

Summary of Utilization Review Guidelines and Timeframes

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Who can do Utilization Review?

No person may conduct a utilization review program for workers' compensation services in the State unless once every 2 years the person registers the utilization review program with the Department of Financial and Professional Regulation and certifies compliance with the Workers' Compensation standards or Health Utilization Management Standards of URAC sufficient to achieve URAC accreditation or submits evidence of accreditation by URAC for its Workers' Compensation Utilization Management Standards or Health Utilization Management standards.

How do I file a complaint about a Utilization Review Program?

There are 2 ways to file a complaint.

1. <https://www.idfpr.com/dpr/FILING/Complaint.asp>
2. Department of Financial and Professional Regulation
Division of Professional Regulation
Complaint Intake Unit
100 West Randolph Street, Suite 9-300
Chicago, IL 60601
Phone: 312/814-6910

What types of Utilization Review may be conducted?

- a. Prospective Utilization Review (Excluding First Aid or Emergency Care)
- b. Concurrent Utilization Review
- c. Retrospective Utilization Review

What are the timeframes in which a Prospective Utilization Review must be completed?

- a. URGENT: As soon as possible based on the clinical situation, but in no case later than 72 hours of the receipt of request.
- b. Non-URGENT: Within 15 calendar days of receipt of request

- c. For Non-URGENT cases this period may be extended one time by the organization for up to 15 calendar days:
 - (i) Provided that the organization determines that an extension is necessary because of matters beyond the control of the organization; **and**
 - (ii) Notifies the worker, prior to the expiration of the initial 15 calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision; **and**
 - (iii) If a worker fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the worker must be given at least 45 calendar days

What are the timeframes in which a Concurrent Utilization Review must be completed?

- a. For reductions or terminations in a previously approved course of treatment, the *organization* issues the determination early enough to allow the patient to request or review and receive a review decision before the reduction or termination occurs: **AND**
- b. For requests to extend a current course of treatment, the *organization* issues the determination within:
 - (i) 24 hours of the request for a utilization review determination, if it is a case involving urgent care and the request for extension was received at least 24 hours before the expiration of the currently certified period or treatments; **or**
 - (ii) 72 hours of the request for a utilization review determination, if it is a case involving urgent care and the request for extension was received less than 24 hours before the expiration of the currently certified period or treatments.

What are the timeframes in which a Retrospective Utilization Review must be completed?

- a. Within 30 calendar days of the receipt of request for a utilization review determination.
- b. This period may be extended one time by the utilization review organization for up to 15 calendar days:
 - (i) Provided that the utilization review organization determines that an extension is necessary because of matters beyond the control of the organization; **and**
 - (ii) Notifies the worker, prior to the expiration of the initial 30 calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision; **and**

- (iii) If a worker fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the worker must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information.

How is URGENT defined?

URAC does not define however the Department of Labor (DOL) defines URGENT as an injury that “could seriously jeopardize the life of health of the consumer or the ability of the consumer to regain maximum function.”

What are the required qualifications of the Peer Clinical Reviewer?

- a. Are appropriate *health professionals*;
- b. Are qualified, as determined by the *medical director* or *clinical director*, to render a clinical opinion about the medical condition, procedures, and treatment under review; **and**
- c. Hold a current and valid *license*:
 - (i) In the same licensure category as the *ordering provider*; **or**
 - (ii) As a doctor of medicine or doctor of osteopathic medicine.

What if I do not agree with the Utilization Review findings (PRE-APPEAL)?

- a. The organization provides, within one business day of a request by the attending physician or ordering provider, the opportunity to discuss the utilization review non-certification decision:
 - (i) With the clinical peer reviewer making the initial determination; **or**
 - (ii) With a different clinical peer, if the original clinical peer reviewer cannot be available within one business day); **and**
- b. If a peer-to-peer conversation or review of additional information does not result in a certification, the organization informs the provider and worker of the right to initiate an appeal and the procedure to do so.

What is the Utilization Review appeal process?

The Utilization Review organization maintains a formal process to consider appeals of non-certifications that includes:

- a. The availability of standard appeal for non-urgent cases and expedited appeal for cases involving urgent care; **and**

- b. Written appeals policies and procedures that:
 - (i) Clearly describe the appeal process, including the right to appeal of the worker, provider, or facility rendering service;
 - (ii) Provide for explicit time frames for each stage of the appeal resolution process; **and**
 - (iii) Are available, upon request, to any worker, provider, or facility rendering service.

What are the Utilization Review appeals timeframes?

- a. Expedited appeals: Should be completed, with verbal notification of determination to the requesting party with 72 hours of the request followed by a written confirmation of the notification within 3 calendar days to the patient and attending physician or other ordering provider or facility rendering service.
- b. Standard appeals: Should be completed and written notification of the appeal decision issued, within 30 calendar days of the receipt of the request for appeal to the patient and attending physician or other ordering provider or facility rendering service.

What are the required qualifications of the Appeal Peer Reviewer Qualifications?

- a. Are clinical peers;
- b. Hold an active, unrestricted license to practice medicine or a health profession;
- c. Are board-certified (if applicable) by:
 - (i) A specialty board approved by the American Board of Medical Specialties (doctors of medicine); **or**
 - (ii) The Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine);
- d. Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; **and**
- e. Are neither the individual who made the original non-certification, nor the subordinate of such an individual.