MEDREVIEW

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Utilization Review Plan

Contents

Introduction

MedReview's utilization review process is pursuant to and in compliance with Labor Code Sections 4610, 4610.5, and title 8, California Code of Regulations (CCR), Sections 9792.6.1 through 9792.10.1.

MedReview's utilization review process is governed by written policies and procedures that ensure decisions are based on medical necessity to cure and relieve treatment recommendations by physicians. All decisions are consistent with the California Medical Treatment Utilization Schedule (MTUS), including the drug formulary, adopted pursuant to Labor Code Section 5307.27. MedReview updates and reviews the treatment guidelines per CCR Section 9792.25.1(a) MTUS Methodology for Evaluating Medical Evidence.

Pursuant to CCR 9792.6.1(v), "Reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice.

Pursuant to Labor Code Section 4610(g)(3)(B)(i), MedReview shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications or denials made by the physician under this section.

A "utilization review decision" means a decision pursuant to Labor Code Section 4610 to approve, modify, or deny a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code Sections 4600 or 5402(c).

This Utilization Review Plan is available to the public upon request. The claims administrator may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed $0.25 per page plus actual postage costs.

Medical Director and Personnel

MedReview's Medical Director is William Logan Tontz, Jr., M.D. Dr. Tontz is a practicing physician and surgeon who holds an unrestricted license to practice medicine in the State of California. Dr. Tontz's specialty is Orthopedic Surgery.

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The Medical Director ensures that the process by which MedReview prospectively, retrospectively, or concurrently reviews and approves, modifies, or denies treatment recommendations by physicians complies with the requirements of Labor Code Section 4610. Pursuant to CCR Section 9792.6.1(o), the Medical Director is a physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California.

The Medical Director is responsible for all utilization review decisions. In addition to his duties as a reviewer, he is available to suggest courses of action to secure the medical information necessary to complete a review; available to provide additional resources of information to aid the non-physician reviewers with the primary review process; provides input and guidance to the other reviewers where appropriate; communicates with the requesting physicians when appropriate; reviews policies regarding the utilization review process; and provides educational information to the non-physician reviewers.

MedReview's Utilization Review is comprised of contracted physician reviewers licensed to practice in any state or the District of Columbia by their appropriate licensing boards, non-physician reviewers, consisting of licensed, certified, and trained health professionals, and assisting clerical personnel.

MedReview's physician reviewers are competent to evaluate the specific clinical issues involved in medical treatment services and, where these services are within the reviewer's scope of practice, may approve, modify, or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury. Reviewers function as a secondary review when the non-physician reviewer is unable to approve medical treatment per appropriate guidelines.

MedReview's non-physician reviewers are comprised of individuals who possess an active, professional license or certification to practice as a health professional (Registered Nurse (RN), Certified Medical Assistant (MA) and Licensed Vocational Nurse (LVN)). MedReview's non-physician reviewers function as a primary reviewer applying specific criteria to requests for authorization for medical services. The non-physician reviewer may approve requests for authorization of medical services. The non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appears to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization. The non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision, but in no event, shall this exceed the time limitations per regulations. The non-physician reviewer shall not modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve or due to incomplete or insufficient information

MedReview's clerical personnel assist in the utilization review process by assigning received requests for authorization of medical treatment for initial review by a non-physician reviewer. Additionally, the clerical personnel are available to answer telephone calls between the hours of 9:00 a.m. to 5:30 p.m., on business days, for healthcare providers to request authorization for medical services.

MedReview's transcription personnel proofreads and formats the reviewers' typed decisions and drafts MedReview letters.

Utilization Review Process

Receipt of Request for Authorization

MedReview personnel are available by telephone from 9:00 a.m. to 5:30 p.m., on business days, to receive treatment requests. A facsimile number is maintained for after-hours treatment requests. The utilization review process for responding to a treatment request begins when the request for authorization is first received by mail, facsimile, or electronic mail.

Pursuant to CCR Section 9792.9.1(c)(2)(A), upon receipt of a request for authorization as described in subdivision (c)(2)(B), or a DWC Form RFA that does not identify the employee or provider, does not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity for the requested treatment, or is not signed by the requesting physician, a non-physician reviewer, as allowed by Section 9792.7, or reviewer must either regard the request as a complete DWC Form RFA and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete," specifying the reasons for the return of the request no later than five (5) business days from receipt. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

Utilization review of a medical treatment request may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

Unless additional information is requested necessitating an extension, the utilization review process shall meet the required timeframes.

The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA, pursuant to CCR Section 9792.9.1(c)(1).

Pursuant to Labor Code Section 4610(b)-(c), for all dates of injury occurring on or after January 1, 2018, any request(s) for authorization received for emergency treatment services and medical treatment rendered, for a body part or condition that is accepted as compensable by the employer, within the 30 days following the initial date of injury shall be authorized without prospective utilization review, except as provided in subdivision (c).

Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

- ~ Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.
- ~ Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.
- ~ Psychological treatment services.
- ~ Home health care services.
- ~ Imaging and radiology services, excluding X-rays.
- ~ All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule.
- ~ Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
- ~ Any other service designated and defined through rules adopted by the administrative director.

Timeframes and Notification

Prospective or concurrent utilization review decisions will not exceed five (5) business days from the date of receipt of the request for authorization. During the utilization review process, the reviewer or non-physician reviewer shall request information reasonably necessary to make a determination from the treating physician within five (5) business days from the date of receipt of the request for authorization.

Prospective decisions regarding requests for treatment covered by the MTUS Drug Formulary shall be made no more than five working days from the date of receipt of the medical treatment request.

Prospective or concurrent decisions related to an expedited review will not exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. A request

for expedited review must be supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review would be detrimental to the injured worker's condition.

Retrospective decisions shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination.

All decisions to approve a request for authorization shall specify the following:

- ~ The date the request for authorization was first received.
- ~ The medical treatment service requested.
- ~ The medical treatment service approved.
- ~ The date of the decision.

Prospective, concurrent, or expedited approvals shall be communicated to the requesting physician within 24 hours of the decision, initially by telephone, facsimile, or, if agreed to by the parties, secure email. Telephone communication of the decision shall be followed with a written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review. For retrospective approvals, the written decision shall be communicated to the requesting physician, the injured worker, and his or her attorney/designee, if applicable.

Pursuant to CCR Section 9792.6.1(a), 'Authorization' means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury.

Payment, or partial payment, of a medical bill for services requested, within the 30-day timeframe, shall be deemed a retrospective approval.

Pursuant to CCR Section 9792.9.1(e)(1), the review and decision to deny or modify a request for medical treatment must be conducted by a reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice.

Prospective, concurrent, or expedited decisions to modify or deny shall be communicated to the requesting physician within 24 hours of the decision, initially by telephone, facsimile, or, if agreed to by the parties, secure email. Telephone communication of the decision shall be followed with a written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.

For retrospective decisions to deny part or all of the requested medical treatment, the written decision shall be communicated to the requesting physician, the injured worker, and his or her attorney/designee, if applicable, within 30 days of receipt of request for authorization and medical information that is reasonably necessary to make a determination.

Written decisions to modify or deny requests for authorization shall be provided to the requesting physician, the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall be signed by either the claims administrator or the reviewer, and shall only contain the following information specific to the request, pursuant to CCR Section 9792.9.1(e)(5):

~ The date on which the request for authorization was first received.

~ The date on which the decision is made.

~ A description of the specific course of proposed medical treatment for which authorization was requested.

~ A list of all medical records reviewed.

~ A specific description of the medical treatment service approved, if any.

~ A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to Section 9792.8. If a utilization review decision to modify or deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision, the specific information that is needed, the date(s) and time(s) of attempts made to contact the physician to obtain the necessary information, and a description of the manner in which the request was communicated.

~ The Application for Independent Medical Review, DWC Form IMR, with all fields, except for the signature of the employee, to be completed by the claims administrator. The application, set forth in Section 9792.10.2, and the written decision provided to the injured worker shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.

~ A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code Section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 10 days after service of the utilization review decision(s) for formulary disputes and 30 days after service of the utilization review decision(s) for all other medical treatment disputes.

~ The following mandatory language:

  ~ "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.

  and

  ~ "For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

~ Details about the claims administrator's internal utilization review appeals process for the requesting physician and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code Section 4610.5 and 4610.6, but may be pursued on an optional basis.

~ The written decision modifying or denying treatment authorization provided to the requesting physician containing the name and specialty of the reviewer or expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision discloses the hours of availability of either the reviewer, the expert reviewer, or the medical director for the treating physician to discuss the decision which is, at a minimum, four (4) hours per week during normal business hours, 9:00 a.m. to 5:30 p.m., Pacific Time, or an agreed upon scheduled time to discuss the decision with the requesting physician. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Emergency Health Care Services and Concurrent Decisions to Deny

Pursuant to CCR Section 9792.6.1(i), "Emergency health care services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy. Emergency health care services do not require prior authorization and may be subjected to retrospective review. Pursuant to CCR Section 9792.9.1 (e)(2), failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services

may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.

A concurrent decision to deny authorization for medical treatment must meet the following requirements prior to discontinuation of medical care:

- ~ The requesting physician shall be notified of the decision.
- ~ A care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee.
- ~ Medical care provided during the review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.

Timeframe Extension

Except for treatment requests made pursuant to the MTUS Drug Formulary, when additional information reasonably necessary to make a determination is requested necessitating a timeframe extension, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization.

If the requested information is not received within fourteen (14) days from the receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

A reviewer may ask for the following:

- ~ An additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.
- ~ A specialized consultation and review of medical information by an expert reviewer.

When a reviewer asks for the above, the reviewer shall, within five (5) business days from the date of receipt of the request for authorization, notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, in writing, that the reviewer cannot make a decision within the required timeframe. The written notification will include the anticipated date on which a decision will be rendered.

If the results of the additional examination or test are not received within thirty (30) days from the receipt of the completed request for authorization for prospective, concurrent, or retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

Upon receipt of the requested information:

- ~ For prospective and concurrent review:

- a non-physician reviewer shall make the decision to approve the request for authorization within five (5) business days of receipt of the information
  or
- a reviewer shall make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information.

The requesting physician shall be notified by telephone, facsimile, or, if agreed to by the parties, secure email within 24 hours of making the decision. The written decision shall include the date the information was received and the decision shall be communicated in the manner set out in Section 9792.9.1(d) or (e), whichever is applicable.

~ For prospective and concurrent decisions related to an expedited review:
- a non-physician reviewer shall make the decision to approve the request for authorization within 72 hours of receipt of the information
  or
- a reviewer shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information.

The requesting physician shall be notified by telephone, facsimile, or, if agreed to by the parties, secure email within 24 hours of making the decision. The written decision shall include the date the information was received and the decision shall be communicated in the manner set out in Section 9792.9.1(d)(2) or (e)(3), whichever is applicable.

~ For retrospective review:
- a non-physician reviewer shall make the decision to approve the request for authorization within thirty (30) calendar days of receipt of the information
  or
- a reviewer shall make the decision to approve, modify, or deny the request for authorization within thirty (30) calendar days of receipt of the information.

The written decision to approve shall include the date it was made and shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.

The written decision to deny part or all of the requested medical treatment shall include the date it was made and shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of request for authorization and medical information that is reasonably necessary to make a determination.

Documentation

Pursuant to CCR Section 9792.9.1(g), whenever a reviewer issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the claims administrator's file must document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail.

Pursuant to Labor Code Section 4610(k), a utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Utilization Review Decision-Making Process

Pursuant to Labor Code Section 4610(h), the criteria or guidelines used in MedReview's utilization review process to determine whether to approve, modify, or deny medical treatment services are all of the following:

- Developed with involvement from actively practicing physicians.
- Consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.
- Evaluated at least annually and updated if necessary.
- Disclosed to the physician and the employee, if used as the basis of a decision to modify or deny services in a specified case under review.
- Available to the public upon request (no copying fees apply).

Non-physician reviewers and reviewers conduct the following medical evidence search sequence for the evaluation and treatment of injured workers:

- ~ Search the recommended guidelines set forth in the current MTUS to find a recommendation applicable to the injured worker's medical condition or injury.
- ~ In the limited situation where a medical condition or injury is not addressed by the MTUS or if the MTUS' presumption of correctness is being challenged, then:
    - o Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in Section 9792.25.1.
- ~ If no applicable recommendation is found in ACOEM or ODG, or if the reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then:
    - o Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury. Medical treatment guidelines can be found in the National Guideline Clearinghouse. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in Section 9792.25.1.

- ~ If no applicable recommendation is found in the National Guideline Clearinghouse, then:
    - o Search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in Section 9792.25.1. A search for peer-reviewed published studies may be conducted by accessing the U.S. National Library of Medicine's database of biomedical citations and abstracts.

IMR Appeals Process

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code Section 4610.5 and 4610.6. An objection to the utilization review decision(s) must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on the injured worker's behalf on the Application for Independent Medical Review, DWC Form IMR, enclosed with the Utilization Review decision, within 10 days after service of the utilization review decision(s) for formulary disputes and 30 days after service of the utilization review decision(s) for all other medical treatment disputes.

Pursuant to Labor Code section 4610.5(h)(1)(A)-(B), the employee may submit a request for independent medical review to the division. The request may be made electronically under rules adopted by the administrative director.

The request shall be made no later than as follows:

(A) For formulary disputes, 10 days after the service of the utilization review decision to the employee.
(B) For all other medical treatment disputes, 30 days after the service of the utilization review decision to the employee.

Workers' Compensation Alternative Dispute Resolution Programs

Some clients have employees that belong to Police Officers' Associations and Fire Fighters' Associations. A portion of these associations have agreed upon Alternate Dispute Resolution (ADR) programs. These ADR processes replace the Independent Medical Review (IMR) procedures.

Utilization Review Appeals Process

The Internal Utilization Review Appeals Process (Appeal) is as follows:

It is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code Sections 4610.5 and 4610.6, but may be pursued on a voluntary basis. The injured worker or the treating physician must request an Appeal of the decision(s) within 10 days after receipt of the utilization review decision(s) by submitting additional information. The determination of the Appeal will be issued within 30 days of receipt of the Appeal. An Appeal shall be considered complete upon the issuance of a final Independent Medical Review (IMR) determination.

For information about the Workers' Compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll free 1-800-736-7401.

Confidentiality Policy

Due to the nature of our work, it is imperative that employees maintain strict confidentiality when it comes to our clients' matters as well as our own policies and procedures. A breach of confidentiality will result in disciplinary action, including possible termination of employment.

Confidentiality Policy (Physician Reviewers)

Consultant agrees to maintain the confidentiality provisions of the materials reviewed and discussions conducted hereunder. Consultant understands and agrees that all information or data that Consultant receives from Administrator, or at the direction of Administrator, in connection with the process of providing services hereunder will be deemed confidential and may not be disclosed to anyone other than Administrator or its employees directly responsible for working with Consultant.

Definitions

Concurrent Review: Utilization review conducted during an inpatient stay. CCR Section 9792.6.1(c).

Expedited Review: Utilization review or independent medical review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to the potential loss of life, limb, or other major bodily functions, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function. CCR Section 9792.6.1(j).

Prospective Review: Any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services. CCR Section 9792.6.1(s).

Retrospective Review: Utilization review conducted after medical services have been provided and for which approval has not already been given. CCR Section 9792.6.1(u).

Physician Review Services

MedReview Inc. contracts with the following physicians/companies for <u>Physician Review</u> services:

Neil S. Ghodadra, M.D.
Orthopedic Surgery
License No. A 116163

Roman A. Shulze, D.O.
Family Practice and Occupational Medicine
License No. 8047

Aaron Emil McCoy, D.O.
Anesthesiology
License No. 15451

Scott McElmeel, M.D.
Anesthesiology
License No. C 153971

John V. Flores, PhD, MBBS, D.C.
Chiropractic and Sports Medicine
License No. 25215

William L. Tontz, M.D.
Orthopedic Surgery
License No. A 69746

Leslie R. Cadet, M.D.
Occupational Medicine
License No. A 164363

Advanced Medical Reviews, Inc.
Medical Director: Charles Totaro Carnel, M.D.
Medical Director Specialty: Physical Medicine & Rehabilitation
Medical Director License No. MD.27631 (Alabama)

MedReview Inc. contracts with the following physicians/companies for <u>Expert Review</u> services:

Network Medical Review Co. Ltd.
Medical Director: Robert C. Porter, M.D.
Medical Director Specialty: Occupational Medicine
Medical Director License No. 33237