CITY OF Richmond CALIFORNIA

# CARVE-OUT PRIOR AUTHORIZATION PROGRAM: CITY OF RICHMOND

Date: _____

Re: Employee: _____
Employer: City of Richmond
DOI: _____
Claim #: _____

To Whom It May Concern:

Please be advised that the City of Richmond has a Prior Authorization Program. This program allows you to proceed with treatment and/or ancillary services without having to send a written request for authorization (RFA) and we guarantee payment for these services. The treating physician will be responsible to determine what treatment and/or services are reasonable and necessary to cure the effects of the injury.

Please post the following authorization in your clinic for future reference and/or copy and attach to any billing that meets this requirement. If you have any issues regarding the non-payment of a submitted bill under this program and you have included this notice as verification of your authorization, contact Tricia Baker, AVP Operations AIMS at (916) 563-1900.

PLEASE NOTE: All of the listed procedures and ancillary services should be provided by the City of Richmond's vendor referral program (see attached Vendor Referral Forms).

If you have any questions regarding the above, please feel free to contact me at (510) 620-6974 or e-mail at Laura_Marquez@ci.richmond.ca.us.

Sincerely,

Laura Marquez
Assistant Risk Manager

CITY OF Richmond CALIFORNIA

**Please Provide This Letter to Your Treating Physician**

**SUBJECT: CITY OF RICHMOND PRIOR AUTHORIZATION PROGRAM**

The Prior Authorization Program allows medical providers to provide medical procedures on accepted and delayed claims without Utilization Review or submitting a Request for Authorization for the Examiner to approve.

**The Prior Authorization Program will include the following procedures or ancillary services:**

Up to 24 Physical Therapy Sessions
Up to 24 Chiropractic or Acupuncture Sessions
Routine Office Visit and Follow Ups
Specialty Referrals
MRI or CT Scan
EMG/NCS
X-Rays
Basic Durable Medical Equipment: Splints, crutches, braces, cane, walker, standard wheelchair rental, off-the-shelf braces, walking boots, slings, hot and cold packs.

No provider authorization letters will be sent by the City claims administrator or designated Utilization Review Organization for the procedures or services that fall under this Program.

All vendors who schedule Physical Therapy sessions, conduct Diagnostic Testing and/or supply Durable Medical Equipment have committed to contact the injured worker within 1 working day of receipt of referral (from the doctor or from AIMS) and the first appointment will take place within 5 working days from the referral date. If your treating physician is making the Specialty Referral please contact AIMS immediately to advise and assist with the scheduling and coordination of medical records. AIMS can be reached at (916)563-1900.

Specialist referrals generally take anywhere from 14 to 21 working days for the initial visit, as these offices are not set up as Urgent Care Facilities that process/handle large volume of injured employees. If the referral is sent through AIMS you will be contacted within 1 working day of receipt of the referral to discuss a specialist and be provided assistance in scheduling said appointment.

CITY OF Richmond CALIFORNIA

# Contracted Managed Care Providers

| For MRI or CT Scan |
| --- |
| ***Coast to Coast Diagnostics***<br>www.c2cdiagnostics.net<br>Phone 800-730-9263<br>Fax 800-664-2440<br>www.c2cdiagnostics.net/scheduling |

| For Physical Therapy or Chiropractic Treatment |
| --- |
| ***MedRisk***<br>www.medrisknet.com<br>Phone 800-225-9675 Fax 877 455-4440 email<br>medriskreferrals@medrisknet.com |

| For Durable Medical Equipment |
| --- |
| ***Conexus***<br>Fax 844-821-3632<br>Phone 844-261-2996<br>Referral@conexusmedical.com<br>www.conexusmedical.com |

## CONEXUS MEDICAL E-MAIL/FAX REFERRAL FORM

**E-mail Address: referral@conexusmedical.com**

**Or Fax To: 844-821-3632**

*****To expedite requests for City of Richmond injured employees, please submit form and the Rx**

**PHYSICIAN NAME:** _____ **REQUEST DATE:** _____/_____/_____

**PHONE:** (  ) _____ **FAX:** (  ) _____

**CLAIMANT/PATIENT INFORMATION**

**PATIENT NAME:** _____ **D.O.B.:** _____/_____/_____

**GENDER:** _____ **HEIGHT:** _____ **WEIGHT:** _____ **DOI:** _____/_____/_____

**ADDRESS:** _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

**PHONE: (  )**_____ **SECONDARY PHONE:** (  ) _____

**REFERRAL INFORMATION**

**DELIVERY DATE:** ____/____/_____ **SURGERY DATE:** ____/____/_____

**EQUIPMENT NEEDED /QUANTITY:**

**DME** ☐**Purchase** ☐ **Rent** If rental, duration? _____

ITEM(S): _____

**DIAGNOSTIC TESTING** Test(s): _____

**HEARING AIDS/TESTING** Notes: _____

**HOME HEALTH CARE** Services: _____

**NOTES /ADDITIONAL INFORMATION:**


## CONEXUS MEDICAL E-MAIL/FAX REFERRAL FORM

**E-mail Address: referral@conexusmedical.com**

**Or Fax To: 844-821-3632**

*****To expedite requests for City of Richmond injured employees, please submit form and the Rx**

**PHYSICIAN NAME:** _____ **REQUEST DATE:** _____/_____/_____

**PHONE:** (  ) _____ **FAX:** (  ) _____

**CLAIMANT/PATIENT INFORMATION**

**PATIENT NAME:** _____ **D.O.B.:** _____/_____/_____

**GENDER:** _____ **HEIGHT:** _____ **WEIGHT:** _____ **DOI:** _____/_____/_____

**ADDRESS:** _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

**PHONE: (  )**_____ **SECONDARY PHONE:** (  ) _____

**REFERRAL INFORMATION**

**DELIVERY DATE:** ____/____/_____ **SURGERY DATE:** ____/____/_____

**EQUIPMENT NEEDED /QUANTITY:**

**DME** ☐**Purchase** ☐ **Rent** If rental, duration? _____

ITEM(S): _____

**DIAGNOSTIC TESTING** Test(s): _____

**HEARING AIDS/TESTING** Notes: _____

**HOME HEALTH CARE** Services: _____

**NOTES /ADDITIONAL INFORMATION:**

Coast 2 Coast MEDICAL NETWORK
A Medical Corporation
Superior service. Results you can count on

# TPA – AIMS
## Employer: The City Of Richmond
# Diagnostic Referral and Script for Services

**Phone: 800-730-9263 - Fax: 800-644-2440**
**orders@c2cdiagnostics.net**
**www.C2CDiagnostics.net**

**SCHEDULE AN APPOINTMENT**

| | |
|---|---|
| Patient's Name * | |
| Patient's Address * | |
| Patient's City, State Zip * | |
| Patient's Home Phone * | |
| Patient's Work Phone | |
| Patient's E-mail | |
| Patient's Date of Birth * | |
| Last 4# of Patient's Social Security Number | |
| Employer Name | City of Richmond |
| Insurance Company | AIMS PO Box PO Box 269120, Sacramento, CA 95827<br>Fax: (916)563-1919 Phone: (916)563-1900 |
| Insurance Claim Number (if known) | |
| Date of Injury (mm/dd/yyyy) | |
| Prescription Details | |
| Films? With contrast, without, etc. | |
| Special Request | |
| Body Part | |
| Referring Physician | |
| Referring Physician's Address | |
| Contact | |
| Referring Physician's Phone | |
| Referring Physician's Fax | |
| Physician's Signature & Date | |
| Contact information to e-mail or fax reports | |

# Physician's Referral Form for Physical Medicine

Please use this form to refer your patient to MedRisk's national network of expert providers, specializing in the treatment of work-related injuries. **Please email to: medriskreferrals@medrisknet.com or fax to 877-455-4440.** If you have any questions call MedRisk at 800-225-9675. Thank you.

## Submission Information

**Submitted By: Referring Physician**

Physician Name: _____

Physician Phone: _____

Adjuster Name: _____ Phone #: _____ Email: _____

NCM Name: _____ Phone #: _____ Email: _____

Payer Name: **AIMS**

## Patient Information

Claim Number: _____

First Name: _____ Last Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Last 4 SS: _____ Patient Language: _____

Patient Phone: _____ Additional Phone: _____

Diagnosis: _____ Body Part: _____ Date of Injury: _____

Employer: _____ Jurisdiction State: **CA**

**Services Prescribed:** ☐ Physical Therapy ☐ Occupational Therapy ☐ Chiropractic Care ☐ Aquatic Therapy

☐ Acupuncture ☐ Functional Capacity Evaluation ☐ Hand Therapy ☐ Work Conditioning/Work Hardening

# Visits Authorized: _____ Frequency: _____ Duration: _____

Special Instructions: _____

_____

I hereby certify these services as medically necessary for the patient's plan of care:

Physician Signature: _____ Date: _____