



CSURMA *California State University Risk Management Authority*



Utilization Review Case Studies

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Utilization Review Timeline

§ 9792.9. Utilization Review Standards—Timeframe, Procedures and Notice Content

- (a) The request for authorization must be in written form.
- (b) The utilization review process shall meet the following timeframe requirements:
 - (1) Prospective or concurrent 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 authorization.
 - (2) If appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested within five (5) working days from the date of receipt 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.
 - (A) If the reasonable information requested by the claims administrator is not received within 14 days of the date of the original written request by the provider, the claims administrator may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.
- (d) Prospective or concurrent decisions related to an expedited review shall be made 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. The provider must indicate the need for an expedited review upon submission of the request. Decisions related to expedited review refer to the following situations:
 - (1) When the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or
 - (2) The normal timeframe for the decision-making process, as described in subdivision (b), would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

Utilization Review Timeline

§ 9792.9. Utilization Review Standards—Timeframe, Procedures and Notice Content – Continued

- (e) The review and decision to deny, delay or modify a request for medical treatment must 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.
- (3) Decisions to approve, modify, delay or deny a physician's request for authorization prior to, or concurrent with, the provision of medical treatment services to the injured worker shall be communicated to the requesting physician within 24 hours of the decision. Any decision to approve, modify, delay or deny a request shall be communicated to the physician initially by telephone or facsimile. 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 24 hours for concurrent review and within two business days for prospective review. For purposes of this section "normal business day" means a business day as defined in section 9 of the Civil Code.

Case Study #1

- 41 year old employee with a left hamstring injury in 1998.
- After 6 years of uneventful treatment, 3 requests were made for a new surgical procedure in Boston to treat hamstring injuries.
- All 3 requests for the surgery were non-certified as there was no medical support in published evidence based, nationally recognized guidelines for the surgery and due to the experimental nature of the surgery.
- When an employee chooses to dispute a non-certification they are entitled to a medical evaluation from a panel qualified medical evaluator (QME). The employee elected this option.
- The panel QME indicated that while the symptoms may have some basis in a non-industrial degenerative disk disease which requires diagnostic work-up, the surgery for the hamstring was recommended by the QME as well.
- The surgery was provided and does not appear to have been successful in alleviating the symptoms.

Case Study #2

- 60 year old employee with a 2006 non-specific wrist, arm, shoulder and neck pain claim.
- A request was made for shoulder surgery early in this claim.
- The medical reports indicated that improvement was occurring as a result of the physical therapy being provided.
- The surgery was non-certified due to an inadequate trial of conservative treatment. Insufficient severity of disability and conflicting diagnostic evaluations.
- The treating physician appealed the decision to the physician who made the determination. The decision remained a non-certification.
- This was explained to the employee who continued with the conservative treatment, returned to work 2 weeks after the decision and continues to improve.

Case Study #3

- 47 year old employee with a 2006 cumulative trauma low back claim.
- A request was made for 18 chiropractic visits.
- The nurse contacted the chiropractor and negotiated the treatment down to 6 visits.
- After the 6 visits, the chiropractor requested 12 more visits (back to the original 18 requested).
- The nurse reminded the chiropractor that they had agreed to 6 visits. The chiropractor provided necessary evidence of medical improvement.
- Based on this and the ACOEM guidelines acceptance of DC treatment in the initial weeks after an injury, the nurse allowed 6 more visits which the chiropractor accepted.
- The end result was a savings of 6 visits. The employee is doing well.

Case Study #4

- 50 year old employee with a 2002 cumulative trauma bilateral upper extremity claim.
- A request was made for 12 occupational therapy visits.
- The employee had previously undergone 2 carpal tunnel surgeries and had already received 18 occupational therapy visits.
- ACOEM guidelines indicate that occupational therapy is to be used to provide instruction and education in a home exercise program.
- The request was non-certified as the treatment exceeded the guidelines with insufficient treating physician follow-up and due to the fact that the treatment can be done at home by the employee.