



BROADSPIRE

a Crawford Company

Broadspire

**Utilization Management
Program Plan**

February 2008

TABLE OF CONTENTS

INTRODUCTION	Page 3
PROGRAM PLAN	Page 4
EXHIBITS	
Exhibit 1 – Medical Director	Page 6
Exhibit 2 – Medical Dept Clinical Content P&P	Page 7
Exhibit 3 – Medical Dept Credentialing P&P	Page 8
Exhibit 4 – UM Pre-certification Process P&P	Page 9
Exhibit 5 – UM Notification of Certification P&P	Page 11
Exhibit 6 – UM Notification of Non-certification Process P&P	Page 12
Exhibit 7 – UM Appeals Procedure P&P	Page 16
Exhibit 8 – Broadspire CA Jurisdictional Guidelines (JuD)	Page 18
Exhibit 9 – UM Hours of Operation P&P	Page 22

INTRODUCTION

This document contains the Broadspire Utilization Management Program including the following:

- (a) The utilization review program plan containing:
 - A medical director with an unrestricted license to practice medicine in California;
 - A description of the UM Process;
 - A description of the specific criteria utilized routinely in the review and decision-making process
 - The Medical Department P&Ps

- (b) Compliance with Labor Code section 4610 including:
 - A description of the qualifications and functions of the personnel

- (c) The utilization review:
 - Policies and Procedures – The documented policies are global in nature and are used in conjunction with the state specific Jurisdictional Guidelines (JuD) for state specific requirements;
 - Pre-certification process P&P;
 - Notification of Certification (Approval) process P&P
 - Notification of Non-Certification process P&P
 - Appeals procedure P&P
 - CA Jurisdictional Guidelines Database (JuD)
 - Utilization review plan availability P&P;

PROGRAM PLAN

The Broadspire Utilization Management Program is overseen by the full time Medical Director Jacob Lazarovic, MD, FAAFP, CA license number G41008. (See exhibit 1.); mailing address – 1601 SW 80th Terrace Plantation FL 33324; phone – 954-693-1774. The Medical Director, Dr. Lazarovic, is responsible for all decisions made in Broadspire’s utilization review process.

The Broadspire Utilization Management Program includes the following components:

PRE-ADMISSION/PRE-CERTIFICATION/PRE-AUTHORIZATION REVIEW – Evaluation and determination regarding the medical necessity and appropriateness for projected treatment/admissions.

CONCURRENT REVIEW – Ongoing review of the medical necessity and appropriateness of continued services during inpatient hospitalization. Reviews are conducted based on the severity or complexity of the patient’s condition and in treatment or discharge planning activities. Inpatient reviews are not conducted on a daily basis but are usually conducted at least every three days.

RETROSPECTIVE REVIEW – A review of complete medical records following discharge to determine appropriate utilization of services. Retrospective reviews may be conducted after inpatient or outpatient services are rendered.

Emergency care does not need to be approved in advance. Injured workers with an emergency condition are to proceed to the nearest emergency facility. Emergency health care services, however, may be subjected to retrospective review. “Emergency health care services” is defined in California laws as; 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.

During the Utilization Review process, Broadspire applies and utilizes American College of Occupational and Environmental Medicine (ACOEM) guidelines as its primary source of criteria. In the event that the utilization review request is not addressed by ACOEM guidelines, Broadspire applies and utilizes commercially available criteria by *InterQual*, internally developed criteria and other state treatment guidelines where applicable. Criteria are developed through comprehensive study of the accepted standards of practice, literature research, networking, consultation and contribution by actively practicing providers certified in their areas of expertise. Criteria are reviewed on an annual and as needed basis. Such guidelines will be utilized until such time that the state adopts another treatment utilization schedule. Criteria may be released to providers and/or patients upon request. (See exhibit 2.)

The *Medical Disability Advisor* (MDA) by Presley Reed, M.D. is utilized to evaluate disability duration during the case management and disability management processes.

Utilization Management staff include full time registered nurse reviewers and a physical therapist. A diverse range of peer review physician consultants are routinely available to render utilization review determinations and ensure specialty matching with providers rendering care. Additionally, there are supervisory and training personnel plus the full time Medical Director.

Professional review staffs are evaluated initially through the Human Resources Department. Licenses and references are verified. Each professional applicant must undergo an interview process and demonstrate appropriate experience within their area of clinical expertise. Physicians are board certified in their area of specialty and have undergone a formal credentialing process which includes contacting the individual state boards to verify licensure. (See exhibit 3.)

Broadspire California Utilization Management Plan

Cases are initially reviewed by a nurse reviewer utilizing the aforementioned clinical criteria. If the case meets criteria, a certification (approval) recommendation will be made with concurrent review conducted as needed for ongoing treatment. In accordance with section 9792.6 (b) of the California Code of Regulation, "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on the Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the DWC Form PR-2.

In the event that a case does not meet the established criteria, a referral is made to the appropriate Physician Reviewer. If it is determined that the case still does not meet criteria after contact with the prescribing provider and review by the Physician Reviewer*, a non-certification recommendation will be issued. Only Physician Reviewers may recommend modification, delay or denial (non-certification) of services based on clinical rationale. (See exhibit 4.)

Verbal notification of all certification recommendations will be given to the provider(s) in accordance with the more stringent of URAC and/or state specified time frames. For California UR, prospective or concurrent decisions are made within five (5) working days from the date of receipt of the written request for authorization. If appropriate information necessary to render a decision is not provided with the original request for authorization, the information will be requested within the five (5) working days from the date of receipt of the written request. 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. For retrospective review, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination. (See exhibits 5 & 8.)

Written notification to the provider(s) and patient/representative will follow the verbal notification. Any written non-certification recommendation will include a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Written notification letters include instructions for initiating the appeals process and state mandated language. (See exhibit 6.)

Broadspire provides an appeals process to the provider and patient in the event of a non-certification decision. In California an appeal may be requested within twenty (20) days** of the original determination through the reconsideration, expedited and/or standard appeal procedures. (See exhibit 7.)

Hours of operation are from 8:00a.m. To 8:30p.m. EST, Monday through Friday. After hours, weekend and holiday calls are handled by a voice mail system. Broadspire quality standards require that all phone messages be returned by the following business day. (See exhibit 9.) Requests may also be faxed at any time to 770-777-6447.

The Broadspire utilization review plan is available upon request.

The Broadspire Utilization Management Program is accredited by URAC for Worker's Compensation Utilization Management.

*Note: A referral may be made to an outside peer review agency in order to ensure that a peer with appropriate licensure renders the determination when applicable.

EXHIBIT 1

Medical Board of California



1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Consumer Information Line: (916)
263-2382

Physician Information

Licensee Name: JACOB LAZAROVIC, MD
License Type: PHYSICIAN AND SURGEON
License Number: G41008
License Status: [LICENSE RENEWED & CURRENT](#)
Public Record Actions: NONE AVAILABLE ON WEB SITE (To find out what information is and is not available on the Web site, please click [here.](#))
Original Issue Date: OCTOBER 09, 1979
Expiration Date: AUGUST 31, 2009
Address: 1941 N W 25TH STREET
BOCA RATON, FL 33431
County: OUT OF STATE

[http://www2.dca.ca.gov/pls/wllpub/WLLQRYNA\\$LCEV2.QueryView?P_LICENSE_NUMBER=41008&P_LTE_ID=790](http://www2.dca.ca.gov/pls/wllpub/WLLQRYNA$LCEV2.QueryView?P_LICENSE_NUMBER=41008&P_LTE_ID=790)

EXHIBIT 2

Medical Department Policies and Procedures

Subject: Clinical Content
Origination Date: 7/15/03
Revision Date: 3/15/05
Performed By: Medical Department

Policy: Evidence based clinical content will be developed by the medical department with participation of specialty physicians and annually reviewed and updated as appropriate.

Procedure:

1. A literature search and review will be conducted on the topic for which evidence based clinical content is being developed.
2. Each topic developed will include a resource bibliography citing all references utilized in the development of the clinical content. References may include but are not limited to:
 - Textbooks
 - Professional health care journals
 - Professional providers/physician review consultants
 - Specialty societies
 - Established guidelines
 - Online research
3. A first draft will be reviewed by appropriate physician review consultants.
4. Upon incorporation of the physician review consultant's recommendations, the content will be submitted to the Medical Director for final approval prior to implementation.
5. Clinical content documents are posted in the appropriate databases by the medical department administrative assistant
6. E-mail notification of new or updated clinical content is communicated to staff by the medical department administrative assistant.
7. Internally developed clinical content will be evaluated at least annually in compliance with URAC standards and regulatory requirement.
8. If in the course of the review and evaluation the medical department determines that the current criteria require revision, an update will be developed.
9. Revised versions of clinical content are electronically filed in the "G" drive within the "Clinical Content" folder. The directory will store a history of all versions. The medical department administrative assistant maintains the directory.
10. New criteria are assigned a name, type and a version number of 1.0. Revised criteria are assigned a revision date within the document. The document is electronically saved as a new file with the same name, type and the new subsequent version number.
11. The outdated version of the clinical content is removed from the Medical Department General Use and the appropriate departmental databases and replaced with the revised version.
12. The criteria used in the determination process may be disclosed, upon request, to the treating provider and/or claimant.

EXHIBIT 3

Medical Department Policies and Procedures

Subject: Credentialing for Physician Review Consultants
Origination Date: 4/16/99
Revision Date: 3/16/05
Performed By: Physician Review Services Coordinator

Policy: Physician Review Consultants shall be credentialed on initial contract and Re-credentialed every three years per URAC standards through contract with FOCUS.

Procedure:

1. The credentialing process for physicians eligible for participation on the Physician Review Services (PRS) panel, is delegated to FOCUS
2. FOCUS initiates the credentialing of prospective consultants upon receipt of the physician's name, address and contact phone number
3. Focus is responsible for re-credentialing of panel consultants
4. FOCUS will submit credentialing reports to the PRS coordinator monthly
5. FOCUS will provide policies and procedures regarding related delegated functions as needed
6. Physician Review Consultants must have a current, unrestricted professional license
7. Physician Review Consultants must be board certified by the approved board in provider's practicing specialty (if applicable)*
The following are the approved certifying boards:
 - All member boards of the American Board of Medical Specialties
 - All member boards of the American Osteopathic Association
 - American Board of Podiatric Surgery
 - American Board of Primary Podiatric Medicine
8. Physician Review Consultants are credentialed and re-credentialed according to URAC credentialing standards

* Exceptions to board certification status may be required to satisfy operational needs.

EXHIBIT 4

UM P&P Manual

Utilization Management

Regulatory References: URAC UM 6, 17, 24, 26, 27
Policies and Procedures
Subject: Pre-certification Process
Origination Date: April 1994
Revision Date: 5/25/06
Performed By: All Utilization Management Services

Policy: The Utilization Management Department receives and reviews requests for pre-certification (prospective) review of proposed treatment within appropriate time frames and in accordance with URAC Standards and relevant state regulations.

CA JuD –
Exhibit 8

Procedure:

1. A request for pre-certification (prospective review) may be received from worker or a representative of the worker, the claims adjuster, the facility rendering the service, the provider, a state regulator, FCM, TCM or SNR, via:
 - a. Electronic referral (from the claims adjuster)
 - b. Telephone
 - c. Facsimile
 - d. Interdepartmental referral
2. When a request for pre-certification is received from a provider, the claims adjuster and case manager are notified of the referral via phone or e-mail at the initiation of each new case except for cases in Texas and Massachusetts. An interdepartmental Communication Service Code (C6500) is entered into the case noting the conversation with the case manager. Notification of the claims technician is not required for continued care requests once the review is initiated.
3. Demographic information is obtained by the Claim Intake Representative and the case set-up is completed. The Claim Intake Representative will forward cases to the case distribution area for timely distribution to review staff.
4. The case is triaged to obtain the necessary medical information* to complete the review, which may include but is not limited to: treatment plan; symptoms; diagnostic studies; past treatment history; and discharge plan. Information may be accepted from any reasonably reliable source that will assist in the certification process.
5. The pre-certification review will be completed within the relevant or appropriate time frame:
 - a. 72 hours of the request *if it is a case involving urgent care.***or
 - b. 5 calendar days of the receipt of the request *if it is a case involving non-urgent care*, or
 - c. ***State regulatory requirements. (per the Jurisdictional Guidelines Database “JuD”)
6. If the proposed treatment meets the accepted criteria, notification is made within the relevant or appropriate timeframe as noted above. Notification timeframes are inclusive of the entire UM process, from receipt of the request for a UM decision to the issuance of the determination both verbal and written.

CA JuD –
Exhibit 8

Broadspire California Utilization Management Plan

Providers are notified verbally and in writing. Patients are notified as deemed necessary by the state requirements.

7. If the proposed treatment does not meet the criteria, the case is referred to the Peer Consultant for review. If non-certification is recommended, notification including method of initiating the Appeal process is forwarded to the provider (2) and patient, if applicable, within the appropriate timeframe.
8. The claims adjuster/administrator is notified both verbally and in writing of any non-certification recommendations. The case manager is notified of the determination either by phone or electronically.
9. Review determinations are based solely on the medical information obtained at the time of the review determination.
10. Pre-authorization determinations will be reversed only when information provided to the UM department is materially different than was reasonably available at the time of the original determination.

Example: If a claims adjuster receives copies of medical records such as an IME or Designated Doctors report that were not available at the time of the UR review, the claims adjuster may forward the information to UR for review. If the information in the report does not support the treatment previously authorized, the department may perform a retrospective review and reverse the original treatment decision.

11. When a patient is represented (e.g. attorney) in a workers' compensation claim, written notification will be provided to the attorney or patient representative in accordance with jurisdictional requirements.
12. The nurse will document treatment approvals using a forty five-day window or the specific timeframe requested by the provider not to exceed 45 days. If the treatment is not rendered within the projected time frame, the provider may request a time extension to render the previously approved treatment. The new date range will be documented in the case and the provider will be verbally notified of the extension.

Notes:

1. See Jurisdictional Guidelines Database (JUD) for state regulatory requirements.
2. See Texas Pre-Authorization Process P&P
3. The attorney receives written notification of determinations in the benefit states of CO, OH, MA, ME, and TX

CA JuD –
Exhibit 8

EXHIBIT 5

**UM P&P Manual-
Utilization Management**

**Regulatory References:
Policies and Procedures**

URAC UM 17, 18, 19, 20

Subject:

Notification of Certification for Prospective, Concurrent and Retrospective Treatment

Origination Date:

April 1994

Revision Date:

5/17/06

Performed By:

All Utilization Management Services

Policy:

If the prescribed treatment meets the appropriate criteria, recommendation for certification is conveyed to the appropriate entities in compliance with URAC Standards and relevant state regulations.

In workers' compensation where the patient bears no financial responsibility, patients do not receive copies of notification letters unless required by state regulations. Please refer to the Jurisdictional Guidelines Database ("JuD") for state specific notification requirements.

Procedure

CA JuD –
Exhibit 8

1. The timeframes in which prospective, continued stay/concurrent and retrospective review recommendations for certification of treatment are made will be made based on the state regulatory requirements (per the jurisdictional guidelines database [JuD]). If no guidelines specified by the State, notification will be made according to URAC guidelines.
2. The certification recommendation will be provided by telephone to the requesting party (e.g. attending physician or other ordering provider and facility rendering service) within the above time frames.
3. Written notification of the recommendation for certification will be mailed to the appropriate parties (please see JuD for parties to be notified) based on the timeframes mandated by the state. If no timeframe specified by the State, notification will be sent based on URAC timeframes.
4. The Claims Adjuster/administrator will be notified via electronic transfer within 24 hours of the determination.

EXHIBIT 6

**UM P&P Manual
Utilization Management
Regulatory References
Policies and Procedures**

URAC UM 22, 23

Subject:

Notification of Non-Certification Process

Origination Date:

May 14, 1997

Revision Date:

3/7/05

Performed By:

All Utilization Management Services

Policy: The Utilization Management Department shall provide notification of its non-certification determinations in accordance with URAC standards and relevant regulatory guidelines.

In workers' compensation where the patient bears no financial responsibility, patients do not receive copies of notification letters unless expressly required by state regulations. Please refer to the Jurisdictional Guidelines Database ("JuD") for state specific notification requirements.¹

CA JuD –
Exhibit 8

Procedure:

1. When a request for treatment or services is received, the treatment request and the clinical information submitted by the provider are compared with appropriate criteria.
2. If the information received does not meet criteria, the UM Reviewer will schedule a peer review using the **Physician Review Services Database** and complete the process according to the **Referral to Peer Consultant P&P**.
3. During the review process, prior to a determination being rendered, a peer to peer contact will be offered to the provider. If the provider has requested contact with the peer, the peer will contact the provider during the review to discuss the case and obtain additional clinical information.
4. The UM reviewer will follow Notification of Certification Process for certification of treatment or services.
5. When a determination is made not to certify a requested treatment, procedure or service, the requesting provider and/or other provider/facility rendering services shall be notified by telephone and in writing within the appropriate notification timeframes based on type of review or State guidelines. These timeframes are inclusive of the entire UM process, from the receipt of the request for a UM decision to issuance of both the verbal and written documentation.
6. Verbal notification shall include the principal reason for the non-certification determination and will inform the provider of the option to appeal the determination. The offer of a peer to peer contact is documented in the Physician Review/General Service Code (R1026).
7. Written notification shall include the principal reason for the non-certification and instructions for initiating an appeal and/or the option to request the clinical rationale for the determination in writing. The patient shall be notified in states where written notification is required by state regulation or rule.
8. The clinical rationale and/or clinical review criteria used to make the non-certification determination will be made available upon written request by the patient, provider or facility.

Broadspire California Utilization Management Plan

9. When a patient is represented (e.g. attorney) in a workers' compensation claim, written notification will be provided to the attorney or patient representative as required by state regulation or rule.
10. For Group Health, patients will receive written copies of all determination letters.

CA JuD – Exhibit 8

Notes:

1. See Jurisdictional Guidelines Database for state regulatory requirements.
2. See Communication Prior to NC P&P
3. States requiring patient notification include: Arkansas, Arizona, Connecticut, Florida, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Texas, Virginia.
4. The attorney receives written notification of determinations in the benefit states of CA, CO, OH, MA, ME, and TX.

Related policies: Massachusetts Utilization Management, Texas Health Utilization Management

EXHIBIT 6

Sample UR Letters



EXHIBIT 7

UM P&P Manual

Utilization Management

Regulatory References

URAC UM 30, 31, 32, 33, 34, 35, 36

Policies and Procedures

Subject:

Appeals Procedure

Origination Date:

April 1993

Revision Date:

5/18/06

Performed By:

All Utilization Management Services

Policy: Broadspire provides an appeal procedure, upon request, to the attending physician, health care facility or patient/enrollee if a non-certification recommendation is made for medical treatment/services. The following guidelines were constituted on behalf and for the rights of the above mentioned parties. Broadspire will comply with all Federal and State regulatory guidelines. Refer to the Jurisdictional Guidelines Database for state regulatory guidelines.*

Appeal reviews will be conducted by clinical peers who:

- Are Health Professionals
- Are qualified, as determined by the medical director, to render a clinical opinion about the medical condition, procedures, or treatment under review
- Hold a current, unrestricted and valid license in the same licensure category as the ordering provider or as a doctor of medicine or osteopathy
- Are Board certified (if applicable) by a specialty board approved by American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists
- Are in the same profession and in a similar specialty as typically manages the medical condition
- Are neither the individual who made the original non-certification nor the subordinate of such an individual

Procedure:

CA JuD –
Exhibit 8

1. The appeals procedure should be initiated within 60 days of the initial non-certification determination for workers compensation or state specific time frame as described in the Jurisdictional Guidelines Database. For Health, the provider, facility or patient has 180 days from the date of the non-certification to request an appeal.
2. The provider, facility and/or patient may submit written comments, documentation, records, or other information relating to the case with the appeal request.
3. The Utilization Management department will take into account all information submitted without regard to whether such information was submitted or considered on the initial review of the case. Information may be transmitted via fax, telephone, or other means. If no additional information is received from the provider, the determination is rendered based on existing medical information.
4. Case documentation for all appeals will contain:
 - The name of the patient, provider and facility rendering service;
 - Date of appeal reviews, documentation of actions taken, and final resolution;
 - Copies of all correspondence from the patient, provider or facility rendering service and information related to the appeal determination.

Broadspire California Utilization Management Plan

5. The expedited and standard appeals processes are described below:

EXPEDITED APPEALS (Urgent, Imminent or Ongoing Care)

After an initial adverse determination, the attending physician or other ordering provider, facility, or patient/enrollee may assert his/her right for an expedited appeal verbally or in writing for any urgent, imminent or ongoing services.

- An Urgent request is defined as any request for utilization management determination with respect to which their application of the time periods for making non-urgent care determinations
 - a. could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function, or
 - b. in the opinion of a physician with knowledge of the consumer's medical condition, would subject the consumer to severe pain that cannot be managed without the requested care or treatment.
- Examples of imminent or ongoing care may include but are not limited to such services as inpatient hospitalization, work hardening, work condition, and chronic pain program.
 - a. Verbal notification of the determination is provided to the attending physician or other ordering provider or facility rendering service, within 72 hours of initiating the expedited appeal process.
 - b. The expedited appeal is completed (i.e. written notification of the determination is issued) as soon as possible, but no later than 72 hours after the initiation of the appeal process.
 - c. Written notification shall be sent to the patient/enrollee and attending physician or other ordering provider and facility rendering service (if applicable.)
 - d. In the event an expedited appeal is not resolved or if the treating provider disputes the result, the treating provider or patient may request an appeal through the Standard Appeal process.

STANDARD APPEAL (Non-imminent Ongoing Care)

Decision(s) of the Physician Reviewer may be appealed by the attending physician or other ordering provider, facility, or patient/enrollee may assert his/her right for a standard appeal by verbal or written request.

- The Standard Appeals process may be used in the event that an Expedited Appeal is not resolved (as appropriate) or after a non-certification decision has been made for non-imminent ongoing services.
- An appeal of a retrospective review will be conducted as a Standard Appeal.
 - a. Verbal notification of the determination is provided to the attending physician or other ordering provider or facility rendering service, within thirty (30) days of the initiation of the appeal request
 - b. Standard appeal determinations are completed (i.e. written notification of the appeal decision is issued) within thirty (30) days of the initiation of the appeal request. **
 - c. Written notification shall be sent to the patient/enrollee and attending physician or other ordering provider and facility rendering service (if applicable.)

Broadspire California Utilization Management Plan

WRITTEN NOTIFICATION of appeal determinations includes the following information:

- a. The treatment requested and the party requesting the appeal;
- b. The determination relating to the treatment reviewed;
- c. The principal reasons for the determination to uphold the non-certification;
- d. The appeal letter templates include:
 - A statement indicating a standard appeal may be requested after an expedited appeal adverse determination.
 - A statement indicating the clinical rationale used to make the determination will be made available in writing upon request.

Examples of Documentation:

EXAMPLE #1

Treatment Requested: Appeal, by Dr. R. Jones, of non-certification determination for Physical Therapy, 3 times a week for 4 weeks for lumbar sprain 1/2/02-1/30/02.

Determination: This appeal upholds the previous denial of Physical Therapy.

Rationale: The determination was based on review of ACOEM Low Back Complaints guideline and orthopedic physician review. The current evaluation findings from Dr. Jones dated 12/28/01, notes full lumbar range of motion and strength. There are no functional deficits noted in the evaluation.

EXAMPLE #2

Treatment Requested: Appeal, by Dr. R. Jones, of non-certification determination for Physical Therapy, 3 times a week for 4 weeks for lumbar sprain 1/2/02-1/30/02.

Determination: This appeal overturns the previous denial of Physical Therapy.

Rationale: The determination was based on review of ACOEM Low Back Complaints guideline, orthopedic physician review, and review of the additional documentation supplied by Dr. Jones including a current evaluation dated 12/28/01. The current evaluation supports additional treatment related to limited lumbar range of motion and strength as well as functional deficits noted by impaired gait and limited lifting ability.

Notes:

* States w/ varying appeals regulations include: Arkansas, California, Connecticut, Florida (Health), Kentucky, New York, Ohio, Oklahoma, Massachusetts, Texas (Health)

** Connecticut Standard Appeals are completed within 30 days of receipt of information necessary to complete the determination. URAC time frame is more stringent and will take precedence.

EXHIBIT 8

Jurisdictional Guidelines (JuD)

State: California
Section: Law and Regulations

Utilization Management Requirements

<p>UM Required For:</p>	<p>For injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 physical therapy and 24 occupational therapy visits per industrial injury, unless carrier authorizes additional visits in writing.</p> <p>California Labor Code 4604.5 (d)</p>
<p>UM may be requested by:</p>	<p>A request for authorization for a course of treatment must be in written form. An oral request for authorization must be followed with a written confirmation of the request within seventy-two (72) hours.</p> <p>DWC Administrative Rules: Section 9792.6 (e)(o)</p>
<p>Emergency Treatment Provisions:</p>	<p><u>Emergency care does not need to be approved in advance.</u> Injured workers with an emergency condition are to proceed to the nearest emergency facility. Emergency health care services, however, may be subjected to retrospective review.</p> <p>Expedited review - when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.</p> <p>The requesting physician must indicate the need for an expedited review upon submission of the request.</p> <p>A decision 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.</p> <p>California Labor Code 4610 (g)(2) DWC Administrative Rules 9792.6 (g), 9792.9 [(a)1, (e)]</p>
<p>UM Decision Turnaround Time:</p>	<p>At a minimum, the jurisdictional guidelines(below) will be followed and we will strive to meet the more stringent URAC guidelines -> Prospective or concurrent decisions must be made within five (5) working days from the date of receipt of the written request for authorization. If appropriate information necessary to render a decision is not provided with the original request for authorization, the information will be requested within the five (5) working days from the date of receipt of the written request. 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.</p> <p>In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.</p> <p>California Labor Code 4610 (g)(1) DWC Administrative Rules 9792.9 [(b)(1&2)(c)]</p>

Broadspire California Utilization Management Plan

<p>State Treatment Guidelines:</p>	<p>During the Utilization Review process, Broadspire applies and utilizes American College of Occupational and Environmental Medicine (ACOEM) guidelines as its primary source of criteria. In the event that the utilization review request is not addressed by ACOEM guidelines, Broadspire applies and utilizes commercially available criteria by <i>InterQual</i>, internally developed criteria that are developed through comprehensive study of the accepted standards of practice, literature research, networking, consultation and contribution by actively practicing providers certified in their areas of expertise. Criteria are reviewed on an annual and as needed basis. DWC Administrative Rules 9792.8</p> <p>You may utilize PAC or InterQual criteria to render a utilization review determination for a diagnosis unavailable in the ACOEM.</p> <p>Individual treatment guidelines and the California UM Program Plan may be released upon request. The UM Program Plan may be released via electronic means at no fee. If a hard copy of the UM Program Plan is requested, a charge not to exceed \$0.25 per page plus postage costs would be applied. DWC Administrative Rules 9792.7(d)(1)</p>
<p>Special Noncert Procedures:</p>	<p>In the case of concurrent review, medical care <u>shall</u> not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request but shall not include the rationale, criteria or guidelines used for the decision. DWC Administrative Rules 9792.10 (b)(1)</p> <p>Authorization requests may only be modified, delayed or denied by a physician with education, training, expertise and experience pertinent to evaluating the specific clinical services under review.</p> <p>Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians must include clear and concise explanation of reasons for the determination, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. California Labor Code 4610 (g)(4) DWC Administrative Rules 9792.9 (j) (1-7)</p>
<p>Special Licensure Requirements:</p>	<p>The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in the state of California. The medical director is licensed in the state of California.</p> <p>Only a licensed physician competent to evaluate the specific clinical issues of the treatment request may modify, delay or deny authorization requests for reasons of medical necessity to cure and relieve the workers compensation injury. Peer reviewers do not require California licensure.</p>
<p>Direct Access to PT:</p>	<p>CA is a direct access state, but workers' comp law requires a physician referral for PT. CA Business and Professions Code for PT (Added 9/14/2005) 2630. It is unlawful for any person or persons to practice, or offer to practice, physical therapy in this state for compensation received or expected, or to hold himself or herself out as a physical therapist, unless at the time of so doing the person holds a valid, unexpired, and unrevoked license issued under this chapter.</p>

<p>Notification Requirements:</p>	<p>UM decisions must be communicated to the physician initially via telephone or fax within 24 hours of the decision to approve, modify, delay, or deny requests for</p>
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Broadspire California Utilization Management Plan

	<p>authorization.</p> <p>A written decision modifying, delaying or denying treatment authorization shall be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker’s attorney.</p> <p>Written notification of a modification, delay, or denial of requests by physicians for authorization must be provided to the claimant and the physician within 24 hours of the decision for concurrent review and within 2 business days of the decision for prospective review. Please refer to the UM decision turn around time referenced above. California Labor Code 4610 (g) (3A) DWC Administrative Rules 9792.9 (b)(4)</p> <p>In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination. California Labor Code 4610 (g)(1) DWC Administrative Rules 9792.9 (c)</p> <p>Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians must include clear and concise explanation of reasons for the determination, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.</p> <p>Letters modifying, delaying or denying services must include:</p> <ul style="list-style-type: none"> - Peer name and specialty; - phone # and hours of availability (this is included in the standard letter template); - medical criteria upon which the denial is based; - state specific dispute statement (this is included in the standard letter template) <p>California Labor Code 4610 (g)(4) DWC Administrative Rules 9792.9 (j)(1-7)(k)</p> <p>The California Notice of Non-Certification and Exception UR letter (R4089) contains language directly from the UR regulations describing the claimant's responsibilities. This letter can be utilized for denials on retrospective & concurrent reviews as well as exceptions, reconsiderations, and appeals.</p>
<p>Appeals:</p>	<p>A patient and/or provider has the right to use the internal appeal process (i.e. URAC) or to use the dispute resolution process outlined in Labor Code 4062 (http://www.leginfo.ca.gov/cgi-bin/displaycode?section=lab&group=04001-05000&file=4060-4068). An appeal or dispute must be requested within 20 days of receipt of the UR decision (or other mutually agreed upon extended time frame.)</p> <p>DWC Administrative Rules 9792.10 (3)</p>
<p>Notes:</p>	<p>California Labor Code 4999 (b) (effective 1/1/2000), CA recognizes URAC accreditation for Telephonic Medical Advice Programs (i.e. not UR.) http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=04001-05000&file=4999-4999.9</p> <p>For Claims adjuster reference: Spinal Surgery Disputes In situations where the employer disagrees with the treating physician's report recommending spinal surgery:</p>

Broadspire California Utilization Management Plan

	<p>If the employee is represented by an attorney, the parties shall seek agreement on a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation within 10 days.</p> <p>If no agreement is reached within 10 days, or if the employee is not represented by an attorney, an orthopedic surgeon or neurosurgeon shall be randomly selected by the administrative director to prepare a second opinion report resolving the disputed surgical recommendation.</p> <p>Examinations shall be scheduled on an expedited basis.</p> <p>The second opinion report shall be made available to both parties within 45 days of receipt of the treating physician's report.</p> <p>If the second opinion report recommends surgery, the employer shall authorize the surgery.</p> <p>If the second opinion report does not recommend surgery, the employer shall file a declaration of readiness to proceed. This form can be found by clicking on the link below: http://www.dir.ca.gov/DWC/DOR.pdf California Labor Code 4062(b)</p>
<p>Authority Source:</p>	<p>Administrative Code/Rule, Division of Workers Compensation</p> <p>California Labor code 4600-4614.1 http://www.leginfo.ca.gov/cgi-bin/displaycode?section=lab&group=04001-05000&file=4600-4614.1</p> <p>California Labor code 4060-4068 http://www.leginfo.ca.gov/cgi-bin/displaycode?section=lab&group=04001-05000&file=4060-4068</p> <p>DWC Administrative Rules: http://www.dir.ca.gov/dwc/DWCPropRegs/UR_TextFinalRegulations.pdf</p> <p>(http://www.dir.ca.gov/t8/ch4_5sb1a5_5_1.html)</p> <p>Revised 8/11/06 da</p>

EXHIBIT 9

**Utilization Management
Policies and Procedures**

Regulatory References : **UM 2, 3**

Page 1

Subject: Hours of Operation
Origination Date: April 1994
Revision Date: 2/14/96, 11/12/98. 4/6/99, 08/2/02, 6/18/03, 2/9/05, 3/17/07,
Performed By: All Utilization Management Services

Policy: Review staff are available via a toll free phone number to perform utilization review/pre-certification, Monday through Friday between the hours of 8:00am and 8:30pm Eastern Standard Time. Requests also may be faxed at any time.

Procedure:

Time zone	EST	CST	MST	PST
	8 am -5:30pm	8 am -5:30pm	8 am -5:30pm	8 am -5:30pm
Equals in EST	8 am -5:30pm	9am -6:30pm	10am -7:30pm	11am-8:30pm

A toll free number is available for incoming callers (800) 800 -7660 - Plantation office
(800) 541-5975 – Atlanta office

UR Fax number 770-777-6447

At the close of business hours until 8:00 am Eastern standard time on the next business day, telephone calls are handled by a voice mail message system.

The caller is instructed to provide information on the case and is informed that the call will be returned by the Broadspire Utilization Review personnel on the next business day.

In the event that a specific reviewer is not available during business hours, the call will be routed to the reviewer's confidential voice mail. Voice mails received before 12:00pm will be returned the same business day, voice mails received after 12:00pm will be returned the next business day.

Notes:

Approved By:	Daad McGovern, RN, BSN, ARNP	Date: 3/17/07
Title/Type Name	Vice President, TCM, UM, SNR	

Reviewed by:	Melanie Mathelier, RN, BSN, MSN, CRRN	Date: 3/17/07
Title/Type Name	UM Manager	

Revised by:	Cynthia Wedderburn, RN	Date: 3/17/07
	UM Supervisor	
	Nancy Murphy, RN, BHS, CQAUR	Date: 2/20/2008
	National Compliance Manager, Medical Management	
