Back To Chiropractic Continuing Education Seminars

Work Comp: Utilization Review ~ 4 Hours

Revised 06/5/2025

This course counts as 4 hours toward the 12 hour every 2 year requirement for renewing your QME status for the California Department of Industrial Relations, Division of Worker's Compensation (DWC).

This course will no longer count as of April 1st 2026.

Visit our website for new mandatory requirements, (16 hours every 2 years).

This course also counts as a 4 hour CE elective for the Board of Chiropractic Examiners for the state of California.

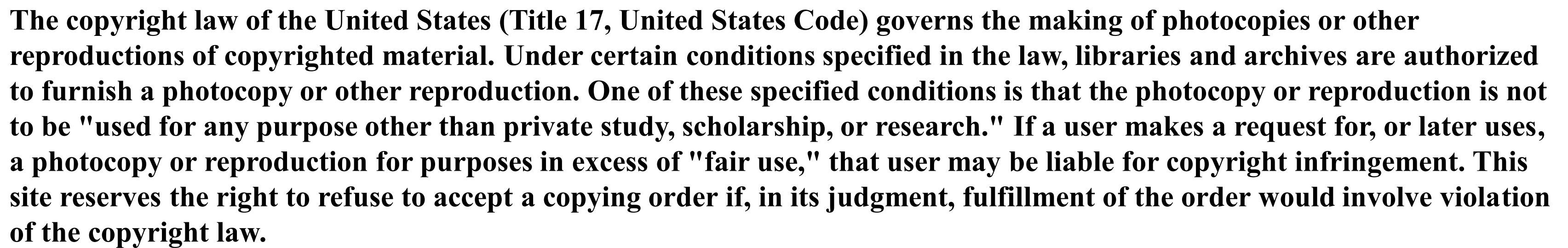
Back To Chiropractic CE Seminars

Work Comp: Utilization Review ~ 4 Hours

Welcome to Back To Chiropractic Online CE exams:

This course counts toward your California Board of Chiropractic Examiners CE.
(also accepted in other states, check our website or with your Chiropractic State Board)

The California Board requires that you complete all of your CE hours BEFORE the end of your Birthday month. We recommend that you send your chiropractic license renewal form and fee in early to avoid any issues.



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Exam Process: Please read all instructions before starting!

1. You must register/pay first. If you haven't, please return to: backtochiropractic.net
2. Open a new window or a new internet tab & drag it so it's side-by-side next to this page.
3. On the new window or new tab you just opened, go to: backtochiropractic.net website.
4. Go directly to the Online section. DON'T register again.
5. Click on the Exam for the course you want to take. No passwords needed.
6. Follow the Exam instructions.
7. Upon passing the exam you'll be able to immediately download your certificate, and it'll also be emailed to you. If you don't pass, you can repeat the exam at no charge.

   Please retain the certificate for 4 years.
   If you get audited and lose your records, I'll have a copy.

I'm always a phone call away... 707.972.0047 or email: marcusstrutzdc@gmail.com

Marcus Strutz, DC
Back To Chiropractic CE Seminars

Utilization Review in Workers' Compensation

How to get a "Yes" from UR

Tel: (408) 691-4012 | Email: drcrafts@sbcglobal.net

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Types of Review

- **Prospective Review:** Conducted prior to the delivery of health care services
- **Concurrent Review:** Conducted when the patient is receiving the health care services or during hospitalization
- **Retrospective Review:** Conducted after the patient has received the health care services
- **Extension Review:** When additional information is requested on either a prospective or concurrent RFA
- **Reconsideration Review:** Conducted if the additional information requested by the URO is received after a decision was already made
- **Expedited Review:** Conducted if there is a serious and imminent threat to the health of the injured worker, and must be certified
- **Appeal Review:** Conducted after an adverse UR decision by a different physician reviewer who must be board certified and in the appropriate scope of practice
- **Peer to Peer Review:** Conducted after an adverse UR decision by the same physician reviewer

UR Required Decision Timeframes

Review Type:	Prospective	Concurrent	Retrospective	Expedited
When is it Performed?	Prior to delivery of services	While the service is being provided	After the service has been provided	Prior to delivery of services
Timeframe	5 Business Days from first receipt of request.	5 Business Days Same as prospective.	30 Days from receiving necessary information required to make decision.	72 Hours or less
Timeframe (Extension)	14 Calendar Days from date of receipt of the original RFA (If additional medical information is needed and request was made prior to 5th business day)	14 Calendar Days from date of receipt of the original RFA (If additional medical information is needed and request was made prior to 5th business day)	None	None

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	31	1	2	3	4 **Prospective REQUEST RECEIVED COUNTED AS DAY 0**	5
6	7	8	9	10	11 Veteran's Day	12
13	14 **Prospective due if no addl. Info. requested**	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			3

Required Guidelines

- MTUS - http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS/MTUS_Regulations.htm
- ACOEM – 2004, 2nd edition
- Official Disability Guidelines

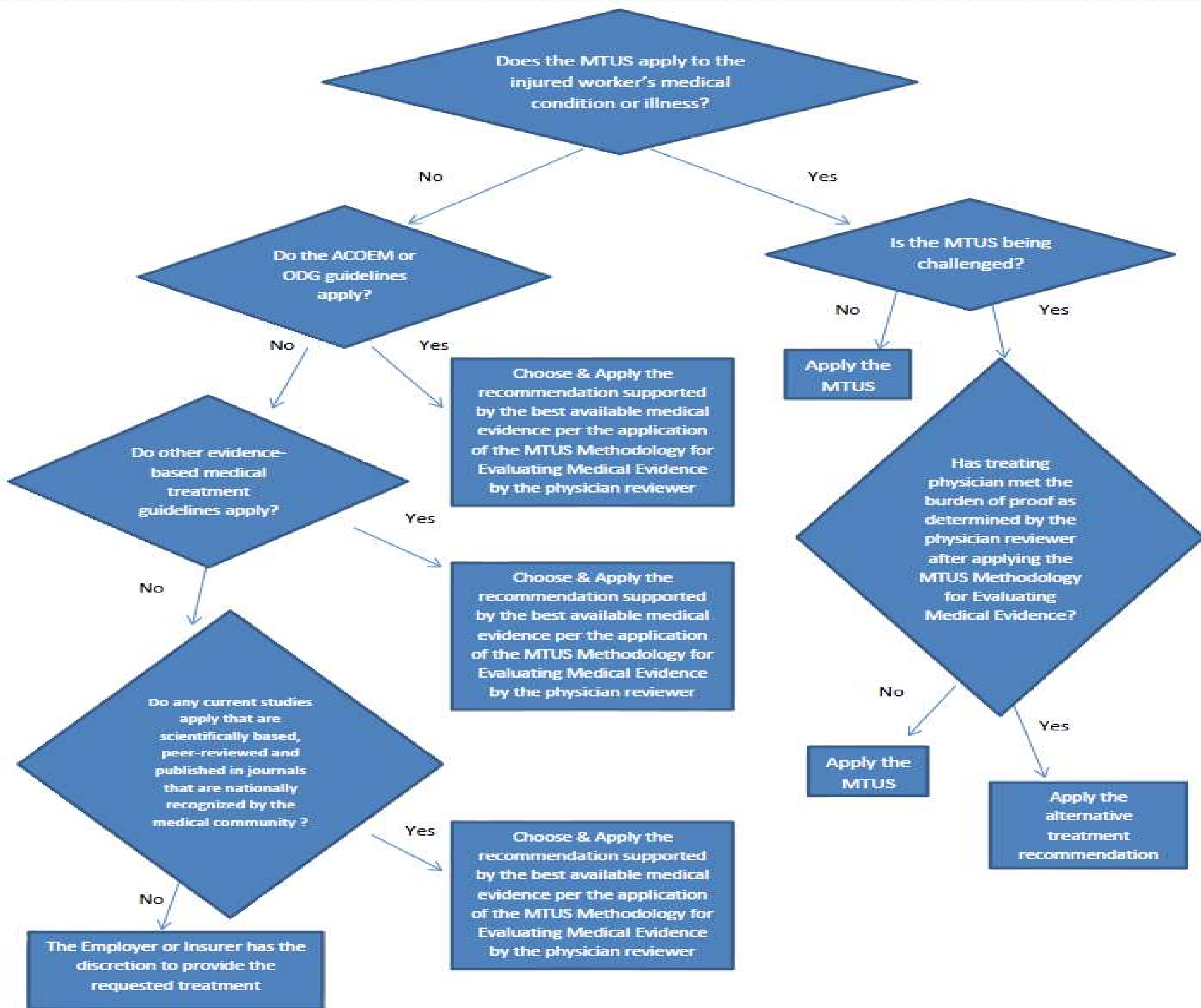
Guidelines

8 CCR § 9792.25. Presumption of Correctness, Burden of Proof and Strength of Evidence.

(a) The MTUS is presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in the MTUS for the duration of the medical condition. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof.

(b) For all conditions or injuries not addressed by the MTUS, authorized treatment and diagnostic services shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community.

(c)(1) For conditions or injuries not addressed by either subdivisions (a) or (b) above; for medical treatment and diagnostic services at variance with both subdivisions (a) and (b) above; or where a recommended medical treatment or diagnostic service covered under subdivision (b) is at variance with another treatment guideline also covered under subdivision (b), the following ACOEM's strength of evidence rating methodology is adopted and incorporated as set forth below, and shall be used to evaluate scientifically based evidence published in peer-reviewed, nationally recognized journals to recommend specific medical treatment or diagnostic services:



Does the MTUS apply to the injured worker's medical condition or illness?
No
Yes
Do the ACOEM or ODG guidelines apply?
Is the MTUS being challenged?
No
Yes
No
Yes
Apply the MTUS
Choose & Apply the recommendation supported by the best available medical evidence per the application of the MTUS Methodology for Evaluating Medical Evidence by the physician reviewer
Do other evidence-based medical treatment guidelines apply?
Yes
Has treating physician met the burden of proof as determined by the physician reviewer after applying the MTUS Methodology for Evaluating Medical Evidence?
No
Choose & Apply the recommendation supported by the best available medical evidence per the application of the MTUS Methodology for Evaluating Medical Evidence by the physician reviewer
Do any current studies apply that are scientifically based, peer-reviewed and published in journals that are nationally recognized by the medical community ?
No
Yes
Apply the MTUS
Apply the alternative treatment recommendation
Yes
Choose & Apply the recommendation supported by the best available medical evidence per the application of the MTUS Methodology for Evaluating Medical Evidence by the physician reviewer
No
The Employer or Insurer has the discretion to provide the requested treatment

Chiropractic Guidelines by Body Part

- **Neck Pain** (ODG) states 9 visits over 8 weeks.
- **Cervical Strain** (ODG) states (Grade I) = 6 visits over 3 weeks; (Grade II) = 6 visits over 3 weeks; (Grade III) = 10 visits over 6 weeks; (Severe Grade III) = Up to 25 visits over 6 months.
- **Cervical Radiculopathy** (ODG) states 6 visits over 3 weeks; with functional improvement 18 visits over 8 weeks.
- **Cervical/Post Laminectomy** (ODG) states 14-16 visits over 12 weeks.
- **Low Back** (ODG) states (Mild) = 6 visits over 2 weeks; (Severe) = 6 visits over 2 weeks; (Severe w/objective/functional improvement) = 18 visits over 8 weeks.
- **Low Back (Flare-Ups)** = 1-2 visits every 4-6 months.
  Hip (ODG) states up to 10 visits.

Chiropractic Guidelines by Body Part

- **Shoulder** (ODG) states 9 visits over 8 weeks.
- **Forearm, wrist, hand** (ODG) states despite not recommended, may allow for 9 visits over 8 weeks.
- **Knee** (ODG) states despite not recommended, may allow 12 visits over 8 weeks.
- **Ankle** (ODG) states despite not recommended, may allow 9 visits over 8 weeks.

Chiropractic Guidelines - ODG

- **Regional Neck Pain:**

9 visits over 8 weeks

- **Cervical Strain:**

Intensity & duration of care depend on severity of injury as indicated below, but not on causation. These guidelines apply to cervical strains, sprains, whiplash (WAD), acceleration/deceleration injuries, motor vehicle accidents (MVA), including auto, and other injuries whether at work or not. The primary criterion for continued treatment is patient response, as indicated below.

Mild (grade I - Quebec Task Force grades): up to 6 visits over 2-3 weeks

Moderate (grade II): Trial of 6 visits over 2-3 weeks

Moderate (grade II): With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, avoid chronicity

Severe (grade III): Trial of 10 visits over 4-6 weeks

Severe (grade III): With evidence of objective functional improvement, total of up to 25 visits over 6 months, avoid chronicity

- **Cervical Nerve Root Compression with Radiculopathy:**

Patient selection based on previous chiropractic success --

Trial of 6 visits over 2-3 weeks

With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity and gradually fade the patient into active self-directed care

- **Post Laminectomy Syndrome:**

14-16 visits over 12 weeks

Functional Improvement

- Why is documenting "Functional Improvement" so important in Utilization Review?

Functional Improvement

Section 9792.20 of the MTUS Medical Treatment Utilization Schedule-CA 2009 MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, p. 48

Functional improvement measures
Definitions:

- (f) "**Functional improvement**" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment.

- Recommended. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include the following categories:

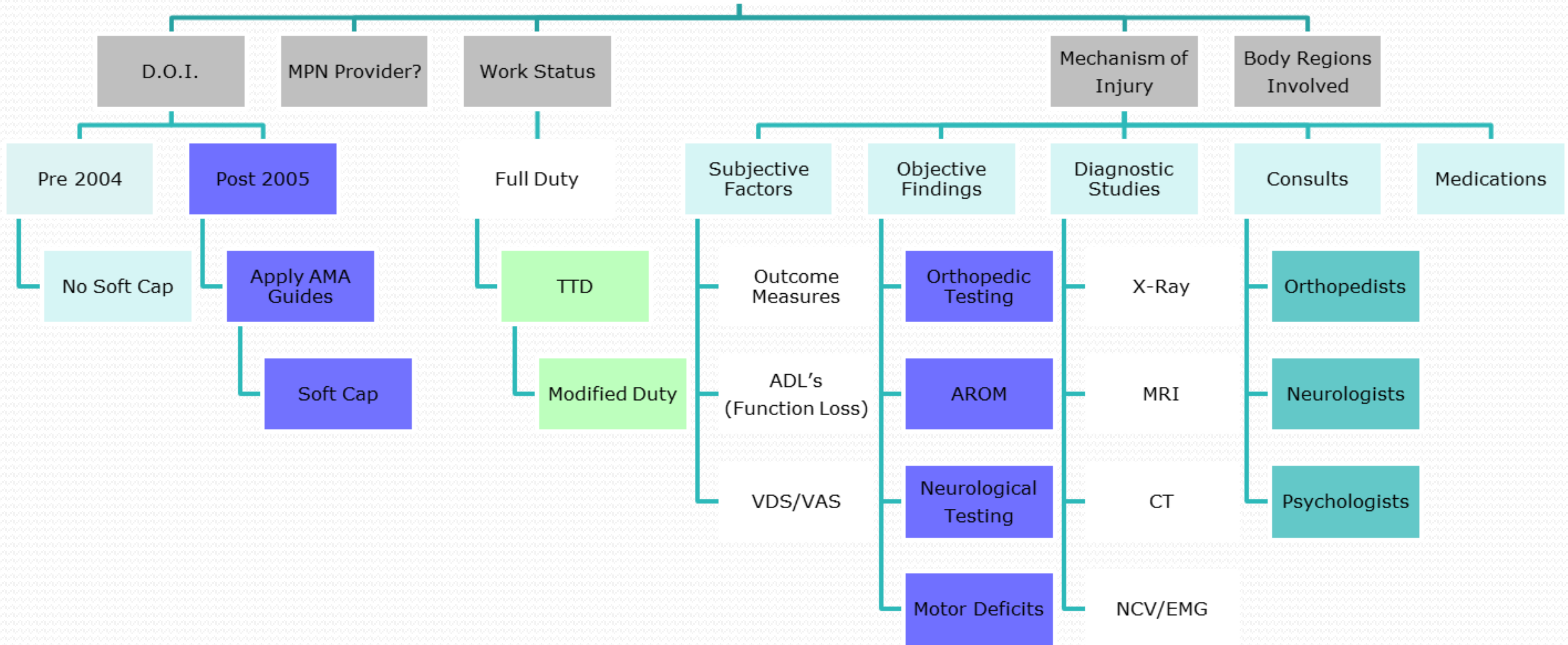
- Work Functions and/or Activities of Daily Living, Self Report of Disability (e.g., walking, driving, keyboard or lifting tolerance, Oswestry, pain scales, etc): Objective measures of the patient's functional performance in the clinic (e.g., able to lift 10 lbs floor to waist x 5 repetitions) are preferred, but this may include self-report of functional tolerance and can document the patient self-assessment of functional status through the use of questionnaires, pain scales, etc (Oswestry, DASH, VAS, etc.)

Functional Improvement

- **Physical Impairments** (e.g., joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of clinical exam findings. ROM should be in documented in degrees.

- Approach to Self-Care and Education Reduced Reliance on Other Treatments, Modalities, or Medications: This includes the provider's assessment of the patient compliance with a home program and motivation. The provider should also indicate a progression of care with increased active interventions (vs. passive interventions) and reduction in frequency of treatment over course of care. (California, 2007)

- For chronic pain, also consider return to normal quality of life, e.g., go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life. (Cowan, 2008)


UR Nurse
Case Review
(Medical Records)
D.O.I.
MPN Provider?
Work Status
Mechanism of Injury
Body Regions Involved
Pre 2004
Post 2005
Full Duty
Subjective Factors
Objective Findings
Diagnostic Studies
Consults
Medications
No Soft Cap
Apply AMA Guides
Soft Cap
TTD
Modified Duty
Outcome Measures
ADL's (Function Loss)
VDS/VAS
Orthopedic Testing
AROM
Neurological Testing
Motor Deficits
X-Ray
MRI
CT
NCV/EMG
Orthopedists
Neurologists
Psychologists

Intensity vs. Frequency

- **FREQUENCY OF PAIN/SYMPTOMS:**
- **CONSTANT** Occurring approximately **75-100%** of the time
- **FREQUENT** Occurring approximately **50-75%** of the time
- **INTERMITTENT** Occurring approximately **25-50%** of the time
- **OCCASIONAL** Occurring approximately **0-25%** of the time

- **INTENSITY OF PAIN/SYMPTOMS:**
- **SEVERE (9-10)** Severe pain would preclude the activity precipitating the pain.
- **MODERATE (5-8)** Moderate pain can be tolerated, but would cause a marked handicap in the performance of the activity precipitating the pain.
- **SLIGHT (3-4)** Slight pain can be tolerated, but would cause some handicap in the performance of the activity precipitating the pain.
- **MINIMAL (1-2)** Minimal (same as mild) pain would constitute an annoyance, but would cause no handicap in the performance of the particular activity. (Minimal pain is a non-ratable permanent disability)

Qualifications of Personnel

- No person, other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the licensure and scope of the physician's practice, can delay, modify or deny, requests for authorization (RFAs) of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

Who can be a Physician Reviewer?

- A “reviewer” is a physician defined in LC 3209.3; licensed to review services within their scope of practice.
  - Medical Doctor
  - Doctor of Osteopathy
  - Doctor of Chiropractic
  - Psychologist
  - Acupuncturist
  - Optometrist
  - Dentist
  - Podiatrist

Non-Physician Reviewer

- A non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. A non-physician reviewer may approve/authorize requests for authorization of medical services.
- This is considered a <u>first level review</u>.
- Non-Physician reviewers are typically the claims examiners, or nurses.
- A Non-Physician reviewer may NEVER deny, or modify a treatment request.

The UR Determination

- 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.

- Note: 5:30 PST = End of Business Day (M-F)

Utilization Review Penalties/Fines

$50,000.00	**Failure to Establish UR Plan** **Failure to Have a Medical Director**
$25,000.00	Decision Outside Scope of Practice
$15,000.00	Untimely Response to Expedited Request
$5,000.00	Denying Treatment because Condition is not in MTUS

Utilization Review Penalties/Fines

Penalty:	Fine	CCR
Not Attaching IMR Application form to URD	$2,000.00	(c)(1) For the failure to provide the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, with a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(l) or 9792.9.1: $2,000.
Records are not timely delivered to Maximus upon notice	<$5000.00	(6) For the failure to timely provide all information required by section 9792.10.5(a) and (c): $500.00 for each day the response is untimely up to a maximum of $5,000.00.

Utilization Review Penalties/Fines

Penalty:	Concurrent	Prospective	Retrospective
Not Responding to RFA	$2,000.00	$1,000.00	$500.00
Late Response to RFA	$100.00	$100.00	$100.00

DWC Form RFA

- CCR 9792.9.1(t)
- Beginning on Jan. 1, 2013, for all occupational injuries occurring on or after that date, and on July 1, 2013 for all dates of injury, the DWC will require the use of a **Request for Authorization (RFA) form** that must accompany all treatment requests (*i.e. DFR/5021, PR-2, RFA Narrative*) made by treating physicians.
- The **DWC form RFA** will specify treatment requests subject to utilization review.
- Optionally required?
- DWC FAQs, http://www.dir.ca.gov/dwc/SB863/SB863_FAQs.htm

DWC Form RFA

- Alternatively, CCR 9792.9.1(c)(2)(B)

- The ***claims administrator may accept a request for authorization for medical treatment that <u>does not</u> utilize the <u>DWC Form RFA</u>***, provided that:

  (1) "Request for Authorization" is clearly written at the top of the first page of the document;

  (2) all requested medical services, goods, or items are listed on the first page; and

  (3) the request is accompanied by documentation substantiating the medical necessity for the requested treatment.

- **The claims administrator has the choice to go forward with an RFA or any document that is not complete, but most are now requiring the use of a DWC From RFA with all treatment requests.**

DWC Form RFA

How to document an **Incomplete DWC form RFA**:

- DWC Form RFA that:
- does not identify the employee or provider,
- does not identify a recommended treatment,
- is not accompanied by documentation (i.e. DFR, PR-2, RFA Narrative) substantiating the medical necessity for the requested treatment,
- or is not signed by the requesting physician,

- a non-physician reviewer as allowed by section 9792.7 or reviewer must either treat or regard the form request as a complete DWC Form RFA and comply with the timeframes for decision set forth in this section
- **or return it to the requesting physician marked "not complete,"**
- specifying the reasons for the return of the request no later than five (5) business days from receipt.
- The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

Complete the DWC Form RFA and attach to your treatment request every time.

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☐ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information			
Name (Last, First, Middle):			
Date of Injury (MM/DD/YYYY):		Date of Birth (MM/DD/YYYY):	
Claim Number:		Employer:	
Requesting Physician Information			
Name:			
Practice Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
Specialty:		NPI Number:	
E-mail Address:			
Claims Administrator Information			
Company Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)

Requesting Physician Signature:	Date:

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

If UR denies treatment, can a QME still help?

Q: How does SB 863 change an injured worker's ability to appeal a UR denial or modification?

A: SB 863 ultimately will require all treatment disputes resulting from utilization review to go through the IMR (Independent Medical Review) process. A QME may no longer address treatment disputes.

- **After 07/01/2013 all DOIs will have treatment disputes handled by**
  1. The IMR Process
  2. The URO's Internal Voluntary Appeal Process
  3. Both appeal routes may occur concurrently

Expedited Treatment Requests

Expedited RFAs – 9792.9.1(c)(4)

- Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization 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 requesting **physician must certify** in writing and document the need for an expedited review upon submission of the request.
- A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an **imminent and serious threat to his or her health**, or that the
- timeframe for utilization review under subdivision (c)(3) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (c)(3).
- **If the provider fails to certify the reason it is an expedited review**, then it **may be treated as a regular review.**

Expedited Treatment Requests

Expedited RFAs – 9792.9.1(c)(4)

- If an RFA is marked as "Expedited," it must be certified by the requesting physician. In other words, the requesting provider must justify/explain why the request for treatment is urgent and delaying the decision may be detrimental and/or cause imminent danger to the health/life of the injured worker.
- The requesting provider will mark the RFA as expedited by **checking the Expedited box** on the DWC form RFA.
- The URO will assess all expedited requests to ensure that an expedited request is truly urgent and will triage your request above other less urgent requests.

Independent Medical Review (IMR)

IMR physicians will provide expert opinion based on Labor Code section 4610.5(c)(2):

- California's Medical Treatment Utilization Schedule (**MTUS**)
- Evidence based medicine (**EBM**) to reduce medical treatment costs and eliminate unnecessary and ineffective treatment.

Independent Medical Review
What Guidelines do IMR physicians use?

"**Medically necessary**" and "**medical necessity**" mean medical treatment that is reasonably required to *cure or relieve the injured employee of the effects of his or her injury* and based on the following standards, which **shall be applied in the order listed**, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:

(A) The guidelines adopted by the administrative director pursuant to Section 5307.27.

(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious

Independent Medical Review
How do UR Decisions Hold Up in IMR?

Summary:

- Solid UR decisions backed by defensible rationales and guidelines will help reduce or eliminate the number of IMR requests, and potential requests that are actually sent for IMR.

- **CWCI – EXECUTIVE SUMMARY**

April 2015

Independent Medical Review Outcomes In California Workers' Compensation

Rena David, Stacy Jones, Brenda Ramirez and Alex Swedlow

- **IMR Final Determinations:** ~91% Upheld, ~9% Overturned

Independent Medical Review

How do Chiropractors Hold Up in IMR?

Exhibit 7: Volume, Distribution & Uphold Rates: IMR Decisions by Requested Service

Service Type	# of Services	% of Services	% Upheld
Prescription Drugs	113,169	44.7%	91.9%
Durable Medical Equipment, Prosthetics, Orthotics, Supplies	24,720	9.8%	93.7%
Physical Therapy	23,583	9.3%	94.0%
Injections	15,004	5.9%	92.2%
Diagnostic Tests & Measurements	12,382	4.9%	87.9%
Surgery	11,891	4.7%	88.5%
MRI/CT/PET Scans	9,635	3.8%	89.1%
Laboratory & Pathology	7,314	2.9%	87.3%
Acupuncture	5,413	2.1%	94.1%
Psych	5,255	2.1%	84.9%
Chiropractic	4,717	1.9%	95.4%
Evaluation & Management	4,178	1.7%	79.5%
Functional Restoration	2,961	1.2%	92.6%
Non-Surgical Procedures	2,407	1.0%	93.3%
Other Radiology	2,396	0.9%	88.6%
Pain Management	2,025	0.8%	80.3%
Home Health Care	1,623	0.6%	97.1%
Other	4,265	1.7%	90.4%
Total[10]	**252,938**	**100%**	91.4%

Independent Medical Review
How did chiropractic do with IMR in 2014?

- Chiropractic ranked 11th for most disputed denied treatment sent to IMR
- 4,717 chiropractic visits reviewed by IMR
- 1.9% of all treatment services reviewed by IMR was for chiropractic
- 95% of the time IMR upheld the chiropractic treatment denied by UR

Independent Medical Review
How did chiropractic do with IMR in 2014?

- **What does this mean?**
- Only a small pool of denied chiropractic care is presented for IMR
- IMR is upholding UR decisions 95% of the time because chiropractors are not substantiating their treatment with medical necessity and guidelines

Independent Medical Review
Seek Recourse Prior to IMR

- If your treatment is denied, request for a Peer to Peer immediately.
- A Peer to Peer will allow you to arrange a date and time to speak with the UR physician and explain why the treatment should be approved based on medical necessity and treatment guidelines.
- If the Peer to Peer physician still denies your treatment, then request for a Voluntary Appeal (within 10 calendar days of the UR Denial).
- The Voluntary Appeal requires that a different UR physician review your request.
- In most cases, either the Peer to Peer, or Voluntary Appeal results in overturned UR denials, or modifications to allow for some course of care. This saves time and expedites needed treatment.

Independent Medical Review
IMR Fees ($)

- **IMR Fees**
  Any IMR application submitted on or after January 1, 2015 will be subject to the following fee schedule:

  Standard IMRs Involving Non-Pharmacy Claims
  Fee effective April 1, 2014: $420 per IMR
  Fee effective Jan. 1, 2015: $390 per IMR

  Standard IMRs Involving Pharmacy Only Claims
  Fee effective April 1, 2014: $390 per IMR
  Fee effective Jan. 1, 2015: $345 per IMR

- *IMRs Terminated or Dismissed Not Forwarded to a Medical Professional Reviewer:*
  Fee effective April 1, 2014: $160 per IMR
  Fee effective Jan. 1, 2015: $123 per IMR

IMR Application Form

1. Check Box added for Modification after Appeal.

IMR Preclusions (IMR Application must be generated and attached to UR Determination letter)

Preclusions to IMR:

1. Disputed body part(s)/Causation.
2. IMR excluded for UR denials based on Lack of Information.
3. Untimely UR Decision (WCAB)/Dubon 2

State of California, Division of Workers' Compensation
APPLICATION FOR INDEPENDENT MEDICAL REVIEW
DWC Form IMR

TO REQUEST INDEPENDENT MEDICAL REVIEW:

1. **Sign and date this application and consent to obtain medical records.**
2. **Mail or fax the application and a copy of the written decision you received that denied or modified the medical treatment requested by your physician to:**
   DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
   FAX Number: (916) 605-4270
3. **Mail or fax a copy of the signed application to your Claims Administrator.**

Type of Utilization Review: ☐ Regular ☐ Expedited	Modification after Appeal ☐
Employee Name (First, MI, Last):	
Address:	
Phone Number:	Employer Name:
Claim Number:	Date of Injury (MM/DD/YYYY):
WCIS Jurisdictional Claim Number (if assigned):	EAMS Case Number (if applicable):
Employee Attorney (if known):	
Address:	
Phone Number:	Fax Number:
Requesting Physician Name (First, MI, Last):	
Practice Name:	Specialty:
Address:	
Phone Number:	Fax Number:
Claims Administrator Name:	
Adjuster/Contact Name:	
Address:	
Phone Number:	Fax Number:
Disputed Medical Treatment (complete below section)	
Primary Diagnosis (Use ICD Code where practical):	
Date of Utilization Review Determination Letter:	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☐ No Reason:	
List each specific requested medical services, 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:

DWC Form IMR (version 01/2014) Page 1

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 ONE 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 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 thirty-five (35) days from the mailing date of the written determination letter informing you that the medical treatment requested by your treating physician was denied or modified.**
- 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 offices by calling toll-free 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, 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 to review my application.

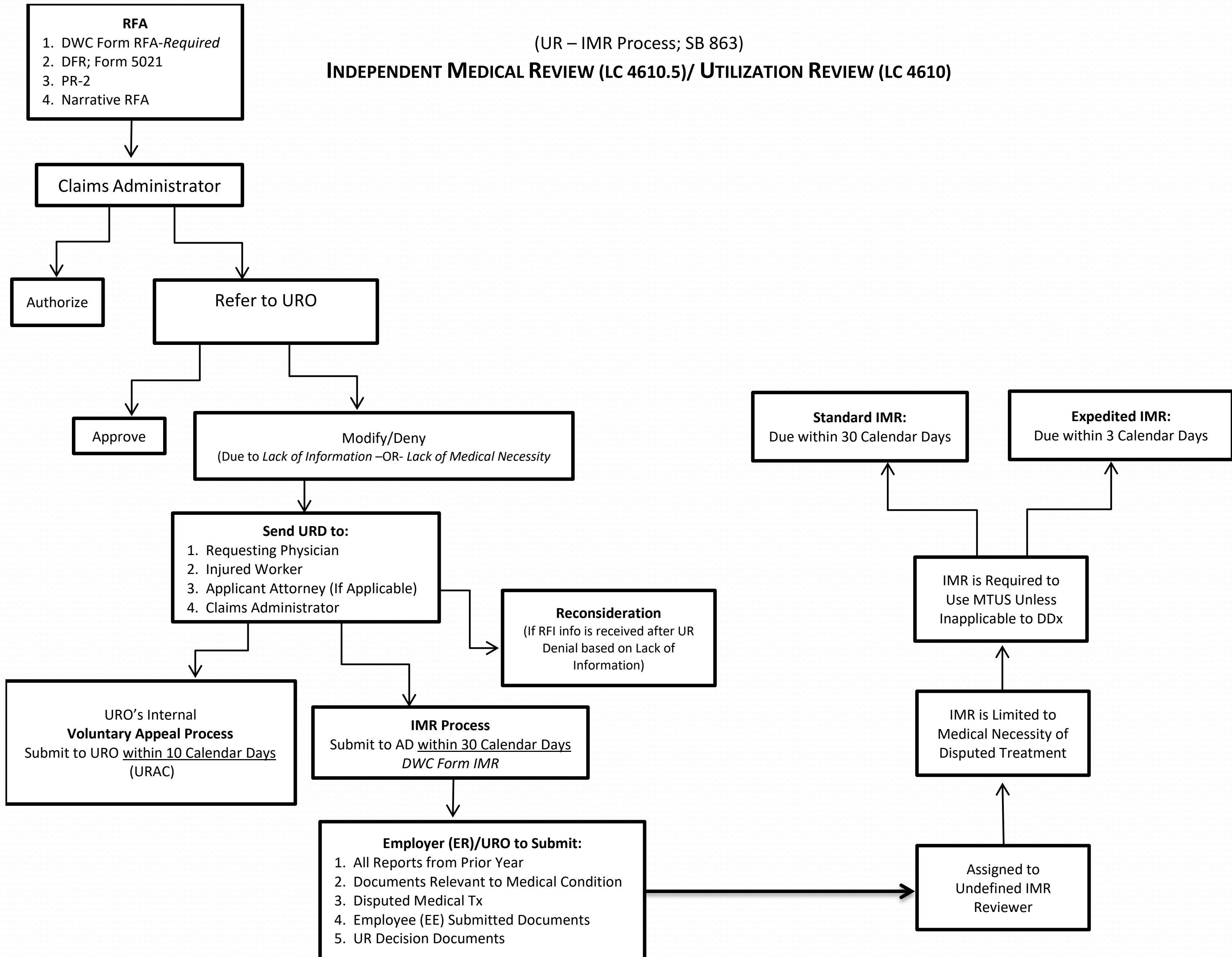
In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative 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 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 their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:		
I am a/an:		
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	
State Bar Number (if applicable):		
Representative Signature:		Date:


(UR – IMR Process; SB 863)
INDEPENDENT MEDICAL REVIEW (LC 4610.5)/ UTILIZATION REVIEW (LC 4610)
RFA
1. DWC Form RFA-Required
2. DFR; Form 5021
3. PR-2
4. Narrative RFA
Claims Administrator
Authorize
Refer to URO
Approve
Modify/Deny
(Due to Lack of Information –OR- Lack of Medical Necessity
Send URD to:
1. Requesting Physician
2. Injured Worker
3. Applicant Attorney (If Applicable)
4. Claims Administrator
Reconsideration
(If RFI info is received after UR Denial based on Lack of Information)
URO's Internal
Voluntary Appeal Process
Submit to URO within 10 Calendar Days
(URAC)
IMR Process
Submit to AD within 30 Calendar Days
DWC Form IMR
Employer (ER)/URO to Submit:
1. All Reports from Prior Year
2. Documents Relevant to Medical Condition
3. Disputed Medical Tx
4. Employee (EE) Submitted Documents
5. UR Decision Documents
Assigned to Undefined IMR Reviewer
IMR is Limited to Medical Necessity of Disputed Treatment
IMR is Required to Use MTUS Unless Inapplicable to DDx
Standard IMR:
Due within 30 Calendar Days
Expedited IMR:
Due within 3 Calendar Days

Application for IMR – WCIS & EAMS

- **FYI:**

A. The WCIS number is generated when the claims administrator sends the First Report of Injury (FROI) to the DWC via EDI to notify of the industrial claim. In return, the DWC will generate the WCIS number and send back to the claims administrator. Therefore, only the claims administrator will be able to provide the WCIS number, and it is REQUIRED to appear on the IMR Application form.

B. The EAMS number will be generated on litigated claims. Therefore, the EAMS number will only be applicable on litigated cases.

SB863 vs. Duplicate RFAs

- UR determinations that modify, delay, or deny treatment recommendations are considered **valid for 12 months** absent any documented change in facts material to the basis of the utilization review decision.
- This will **eliminate needless UR on duplicate RFAs**.
- Same treatment requests from a different requesting provider will not be considered duplicative and are subject to UR based on unique and different medical evidence presented in the individual RFA.

- Title 8, California Code of Regulations 9792.9.1(h) provides that a utilization review decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision

  If there was no documented change in the facts material to the basis of the earlier utilization review decision provided with your current DWC Form RFA, then no utilization review will be done on your DWC Form RFA listing the same treatment.

How does a URO Handle Medical Necessity & Causation on a "New" Body Part?

- ~~*Simmons v. California (2005)*~~
- ~~*UR must be done on a "new" body part submission*~~
- Claims Administrators must resolve the disputed claims issues ***before*** requesting utilization review (This applies to all DOIs).
- UR will no longer be involved in ***disputed body parts*** or ***denied claims***.

How does a URO Handle Medical Necessity & Causation on a "New" Body Part?

- (b) Utilization review of a medical treatment request made on the DWC Form RFA **may be deferred** if the claims administrator **disputes liability** for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.
- (1) If the claims administrator disputes liability it may, no later than five (5) business days from receipt of the DWC Form RFA, issue a written decision deferring utilization review of the requested treatment.
- The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.
- **The written decision shall only contain the following information specific to the request:**
- (A) The date on which the DWC Form RFA was first received.
- (B) A description of the specific course of proposed medical treatment for which authorization was requested.
- (C) A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.
- (D) A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

How does a URO Handle Medical Necessity & Causation on a “New” Body Part?

- **(E) The following mandatory language advising the injured employee:**

  “You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster’s name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me. and “For information about the workers’ compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers’ Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.”

Dubon 2

- A UR decision is only invalid if it is untimely. The previous ruling about **material procedural defects** was overturned.
- "Accordingly, where a defendant's UR decision is untimely, it is invalid and not subject to IMR.
- The WCAB has exclusive jurisdiction to resolve the timeliness issue and then the WCJ must determine whether or not the requested treatment is **reasonable & necessary**. Reasonable & necessary is defined by the Evidence Based Medicine. **It is the applicant's burden to show that the treatment requested is reasonable & necessary.**
- "With the exception of timeliness, all other requirements go to the validity of the medical decision or decision-making process. The sufficiency of the medical records provided, expertise of the reviewing physician and compliance with the MTUS are all questions for the medical professional."
- "To allow a WCJ to invalidate a UR decision based on any factor other than timeliness and substitute his or her own decision on a treatment request violates the intent of SB 863."
- "Where there is no timely UR decision subject to IMR, the issue of medical necessity must be determined by the WCAB. (§§ 4604, 5300.)"

Dubon 2

- It is not the "end of the world" when a UR decision is untimely.
- "Thus, where a defendant's UR decision is untimely, **the injured employee is nevertheless entitled only to "reasonably required" medical treatment** (§ 4600(a)) **and it is the employee's burden** to establish his or her entitlement to any particular treatment (§§ 3202.5, 5705), including showing either that the treatment falls within the presumptively correct MTUS or that this presumption has been rebutted.
- (§ 4604.5; see also § 5307.27.) Moreover, to carry this burden, **the employee must present substantial medical evidence.**"

Key UR Changes

- **Any appeal modification would require a IMR application form.**
- Carrier receipt date in absence of evidence of mailing, the DWC form RFA is deemed received 5 days after the latest date written on the document. <u>Seems to take the burden off of the provider who doesn't include a POS.</u>

Key UR Changes

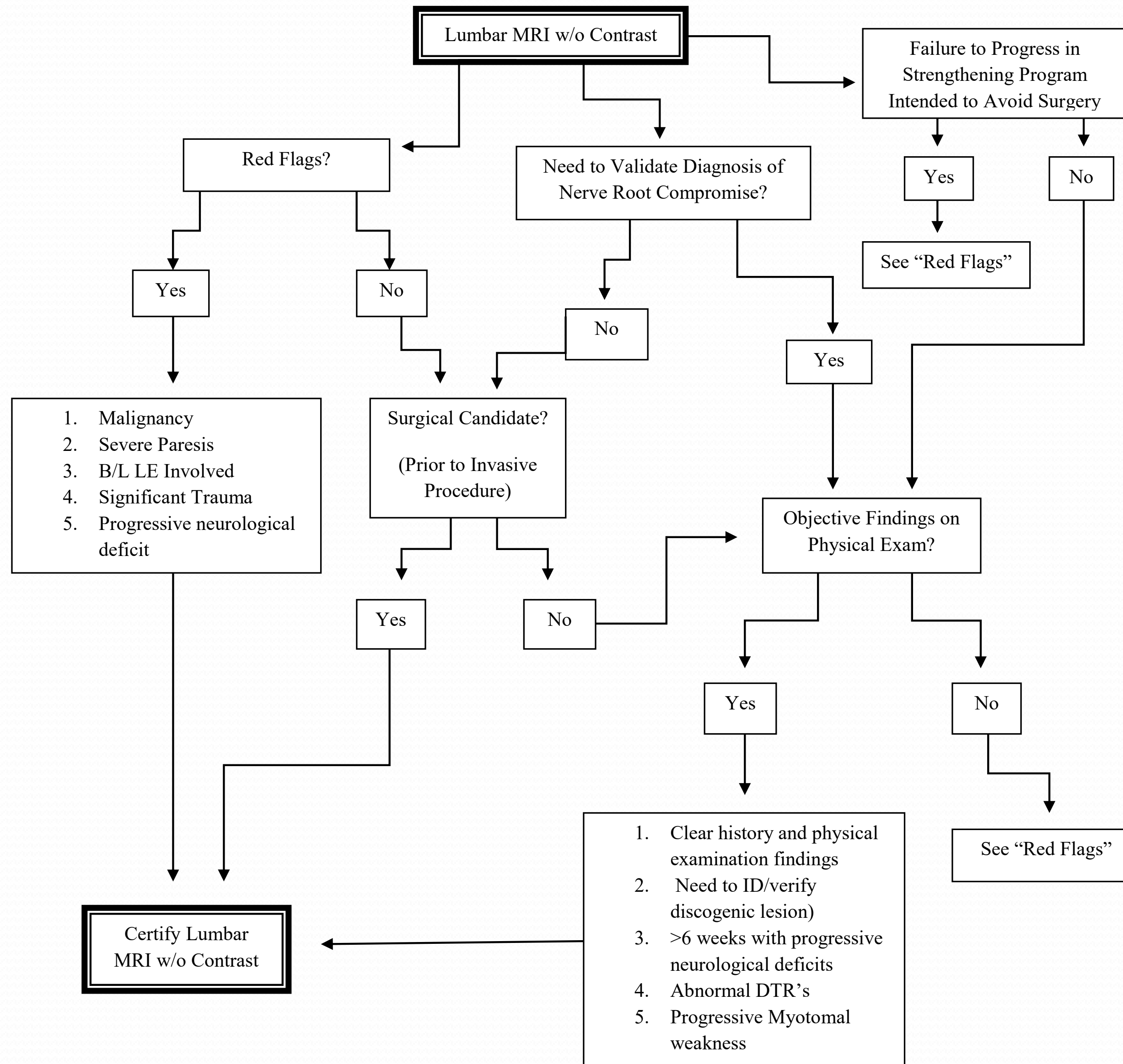
Dubon 2

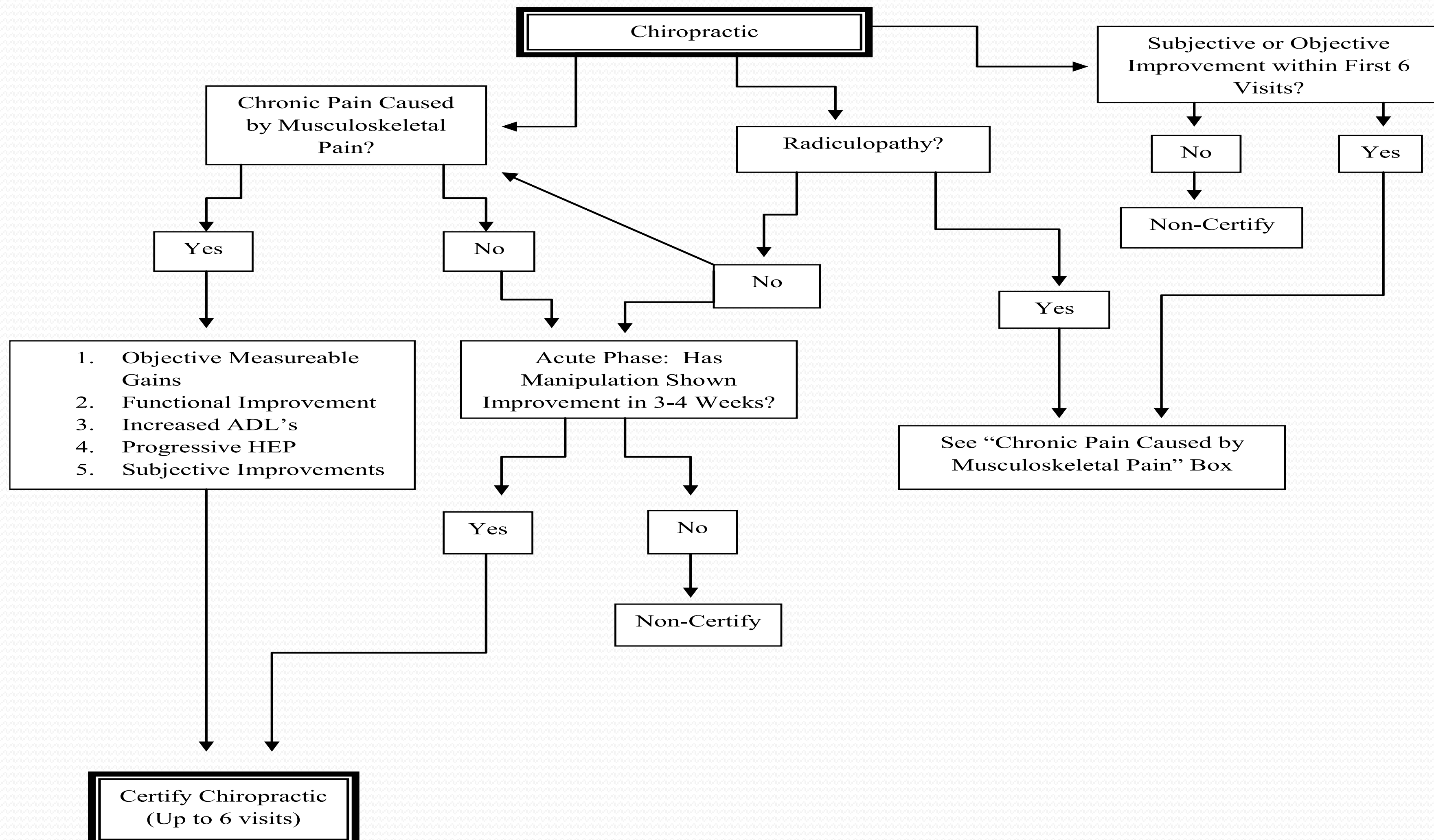
- A utilization review (UR) decision is invalid and not subject to independent medical review (IMR) if it is untimely.
- Legal issues surrounding timeliness of a UR decision must be resolved by the Workers' Compensation Appeals Board (WCAB), and is precluded from the IMR process.
- Other treatment disputes regarding a UR decision must be settled through the IMR process.
- If a UR decision is late, then the issue of medical necessity may be made at the WCAB on the basis of substantial medical evidence consistent with Labor Code section 4604.5

Algorithms

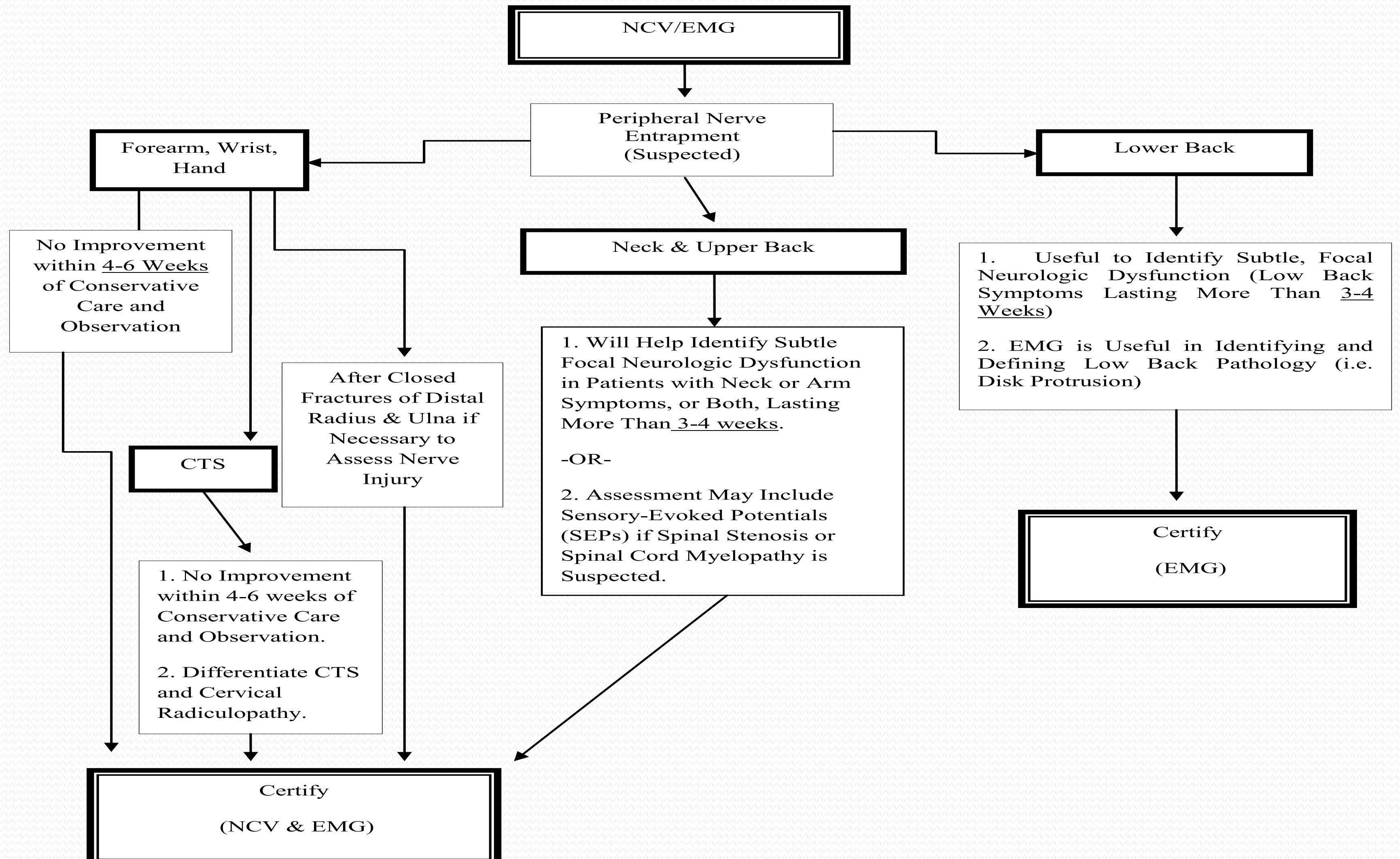
- The following algorithms will help the requesting provider determine if their patient meets the criteria defined in the medical treatment guidelines.
- The doctor must be sure to include the details in the guidelines to justify to UR that the treatment is in fact medically necessary.
- UR is only looking for medical necessity and the decision must be based on the treatment guidelines.
- Doctors who do not follow the treatment guidelines will most likely never have their treatment requests approved in UR.

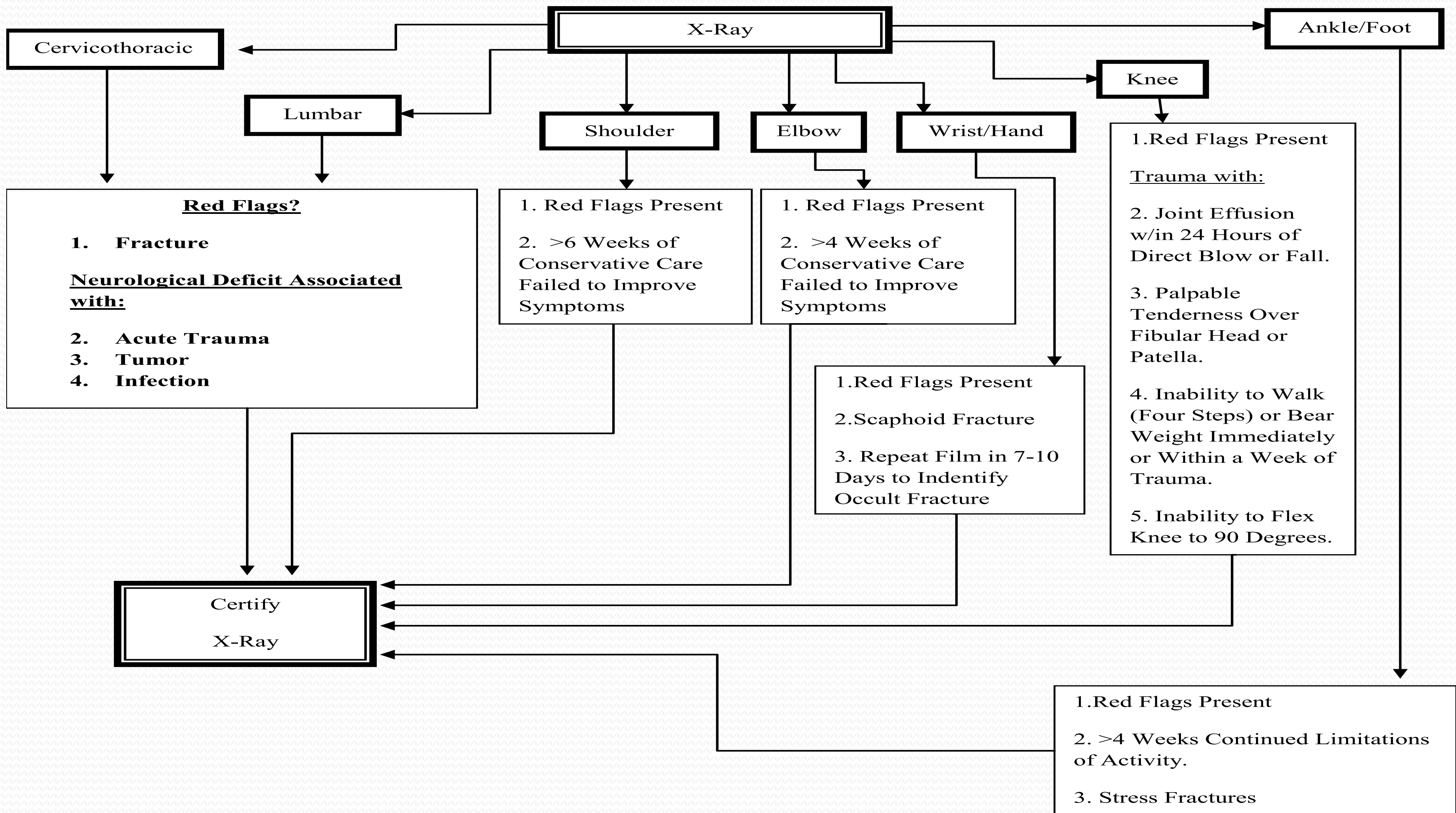
MRI Algorithm



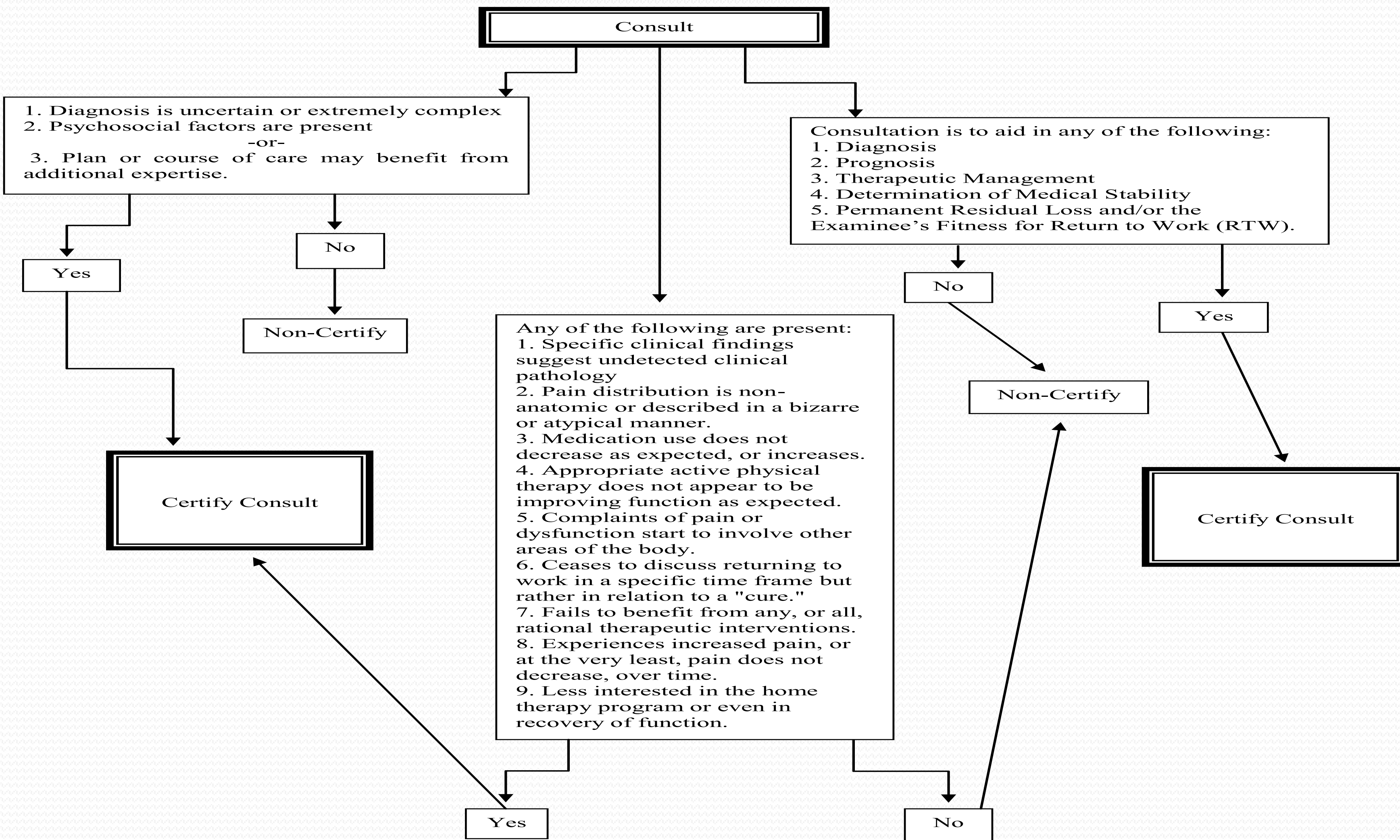


Chiropractic
Chronic Pain Caused by Musculoskeletal Pain?
Radiculopathy?
Subjective or Objective Improvement within First 6 Visits?
Yes
No
No
Yes
No
Yes
Non-Certify
1. Objective Measureable Gains
2. Functional Improvement
3. Increased ADL's
4. Progressive HEP
5. Subjective Improvements
Acute Phase: Has Manipulation Shown Improvement in 3-4 Weeks?
See "Chronic Pain Caused by Musculoskeletal Pain" Box
Yes
No
Non-Certify
Certify Chiropractic (Up to 6 visits)


NCV/EMG
Peripheral Nerve Entrapment (Suspected)
Forearm, Wrist, Hand
Lower Back
Neck & Upper Back
No Improvement within 4-6 Weeks of Conservative Care and Observation
After Closed Fractures of Distal Radius & Ulna if Necessary to Assess Nerve Injury
CTS
1. No Improvement within 4-6 weeks of Conservative Care and Observation.
2. Differentiate CTS and Cervical Radiculopathy.
1. Will Help Identify Subtle Focal Neurologic Dysfunction in Patients with Neck or Arm Symptoms, or Both, Lasting More Than 3-4 weeks.
-OR-
2. Assessment May Include Sensory-Evoked Potentials (SEPs) if Spinal Stenosis or Spinal Cord Myelopathy is Suspected.
1. Useful to Identify Subtle, Focal Neurologic Dysfunction (Low Back Symptoms Lasting More Than 3-4 Weeks)
2. EMG is Useful in Identifying and Defining Low Back Pathology (i.e. Disk Protrusion)
Certify
(EMG)
Certify
(NCV & EMG)



X-Ray
Cervicothoracic
Lumbar
Shoulder
Elbow
Wrist/Hand
Knee
Ankle/Foot
Red Flags?
1. Fracture
Neurological Deficit Associated with:
2. Acute Trauma
3. Tumor
4. Infection
1. Red Flags Present
2. >6 Weeks of Conservative Care Failed to Improve Symptoms
1. Red Flags Present
2. >4 Weeks of Conservative Care Failed to Improve Symptoms
1.Red Flags Present
2.Scaphoid Fracture
3. Repeat Film in 7-10 Days to Indentify Occult Fracture
1.Red Flags Present
Trauma with:
2. Joint Effusion w/in 24 Hours of Direct Blow or Fall.
3. Palpable Tenderness Over Fibular Head or Patella.
4. Inability to Walk (Four Steps) or Bear Weight Immediately or Within a Week of Trauma.
5. Inability to Flex Knee to 90 Degrees.
Certify X-Ray
1.Red Flags Present
2. >4 Weeks Continued Limitations of Activity.
3. Stress Fractures



Consult
1. Diagnosis is uncertain or extremely complex
2. Psychosocial factors are present
-or-
3. Plan or course of care may benefit from additional expertise.
Yes
No
Non-Certify
Certify Consult
Any of the following are present:
1. Specific clinical findings suggest undetected clinical pathology
2. Pain distribution is non-anatomic or described in a bizarre or atypical manner.
3. Medication use does not decrease as expected, or increases.
4. Appropriate active physical therapy does not appear to be improving function as expected.
5. Complaints of pain or dysfunction start to involve other areas of the body.
6. Ceases to discuss returning to work in a specific time frame but rather in relation to a "cure."
7. Fails to benefit from any, or all, rational therapeutic interventions.
8. Experiences increased pain, or at the very least, pain does not decrease, over time.
9. Less interested in the home therapy program or even in recovery of function.
Yes
No
Consultation is to aid in any of the following:
1. Diagnosis
2. Prognosis
3. Therapeutic Management
4. Determination of Medical Stability
5. Permanent Residual Loss and/or the Examinee's Fitness for Return to Work (RTW).
No
Yes
Non-Certify
Certify Consult

Outcome Measure Tools

Disabilities of the Arm, Shoulder and Hand

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

Disabilities of the Arm, Shoulder and Hand

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\left[\frac{\text{sum of n responses}}{n} - 1\right] \times 25$, where n is equal to the number of completed responses.

A DASH score may not be calculated if there are greater than 3 missing items.

Outcome Measure Tools

Disabilities of the Arm, Shoulder and Hand

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including home-making if that is your main work role).

Please indicate what your job/work is: ______

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you: ______

❒ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may not be calculated if there are any missing items.

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Outcome Measure Tools

NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name ______________________________ **Date** ______________

Please read carefully:

This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ONE CHOICE which applies to you. We realize you may consider that two of the statements in any one section relate to you but please just mark the one box, which most closely describes your problem right now.

SECTION 1 – Pain Intensity
A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (washing, dressing, etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 – Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives extra pain.
C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 – Reading
A. I can read as much as I want with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 - Headaches
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 – Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I cannot concentrate at all.

SETION 7 – Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8 – Driving
A. I can drive without any neck pain.
B. I can drive as long as I want with slight pain in my neck.
C. I can drive as long as I want with moderate pain in my neck.
D. I cannot drive as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 – Sleeping
A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr. sleepless).
C. My sleep is mildly disturbed (1-2 hrs. sleepless).
D. My sleep is moderately disturbed (2-5 hrs. sleepless).
E. My sleep is greatly disturbed (3-5 hrs. sleepless).
F. My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – Recreation
A. I am able to engage in all my recreation activities with no neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of pain in my neck.
F. I cannot do any recreation activities at all.

OTHER COMMENTS:

____
____
____

____
Examiner

With Permission from: Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

Outcome Measure Tools

The Oswestry Low Back Pain Disability Questionnaire

Overview:

The Oswestry Low Back Pain Disability Questionnaire can be used to assess patients with low back pain by determining its impact on the activities of daily living. It was developed at the Robert Jones and Agnes Hunt Orthopaedic Hospital in Oswestry Shropshire England.

Questionnaire description:

- 10 sections describing the pain and its impact
- Each section scored from 0 to 5 with higher values indicating more severe impact.

Section 1: Pain Intensity

- I can tolerate the pain I have without having to use pain killers. [0 points]
- The pain is bad but I manage without taking pain killers. [1 point]
- Pain killers give complete relief from pain. [2 points]
- Pain killers give moderate relief from pain. [3 points]
- Pain killers give very little relief from pain. [4 points]
- Pain killers have no effect on the pain and I do not use them. [5 points]

Section 2: Personal Care

- I can look after myself normally without causing extra pain. [0 points]
- I can look after myself normally but it causes extra pain. [1 point]
- It is painful to look after myself and I am slow and careful. [2 points]
- I need some help but manage most of my personal care. [3 points]
- I need help every day in most aspects of self care. [4 points]
- I do not get dressed wash with difficulty and stay in bed. [5 points]

Section 3: Lifting

- I can lift heavy weights without extra pain. [0 points]
- I can lift heavy weights but it gives extra pain. [1 point]
- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned for example on a table. [2 points]
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. [3 points]
- I can lift only very light weights. [4 points]
- I cannot lift or carry anything at all. [5 points]

Section 4: Walking

- Pain does not prevent me walking any distance. [0 points]
- Pain prevents me walking more than 1 mile. [1 point]
- Pain prevents me walking more than 0.5 miles. [2 points]
- Pain prevents me walking more than 0.25 miles. [3 points]
- I can only walk using a stick or crutches. [4 points]
- I am in bed most of the time and have to crawl to the toilet. [5 points]

Section 5: Sitting

- I can sit in any chair as long as I like. [0 points]
- I can only sit in my favourite chair as long as I like. [1 point]
- Pain prevents me sitting more than 1 hour. [2 points]
- Pain prevents me from sitting more than 0.5 hours. [3 points]
- Pain prevents me from sitting more than 10 minutes. [4 points]
- Pain prevents me from sitting at all. [5 points]

Section 6: Standing

- I can stand as long as I want without extra pain. [0 points]
- I can stand as long as I want but it gives me extra pain. [1 point]
- Pain prevents me from standing for more than 1 hour. [2 points]
- Pain prevents me from standing for more than 30 minutes. [3 points]
- Pain prevents me from standing for more than 10 minutes. [4 points]
- Pain prevents me from standing at all. [5 points]

Section 7: Sleeping

- Pain does not prevent me from sleeping well. [0 points]
- I can sleep well only by using tablets. [1 point]
- Even when I take tablets I have less than 6 hours sleep. [2 points]
- Even when I take tablets I have less than 4 hours sleep. [3 points]
- Even when I take tablets I have less than 2 hours of sleep. [4 points]
- Pain prevents me from sleeping at all. [5 points]

Outcome Measure Tools

Section 8: Sex Life

- My sex life is normal and causes no extra pain. [0 points]
- My sex life is normal but causes some extra pain. [1 point]
- My sex life is nearly normal but is very painful. [2 points]
- My sex life is severely restricted by pain. [3 points]
- My sex life is nearly absent because of pain. [4 points]
- Pain prevents any sex life at all. [5 points]

Section 9: Social Life

- My social life is normal and gives me no extra pain. [0 points]
- My social life is normal but increases the degree of pain. [1 point]
- Pain has no significant effect on my social life apart from limiting my more energetic interests such as dancing. [2 points]
- Pain has restricted my social life and I do not go out as often. [3 points]
- Pain has restricted my social life to my home. [4 points]
- I have no social life because of pain. [5 points]

Section 10: Travelling

- I can travel anywhere without extra pain. [0 points]
- I can travel anywhere but it gives me extra pain. [1 point]
- Pain is bad but I manage journeys over 2 hours. [2 points]
- Pain restricts me to journeys of less than 1 hour. [3 points]
- Pain restricts me to short necessary journeys under 30 minutes. [4 points]
- Pain prevents me from travelling except to the doctor or hospital. [5 points]

total score = SUM(points for all 10 sections)

disability in percent = (total score) / 50 * 100

If not all of the questions are answered then

disability in percent = (total score) / (5 * (number of questions answered)) * 100

Interpretation:

- 0% to 20%: minimal disability: The patient can cope with most living activities. Usually no treatment is indicated apart from advice on lifting sitting and exercise.
- 21%-40%: moderate disability: The patient experiences more pain and difficulty with sitting lifting and standing. Travel and social life are more difficult and they may be disabled from work. Personal care sexual activity and sleeping are not grossly affected and the patient can usually be managed by conservative means.
- 41%-60%: severe disability. Pain remains the main problem in this group but activities of daily living are affected. These patients require a detailed investigation.
- 61%-80%: crippled. Back pain impinges on all aspects of the patient's life. Positive intervention is required.
- 81%-100%: These patients are either bed-bound or exaggerating their symptoms.

References:

Fairbank JCT Davies JB. The Oswestry low back pain disability questionnaire. Physiotherapy. 1980; 66: 271-273.

Outcome Measure Tools

The Roland-Morris Low Back Pain and Disability Questionnaire

Patient name: ________________________ **File #**____________ **Date:**____________

Please read instructions: When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try to get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back.
- ☐ I have trouble putting on my sock (or stockings) because of the pain in my back.
- ☐ I can only walk short distances because of my back pain.
- ☐ I sleep less well because of my back.
- ☐ Because of my back pain, I get dressed with the help of someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

Instructions:

1. The patient is instructed to put a mark next to each appropriate statement.

2. The total number of marked statements are added by the clinician. Unlike the authors of the Oswestry Disability Questionnaire, Roland and Morris did not provide descriptions of the varying degrees of disability (e.g., 40%-60% is severe disability).

3. Clinical improvement over time can be graded based on the analysis of serial questionnaire scores. If, for example, at the beginning of treatment, a patient's score was 12 and, at the conclusion of treatment, her score was 2 (10 points of improvement), we would calculate an 83% (10/12 x 100) improvement.

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☒ New Request ☐ Resubmission – Change in Material Facts

☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health

☐ Check box if request is a written confirmation of a prior oral request.

Employee Information			
Name (Last, First, Middle): LAST, First			
Date of Injury (MM/DD/YYYY): 03/07/2014		Date of Birth (MM/DD/YYYY): 06/20/1920	
Claim Number: 1234567890	EAMS#: ADJ-123456	Employer: City of San Jose	
Requesting Physician Information			
Name: Glenn Crafts, DC			
Practice Name: Chiropractic Pain Care Center		Contact Name: Glenn Crafts	
Address: 123 Rose Blvd., Suite 123		City: San Jose	State: CA
Zip Code: 95128	Phone: 408-555-1234	Fax Number: 408-555-1235	
Specialty: Chiropractic		NPI Number: 1234567890	
E-mail Address:			
Claims Administrator Information			
Company Name: Managed Care Administrators		Contact Name:	
Address: PO Box 123		City: Concord	State: CA
Zip Code: 94522	Phone: 925-555-1234	Fax Number: **925-555-1235**	
E-mail Address:			
Requested Treatment (see instructions for guidance; attached additional pages if necessary)			
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.			

Note: Myofascial Release CPT = 97140 97250 is now obsolete.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Lumbosacral Radiculitis	724.4	Chiropractic Manipulation	98940	8 Treatments
Lumbosacral Radiculitis	724.4	Myofascial Therapy	97250	8 Treatments
Lumbosacral Radiculitis	724.4	Therapeutic Exercise	97110	8 Treatments
Lumbosacral Radiculitis	724.4	Interferential Therapy	97014	8 Treatments
Lumbosacral Radiculitis	724.4	Ultrasound	97035	8 Treatments
Lumbosacral Radiculitis	724.4	Traction	97012	8 Treatments
Requesting Physician Signature:				Date: **04/8/2015**
Claims Administrator/Utilization Review Organization (URO) Response				
☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay) ☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)				
Authorization Number (if assigned):			Date:	
Authorized Agent Name:			Signature:	
Phone:	Fax Number:		E-mail Address:	
Comments:				

State of California
Division of Worker's Compensation

Additional Pages Attached ❐

PRIMARY TREATING PHYSICIANS PROGRESS REPORT (PR-2)

Check the box (es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e. has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or IMC Form 81556.

☒ Periodic Report (required 45 days after last report) ☒ **Change in treatment plan** ☐ Discharged
☐ **Change in work status** ☐ Need for referral or consultation ☐ Info. Requested by: __________
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☒ other: **RFA (Prospective- 8 Visits)**

Patient:

Last: WORKER First: Joe M.I: Sex: M DOB: 06/20/29
Address: 1001 Street Drive City: San Jose State: CA Zip: 95123
Occupation: Operator SS#: 000-00-0000 Phone: 555-555-0000

Claims Administrator: 925-555-0000 Claims Examiner: Adjustor Jones Email: adjustor@adjustor.com
Name: **Claims Administrator** Claim Number: **123456789** **EAMS#: ADJ-12345** D.O.I.: 03/07/2014
Address: PO Box 000 City: San Jose: CA Zip: 94123 **UR Fax: 000-555-0000**

Employer name: City of ABC

Subjective complaints: (As of 04/06/15)

Patient has continued to show and demonstrate functional improvement with treatment to date. The outcome measures listed below clearly confirms that he has improved with diminishing Roland Morris scores, which began at 11/50 to now 5/50. He continues to work full duty without any restrictions. I kindly request that an additional 8 visits be authorized to continue to gain function, increase range of motion, decrease pain, and fully restore ADLs to this injured worker and most importantly to prevent losing any gains to date with regard to the aforementioned and including strength, limited neurological deficits/paresthesias into his lower extremity and ability to perform his work duties. The goal is to continue to achieve positive symptomatic and objective measureable gains in functional improvement to return to pre-injury level. He previously reported moderate lower back pain that may become severe and refers into the right lower extremity, which is now reported as slight pain becoming moderate pain at its worst. Frequency of pain is also decreased with care from frequent to constant, which is now intermittent. Difficulty to perform ADLs has also improved (i.e. able to drive/ride motorcycle longer without back/leg pain, improved lifting, pushing, pulling ability with diminished LBP).

Objective findings: (As of 04/08/15)

Inspection: Right antalgic lean resolved.
Palpation: Palpable tenderness/trigger points with moderate (previously severe) spasm over lumbar paraspinals, right quadratus lumborum, and right piriformis. Right posterior serratus inferior trigger point resolved.
Lumbar AROM: Moderately (previously severely) diminished with flexion, extension; Slight (previously moderately) decreased with left (previously bilateral) lateral flexion and rotation.
Orthopedic Exam: (+) SLR on the right for localized SI joint pain & upper hamstrings. (prior pain into the right gluteus resolved). (+) Right Seated Kemps for SI joint pain locally (previously elicited radiation into the right gluteus.) Valsalva was unremarkable. Seated Dural Nerve Root Stretch test produced localized lumbar pain/restriction in forward flexion.
Myotomal Testing: (4-5/5) Lumbar pain with psoas resolved, but mild to slight pain with quadriceps and slight to moderate pain with hamstrings testing.
Neurological Testing: DTR's +2/4 B/L UE. Other neuro tests unremarkable (light touch, 2 pt discrimination, vibration)
Outcome Measure Tools: Roland Morris
03/23/15=RM: **11**/50
04/06/15=RM: **5**/50

Diagnoses:

1. LUMBAR SPINE UNSPEC. RADICULITIS (724.4)

Treatment Plan: Chiropractic Manipulative Therapy with Ice/Heat (98940), Myofascial therapy (97250), Therapeutic exercises (97110), Interferential therapy (97014), Traction (97012) and Ultrasound (97035); 2 *times a week for 4 weeks = 8 Chiropractic Visits*

UR REQUEST FOR PRE-AUTHORIZATION (PROSPECTIVE): 8 TREATMENTS
Home care exercises: Static hamstrings, quadratus lumborum & piriformis stretching and core stabilization exercises as described at this office.

Work/Status: This patient has been instructed to:
- ☐ Remain off work until: ______________
- ☐ Return to *modified* work on ___________with the following limitations or restrictions:
- ☑ Return to full duty on 04/06/2015 with no limitations or restrictions

Primary Treating Physician: Date of exam: 04/06/15
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3

Signature: ________________________________ Cal. Lic. # DC-12345

Executed at: Santa Clara County, CA
Name: Glenn Crafts, D.C., Q.M.E.
Address: 123 N. Rose Blvd., Suite 101 San Jose, Ca 95123
Next report due no later than: 05/23/2015

Date: 04/08/15
Specialty: Chiropractic
Phone: (408) 555-1234
Fax: (408) 555-1235

DWC Form Pr-2 (rev. 1/1/99)

Claimant:	[redacted]	Employer:	[redacted]
Claim #:	[redacted]	Carrier/TPA:	
DOI:	03/07/2014	Claims Examiner:	
RFA Received:	04/08/2015	Review #:	
Decision Date:	04/17/2015		

UTILIZATION REVIEW DETERMINATION

[redacted] Managed Care has been asked to notify you that the adjuster, [redacted] has given authorization for the below noted treatment request.

REQUEST FOR AUTHORIZATION:

Additional chiropractic visits for low back Qty. 8

After careful review of the submitted medical information listed below, the determination is noted below.

DETERMINATION:

Your Initial Prospective UR request has received a recommendation of: Carrier Approval.

Authorization Timeframe:

04/17/2015 - 07/17/2015

Should this employer be part of a specific network, facility and/or vendor information is noted below.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 7244 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL RE

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.
1	04	15	15	04	15	15	11		97140	59	A	44 28	1		NPI
2	04	15	15	04	15	15	11		98940		A	38 50	1		NPI
3	04	15	15	04	15	15	11		97014		A	19 80	1		NPI
4	04	15	15	04	15	15	11		97012		A	19 80	1		NPI
5	04	15	15	04	15	15	11		97110		A	38 00	1		NPI
6	04	15	15	04	15	15	11		97035		A	22 44	1		NPI

Don’t forget to bill for your PR-2 & Re-Exam

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 7244 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL RE

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.
1	05	06	15	05	06	15	11		WC002		A	15 00	1		NPI
2	05	06	15	05	06	15	11		99213	25	A	47 60	1		NPI

Physical Medicine Modalities

CPT	Description
THERAPEUTIC PROCEDURES:	**Physician/therapist <u>required</u> to have direct (one on one) patient contact**
97140-59 (Myofascial Release)	Manual therapy techniques (i.e. mobilization/manipulation, manual lymphatic drainage, manual traction) 1 or more regions, each 15 minutes
97110 (Therapeutic Exercise)	Each 15 minutes; therapeutic exercises to develop strength & endurance, ROM & flexibility.
97112 (Neuromuscular Re-education)	Movement, balance, coordination, posture and/or proprioception for sitting/standing activities.
MODALITIES:	***Supervised*: <u>Does not require</u> direct (one on one) patient contact by the provider**
97012 (Traction)	Mechanical
97014 (Electrical Stimulation)	EMS Unattended
97010 (Moist Heat Therapy/Cryotherapy)	1 or more areas; hot or cold packs
MODALITIES:	***Constant Attendance*: Requires direct (one on one) patient contact by the provider**
97035 (Ultrasound)	Therapeutic ultrasound
CHIROPRACTIC MANIPULATIVE Tx	Influence joint and neurophysiological function.
98940 (Chiropractic Manipulation)	CMT (Spinal; 1 to 2 regions)

W-9

- Always include a completed W-9 form when billing an insurance company for the first time.
- The insurance carrier will need to add the provider as a new vendor of services.
- Usually, if the insurance carrier does not have your completed W-9 on the initial billing, it will delay payment until they have it.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ► ____
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any) ____
Exemption from FATCA reporting code (if any) ____
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person ►** **Date ►**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

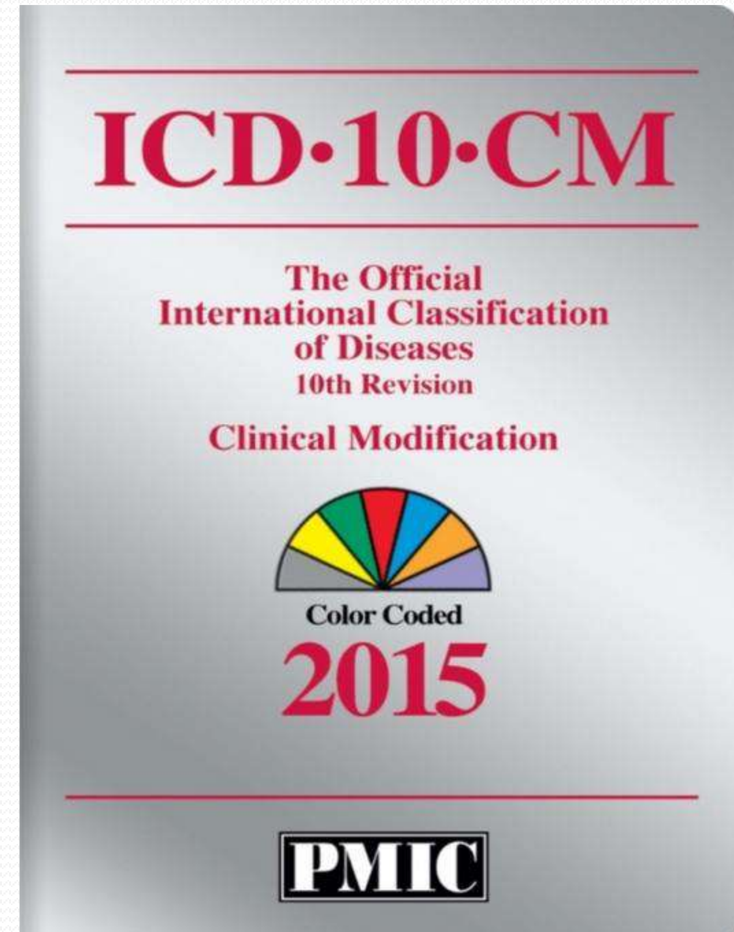
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Proof of Service

How can you prove you sent your treatment request?

- Proof of Service
- Email confirmation
- Fax proof/confirmation of delivery

- ICD-9 ~ 14,000 Codes
- ICD-10 ~ 70,000 Codes



ICD-10

- Providers must use ICD-10 codes for all services rendered > 10/01/2015
- Providers must use ICD-9 codes for all services rendered < 10/01/2015
- Visit the CMS website to prepare: **http://www.cms.gov/Medicare/Coding/ICD10/Index.html**
- Obtain access to ICD-10 codes: Coding books, practice management software/updates/HER (Electronic Health Records), smartphone apps.

ICD-10

Implementing ICD-10 codes effective 10/01/2015 will:

- 1. Avoid claims being rejected because of obsolete (ICD-9) coding
- 2. Avoid the need to re-submit claims using the proper ICD-10 coding
- 3. Avoid delays in receiving payment for treatment rendered

Exclude Notes

- **Excludes 1**
- A type 1 Excludes note means "NOT CODED HERE!"
- Excludes 1 indicates that the code excluded should never be used at the same time as the code above the Excludes 1 note.
- Excludes 1 is used when 2 conditions cannot occur at the same time (i.e. Congenital vs. Acquired)

Exclude Notes

- **Excludes 2**
- A type 2 Excludes note represents "NOT INCLUDED HERE"
- Excludes 2 note indicates the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time.
- When Excludes 2 note appears under a code, it is acceptable to use both the code and the excluded code together.

ICD-10

- Visit the CMS website to prepare: http://www.cms.gov/Medicare/Coding/ICD10/Index.html
- Select 2016 ICD-10 and GEMS to download code tables & index

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ICD-10

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2016 ICD-10-CM and GEMs

The 2016 ICD-10-CM files below contain information on the new diagnosis coding system, ICD-10-CM, that is a replacement for ICD-9-CM, Volumes 1 and 2.

Downloads

- 2016 Code Descriptions in Tabular Order [ZIP, 2MB]
- 2016 Code Tables and Index [ZIP, 16MB]
- 2016 ICD-10-CM Duplicate Code Numbers [ZIP, 64KB]
- 2016 Addendum [PDF, 79KB]
- 2016 General Equivalence Mappings (GEMs) – Diagnosis Codes and Guide [ZIP, 1MB]
- 2016 Present On Admission (POA) Exempt List [ZIP, 1MB]
- 2016 ICD-10-CM Guidelines [PDF, 1MB]
- 2016 Reimbursement Mappings – Diagnosis Codes and Guides [ZIP, 449KB]

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ICD-10 (Commonly Used by Chiropractors)

- **Chapter 13**
- Diseases of the musculoskeletal system and connective tissue (**M00-M99**)

This chapter contains the following blocks:

M00-M02	Infectious arthropathies
M05-M14	Inflammatory polyarthropathies
M15-M19	Osteoarthritis
M20-M25	Other joint disorders
M26-M27	Dentofacial anomalies [including malocclusion] and other disorders of jaw
M30-M36	Systemic connective tissue disorders
M40-M43	Deforming dorsopathies
M45-M49	Spondylopathies
M50-M54	Other dorsopathies
M60-M63	Disorders of muscles
M65-M67	Disorders of synovium and tendon
M70-M79	Other soft tissue disorders
M80-M85	Disorders of bone density and structure
M86-M90	Other osteopathies
M91-M94	Chondropathies
M95	Other disorders of the musculoskeletal system and connective tissue
M96	Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified
M99	Biomechanical lesions, not elsewhere classified

ICD-10 (Commonly Used by Chiropractors)

- **Other dorsopathies (M50-M54)**

- **Excludes1:**
- current injury - see injury of spine by body region
- Discitis NOS (M46.4-)
- **Discitis, unspecified**
- **Discitis** = infection of the intervertebral disc space

ICD-10 (Commonly Used by Chiropractors)

- **Other dorsopathies (M50-M54)**

M54.1 Radiculopathy

Brachial neuritis or radiculitis NOS
Lumbar neuritis or radiculitis NOS
Lumbosacral neuritis or radiculitis NOS
Thoracic neuritis or radiculitis NOS
Radiculitis NOS

Excludes1: neuralgia and neuritis NOS (M79.2)
radiculopathy with cervical disc disorder (M50.1)
radiculopathy with lumbar and other intervertebral disc disorder (M51.1-)
radiculopathy with spondylosis (M47.2-)

M54.10 Radiculopathy, site unspecified

M54.11 Radiculopathy, occipito-atlanto-axial region

M54.12 Radiculopathy, cervical region

M54.13 Radiculopathy, cervicothoracic region

M54.14 Radiculopathy, thoracic region

M54.15 Radiculopathy, thoracolumbar region

M54.16 Radiculopathy, lumbar region

M54.17 Radiculopathy, lumbosacral region

M54.18 Radiculopathy, sacral and sacrococcygeal region

ICD-10 (Commonly Used by Chiropractors)

- **Other dorsopathies (M50-M54)**

M54.2 Cervicalgia

Excludes1: cervicalgia due to intervertebral cervical disc disorder (M50.-)

M50.0 Cervical disc disorder with myelopathy

M50.00 Cervical disc disorder with myelopathy, unspecified cervical region

M50.01 Cervical disc disorder with myelopathy, high cervical region
C2-C3 disc disorder with myelopathy
C3-C4 disc disorder with myelopathy

M50.02 Cervical disc disorder with myelopathy, mid-cervical region
C4-C5 disc disorder with myelopathy
C5-C6 disc disorder with myelopathy
C6-C7 disc disorder with myelopathy

M50.03 Cervical disc disorder with myelopathy, cervicothoracic region
C7-T1 disc disorder with myelopathy

ICD-10 (Commonly Used by Chiropractors)

- **Other dorsopathies (M50-M54)**

M54.3 Sciatica

Excludes1: lesion of sciatic nerve (G57.0)
sciatica due to intervertebral disc disorder (M51.1-)
sciatica with lumbago (M54.4-)

M54.30 Sciatica, unspecified side

M54.31 Sciatica, right side

M54.32 Sciatica, left side

M54.4 Lumbago with sciatica

Excludes1: lumbago with sciatica due to intervertebral disc disorder (M51.1-)

M54.40 Lumbago with sciatica, unspecified side

M54.41 Lumbago with sciatica, right side

M54.42 Lumbago with sciatica, left side

M54.5 Low back pain
Loin pain
Lumbago NOS

Excludes1: low back strain (S39.012)

lumbago due to intervertebral disc displacement (M51.2-)
lumbago with sciatica (M54.4-)

ICD-10 (Commonly Used by Chiropractors)

- **Soft tissue disorders (M60-M79)**
- **Disorders of muscles (M60-M63)**

M62.83 **Muscle spasm**

M62.830	**Muscle spasm of back**
M62.831	**Muscle spasm of calf** Charley-horse
M62.838	**Other muscle spasm**

ICD-10 (Commonly Used by Chiropractors)

- **Other soft tissue disorders (M70-M79)**
- **M70 Soft tissue disorders related to use, overuse and pressure**

M70.2 Olecranon bursitis
- M70.20 Olecranon bursitis, unspecified elbow
- M70.21 Olecranon bursitis, right elbow
- M70.22 Olecranon bursitis, left elbow

M70.3 Other bursitis of elbow
- M70.30 Other bursitis of elbow, unspecified elbow
- M70.31 Other bursitis of elbow, right elbow
- M70.32 Other bursitis of elbow, left elbow

M70.4 Prepatellar bursitis
- M70.40 Prepatellar bursitis, unspecified knee
- M70.41 Prepatellar bursitis, right knee
- M70.42 Prepatellar bursitis, left knee

M70.5 Other bursitis of knee
- M70.50 Other bursitis of knee, unspecified knee
- M70.51 Other bursitis of knee, right knee
- M70.52 Other bursitis of knee, left knee

ICD-10 (Commonly Used by Chiropractors)

- **Other soft tissue disorders (M70-M79)**
- **M70 Soft tissue disorders related to use, overuse and pressure**

M70.6 Trochanteric bursitis
Trochanteric tendinitis

- **M70.60 Trochanteric bursitis, unspecified hip**
- **M70.61 Trochanteric bursitis, right hip**
- **M70.62 Trochanteric bursitis, left hip**

M70.7 Other bursitis of hip
Ischial bursitis

- **M70.70 Other bursitis of hip, unspecified hip**
- **M70.71 Other bursitis of hip, right hip**
- **M70.72 Other bursitis of hip, left hip**

ICD-10 (Commonly Used by Chiropractors)

- M75 Shoulder lesions
- **Excludes2: shoulder-hand syndrome (M89.0-)**

M75.0 Adhesive capsulitis of shoulder
Frozen shoulder
Periarthritis of shoulder

M75.00 Adhesive capsulitis of unspecified shoulder

M75.01 Adhesive capsulitis of right shoulder

M75.02 Adhesive capsulitis of left shoulder

ICD-10 (Commonly Used by Chiropractors)

- M75 Shoulder lesions
- NOTE: Code the correct laterality (right vs. left)
- Note Excludes1 code – Do not use S46.01 (strain) with M75 (non-traumatic)

M75.1 Rotator cuff tear or rupture, not specified as traumatic
Rotator cuff syndrome
Supraspinatus tear or rupture, not specified as traumatic
Supraspinatus syndrome

Excludes1: tear of rotator cuff, traumatic (S46.01-)

M75.10 Unspecified rotator cuff tear or rupture, not specified as traumatic

M75.100 Unspecified rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic

M75.101 Unspecified rotator cuff tear or rupture of right shoulder, not specified as traumatic

M75.102 Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic

M75.11 Incomplete rotator cuff tear or rupture not specified as traumatic

M75.110 Incomplete rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic

M75.111 Incomplete rotator cuff tear or rupture of right shoulder, not specified as traumatic

M75.112 Incomplete rotator cuff tear or rupture of left shoulder, not specified as traumatic

M75.12 Complete rotator cuff tear or rupture not specified as traumatic

M75.120 Complete rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic

M75.121 Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic

M75.122 Complete rotator cuff tear or rupture of left shoulder, not specified as traumatic

S46.01 Strain of muscle(s) and tendon(s) of the rotator cuff of shoulder

S46.011 Strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder

S46.012 Strain of muscle(s) and tendon(s) of the rotator cuff of left shoulder

S46.019 Strain of muscle(s) and tendon(s) of the rotator cuff of unspecified shoulder

ICD-10 (Commonly Used by Chiropractors)

- M77 Other enthesopathies
- NOTE: Code the correct laterality (right vs. left)

M77.0 Medial epicondylitis

- **M77.00 Medial epicondylitis, unspecified elbow**
- **M77.01 Medial epicondylitis, right elbow**
- **M77.02 Medial epicondylitis, left elbow**

M77.1 Lateral epicondylitis
Tennis elbow

- **M77.10 Lateral epicondylitis, unspecified elbow**
- **M77.11 Lateral epicondylitis, right elbow**
- **M77.12 Lateral epicondylitis, left elbow**

ICD-10 (Commonly Used by Chiropractors)

- M79 Other and unspecified soft tissue disorders, not elsewhere classified

M79.7 Fibromyalgia
Fibromyositis
Fibrositis
Myofibrositis

M79.1 Myalgia
Myofascial pain syndrome

Excludes1: fibromyalgia (M79.7)
myositis (M60.-)

ICD-10 (Commonly Used by Chiropractors)

- **Chapter 20**
- **External causes of morbidity (V00-Y99)**

This chapter contains the following blocks:

V00-X58	Accidents
V00-V99	Transport accidents
V00-V09	Pedestrian injured in transport accident
V10-V19	Pedal cycle rider injured in transport accident
V20-V29	Motorcycle rider injured in transport accident
V30-V39	Occupant of three-wheeled motor vehicle injured in transport accident
V40-V49	Car occupant injured in transport accident
V50-V59	Occupant of pick-up truck or van injured in transport accident
V60-V69	Occupant of heavy transport vehicle injured in transport accident
V70-V79	Bus occupant injured in transport accident
V80-V89	Other land transport accidents
V90-V94	Water transport accidents
V95-V97	Air and space transport accidents
V98-V99	Other and unspecified transport accidents
W00-X58	Other external causes of accidental injury
W00-W19	Slipping, tripping, stumbling and falls

ICD-10 (Commonly Used by Chiropractors)

- **Chapter 20**
- **External causes of morbidity (V00-Y99)**

V49 Car occupant injured in other and unspecified transport accidents

The appropriate 7th character is to be added to each code from category V49
A - initial encounter
D - subsequent encounter
S - sequela

V53 Occupant of pick-up truck or van injured in collision with car, pick-up truck or van

The appropriate 7th character is to be added to each code from category V53
A - initial encounter
D - subsequent encounter
S - sequela

V00.15 Heelies accident
Rolling shoe
Wheeled shoe
Wheelies accident

V00.151 Fall from heelies

V00.152 Heelies colliding with stationary object

V00.158 Other heelies accident

Procedural Coding/Billing

- **Common Chiropractic Treatment**
- **Procedural Coding for Billing/Reimbursement**
- **CA DWC Fee Schedule**

- **<u>Therapeutic Procedures</u>**
- **97530 – Therapeutic Activities**
- **$43.59 Fee Schedule**
- Requires direct 1:1 patient contact by the provider using dynamic activities to improve functional performance
- i.e. bending, lifting, carrying, pushing, pulling, balance
- Define outcome/goals to be attained
- Each 15 minutes

Procedural Coding/Billing

- **Common Chiropractic Treatment**
- **Procedural Coding for Billing/Reimbursement**
- **CA DWC Fee Schedule**

- **Therapeutic Procedures**
- **97110 – Therapeutic Exercise**
- **$40.10 Fee Schedule**
- 1 or more areas
- Exercises to develop strength and endurance, ROM & flexibility
- Define outcome/goals to be attained
- Each 15 minutes

Procedural Coding/Billing

- **Common Chiropractic Treatment**
- **Procedural Coding for Billing/Reimbursement**
- **CA DWC Fee Schedule**

- **Therapeutic Procedures**
- **97112 – Neuromuscular Re-Education**
- **$41.67 Fee Schedule**
- Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.
- Define outcome/goals to be attained

Procedural Coding/Billing

- **Common Chiropractic Treatment**
- **Procedural Coding for Billing/Reimbursement**
- **CA DWC Fee Schedule**

- **Therapeutic Procedures**
- **97140 – Myofascial release**
- **$37.09 Fee Schedule**
- Manual therapy techniques
- i.e. mobilization, manipulation, manual lymphatic drainage, **manual traction**
- 1 or more regions
- Define outcome/goals to be attained
- Each 15 minutes

Procedural Coding/Billing

- **Common Chiropractic Treatment**
- **Procedural Coding for Billing/Reimbursement**
- **CA DWC Fee Schedule**

- **Physical Medicine & Rehabilitation**
- **Modalities (Supervised)**
- **97010 – Hot or Cold Packs**
- **$0.00 Fee Schedule (Disallowed)**

Procedural Coding/Billing

- **Common Chiropractic Treatment**
- **Procedural Coding for Billing/Reimbursement**
- **CA DWC Fee Schedule**

- **Physical Medicine & Rehabilitation**
- **Modalities (Supervised)**
- **97012 – Traction (Mechanical)**
- **$19.69 Fee Schedule**

- **NOTE: This code is for mechanical traction. Manual traction should use CPT 97140.**

Procedural Coding/Billing

- **Common Chiropractic Treatment**
- **Procedural Coding for Billing/Reimbursement**
- **CA DWC Fee Schedule**

- **Physical Medicine & Rehabilitation**
- **Modalities (Constant Attendance)**
- **97035 – Ultrasound**
- **$15.67 Fee Schedule**
- Each 15 minutes

Procedural Coding/Billing

- **Chiropractic Adjustments (Manipulation)/CMT**

CPT	Treatment	Fee Schedule
98940	Spinal Manipulation; 1-2 regions	$ 34.60
98941	Spinal Manipulation; 3-4 regions	$ 50.08
98942	Spinal Manipulation; 5 regions	$ 65.09
98943	Extraspinal; 1 or more regions	$ 33.32

Resources

- State of California Dept. of Insurance – *www.insurance.ca.gov*
- UR and Causation section of FAQs: *http://www.dir.ca.gov/dwc/UtilizationReview/UR_FAQ.htm*
- Division of Workers' Compensation Dept. of Industrial Relations - *http://www.dir.ca.gov/DWC*
- URAC – *www.urac.org*
- MTUS Regulations: *http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS_Regulations/MTUS_Regulations.htm*.
- ACOEM-Occupational Medicine Practice Guidelines 2nd Edition 2004
- CWCI
- ICD-10 CM PMIC 2015
- CPT Plus PMIC 2012

COURSE EVALUATION FOR ADMINISTRATIVE DIRECTOR

As a part of the Administrative Director's ongoing efforts to ensure that courses for Qualified Medical Evaluators offer valuable information on California's Workers' Compensation-related medical evaluation issues, we are asking attendees of the courses approved by the Administrative Director (including distance learning programs) to complete the following Course Evaluation.

COURSE EVALUATION LINK (click here)

TO ALL ATTENDEES: PLEASE RETURN THIS FORM TO THE DWC

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Thanks So Much!

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