug

Checkbox to indicate if drugs are related to non-drug treatment.

Diagnosis, ICD-10 Code, Drug Requested, Strength & Form, Quantity

MTUS Citation: Drug Requested, MTUS, Other Guideline, Specific Citation

"Check box to request prospective review of an exempt drug."

PR-1 Form, Sections B & C

- Section B: Evaluation and Management Worksheet
- Section C: Work Status

UR Approvals

- Circumstances requiring approval
  - Formulary Exemption
  - 30-day Exemption
- Who can approve?
- Timeline
- Elements of an approval

UR Denials (& Modifications)

- Types of Denials
  - Denied b/c not medically necessary
  - Denied b/c lack of info
  - Different from “deferred”
- Who can deny?
- Timeline

UR Mods/Denials

- Communication
  - Initial Communication
  - Written Communication
- Elements of a UR Modification / Denial
- How to reduce # of Mods/Denials?

"Normal Business Day"

- SB 537 clarified "normal business day"
  - Labor Code section 4600.4(b)
  - Does not include Saturday, Sunday, or any day declared by the Governor to be an official state holiday or a holiday listed on the Dept of Human Resources internet website.
    - The day after Thanksgiving is listed as a holiday on the website.

New IMR Application Form

pgs 1 & 2

Application for Independent Medical Review (DWC Form IMR)
Department of Industrial Relations - Division of Workers' Compensation

TO REQUEST INDEPENDENT MEDICAL REVIEW:

- **Sign and date this application and consent to obtain medical records.**
- **Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:**
  Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE DEADLINE FOR FILING IS FOUND ON PAGE 2.**

Type of Utilization Review: Regular ☐ Expedited ☐ Retrospective for Exempt Treatment ☐

Modification after Appeal ☐ Medication Only - MTUS Formulary Drug List: ☐

Employee Name (First, MI, Last)

Address

Telephone Number E-mail

Claim Number Date of Injury (MM/DD/YYYY)

WCIS Jurisdictional Claim Number (if assigned)

Employee Attorney (if known)

Address

Telephone Number E-mail

Claims Administrator Name

Contact Name

Address

Telephone Number E-mail

Requesting Physician Name

Practice Name Specialty

Address

Telephone Number E-mail

DWC Form IMR (7/18) - Page 1

Disputed Medical Treatment

Primary Diagnosis (Use ICD Code where practical)

Mailing Date of the Written Determination Letter

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical neoessity? ◯ Yes ◯ No Reason

List each specific requested medical services, drug, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.

1.
2.
3.
4.

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 15 days from the mailing date of the determination letter. (See date above.) For all other disputes, the deadline is 35 days from the mailing date of the written determination letter. Both deadlines include additional days for mailing. However, under either deadline, add five (5) days if you live outside of California. Your deadline for filing this IMR Application is indicated in the checked box.

IMR Application Filing Deadline

☐ 35 days from the mailing date of the written determination letter.

☐ 15 days from mailing date of written determination letter (MTUS Drug List Medication only)

DWC Form IMR (7/18) - Page 2

New IMR Application Form: DWC Form IMR

pgs 3 & 4

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review (IMR) of the medical treatment request by a physician who is not connected to your Claims Administrator. If the IMR is decided in your favor, your Claims Administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL, DELAY, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE TWO OF THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this form with a copy of the written determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your Claims Administrator.

* The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
* If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. This person may sign the application for you and submit documents on your behalf.
* If the recommended medical treatment that was denied or modified must be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.
* Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

DWC-IMR, c/o Maximus Federal Services, Inc.
P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270

* Your IMR application, along with a copy of the written determination letter, must be received by Maximus Federal Services, Inc. within either thirty-five (35) days from the mailing date of the written determination letter, or fifteen (15) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 15 days from the mailing date of the letter. For all other disputes, the deadline is 35 days from the mailing date of the letter. The application will indicate your filing deadline on Page Two.
* Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written determination letter.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

* Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
* Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
* Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
* If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local e 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (print) _____

I wish to designate

Name of Individual (print) _____

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application and to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the Independent Medical Review Organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the Independent Medical Review Organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature _____ Date _____

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding his or her Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be his or her authorized representative.

Name _____

I am a/an _____

(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____ E-mail _____

State Bar Number (if applicable) _____

Representative Signature _____ Date _____

Updates to IMR Application

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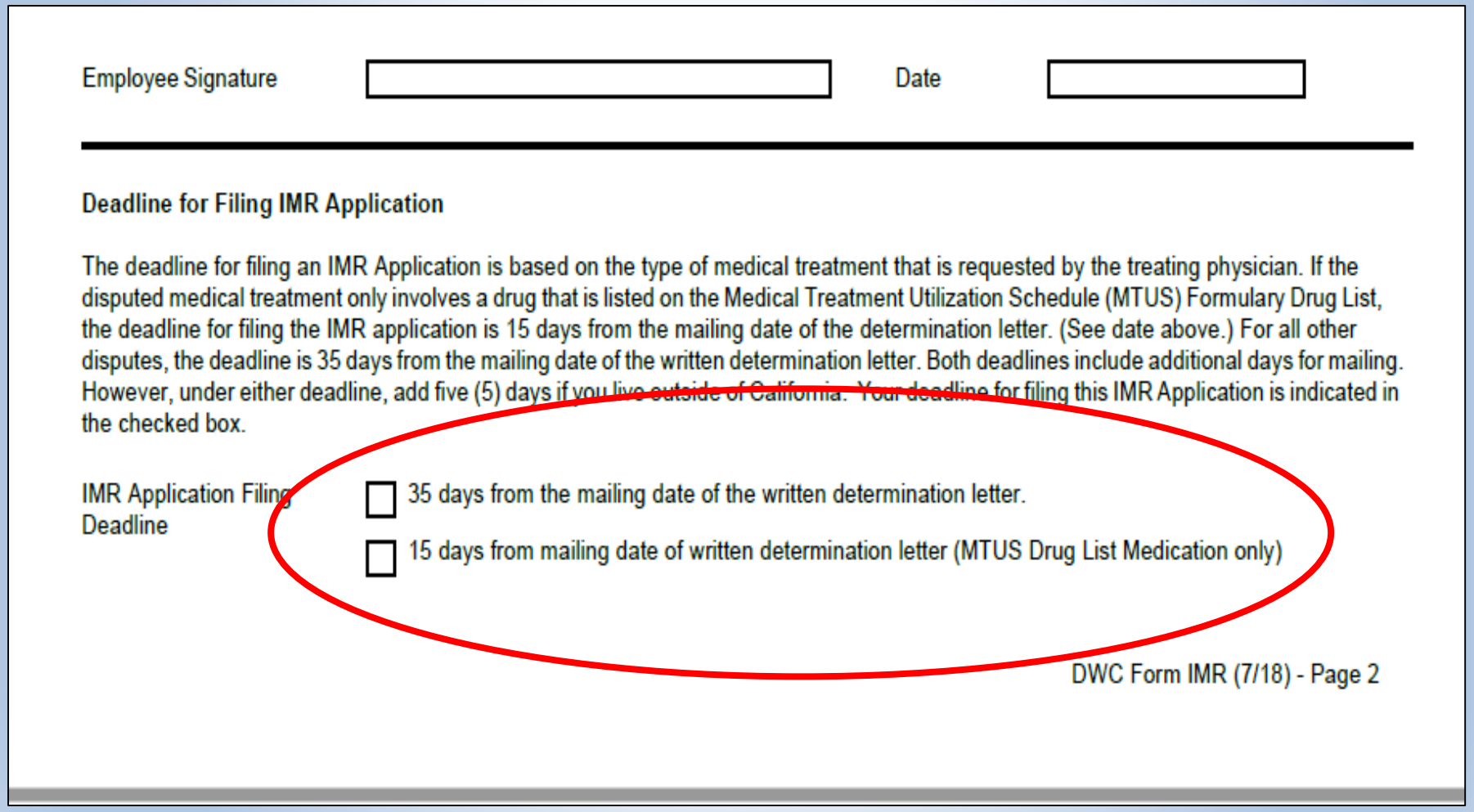
Modification after Appeal ☐ Medication Only - MTUS Formulary Drug List: ☐

Employee Name (First, MI, Last)

Address

Telephone Number E-mail

Updates to IMR Application



Employee Signature [ ] Date [ ]

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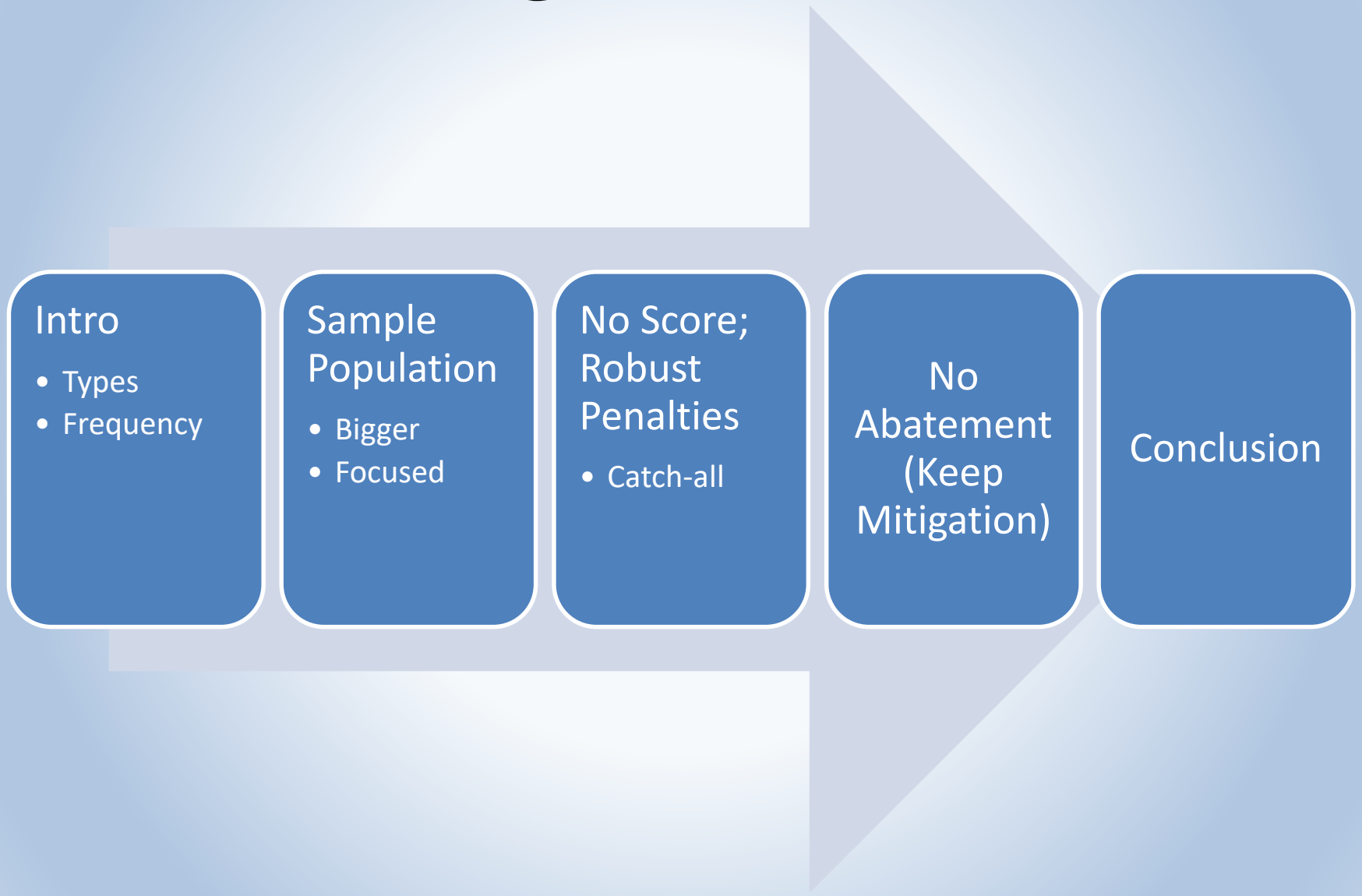
- ☐ 15 days from mailing date of written determination letter (MTUS Drug List Medication only)

DWC Form IMR (7/18) - Page 2

UR Investigations: Overview



UR Investigations

- Types: Routine & Target
- Sample Population
- New format - Schedule of Penalties
  - (a) → UR Plan Requirements
  - (b) → UR Plan Operations
  - (c) → Investigations and Miscellaneous
  - (d) → IMR Related UR Penalties
  - (e) → Catch-all