



Connecting People with Purpose



City & County of San Francisco's Utilization Review Plan

Prepared by the Department of Human Resources Workers'
Compensation Division

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Overview

The City & County of San Francisco (CCSF) is a permissively self-insured public entity for workers' compensation purposes. Illness and injury claims are handled primarily by its self-administered program in the Department of Human Resources' Workers' Compensation Division (WCD). Approximately 20% of claims handled by a contracted Third-Party Administrator, currently Intercare.



Effective 1/1/2004, all claims administrators are required to establish and administer a utilization review process for medical treatment. This document supersedes any previously-filed Utilization Review Plan for CCSF, a copy of which has been filed with the State of California, Division of Workers' Compensation as an attachment to the formal Utilization Review Organization's Plan submitted by the contracted Utilization Review Organization.

Utilization Review Organization (URO)

CCSF contracts with Allied Managed Care, Inc. for its Utilization Review Program. Requests for authorization for medical treatment must be timely sent to the URO for review and a determination of medical necessity unless approved by the claims examiner or pre-authorized through the "Fast Track" preauthorization program.

The Medical Director for the CCSF Program is through the contracted URO and is licensed to practice in California.

The Medical Director is: Alan E. Randle, MD

California Medical License: # **G27961**

Medical Director Allied Managed Care

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CCSF Medical Provider Network (CCSF MPN)

CCSF maintains an approved Medical Provider Network (MPN Identification #1258) to provide treatment for common work-related injuries and illnesses.

“Fast Track” Preauthorization Procedures & Treatment Guidelines

CCSF developed a “Fast Track” Program to streamline the Utilization Review process, expedite the claims review process, and facilitate the delivery of quality medical treatment for the injured worker in order to reach Maximum Medical Improvement and return to work or to a pre-injury status as soon as medically indicated.

This Fast Track Program is designed for the City and County of San Francisco Occupational Health clinics and their primary treating physicians) **to provide expedited medical care without going through the formal request for authorization (RFA) process.** The services described are preauthorized for accepted claims **during the first 180 days from the date of injury** and are not subject to Utilization Review as long as the treatment is consistent with the MTUS, ODG and evidence-based medical guidelines. Participating providers have demonstrated consistent adherence to evidence-based guidelines in their treatment of injured employees.

“Fast Track” Limits: The Fast Track Program applies to all accepted CCSF Workers’ Compensation claims for the first 180 days starting from the Date of Injury. Delayed claims are subject to a \$10,000 cap on medical treatment until a claims decision is made. Delayed claims that become accepted during the first 180 days will continue to be eligible for Fast Track.

Program Participants:

- Saint Francis Occupational Health Clinics;
- California Pacific Medical Center Occupational Health Clinic;
- Kaiser On-the-Job Occupational Health Clinics (all);
- San Francisco Airport Clinic;
- Job Care/Sonora Regional Medical Center;
- Concentra Clinics: Brentwood, Gilroy, Milpitas, Santa Rosa, Potrero Hill, Downtown San Francisco (California St.), South San Francisco
- Stanford Health Care, Tri-Valley, Dublin
- Work Health Solutions, Roseville and
- CCSF MPN providers specializing in Orthopedics, Hand surgery, and Podiatry who have received referrals from any of the above-referenced clinic providers.

Program Requirements: This Fast Track Program provides prior authorization to Primary Treating Physicians who provide care through specified CCSF MPN clinics and to the CCSF MPN specialists in Orthopedics, Hand Surgery, and Podiatry to whom they refer to provide expedited medical care without the need for prior approval from the claims administrator. CCSF WCD has selected these providers because they have demonstrated consistent adherence to evidence-based guidelines in their treatment of injured employees. No formal Request for Authorization (RFA) is required where the treatment meets the following requirements:

1. Treatment must be medically necessary and consistent with the Division of Workers' Compensation Medical Treatment Utilization Schedule (MTUS) or other scientifically-based medical evidence and be medically appropriate for the work-related injury.
2. All treatment must be documented in the Physician's First Report of Injury and regular reporting in the PR-2 format per the Primary Treating Physician reporting guidelines (CCR 9785).
3. To assist in tracking medical treatment services delivered under this program, participating providers are asked to include the following language on the PR-2: *"Per the Fast Track agreement with CCSF this treatment is Pre-Authorized"*.
4. Services will be paid at the appropriate Official Medical Fee Schedule rates, less any discounts through their voluntary participation in a Preferred Provider Organization or at agreed-upon rates under Labor Code section 5307.11.
5. The preauthorized treatment is included in the Fast Track Treatment Guidelines listed below.
6. Treatment provided that is inconsistent with the Fast Track Program are subject to retrospective review.

"Fast Track" Preauthorization Treatment Guidelines:

The following services that meet the program requirements are pre-authorized.

Physical Medicine & Rehabilitation

- Physical or Occupational therapy for up to 12 visits. If there is clear documentation of functional improvement (e.g., decreasing symptoms, increasing function with RTW and/or lessening of work restrictions) and active therapy plan (aerobic exercise, specific stretching and strengthening), an additional 6 visits is deemed approved up to 18 visits total.
- Post-Operative physical therapy that is consistent with the MTUS Post-Surgical Physical Medicine Guidelines.
- Chiropractic treatment for up to 12 visits for all body parts except the elbow, ankle, or for Carpal Tunnel Syndrome. If there is clear documentation of functional improvement over time (e.g., decreasing symptoms, increasing function with RTW and/or lessening of work restrictions, improved ADLs), an additional 6 visits is deemed approved up to 18 visits total.
- Acupuncture for up to 6 visits. If there is clear documentation functional improvement over time (e.g., decreasing symptoms, increasing function with RTW and/or lessening of work restrictions, improved ADLs), an additional 6 visits is deemed approved up to 12 visits total.

- Referral to Secondary Providers in the MPN for a **one-time consultation** to include: pain management assessment, orthopedic surgery consult, dermatology consult, etc.

Injections:

- Medial and Lateral epicondyle – one injection per guidelines
- Up to 2 of the following corticosteroid or similar injections are approved if the first was helpful to the patient.
 - Trigger point
 - Acromioclavicular and Subacromial
 - De'Quervain's
 - Carpal Tunnel
 - Trigger finger
 - Knee
 - When treating radiculopathy (demonstrated dermatomal pain), injections may be done after 30 days of conservative treatment has failed.

Diagnostic Testing:

- Initial MRI's with or without contrast, and or CT scans after major trauma, with progressive documented neurologic deficits, or after (30 days) of conservative care without functional improvement
- EMG/NCV with documented neurologic deficit on exam or after 30 days of conservative care with documented neurological deficit or without improved function
- X-rays for trauma or suspected fracture, bone-joint lesion
- Bone scan to rule out fracture after negative plain film
- Routine pre-operative testing, including cardiac testing – routine EKG, routine cardiac lab work, stress echocardiogram, with ultrasound / Holter monitor / Zio packet, if medically indicated.

Outpatient Surgery

- All Outpatient Knee and Shoulder Arthroscopies after failed conservative treatment.
- All Carpal Tunnel Surgeries (open) where the EMG study is positive and the patient has failed to respond to 30 days of conservative treatment
- Inguinal Hernia repair

Psychological Treatment / Pain Management

- One-time referral to a psychologist to determine compensability and / or to provide a recommended treatment plan
- Cognitive Behavioral Therapy, up to 6 visits
- Initial Evaluation for a Pain Management based on the documented need for such by the PTP

Durable Medical Equipment (DME)

- All medically-indicated Durable Medical Equipment up to \$250.00
Example: slings, crutches, simple braces, wraps, splints, canes, etc.
- Transcutaneous Nerve Stimulators (TNS) units approved for a 30-day trial unless it is for low back pain, which is not recommended per the MTUS
- TNS Purchase: Documentation of improvement by Physical Therapist or PTP; Contact Adjuster for authorization for purchase after a successful 30-day trial
- DME supplies such as electrodes. Batteries for up to 6 months
- CPM (Continuous Passive Motion) machines for post-operative care for the knee for up to 21 days
- Cryotherapy (without compression) rental for one week for post-operative care

Prescription Medications & Controlled Substances

To mitigate the dangers of overdose, addiction, and/or diversion and consistent with the Memorandum of Understanding between CCSF and the CCSF MPN providers, CCSF expects its providers to comply with the guidance set forth in the California Medical Treatment Utilization Schedule (MTUS) and the Chronic Pain Medical Treatment Guidelines as adopted by the Administrative Director of the California Division of Workers' Compensation. CCSF relies on its providers to embrace the guidance set forth in the California Medical Treatment Utilization Schedule, MTUS as adopted by the Administrative Director of the California Division of Workers' Compensation. This guidance includes the formulary that was adopted pursuant to Assembly Bill 1124 and the following current regulations:

State MTUS & Chronic Pain Guidelines:

http://www.dir.ca.gov/dwc/MTUS/MTUS_RegulationsGuidelines.html

Cures Guidelines:

<https://cures.doj.ca.gov>

The following medications are preauthorized:

- Muscle relaxants, not to exceed 30 day supply
- Narcotics/ Opiates, (Norco, Vicodin, Hydrocodone, Oxycodone, Percocet, Percodan) not to exceed 30 days

Claims Examiner Authority

The claims examiner may approve a Request for Authorization (RFA) without formal review where the requested services comply with the Internal Review Guidelines in this document. All reviews, including expedited review, shall be completed and communicated to the requesting physician within the timelines set forth in Labor Code section 4610 and the California Code of Regulations section 9792.9.

Approvals must be timely communicated to the requesting physician by either signing the Request for Authorization form and/or by sending an approval letter (Attachment A).

The examiner may consult the Internal Review Guidelines below to timely approve treatment that is properly requested using a Request for Authorization, or, timely send it to the Utilization Review Organization contracted to provide utilization review services. In situations where the requested treatment appears to be outside of the Internal Review Guidelines but the adjuster believes that the requested services are likely to be in the best interests of the employee and CCSF, the adjuster should seek the opinion from the CCSF Occupational Health Nurse or from their supervisor for guidance.

Example: A physician request for a Magnetic Resonance Image/Scan, which may not be justifiable under the state Medical Treatment Utilization Schedule, but which may serve to resolve an employee's heightened concerns about his or her ability to return-to-work and keep the claim moving forward towards a faster resolution rather than delaying the decision and pushing it towards an Independent Medical Review.

A claims examiner may not deny any RFA unless:

1. The requested treatment is from the same physician and has been previously reviewed and denied by the URO within the last 12 months, and there is no documentation of a change in the facts material to the basis of the UR decision that would make the requested treatment appropriate.
2. Compensability for the injury or treatment of the condition for which the treatment is recommended is disputed pursuant to Labor Code section 4062.

Internal Review Guidelines: Claims examiners may approve the following without having to go through formal Utilization Review for accepted body parts:

Medications

- Non-steroidal anti-inflammatory pain medications (NSAIDs)
- Antidepressants for radicular or neurogenic pain
- Anticonvulsants for radicular or neurogenic pain
- Short-acting opiates, not to exceed 30 day supply from DOI or surgery
- Muscle relaxants, not to exceed 30 day supply from DOI or surgery
- Antibiotics
- Heart or Hypertension medications for accepted Heart and Hypertensive claims with established award for Future Medical care, up to \$1000 per 30-day period. \

Physical Medicine & Rehabilitation

- Physical or occupational therapy for up to 24 visits if clear documentation of functional improvement (e.g., decreasing symptoms, increasing function with RTW and/or lessening of work restrictions) and active therapy plan (aerobic exercise, specific stretching and strengthening exercise). On postoperative claims, the examiner may also approve up to an additional 24 visits of physical therapy postoperatively with clear documentation of functional improvement and active therapy plan as part of the surgeon's postop plan
- Chiropractic treatment for up to 12 visits initially - up to 24 visits if clear documentation of functional improvement over time (e.g., decreasing symptoms, increasing function with RTW and/or lessening of work restrictions, improved Activities of Daily Living [ADLs])
- Acupuncture for up to 12 visits initially – up to 24 visits if clear documentation of functional improvement over time (e.g., decreasing symptoms, increasing function with RTW and/or lessening of work restrictions, improved ADLs)

Diagnostic Testing

- Initial MRI scan (within the time frames recommended by MTUS for the specific condition. Example: greater than 4 weeks for MRI of LS spine for uncomplicated lower back pain);
- Follow-up MRI scans over the life of the claim as recommended by physicians within the CCSF Medical Provider Network on a case-by-case basis;
- CT after major trauma, progressive documented neurologic deficits, or after 3-4 weeks of conservative care without functional improvement or imminent surgery, local injection is likely;

- EMG/Nerve Conduction Velocity with documented neurologic deficit on exam or after 6 weeks of conservative care without documented neurological deficit;
- X-rays for trauma or suspected fracture, bone-joint lesion.

Durable Medical Equipment

- Durable Medical Equipment (DME) as listed in the “Fast Track” guidelines;
- Hearing aids, including insurance and replacement programs;
- DME supplies for other approved DMEs (e.g., electrodes, batteries, cords) up to 6 months.

Exceptions (which must be sent to the URO):

- Spinal Unloading Devices such as orthopedic pneumatic devices;
- Continuous Passive Motion Machines
- Traction Equipment
- Flexion-Extension Devices
- Beds
- Powered Mobility Devices
- Transcutaneous Nerve Stimulators (TNS) for purchase without a 3-month trial and documentation of improvement with its use by a physical therapist or PTP
- All equipment in excess of \$2,500; all non-powered DME more than \$1000

Surgery and Injections

- Carpal tunnel or ulnar release with moderate to severe findings on nerve conduction velocity (NCV) test
- Hernia repair – initial only
- Surgery for displaced fracture
- Surgery for rotator cuff repair with documented MRI findings of rotator cuff tear
- Outpatient Knee surgeries (ACL, Medial Meniscal Repairs) with documented MRI showing partial or total tears
- Hardware removal, non-spine
- Corticosteroid injections, non-spine, for up to 2 injections in one location or anatomical area per year
- Epidural steroid injection for nerve root compression on MRI and neurologic deficit on exam or radicular symptoms (no more than one without documented improvement in function – e.g., decreased symptoms,

RTW and/or lessening of work restrictions, improved ADLs; may repeat up to 3 times total if previously successful with recurrence or worsening of symptoms)

- Pre-operative exam and testing for approved surgeries

Psychological Services

- Psychological Counseling including Cognitive Behavioral Therapy, work-based, for up to 6 visits in cases where there is documentation by the provider of the risk for delayed recovery.

Examples: Claims with two or more serious co-morbid conditions, prior history of multiple claims, high quantity of opioid medication use or abuse, employer dispute, prior psychological diagnoses.

Cancer Treatment

- Cancer treatment that is consistent with protocols recommended by Board Certified Oncologists or Specialists in the treatment of Cancer Diagnoses;
- Medications appropriate for break-through cancer pain, consistent with the MTUS Pain Guidelines.
- Consultations, diagnostic exams, PET scans, and lab work necessary and as recommended by Board Certified Oncologists or Specialists in the treatment of Cancer Diagnoses; to confirm, rule out and track diagnoses and progression/regression thereof.

Exceptions (must be discussed with, and approved by supervisor, and Occupational Nurse Consultant to discuss approval or sending to URO):

- Cancer medications that are experimental and not generally recommended by Board Certified Oncologists or Specialists, or exceed cost of \$3000/monthly
- Inpatient treatment outside of the state of California
- Cancer treatment that is considered experimental or not generally recommended by Board Certified Oncologists or specialists

For any other services that appear to be appropriate for the injury, the examiner may discuss with his or her supervisor or consult with the CCSF Medical Nurse Consultant to determine if the treatment can be approved without formal review.

All other treatment requests should be sent to the contracted Utilization Review Organization.



Workers' Compensation

City and County of San Francisco
Department of Human Resources

One South Van Ness Avenue, 4th Floor
San Francisco, CA 94103
Phone: (415) 557-4800
Fax: (415) 701-5884

Date

[Insert Provider Name]

[Insert Provider Address]

Fax Number:

Re: Employee:
Employer:
Claim#:
Date of Injury:
ADR#:

(expedited prospective/prospective/expedited concurrent/concurrent/retrospective/appeal)

Procedure/Description
Start Date

Dear Provider,

The requested treatment referenced above has been reviewed by your claims administrator, and has been determined to be approved. (denied/delay/modify/withdrawal: for these decisions, the type of person who withdrew the request: requesting physician, claims adjuster, injured employee or his or her attorney, or other person).

If you have any questions about this review or payment, please contact the claim administrator, [examiner name] at [examiner work phone] or by email at [examiner work email].

Sincerely,

[examiner name], Claims Examiner

cc: Injured Employee

NOTICE TO PROVIDER: This notice contains Protected Health Information that may not be shared or disclosed to any other party, without the express approval of the injured employee or the Claims Administrator. This includes the employer or employing City department representative, pursuant to LC§3762(c). Please contact the Claims Administrator with any questions regarding authorized disclosure