

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation
Nashville, Tennessee 37243-0661
UTILIZATION REVIEW CLOSURE

EMPLOYEE INFORMATION

State File # _____ Date of Injury _____ Social Security # _____
 Claimant _____ DOB _____ Sex _____

EMPLOYER INFORMATION

FEIN: _____ Employer: _____
 Street: _____ City: _____ State: _____ Zip: _____

INSURER INFORMATION

Insurer: _____
 Insurer Claim #- _____ Policy Number: _____

UTILIZATION REVIEW INFORMATION

Utilization Review Company _____ TN ID# _____
 License Number _____
 Healthcare Provider _____ MD/Chiro/DO _____
 Treating Facility _____ City _____
 Address _____

Summary of Actions Taken by the Utilization Review Provider (Indicate each type of review performed. List the amount of savings including zero when applicable. Complete the "no actions taken" field if there were no discrepancies. The actual cost and length of physical therapy and chiropractic services must be documented even if there are no savings).

A. **Pre-admission Review** Diagnosis Code _____ CPT Code _____
 Requested length of stay _____
 Authorized length of stay _____
 Actual length of stay _____ Date _____ -
 Identified discrepancy code _____
 In-Patient Savings \$ _____

Comments _____

B. **Concurrent Review** Diagnosis Code _____

Procedure	CPT Code	Identified Discrepancy Code	Cost
TOTAL SAVINGS			\$

Comments _____

C. **Retrospective Review**

Diagnosis Code _____

Procedure	CPT Code	Identified Discrepancy Code	Cost
TOTAL SAVINGS			\$

Comments _____

D. **Chiropractic Services**

Diagnosis Code _____

Requested Service	Cost	Authorized Service	Discrepancy Code	Savings
TOTAL SAVINGS				\$

Length of Treatment _____ (Number of Weeks)

Total Cost of Treatment \$ _____

Comments _____

E. **Physical Therapy**

Diagnosis Code _____

Procedure	CPT Code	Identified Discrepancy Code	Cost
TOTAL SAVINGS			\$

Length of Treatment _____ (Number of Weeks)

Total Cost of Treatment \$ _____

Comments _____

F. No actions were taken.

G. Cost of Utilization Review \$ _____

H. Reviewer's Name _____

UTILIZATION REVIEW CLOSURE FORM INSTRUCTIONS

The State of Tennessee guidelines, requires Utilization Review (UR) providers be certified by accreditation from the Utilization Review Accreditation Commission (URAC), or be compliant with minimum UR standards. Authority: Tennessee Code Annotated, Section 50-6-704, (Section 8 of chapter 812 of the Public Acts of 1992).

The original two-sided utilization review closure form should be submitted to the State of Tennessee, Department of Labor, Division of Workers' Compensation following the conclusion of utilization review services.

Please indicate the type of review(s) performed. List the primary ICD 9 code next to the type of review (for pre- admission review, list the primary admission diagnosis); list other ICD 9 codes on the comment line. CPT codes should be documented.

List the applicable discrepancy code from the list below when a discrepancy is found during a review. If there were no discrepancies, check the "no actions taken" field.

In addition to the reviewed information, all fields above letter "A" and below letter "E" are required to be completed. The actual length and cost of physical therapy and chiropractic services must be documented regardless of findings.

Discrepancy codes

- 01 Inappropriate level of service
- 02 Not medically indicated
- 03 Length of stay exceeds authorization
- 03.1 Length of stay exceeds authorization but is justified
- 03.2 length of stay exceeds authorization and is not justified