RADIUS
PHYSICAL + SPORTS REHAB

Our priority is to ensure a smooth, effective return to work and to the life you enjoy! We help people improve the quality of their lives by eliminating pain efficiently and effectively—so you can get back to doing what matters most.

Understanding The Process of Your Workers' Compensation Care

1. Pre-Authorization Is Required

Radius must receive written approval (typically a Request for Authorization, or "RFA", signed by your insurance adjuster, or a letter from your insurance company) before starting treatment—even if your doctor already recommended it. They typically approve between 6 and 12 visits at a time.

- The RFA comes from your Primary Treating Physician (PTP) to your insurance company for approval. Your PTP only sends out this request for authorization if/when you have an appointment with your PTP in which they recommend physical therapy, chiropractic care, or massage.
- You may experience delays in starting or continuing care, due to the process detailed above. Let us know if you do.
- Radius is not a Primary Treating Provider for Workers Compensation, your PTP is likely the first MD you saw for this injury/case.

2. Treatment Is Limited to What's Approved

Radius and its providers must follow what's authorized by the insurer and based on state guidelines (MTUS). Specifically:

a. The number of visits, per authorization
b. The diagnosis (or area of the body) specified in the authorization

3. Progress Must Be Documented

Your Radius Provider must regularly report your progress to the adjuster.
You may be asked to complete extra forms or evaluations during care.

4. Scheduling Is Time-Sensitive

Appointments and reports must meet insurer timelines. Missed sessions can disrupt care or additional authorizations.

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5. Risk of Discharge for Inactivity

If you stop attending or communicating, the clinic must notify the insurer and may discharge you.
Extended gaps may lead to your case being delayed or closed prematurely.

> ⚠️ **Tip:** Stay in touch with your PT clinic, attend appointments, and let us know if anything is preventing you from participating in care. We're here to help you heal—within the guidelines we're required to follow.

Scheduling & Attendance

- We schedule out the full authorization at time of receipt.
- **Only one visit per day** is allowed under WC regulations - even if the visit type is different (i.e. Physical therapy and Massage therapy must take place on separate days).
- We **cannot schedule without the authorization** in hand.
- There is a **$50 late cancellation fee** for missed or cancelled visits without proper notice (48 hours) that is the responsibility of the patient.
- You have **3 months from the date of authorization approval** to complete the authorized care with us.
    - Please reach out to your adjuster if you need an extension.

What Can Be Treated

- We can **only treat the body part(s)** listed on your authorization.
- If you're experiencing pain elsewhere, talk to your Primary Treating Physician (PTP). Only your PTP can submit a request for additional services.
- **We offer:** Physical Therapy, Massage, Chiropractic, Shockwave

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How Authorizations, and Re-authorizations Work

- You must see your **Primary Treating Physician (PTP)** and discuss any care you'd like to receive.
- Only your PTP can determine whether additional care is clinically indicated. We recommend **scheduling your PTP visit a few days before your current authorization ends** to allow time for processing

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.Authorization Limits:

Per California Labor Code § 4604.5:

- You are limited to **24 visits per injury** for Physical Therapy, Chiropractic, and Acupuncture.
- This is a **“soft” cap**—more visits can be approved if your PTP documents medical necessity and it's approved through **Utilization Review (UR)**.
- Your Workers’ Compensation insurance will **approve, deny, or modify** the request.
- If denied, **appeals must be timely**—talk to your PTP.
  ➤ *Note: We do not receive denial notices, so it is important you notify us if you've been denied.*

What Happens If Your Requested Care Is Denied?

If your doctor recommends treatment and your Workers’ Compensation insurance denies it, don’t panic—you have rights and options. Here’s what you need to know:

Denial Through Utilization Review (UR)

When your doctor submits a Request for Authorization (RFA), the insurance company is required to review and decide whether to approve it. They must respond within:

- ***5 business days** (or up to **14 days** if more information is requested)*

*Only a **licensed physician reviewer**, not your claims adjuster, can issue a denial or change your treatment plan.*

If the treatment is denied, the insurance company must send you:

- *A written explanation of the denial*
- *An **Independent Medical Review (IMR)** form*
- *A pre-addressed envelope to return the form if you want to appeal*

Your Rights After a Denial

*If your treatment is denied because the insurer claims it's not medically necessary, you have the right to **request an Independent Medical Review (IMR)**—a neutral process where a third-party doctor reviews your case.*

- *You must submit the IMR form **within 30 days** of receiving the denial notice.*
- *If you miss the 30-day deadline, the denial will remain in effect for **12 months**, unless:*
    - *Your condition **significantly changes**, or*
    - *New medical evidence is available to support the request*

*Your **treating doctor can help** submit documentation for the IMR.*

What Is an Independent Medical Review (IMR)?

- *The IMR is conducted by a neutral doctor assigned by the state—not your insurance.*
- *This doctor decides if the treatment is medically necessary.*
- *If the IMR agrees with your treating doctor, the insurance must approve and pay for the treatment.*

What If the Insurance Company Doesn't Respond?

*If your insurance company **does not respond** within the legal time frame for UR:*

***Standard UR decision deadline**:*
*The claims administrator must make a decision **within 5 working days** from the date your doctor submits the RFA*

***If more information is needed**:*
*The decision must be made within **14 days** from the original request date—even while additional documentation is pending*

***Expedited review (for urgent care)**:*
*If the case is serious (e.g., potential loss of life, limb, or bodily function), the claims administrator must decide **within 72 hours** after receiving the necessary information.*

***If no response after 14 days**:*
*Your doctor may file a **Declaration of Readiness to Proceed** to request a hearing. **The claims administrator cannot object to the treatment** if they failed to meet the UR deadline*

Penalties for Unfair Denials

*If the insurance company **unreasonably delays or denies** care you can report the issue to the **DWC Audit Unit**, or get support from your local **Information & Assistance (I&A) Office**.*

The 12-Month Rule

*If you **don't file an IMR** after your care is denied:*

- *That specific treatment **cannot be requested again for 12 months***
- *Exceptions apply if:*
  - *There's a **significant change** in your condition, or*
  - ***New medical evidence** justifies the request*

Take Action Early:
Talk to your treating physician as soon as you receive a denial. Timely follow-up ensures your options stay open and your care stays on track.

Let your clinic know if you need help—we're here to guide you through it.

Transportation Assistance

Workers' Compensation will often cover transportation if your injury limits your ability to drive.

- If this is a limiting factor—especially if your injury prevents you from driving—contact your **nurse case manager** or **adjuster**.

Navigating Insurance

We're here to support you every step of the way.

- If your WC insurance—or a third-party administrator (TPA)—contacts you, please let us know.
- We'll help make sense of the information or requests they provide.

Sent Elsewhere, but Prefer Radius?

- If you're approved but sent to a clinic you didn't choose, you can request your preferred clinic (like ours) to ask for authorization.

- We can reach out to your adjuster on your behalf if you would like your authorization sent to Radius—for **continuity of care and easier scheduling**.

When Claims End

Your Workers' Comp case may close for several reasons:

- **Maximum Medical Improvement (MMI):** Active treatment ends; case remains open for benefits.
- **Compromise & Release:** Full settlement; case is closed.
- **Stipulated Award:** Some future medical care may remain open.
- **Findings and Award (Trial):** Mostly closed; some future medical may be available.
- **5 Years of Inactivity:** Case may be administratively closed.
- **Non-Compliance:** If you stop participating in care, this may be seen as non-compliance.

Inactivity Risks

Failing to attend appointments or discontinuing care without explanation may:

- Be interpreted as **non-compliance**
- Trigger **Utilization Review (UR)** denials
- Cause your claim's administrator to question your ongoing eligibility

Common thresholds:

- **30–60 days** of unexplained inactivity may trigger concern
- **90+ days** often leads to administrative review or closure
- **12+ months** without treatment, temporary disability (TD) payments, communication, or legal filings may result in the claim being considered **abandoned**

In Our Office:

If reschedules or cancellations disrupt continuity of care, we are required to notify your PTP.

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Third-Party Administrators (TPAs)

Many Workers' Compensation carriers in California use **TPAs** to handle claims and services.
TPAs manage injury claims under contract with insurance companies, insurance funds, or self-insured employers.

🩺 When Do You Need a QME?

A **Qualified Medical Evaluator (QME)** is a neutral physician who helps resolve disputes in your claim. You may need a QME if:

- **Your Claim Is Denied**
  The QME evaluates if your injury is work-related and should be covered.
  There's a Dispute About Your Condition
    - You disagree with your treating doctor's report
    - You're told you've reached MMI or P&S status but disagree
    - Further treatment is denied
- **You Don't Have a Treating Doctor in the Employer's MPN**
  A QME helps determine your care needs.
- **Permanent Disability Rating Is Needed**
  After MMI, the QME assigns a rating which impacts benefits and settlements.
- **You're Unrepresented and Disagree With the Insurer**
    - You can request a **QME panel** from the Division of Workers' Compensation (DWC)
    - You must **choose a doctor within 10 days**, or the insurance company will choose for you

⚠️ **Important:**
Your QME appointment is **critical**. Don't miss it—this evaluation can impact your treatment, return-to-work status, and benefits.