

MEDREVIEW

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Utilization Review Plan

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Purpose and Scope

MedReview's Utilization Review Plan is pursuant to revised regulations effective April 1, 2026 and in compliance with Labor Code Sections 4610, 4610.5, and title 8, California Code of Regulations (CCR), Sections 9792.6.1 through 9792.12.

MedReview holds accreditation through the Workers' Compensation Utilization Management Accreditation program administered by URAC.

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(w)(1), "Reviewer" or "physician 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 or physician reviewer's practice.

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 upon request by the public, the claims administrator shall make available the complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process. The claims administrator may make available through electronic means. If a member of the public requests a hard copy of the utilization review plan, 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.

Definitions

The definitions in this section apply to requests for authorization of medical treatment made under Article 5.5.1 for: (1) occupational injuries or illnesses occurring on or after January 1, 2013; and (2) any request where the utilization review decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury. (8 CCR § 9792.6.6.)

URAC: The non-profit organization, located at 1220 L Street, NW, Suite 900, Washington, D.C., 20005, or as indicated online at, that provides accreditation for workers' compensation utilization review programs.

Authorization: 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 pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed "Request for Authorization," as defined in this section, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, sections 9792.9.1 through 9792.12.

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

Denial: A decision by a physician reviewer that the requested treatment or service is not authorized. CCR Section 9792.6.1(f).

Dispute of Liability or Liability Dispute: An assertion by the claims administrator that a factual, medical, or legal basis exists, other than medical necessity, that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment. CCR Section 9792.6.1(g).

Emergency Health Care Services: 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. CCR Section 9792.6.1(i).

Expedited Review: A 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 function, 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 9792.6.1(j).

Expert Reviewer: 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 the medical treatment services and where these services are within the individual's scope of practice, whose consultation for a specialized review has been requested by the claims administrator or utilization review organization, necessitating an extension of time, under section 9792.9.6, prior to the determination of medical necessity. CCR Section 9792.6.1(k).

Material Modification: When the claims administrator changes utilization review vendor(s); makes a change to the utilization review standards as specified in section 9792.7; or changes its medical director, address, company name or corporate structure. CCR Section 9792.6.1(n).

Modification: A decision by a physician reviewer that part of the requested treatment or service is not medically necessary. CCR Section 9792.6.1(r).

MTUS Drug Formulary: The drug formulary adopted by the Administrative Director under Labor Code section 5307.27 and defined in section 9792.27.1(m). The MTUS Drug Formulary contains the MTUS Drug List, which is set forth in section 9792.27.15. CCR Section 9792.6.1(s).

Non-physician Reviewer: An individual designated by the claims administrator or utilization review organization to assist in determining the medical necessity of the requested treatment. A non-physician reviewer may not modify or deny a treatment request. CCR Section 9792.6.1(w)(2).

Normal Business Day / Working Day: Does not include Saturday, Sunday, or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website. CCR Section 9792.6.1(cc).

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(t).

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(v).

Request for Authorization: A written request for a specific course of proposed medical treatment that meets all of the following criteria: CCR Section 9792.6.1(u).

Completed: The request for authorization identifies both the employee and the requesting provider; identifies with specificity all the recommended treatments in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used; and is accompanied by documentation, issued or created no earlier than 30 days before the date of submission of the request for authorization, that substantiates the need for the requested treatment. A request for authorization shall be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.6. CCR Section 9792.6.1(u)(2).

Utilization Review Plan: The written plan filed with the Administrative Director pursuant to, setting forth the policies and procedures, and a description of the utilization review process. CCR Section 9792.6.1(z).

Utilization Review Process: Utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. The utilization review process begins when a completed request for authorization, or a request for authorization accepted as complete under section 9792.9.1(b), is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization. CCR Section 9792.6.1(aa).

Utilization Review Process

Submission of Requests for Authorization

MedReview personnel are available by telephone at (909) 978-2960 from 9:00 a.m. to 5:30 p.m., on business days, to receive treatment requests. A facsimile number, (909) 978-2970, is maintained for the receipt of after-hours treatment requests. The utilization review process for responding to a treatment request begins when the request for authorization is accepted as a complete request received by mail, facsimile, encrypted electronic mail or electronic data interchange.

Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a claims administrator, non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it "not complete" and return it to the requesting physician, 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 request for authorization.

Intake Process

MedReview, Inc. excludes evaluation or interpretation of clinical information from the initial screening process, does not issue non-certifications based on initial screening and assigns a unique identifier to each request for certification.

Non-clinical staff provide administrative support for initial screening: MedReview limits the use of non-clinical administrative staff to:

- Review service request for completeness of information
- Collect and transfer non-clinical data
- Acquire structured clinical data

Acknowledgment of Receipt

A request for authorization shall be deemed to have been received by the claims administrator or MedReview by facsimile, electronic mail, or by electronic data interchange on the date the form was received if the receiving facsimile, electronic mail address, or clearinghouse electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or MedReview, five days after the latest date the sender wrote on the document. CCR 9792.9.1(a)(C).

A request for authorization transmitted by facsimile, electronic mail, or electronic data interchange after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review.

The first day in counting any timeframe requirement is the day after the receipt of the request for authorization, 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 request for authorization, pursuant to CCR Section 9792.9.3(a).

Tracking and Logging

MedReview ensures that all requests for authorization are date-stamped upon receipt and logged into our claims system to track regulatory timeframes and outcomes.

Dispute of Liability; Deferral

Utilization review of a medical treatment request may be deferred if the claims administrator disputes liability for either a factual, medical, or legal basis exists, other than medical necessity, that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.

Timeframe for Decision Making

MedReview shall meet the required timeframes set forth in CCR Section 9792.9.3, unless additional information is requested necessitating an extension.

Prospective and Retrospective Reviews

Prospective decisions to approve a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. If the initial communication is by telephone, written communication shall issue to the requesting physician within two (2) business days for prospective review.

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.

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. A written decision to approve 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.

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 9792.9.5(a), 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 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 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.

The calculation of time as outlined in this section applies to all utilization review decisions insofar as they do not contravene the timeframes relating to MTUS formulary disputes, which are subject to the requirements of section 9792.9.8.

Concurrent Reviews:

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.

Concurrent decisions to approve a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. If the initial communication is by telephone, written communication shall be issued to the requesting physician within 24 hours of the decision.

A concurrent review decision to deny authorization for medical treatment shall meet the following requirements:

- Medical care shall not be discontinued until the requesting physician has been notified of the decision, and 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 a concurrent review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.

Concurrent 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.

Emergency Health Care Services

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 9792.9.5(b), 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.

Expedited Reviews

Pursuant to CCR 9792.9.3(c), Prospective or concurrent decisions to approve, modify, or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A request for expedited review that is not reasonably 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 under subdivision (b) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (b).

Expedited decisions to approve a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail.

Expedited decisions to modify or deny a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. Written communication of the decision shall issue to the injured worker, and, if applicable, to the injured worker's representative within 72 hours of receipt of the request. Written communication in accordance with this paragraph shall also issue to the requesting physician where the initial communication of the decision to the physician was by telephone.

Notices for Initial Decisions

Written Decision Content Requirements

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

- Specify the date the complete, or accepted as complete, request for authorization was first received
- Specific medical treatment service approved
- Date of the decision
- Date the request for information, exam, or consultation was requested
- Date the information was received

For approvals of a request for authorization of a drug where the request for authorization did not indicate "Do Not Substitute" or "Dispense as Written," the written decision approving the request in generic form shall indicate, "generic substitute authorized".

For approvals of a request for authorization of a drug that is exempt on the Drug Formulary, the written decision approving the request shall indicate, "Exempt per MTUS Drug Formulary".

For approvals of a request for authorization of non-drug treatment that are exempt under section 9792.9.7 (i.e., the 30-day exemption), the written decision approving the request shall identify the exempt treatment as, "30-day exemption".

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 9792.9.5(e):

- The date on which the completed or accepted request for authorization was first received.
- If the timeframe for decision was extended under section 9792.9.6, a specific description of the information needed to make a medical necessity determination of the treatment request; the date(s) and time(s) the request(s) for information, exam, or consultation under subdivision (a)(1)(A), (B), or (C) of section 9792.9.6 were requested; the manner in which the requests were made; and the date the information was first received.
- The date on which the decision is made.
- A description of the specific course of medical treatment set forth on the request for authorization.
- A list of all medical records reviewed.
- A specific description of the medical treatment service approved, if any.

- A clear, concise, and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity or; if applicable, that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation.
- Where the requesting physician has expressly opined that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician shall provide an explanation for why the requesting physician's explanation is insufficient.
- For decisions based on medical necessity, a citation and a description of the relevant medical criteria or guidelines used to reach the decision.
- Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.
- The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee, must be completed by the claims administrator. 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 the timeframe indicated on the last page of the application.
- The following mandatory language advising the injured employee:
 - "You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact'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, if any, including with respect to disputes over the necessity of or availability of the requested information, 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 shall also contain the name and specialty of the reviewer or, if applicable, expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the reviewer, the expert reviewer, or the medical director for the treating physician to discuss the decision which shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time. In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Extension of Timeframe for Decision

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 in accordance with applicable rules in section 9792.9.5(e) and 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, and request, as applicable, the additional examinations or tests required, or indicate that a consultation by an

expert reviewer is needed, in which case, the specialty of the expert reviewer to be consulted must be identified. 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 in accordance with applicable rules in section 9792.9.5(e) and 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 physician reviewer shall make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information.
- 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 physician reviewer shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information.
- 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 requesting physician shall be notified by telephone, facsimile, or, if agreed to by the parties, encrypted email within 24 hours of making the decision. The written decision shall include the date the information was requested and received. The decision shall be communicated in the manner set out in Section 9792.9.4 or 9792.9.4, whichever is applicable.

MTUS Drug Formulary Decisions

For approvals of a request for authorization of a drug where the request for authorization did not indicate "Do Not Substitute" or "Dispense as Written," the written decision approving the request in generic form shall indicate, "generic substitute authorized".

For approvals of a request for authorization of a drug that is exempt on the Drug Formulary, the written decision approving the request shall indicate, "Exempt per MTUS Drug Formulary".

Duplicate Requests (12-month rule)

A utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical necessity shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any 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.

The 12-month rule does not apply to a repeat treatment request if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change. (§9792.9.2 (a))

Utilization Review Criteria

Medical Necessity

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, by the Medical Director.
 - Methods used to review and/or update guidelines:
 - MedReview management and Medical Director are enrolled in subscription emails from DWC regarding any updates to the guidelines and MTUS drug formulary.
 - All updated guidelines are reviewed at quarterly quality meetings or as applicable for the timeframe of the update.
 - All updates to the guidelines and MTUS drug formulary are then shared with the reviewing staff and contracted Physician Reviewers.
 - If needed, updated guidelines and MTUS drug formulary updates are presented with education during staff meetings.
- 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:
 - 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:
 - 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. 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, then:
 - 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.

Authorized Treatment

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.

First 30-Day Exemption

Pursuant to § 9792.9.7., a treating physician specified in Labor Code section 4610(b), may render medically necessary treatment or services to an injured worker without prospective utilization review for the first thirty (30) days after the date of injury.

For approvals of a request for authorization of non-drug treatment that are exempt under section 9792.9.7 (i.e., the 30-day exemption), the written decision approving the request shall identify the exempt treatment as, "30-day exemption".

Unless authorized by the employer or rendered as emergency medical treatment, the below shall be subject to prospective utilization review under this section:

- Pharmaceuticals, to the extent they are not expressly exempt from prospective review under the MTUS Drug Formulary.

- Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician's

office. This includes all necessary and routine pre-operative, intra-operative, and post-operative services performed for the purpose of surgery including, but not limited to, related diagnostic tests or procedures, rehabilitation services, durable medical equipment or supplies, and routine post-surgical pain management treatment or services. For the purpose of this section, "surgery" means: 1) any procedure set forth in the Surgery section of the American Medical Association's *Current Procedural Terminology (CPT®)* which is incorporated by reference at section 9789.31(h), and any updates pursuant to section 9789.36; or 2) any procedure code defined as "surgery" in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule found in the Healthcare Common Procedure Coding System (HCPCS), which is incorporated by reference at section 9789.31(i), and any updates pursuant to section 9789.36.

- Psychological or psychiatric treatment services, which includes diagnostic services, psychotherapy, and other services or procedures to an individual or group in all care settings provided by a physician or other qualified health care provider, and including psychiatric pharmaceuticals, to the extent they are not expressly exempt from prospective utilization review under the MTUS Drug Formulary.
- Home health care services, including health care and other medically necessary services provided to the injured worker in the residential setting.
- Imaging and radiology services, excluding X-rays.
- All durable medical equipment, prosthetics, orthotics, and supplies where the purchase or rental cost of the item with necessary supplies, if any, for the expected course of treatment is greater than \$250.00 as determined by the DWC Official Medical Fee Schedule (OMFS), or, for an unlisted item, where the billed amount will be greater than \$250.00.
- Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies. For the purpose of the subdivision, electrodiagnostic medicine is a medical specialty where the physician uses neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic, neuromuscular, and/or muscular systems. This includes, but is not limited to, procedures set forth in the American Medical Association's *Current Procedural Terminology (CPT®)* Medicine section, under the subheading "Neurology and Neuromuscular Procedures," and any test that measures the speed and degree of electrical activity in the muscles and nerves in order to make a diagnosis.
- Spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections.

Drug Authorization

Pursuant to CCR §9792.9.8, the following drugs can be dispensed to an injured worker without obtaining authorization through prospective review:

- Drugs identified on the MTUS Drug List as exempt under section 9792.27.15
- Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Special Fill policy under section 9792.27.12; and
- Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Perioperative Fill policy under section 9792.27.13.
- Exempt drugs identified in subsection (1) must still be set forth in a request for authorization as required under section 9792.6.1(u), or in a manner agreed upon by the treating physician and the claims administrator.

If additional information is needed to determine medical necessity, a physician reviewer or non-physician reviewer shall request the information from the treating physician within four (4) business days from the date of receipt of the request for authorization.

Prospective decisions to approve, modify, or deny a request for authorization under this section shall not exceed five (5) business days from the date of receipt of the request for treatment.

Appeal and Independent Review

Utilization Review Appeals Process

Appeals of non-certifications are conducted by qualified clinicians who meet the following requirements:

- They were not involved in the initial denial determination.
- They are not subordinates of the individual who made the initial denial determination.
- For each appeal case they accept, attest to:
 - Having a scope of licensure or certification that permits management of the issue under review, or the medical or behavioral health condition, disease, treatment or procedure under review.
 - Current, relevant experience and/or current, relevant knowledge to render a determination for the case under review.

MedReview provides the member, provider, or facility rendering service the opportunity to submit written comments, documents, records and other information relating to the case. All such information is taken into account during the appeals process without regard as to whether such information was submitted or considered in the initial consideration of the case. In the instance of a first level appeal, the organization implements the decision of the first level clinical appeal. MedReview only provides one appeal.

Written notifications are sent to the member, attending physician or other ordering provider/prescriber or facility rendering service.

MedReview, Inc. provides written notification of the adverse appeal decision to the requisite parties and includes the following information in the notice:

- Principal reason(s) for the determination to uphold the non- certification.
- Clinical rationale used in making the non-certification decision.
- Information about additional appeal mechanisms available, if any
- Unique identifier assigned to the initial request for certification

Appeal Notification Time Frames:

- For expedited appeals, the requesting party is informed by written notice with 72 hours of receipt of request.
- For prospective appeals, determinations are communicated within 30 calendar days of receipt of request.
- For retrospective appeals, determinations are communicated within 30 calendar days of receipt of request.

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 and within 10 days for drugs listed on the MTUS Drug List. 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.

Independent Medical Review Filing Process and Timeline

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code Section 4610.5, 4610.6 and §9792.10.1. 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.

Personnel and Qualifications

Medical Director

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.

William Logan Tontz, Jr., M.D.
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St. Pete Beach, FL 33706
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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.

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.

Non-Physician Reviewers

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 appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the 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

Clerical Personnel and Transcription

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.

Expert Review Consultants

MedReview uses an expert reviewer when a specialized consultation and review of medical information is necessary to determine medical necessity, and the consultation cannot reasonably be completed within the standard decision timeframe. An extension of the decision timeframe for this purpose is permitted only under the circumstances set forth in 8 CCR § 9792.9.6(a)(1)(C).

When an expert review consultation is required after receipt of a complete (or accepted) request for authorization, the physician reviewer will provide written notice within five (5) business days from the date of receipt of the request for authorization to the requesting physician, the injured worker, and, if represented, the injured worker's attorney, stating that a decision cannot be issued within the required timeframe and indicating that consultation by an expert reviewer is needed. The notice will also identify the specialty of the expert reviewer to be consulted. (8 CCR § 9792.9.6(a)(2)).

Selection of the expert reviewer specialty is based on the specific clinical issues presented and must be within the expert reviewer's scope of practice and competency to evaluate the request.

Upon receipt of the information generated by or obtained through the expert review consultation (or other information requested under 8 CCR § 9792.9.6(a)(1)), MedReview will issue the utilization review decision within the regulatory timeframes applicable to the type of review: five (5) business days for prospective or concurrent review; 72 hours for prospective or concurrent decisions related to an expedited review; and thirty (30) calendar days for retrospective review.

Plan Submission and Modifications

Initial Submission

As set forth in CCR §9792.7(c)(1)(2), MedReview, shall submit its Utilization Review Plan with a completed DWC Form UR-01, “Utilization Review Plan Application or Modification”, with an original signature by the applicant's medical director.

The utilization review plan shall be submitted in compact discs or flash drives, or other electronic format agreed to by the Administrative Director and the applicant, in word-searchable PDF format. The hard copy of the completed, signed original shall be maintained by the applicant and made available for review by the Administrative Director upon request. Electronic signatures in compliance with California Labor Code section 110.5 or 3206.5 are acceptable.

Material Modifications

As set forth in CCR §9792.7(c)(4), MedReview shall file a material modification of its utilization review plan with the Administrative Director within 30 calendar days of the material modification. The material modification shall include a DWC Form UR-01 set forth in section 9792.7.1, completed as applicable with an original signature by the applicant's medical director, and an attached statement certifying that the utilization review plan, as modified, continues to be in compliance with the rules governing utilization review at sections 9792.6.1 through 9792.12.

The modified utilization review plan shall be submitted in compact discs or flash drives, or other electronic format agreed to by the Administrative Director and the applicant, in word searchable PDF format. Electronic signatures in compliance with California Labor Code section 110.5 or 3206.5 are acceptable.

Material changes may include:

- Ownership changes
- Medical Director changes
- Corporate structure
- Process changes affecting compliance
- Utilization Review vendor changes
- Address or company name changes
- Change to the Utilization Review standards

MedReview, Inc. certifies that the utilization review plan, as modified, continues to be in compliance with the rules governing utilization review at sections 9792.6.1 through 9792.12.

Quality Assurance & Compliance Monitoring

Internal Audits

MedReview conducts routine internal audits to confirm adherence to applicable Labor Code and title 8 CCR requirements, internal policies and procedures, medical necessity criteria, and regulatory decision-making timeframes. Internal audits are designed to identify trends, reduce variation, and support continuous quality improvement across the utilization review process.

Audit reviews include, at a minimum: (1) confirmation that the request was processed and issued within required decision timeframes; and (2) confirmation that the review applied appropriate criteria, including MTUS and other applicable evidence-based guidelines, and that the rationale is consistent with the criteria cited.

Findings are documented and trended. When opportunities for improvement are identified, MedReview, Inc. implements corrective actions (e.g., coaching, training, workflow updates, and/or targeted re-audits) and monitors for sustained compliance.

Accreditation Requirements

MedReview, Inc. shall verify and maintain URAC Workers' Compensation Utilization Management (WCUM) Accreditation for any utilization review process that issues modifications or denials, as required by Labor Code section 4610 and 8 CCR section 9792.7(a)(6)(A).

MedReview, Inc. maintains current URAC WCUM accreditation as a condition of performing utilization review that may result in a modification or denial of a requested medical treatment service. This requirement applies to utilization review plans that modify or deny treatment requests and is established by 8 CCR section 9792.7(a)(6)(A). MedReview Inc.'s accreditation is maintained in good standing by complying with URAC standards and completing all required URAC surveys, audits, and renewal activities within URAC established timeframes.

Proof of accreditation (including the current URAC accreditation letter/certificate and any applicable URAC scope information) is retained in MedReview's compliance files and is made available as required. MedReview will promptly update its utilization review plan submission and related compliance documentation if there is any change that impacts accreditation status, scope, or the entity performing utilization review functions that may modify or deny treatment.

Where MedReview delegates utilization review functions to a utilization review organization (URO) or other vendor, MedReview will ensure that any entity performing utilization review that may modify or deny treatment requests maintains URAC WCUM accreditation (unless exempt under 8 CCR section 9792.7(a)(6)(B), where applicable). MedReview will maintain current documentation identifying delegated utilization review functions and the accredited entity responsible for those functions and will ensure contractual requirements support ongoing compliance with Labor Code section 4610 and title 8 regulations.

Delegated UR Functions

MedReview Inc. contracts with the following companies for Physician Review services:
Advanced Medical Reviews, LLC

MedReview Inc. contracts with the following physicians/companies for Expert Review services:
Network Medical Review Co. Ltd.

Financial Incentive Policy

Pursuant to Labor Code Section 4610(g)(3)(B)(i) & (4), MedReview, Inc. 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.

Documentation & Recordkeeping

Records Retention

MedReview maintains claim records and utilization review documentation in a manner that supports continuity of claims administration, regulatory compliance, client contractual requirements, and appropriate access controls. Retention and disposition practices differ depending on whether the client relationship is active or has terminated, and whether the record is maintained in electronic or hard-copy form.

Active Clients

- **Electronic records.** MedReview retains client claim data and associated electronic files for the duration of the client's engagement with MedReview, regardless of whether individual claims are open or closed.
- **Hard-copy records (non-future medical).** Hard-copy/physical files that are designated as non-future medical and have been closed for five (5) years or more will be destroyed or returned to the client, based on the client's written preference and any applicable contractual requirements.
- **Hard-copy records (future medical).** Future medical hard-copy/physical files are retained indefinitely.

Departing Clients / Transition to a New TPA

- **Electronic file transfer.** Upon termination of the client relationship and transition to another third-party administrator (TPA), MedReview extracts the client's digital data and files from its claims system and provides them to the client and/or the incoming TPA as directed. The incoming TPA assumes responsibility for ongoing storage and retention of the client's records going forward.
- **Hard-copy files.** Hard-copy/physical files are typically returned to the client or transferred to the incoming TPA, consistent with client instructions and applicable contractual requirements.
- **MedReview system copy (temporary).** Following transfer, MedReview retains a copy of the client's data and files within its claims system for up to one (1) year.
 - After one (1) year, MedReview purges the departing client's data from its active systems and retains an offline archive for an additional three (3) to five (5) years, depending on the client's contract requirements.
 - After the offline archive period (three (3) to five (5) years), all remaining archived data is deleted in accordance with MedReview's secure disposal procedures and any applicable contractual requirements.

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 the Administrator or its employees directly responsible for working with Consultant.

Provider & Patient Communications

Physician communications:

- MedReview's Intake staff will communicate with the requesting physician to clarify non-medical information.
- MedReview's Initial Reviewers will communicate with the requesting physician regarding treatment requests, guidelines for medical necessity and request for information.
- MedReview's Physician Reviewers will communicate with the requesting physician regarding all final determinations and internal peer calls.

Patient communications:

- MedReview Inc., copies all claimants on final determinations letters.
- MedReview Inc., does not directly communicate with claimants. All communications with claimants are done by the claims adjuster.

MEDREVIEW

3380 Shelby Street
Ontario, California 91764
Phone (909) 978-2960 | Fax (909) 978-2970

Appendix B:

Client List:

AdminSure, Inc.

Physician Review Services

MedReview Inc. contracts with the following physicians/companies for Physician Review 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

Advanced Medical Reviews, LLC.

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 Expert Review services:

Appendix B:

Network Medical Review Co. Ltd.

Medical Director: Robert C. Porter, M.D.

Medical Director Specialty: Occupational Medicine

Medical Director License No. 33237