

[~Current Date~]

Attn: Director of Claims

[~Insurance Policy #1 Carrier~]

[~Insurance Policy #1 Address~]

Re: Patient: [~Patient Name~]
Policy: [~Insurance Policy #1 Number~]
Insured: [~Responsible Party Name~]
Treatment Dates: [~Admission Date~] - [~Discharge Date~]
Amount: [~Total Charges~]

Dear Director of Claims,

According to our records, your company is reviewing the medical records related to the above referenced treatment. It appears that your company is an accredited member of URAC's utilization management program. As you are likely aware, URAC routinely review's member organization's operations to ensure that members are conducting business in a manner consistent with national standards agreed upon during the accreditation process. One of these standards protects medical providers from the burden of overly broad requests for unnecessary medical documentation.

Please review your request for additional medical documentation for compliance with Standards UM 44-46 which states:

The organization, when conducting routine prospective review, concurrent review, or retrospective review:

- (a) Accepts information from any reasonable reliable source that will assist in the certification process;
- (b) Collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services
- (c) Does not routinely require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available;
- (d) Does not routinely request copies of all medical records on all patients reviewed;
- (e) Requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequently or duration of service, or length of anticipated inability to return to work; and
- (f) Administers a process to share all clinical and demographic information on individual patients among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from enrollees or providers. **(Standard UM 44)**

For prospective review and concurrent review, the organization bases review determinations solely on the medical information obtained by the organization at the time of the review determination. **(Standard UM 45)**

For retrospective review, the organization bases review determinations solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided. **(Standard UM 46)**

It is our position that your request may be more expansive than is necessary to justify the treatment. Therefore, we request that a complete explanation be provided for the need for additional records or that the specific items from the medical records be identified so that those records alone can be submitted for review. Thank you for your assistance

in this matter.

Sincerely,

Claims Analyst