

Form 223

Authorization Request for Medical Treatment / Carrier Response

P A T I E N T	Last Name		First	Middle	Street Address, City, State, Zip			
	Social Security Number		Date of Birth		Phone Number		Date of Injury	
C A R R I E R	Employer's Name			Street Address, City, State, Zip			Phone Number	
	Name				Street Address, City, State, Zip			
Adjuster				Phone Number		Fax Number		
PROVIDER'S INITIAL REQUEST (Level One)								
P R O V I D E R	Provider's Name				Street Address, City, State, Zip			
	Degree and Specialty				Phone Number		Fax Number	
	Diagnosis				Best Time to Contact Provider (Business Days)			
	Date of Verified Transmission		Requested Procedure(s) - Attach Supporting Documentation, If Needed					
CARRIER'S RESPONSE (Level One)								
P R O V I D E R	Date of Verified Transmission		Responsible Person		Acceptance Signature		Denial Signature (Attached Criteria Utilized)	
	PROVIDER'S REQUEST FOR CARRIER'S PHYSICIAN REVIEW (Level Two)							
P R O V I D E R	Date of Verified Transmission		OPTIONAL - Explanation and/or Additional Information					
	CARRIER'S PHYSICIAN'S RESPONSE (Level Two)							
C A R R I E R	Date of Verified Transmission		Responsible Person		Acceptance Signature		Denial Signature (Attached Criteria Utilized)	

R I E R P A T I E N T				
	PATIENT'S ACKNOWLEDGEMENT OF RESPONSIBILITY IF PROCEDURE IS DENIED BY CARRIER I agree that I may become liable for the cost of the medical procedure if it is ultimately determined to not be compensable.			
	Date	Patient's Signature		

NOTICE TO INJURED WORKER: If you disagree with the carrier and cannot resolve your differences by talking with the carrier and/or your treating physician, you should then call the Labor Commission, Division of Industrial Accidents, for further instructions.



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Form 223 – Instructions

The use of Form 223 is governed by the Division of Industrial Accident's Rule R612-300-11 "Utilization Review Standards."

A treating physician may use Form 223 to request authorization for payment for a course of proposed treatment, including surgery, hospitalization or any diagnostic study beyond plain X-rays.

Levels of Review

Level I: The treating physician sends this form with the *Provider's Initial Request (Level One)* portion completed, along with documentation for the requested treatment, to the payer of the claim. The payer is to notify the treating physician within five (5) business days with approval or denial of the request. The payer may use medical or non-medical personnel at this level to make the decision to approve or deny the request. If the request is denied, the payer must send the criteria used in making the decision to deny payment for the procedure requested.

1. A health care provider may use Form 223 to request authorization and payment for proposed medical treatment. The provider shall attach all documentation necessary for the payor to make a decision regarding the proposed treatment.
 - a. Requests for approval of restorative services are governed by the provisions of Section R612-300.5. C. 7 which requires submission of the appropriate RSA form and documentation.
2. Upon receipt of the provider's request for authorization, the payor may use medical or non-medical personnel to apply medically-based criteria to determine whether to approve the request. The payor must:
 - a. Within 5 business days after receiving the request and documentation, transmit Form 223 back to the physician, in a verifiable manner, advising of the payor's approval or denial of the proposed treatment.
 - i. If approval is denied, the payor must include with its denial a statement of the criteria it used to make its determination. A copy of the denial must also be mailed to the injured worker.

Level II: A physician who has been denied authorization for payment for treatment, or has received no response to the request within the five (5) days, may request physician's review of the request by sending the completed *Provider's Request for Carrier's Physician Review (Level Two)* portion of the request for physician review. The requesting physician is to include the days and times that he/she is available to discuss the case with a reviewing physician. The payer's physician reviewer must make a reasonable attempt to contact the treating physician regarding the payer's denial and must complete the review within five (5) business days of the treating physician's request for review. If the authorization for payment for the treatment is denied, the carrier's reviewing physician must send the criteria used to make the decision along with the name and specialty of the reviewing physician to the treating physician.

1. A health care provider who has been denied authorization or has received no timely response may request a physician's review by completing and sending the applicable portion of Commission Form 223 to the payor.
 - a. The provider must include the times and days that he/she is available to discuss the case with the reviewing physician, and must be reasonably available during normal business hours.
 - b. This request for review may be used by a health care provider who has been denied authorization for restorative services pursuant to Subsection R612-300-5.C.7.
2. The payor's physician representative must complete the review within five business days of the treating physician's request for review. Additional time may be requested from the Commission to accommodate highly unusual circumstances or particularly difficult cases.
 - a. The insurer's physician representative must make a reasonable effort to contact the requesting

provider to discuss the request for treatment. The payor shall notify the Commission if an additional five days is needed in order to contact the treating physician or to review the case.

b. If the payor again denies approval of the recommended treatment, the payor must complete the appropriate portion of Commission Form 223, and shall include:

- i. the criteria used by the payor in making the decision to deny authorization; and
- ii. the name and specialty of the payor's reviewing physician;
- iii. appeals information.

c. The denial to authorize payment for treatment must then be sent to the physician, the injured worker and the Commission.

3. The payor's failure to respond to the review request within five business days, by a method which provides certification of transmission, shall constitute authorization for payment of the treatment.

Reduction of Fee for Failure to Follow Utilization Review Standards.

1. In cases in which a health care provider has received notice of this rule but proceeds with non-emergency medical treatment without obtaining payor authorization, the following shall apply:

a. If the medical treatment is ultimately determined to be necessary to treat a workplace injury, the fee otherwise due the health care provider shall be reduced by 25%.

b. If the medical treatment is ultimately determined to be unnecessary to treat a workplace injury, the payor is not liable for payment for such treatment. The injured worker may be liable for the cost of treatment.

2. The penalty provision in D. 1. shall not apply if the medical treatment in question has been preauthorized by some other non-worker's compensation insurance company or other payor.

For a complete text of the rule you may access the rule (R612-300-11) through the Labor Commission's website at www.laborcommission.utah.gov.