California Worker's Compensation Utilization Review Plan

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ACCREDITED
Workers' Compensation
Utilization Management
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Utilization Review Definitions

Appeal means the formal process by which an injured worker, an injured worker's representative, or an injured worker's requesting provider or treating provider may request a reconsideration of a denied or modified determination.

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 pursuant to Labor Code § 4600, subject to the provisions of Labor Code § 5402, set forth on a completed "Request for Authorization," 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 8 CCR § 9792.9.1 through 9792.12.

Availability of Services

i. Pursuant to 8 CCR § 9792.9.1 (a)(3):
    a. Telephone access shall be available from 8:00 AM to 5:30 PM PST on normal business days for health care providers to request authorization for medical services.
    b. The fax number 949-612-9207 is always available to receive requests for authorization for medical services.
    c. After business hours, physicians requesting authorization for medical services have access to the MEDEX voicemail system and the fax number as noted above.

Claimant means a person or entity who submits a claim, or on whose behalf a claim is submitted.

Claims Administrator means any self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party administrator, or other entity subject to Labor Code 4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). It also includes any URO under contract to provide or conduct the claims administrator's utilization review responsibilities.

Clinical oversight means the monitoring and evaluation of clinical integrity of the utilization management program processes and decisions affecting consumers.

Clinical Peer Reviewer means a physician or other health care professional who has the clinical expertise and holds a license or certification to render a clinical opinion or determination about the medical condition, disease, procedures, or treatment under review.

Concurrent Review means utilization review conducted during an inpatient stay.

Course of Treatment means the course of medical treatment set forth in the treatment plan contained on the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021 (found at 8 CCR § 14006.1), or on the applicable physician reporting forms authorized by section 9785.

Denial means medical treatment that has been modified or denied by a Utilization Review decision.

Dispute Liability means 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.

Disputed Medical Treatment means medical treatment that has been modified or denied by a Utilization Review decision.

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.

Evidence-based means based, at a minimum, on a systematic review of literature published in medical journals included in PubMed as well as National Guideline databases such as MTUS and ODG.

Expedited Review means 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.

Expert 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 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 § 9792.9.6, prior to the determination of medical necessity.

Health Care Provider means a provider of medical services and related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization, or medical provider network as provided in Labor Code 4616.

Immediately means within one business day.

Initial Clinical Review means clinical review conducted by appropriately licensed or certified health professionals. The initial clinical review staff may approve requests that meet clinical review criteria but must refer requests that do not meet clinical review criteria to clinical peer review.

Material Modification is when the claims administrator changes utilization review vendor(s); makes a change to the utilization review standards as specified in § 9792.7(c)(2); or changes its medical director, address, company name or corporate structure.

Medical Director is the 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 decisions made in the utilization review process.

Medically Necessary means the evaluation of the severity of injury and degree of impairment to determine issues of the frequency, duration, intensity, and appropriateness of treatment.

Medical Services means the goods and services provided pursuant to Article 2 (starting with Labor Code § 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

Medical Treatment Utilization Schedule means the standards of care adopted by the Administrative Director pursuant to Labor Code § 5307.27 and set forth in Article 5.5.2, beginning with 8 CCR § 9792.20.

Medically Necessary or Medical Necessity means medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury.

Modification means a decision by a physician reviewer that part of the requested treatment or service is not medically necessary.

MTUS Drug Formulary means the drug formulary adopted by the Administrative Director under Labor Code section 5307.27 and defined in § 9792.27.1(m). The formulary contains the MTUS Drug List which is set forth in § 9792.27.15.

Non-Clinical Staff means employees who are not qualified to perform clinical services.

Non-Physician Reviewer means 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.

Normal Business 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' website.

Peer-to-Peer means a good faith attempt at discussion between the physician reviewer and the requesting physician to discern information relevant to a treatment request in order to make a proper determination.

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.

Prospective Review means a utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services.

Request for Authorization means a written request for a specific course of proposed medical treatment.

i. Unless accepted by a claims administrator under section 9792.9.1(b), a request for authorization must be set forth on a "Request for Authorization (DWC Form RFA)" as contained in 8 CCR § 9785.5, completed by a treating physician and is further outlined in § 9785(h).
ii. "Completed" means that the request for authorization identifies both the employee and requesting physician; identifies with specificity all the recommended treatments in the designated section for requests for authorization of 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 § 9792.9.6.
iii. The request for authorization must be signed by the treating physician and may be mailed, faxed, or, if available, sent electronically through encrypted email or EDI to the address, fax number, e-mail address, or designated clearinghouse under § 9781(d)(5). The treating physician may submit the request for authorization with an electronic signature.

Retrospective review means utilization review conducted after medical services have been provided and for which approval has not already been given.

URAC is the non-profit organization, located at 1220 L. Street, NW, Suite 900 Washington, DC 20005, or as indicated online at www.urac.org, that provides accreditation for workers' compensation utilization review programs.

Utilization Review Decision means a decision pursuant to Labor Code § 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 § 4600 or 5402 (c).

Utilization Review Plan means the written plan filed with the Administrative Director pursuant to Labor Code § 4610, setting forth the policies and procedures, and a description of the utilization review process.

Utilization Review Process means 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.

Working Day means “business day” or “normal business day.”

Written includes communication transmitted by fax or in paper form. Email or electronic data interchange (EDI) may be used by agreement of the parties, provided that an employee's health records shall not be transmitted via email or EDI unless sent through an encrypted email or EDI system.

Utilization Management Program Structure

Program Overview

Utilization management is an organized process of managing medical services provided by others; it is a method of quality assurance and cost containment. Utilization review evaluates the necessity, appropriateness, and efficiency of the use of medical services. For purposes of this plan and the requirements of multiple jurisdictions, MEDEX refers to utilization review and utilization management interchangeably. This utilization management plan outlines and describes the program's structure, goals, and objectives (8 CCR § 9792.7(a)).

These processes incorporate reviews based on scientifically and evidence-based, peer-reviewed, medical treatment guidelines nationally recognized by the medical community.

A utilization review determination will be made in a manner that, when necessary, considers special circumstances of the case that may require deviation from relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, an acute condition, or a life-threatening illness. All reviews and determinations are made by appropriately licensed individuals in compliance with California DWC Labor Code § 4600. When necessary, appeal and grievance processes will be made available to the requesting physician, the claimant, and/or the claimant's designated representative. MEDEX's Utilization Management plan is reviewed annually and updated as necessary.

Protection & Confidentiality

The MEDEX UR program adheres to HIPAA Privacy Rules, URAC UM standards, and all California labor codes and regulations. MEDEX is committed to maintaining the confidentiality and security of all medical records, utilization review documentation, claims information, and PHI in accordance with applicable federal and state laws, including the HIPAA of 1996, California privacy laws, URAC UM and CPE standards, as well as applicable workers' compensation confidentiality requirements. MEDEX has established policies and procedures to address confidentiality, privacy, data security, breach response, and proper handling of protected information as part of its overall compliance and quality management programs.

Access to confidential information is limited to authorized personnel whose job responsibilities necessitate it for utilization review, quality assurance, claims administration support, peer review coordination, and other authorized business purposes. MEDEX employs role-based access controls, password-protected systems, multi-factor authentication, and various administrative, technical, and physical

safeguards to protect confidential information from unauthorized access, disclosure, alteration, or destruction.

All employees and designated entities with access to confidential information are required to comply with MEDEX's confidentiality and privacy policies. They receive training on the handling and protection of confidential medical and claims information upon hiring and annually thereafter. Confidentiality obligations are reinforced through employee agreements, internal policies, and ongoing compliance oversight.

Electronic records and communications containing confidential information are maintained and transmitted through secure systems and methods designed to protect data integrity and confidentiality. Physical records containing confidential information are stored in secure locations with controlled access. MEDEX implements reasonable safeguards for the receipt, transmission, storage, and disposal of records and protected information. Medical records and utilization review files are retained in accordance with record retention requirements. When records reach the end of their retention period and are eligible for destruction, MEDEX employs secure destruction methods to prevent unauthorized access to confidential information.

MEDEX Quality Assurance (QA) Committee

MEDEX's QA committee is the decision-making entity and oversees implementation of the UR Plan. The committee reports directly to the Chief Operating Officer. The QA committee meets quarterly to report on and analyze the consistent application of clinical review criteria and ensure compliance with regulatory California and URAC requirements.

MEDEX's QA committee is tasked with ensuring updated clinical criteria are used across all levels of review, performance evaluations pursuant to goals and objectives, and discussing the implementation of solutions that address quality and safety issues. If the client identifies a possible issue with MEDEX's UR determination, the QA committee immediately conducts an internal audit. Should an error be found, corrective action is taken and internal changes are rolled out to prevent such errors in the future.

The QA committee is comprised of individuals with clinical, operational, and compliance expertise to ensure the effectiveness and regulatory compliance of the UR program. the following individuals:

- *Medical Director (Senior Clinical Staff Person)*
    - A board-certified, licensed physician that provides clinical oversight of the UR program, ensuring all determinations and activity are medically appropriate and consistent with evidence-based guidelines.

- *Director of Managed Care and Medical Management (Risk Manager)*
    - A leader experienced in managed care who oversees the overall performance of the UR program, including quality outcomes, regulatory compliance, and corrective action implementation.
- *Legal Counsel (Compliance Officer)*
    - A licensed attorney who provides legal and regulatory guidance to ensure the UR program remains compliant with applicable laws and regulations. Reviews policies, procedures, and QA findings to identify potential risk areas with mitigation strategies.
- *Chief Operating Officer (Contracting Officer)*
    - Senior leadership with experience in managed care operations that provides executive oversight, ensuring contractual obligations are followed, and providing vendor oversight.
- *Utilization Review Supervisor (Quality Leader)*
    - An experienced UR specialist who oversees the department's day-to-day operations, has strong knowledge of UR processes and regulatory requirements. Provides frontline insight into workflow challenges and continuing quality improvement opportunities.

Utilization Review Plan Filing

MEDEX's UR plan shall be filed with the Administrative Director on behalf of the Claims Administrator. The UR plan and any subsequent filings will identify the clients on whose behalf MEDEX performs any UR functions. (8 CCR § 9792.7(c)(1)).The UR plan shall be submitted with two copies of a completed DWC Form UR-01, with the Medical Director's signature, and will be submitted in an electronic, word-searchable PDF format. MEDEX will retain and maintain the hard copy of the completed UR plan, and will present it to the Administrative Director upon request. (8 CCR § 9792.7(c)(2)).

MEDEX will file a material modification of the UR plan within 30 calendar days if there is a change in clients on whose behalf MEDEX conducts UR; change to the UR standards specified in § 9792.7; or a change in medical director, address, company name, or corporate structure. As with the original filing, any material modification UR plan submissions will be in an electronic, word-searchable PDF format. (8 CCR § 9792.7(c)(4)).

Review Criteria

Review criteria used in the utilization review process to determine whether to approve, modify, or deny medical treatment services shall include, in part or in whole, the following guidelines. These standards, in their most current version, will be used as the criteria for screening medical and surgical care for review, either all or in part. The

utilization review does not prohibit authorization of medical treatment beyond what is covered in the guidelines below. (8 CCR § 9792.8(b))

Primary guideline

i. The State of California Medical Treatment Utilization Schedule (MTUS) is considered the primary guideline to be used in Utilization Management decision-making. If MTUS does not address the condition or treatment noted in the Request for Authorization, then the most current of the following guidelines are utilized. (8 CCR § 9792.8(a))

Secondary Guidelines

i. American College of Occupational and Environmental Medicine (ACOEM).
ii. Reed Group Ltd., The Medical Disability Advisor, Workplace Guidelines for Disability.
iii. Work Loss Data Institute. Official Disability Guidelines (ODG) and ODG Treatment in Workers' Compensation.

Standards for all guidelines

i. The process is disclosed to the physician or provider, the injured workers, and, if represented, the injured worker's attorneys, when used as the basis of a decision to modify or deny services.
ii. The process is evaluated quarterly and annually with the UR QA Committee to ensure the most appropriate guidelines are used with each review.

Reviewer Qualifications

First Level Reviewers | Non-physician Reviewer (8 CCR § 9792.7(b)(3)):

i. Must be a licensed Registered Nurse (RN) or Licensed Vocational Nurse (LVN/LPN).
ii. First-level reviewers cannot modify or deny medical treatment requests.
iii. May approve requests for authorization of medical services.
iv. May discuss applicable criteria with the requesting physician, and may reasonably request appropriate additional information necessary to render a decision.

Second Level Reviewers | Physician Reviewer (8 CCR § 9792.7(b)(2)):

i. Must be licensed physicians by a state or the District of Columbia, doctors of osteopathy, chiropractors, psychologists, acupuncturists, optometrists, dentists, or podiatrists.
ii. Are competent to evaluate the specific clinical issues involved in medical treatment services within the scope of the physician advisor's practice, and be Board Certified by a specialty board recognized by the American Board of Medical Specialties or its osteopathic equivalent.

iii. Must have active practice in the major clinical area being reviewed and have admitting privileges and direct patient care responsibilities in a medical treatment facility.

Second Level Reviewer Exclusions and Responsibilities:

i. Will be utilized for all medical and surgical cases not initially approved during the first level review process.
ii. May modify or deny requests for authorization of medical treatment.
iii. Reviewers will not be allowed to review medical treatment or make denial determinations if the injured worker is a member of the reviewer's family.
iv. Reviewers may recuse themselves from reviewing a case in which they feel an objective opinion cannot be rendered.
v. For reconsideration reviews, the reconsideration reviewer is the initial reviewer who issued the adverse determination.
vi. Reviewers must possess a license similar to that of the provider whose services are being reviewed, unless meeting this requirement would compromise the effectiveness or efficiency of the review process.
vii. The second-level reviewer does not have any conflicts of interest or financial incentives to doctors or other providers based on the utilization review decision.

Prior Authorization Protocol

Utilization review will be initiated within one (1) business day of receipt of the completed referral including the official DWC Form RFA and medical records from the primary treating physician, facility, or other provider associated with the medical treatment of the injured worker.

MEDEX administers UR services in accordance with California LAB § 4610 and applicable 8CCR regulations. Requests for medical treatment requiring UR are generally reviewed upon receipt of a completed request for authorization submitted by the requesting provider with supporting clinical documentation.

If applicable, and as directed by the claims administrator, certain medical treatment services may be authorized without submission of a formal Request for authorization. Such authorizations are determined solely by the applicable claims administrator and may include treatment authorized pursuant to regulatory exemptions, employer medical control programs, or other treatment authorized without prospective UR as permitted under applicable regulations. Examples of treatments that may be administratively authorized by certain claims examiners without prospective UR include, but are not limited to:

1. 1 initial diagnostic test per body part per year
2. Plain x-rays for orthopedic injuries
3. Routine pre-operative testing, including CBC, chem panel, chest x-rays, EKGs
4. Initial DME priced under $250
5. Initial total of up to 16 visits across PT, OT, chiro, and/or acupuncture
6. Specialist referrals for consultation only
7. Ergonomic evaluations

MEDEX also recognizes and follows the DWC's regulatory updates pertaining to medical treatment within the first 30 days of injury, which may be exempt from prospective UR when the treatment provided is consistent with MTUS guidelines and Drug Formulary provisions. Services and medications designated as "non-exempt" under this regulation remain subject to UR requirements and statutory decision timelines. These treatments include:

1. Non-exempt pharmaceuticals
2. Non-emergency inpatient/outpatient surgery, including perioperative services
3. Psychological treatment services
4. Home health services
5. Imaging and radiology (excluding x-rays)
6. All DME with a combined total value exceeding $250
7. Electrodiagnostic studies including EMG and NCV

Medical treatment requests submitted through the Request for Authorization process are subject to UR in accordance with applicable labor code provisions and regulations. MEDEX reviews requests for medical necessity based upon the MTUS, evidence-based guidelines, applicable Drug Formulary requirements, and other recognized standards of care as permitted. Services requiring prior authorization and/or UR may include, but are not limited to:

- Non-emergency surgery and invasive interventions
- Elective inpatient and outpatient procedures
- Advanced diagnostic imagining and radiology services excluding plain x-rays
- Physical, occupational, and chiropractic therapy exceeding guideline recommendations
- DME exceeding $250
- Psychological and psychiatric treatment
- Chronic pain management programs, and other intensive in-patient programs
- Specialty referrals (involving ongoing treatment, procedures, or transfers of care)
- MTUS Drug Formulary non-exempt medication, including compound medication/compound topical
- Experimental, investigational, or unsupported treatment requests
- Repeat procedures

All treatment requests are reviewed following the workflow below. MEDEX may request additional reasonable information necessary to complete the UR process in accordance with applicable regulations.

Intake Process

i. RFAs are accepted via fax, secure email, electronic transmission, mail, and other approved methods. All requests are date and time-stamped upon receipt and logged into Arriba to track regulatory timeframes and outcomes. Every RFA is reviewed for urgency and completeness.

ii. Appropriate parties receive an acknowledgement of receipt via fax and/or email within one (1) business day of receipt.

iii. The non-clinical administrative staff base request for authorization timelines based on the following:

   a. A request for authorization is deemed to have been received by MEDEX via fax, email, or EDI on the date the form was received and was electronically date stamped. (8 CCR § 9792.9.1 (a)(1))

      i. If there is no date stamp, the date the form was transmitted shall be deemed to be the date the form was received.

b. A request for authorization received after 5:30PM PST will be counted as received the following business day, unless it is an expedited or concurrent review. (8 CCR § 9792.9.1 (a)(1))
c. A request for authorization received via mail will be counted as received 5 business days after the deposit date in the mail facility. (8 CCR § 9792.9.1(a)(2)(A))
    i. If the request is received via certified mail, the receipt date will be the date received by MEDEX on the receipt date entered on the return receipt.
    ii. If there is an absence of documentation of receipt, the request for authorization will be counted as received 5 days after the latest date the sender wrote on the document.
d. If the physician indicates a need for expedited review on the request for authorization, MEDEX will proceed with expedited review handling procedures.

iv. The non-clinical administrative staff performing the initial screening utilize:
    a. Applicable utilization management requirements and procedures.
    b. A licensed health professional designated to provide guidance as needed.

v. MEDEX limits the use of non-clinical administrative staff to:
    a. Review utilization review requests for completeness of information.
    b. Collect, transmit, and transfer non-clinical data.
    c. Acquire structured clinical data.

vi. The non-clinical staff conducting the initial screening process cannot issue certifications unless instructed by the Claims Administrator via the "Adjuster Authorization" process.

vii. The non-clinical staff logs all RFAs under a unique referral number in Arriba. They enter the date of receipt, and the UR system automatically identifies both target and actual due dates, assisting in tracking regulatory timeframes and outcomes. During the referral entry process, the non-clinical staff person checks and identifies the following in the request for authorization:
    a. "Generic substitute authorized" will be written where drug referrals where "do not substitute" or "dispense as written" are indicated. (8 CCR § 9792.9.4 (a)(2))
    b. "Exempt per MTUS Drug Formulary" will be written for drugs that are exempt on the Drug Formulary. (8 CCR § 9792.9.4 (a)(3))
    c. The "30 day exemption" referral type will be selected and clearly identified for any treatment identified as exempt treatment for an accepted claim within the first 30 days of the date of injury. (8 CCR § 9792.9.4 (a)(4))

viii. During the referral entry process, the non-clinical staff check for the following:
    a. Expedited referrals

b. Referral completeness (8 CCR § 9792.7 (c)(1))
c. 30 day exemption referrals (8 CCR § 9792.9.7)
d. MTUS drug formulary applicability (8 CCR § 9792.9.8)
    i. The intake specialist reviews each pharmaceutical and compound medication request against the state's MTUS Drug Formulary.
    ii. Medications that are exempt must still be submitted to MEDEX on a completed request for authorization.
    iii. Non-exempt medications do not qualify for the 30 day exemption review and will be reviewed prospectively.
    iv. Medications, drugs, and pharmaceuticals not listed within the MTUS Drug Formulary do not qualify for the 30 day exemption review and will be reviewed prospectively.

ix. The non-clinical staff confirms receipt of the request for authorization via fax and email. If the requesting physician has an email on the DWC RFA form, the confirmation of receipt will automatically be issued to that email. If not, the confirmation of receipt will be via fax.
x. The non-clinical staff log all RFAs within the uniquely identified referral number in Arriba. They enter the date of receipt, and the UR system automatically identifies target and actual due dates, helping track regulatory timeframes and outcomes.

First Level Review | Non-Physician Reviewer

i. Receives the escalated referral from the non-clinical intake team.
ii. Requests and receives information and/or the part of the medical record necessary to conduct a prospective, concurrent, or retrospective review pertaining to an admission, treatment, and/or procedure including, but not limited to, frequency, duration, and length of stay.
iii. Reviews the request for medical necessity and appropriateness using the applicable evidence-based guidelines as referenced above under Review Criteria.
iv. May discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the Review Criteria.
v. Communicates the determination for approved prospective and concurrent reviews to all stakeholders via telephone, voicemail, electronic mail, letter, or fax, within five (5) working days from the date of receipt of the accepted Request for Authorization. In no event shall the determination be made more than fourteen (14) calendar days from the date of receipt of the original request for authorization by the health care provider.
vi. All decisions to approve a request for authorization shall specify the date the complete request for authorization was received, medical treatment service requested, the specific medical treatment approved and the date of the decision.

vii. If the First Level Reviewer is unable to issue an approval for the requested treatment, they will refer the case to a Clinical Peer Reviewer. Only a Clinical Peer Reviewer may modify or deny a request for treatment.

Clinical Peer Review | Physician Reviewer

i. Receives the written request from the First Level Reviewer that includes all documentation needed for the review.
ii. Reviews the request for medical necessity and appropriateness using the applicable evidence-based guidelines as referenced above under Review Criteria.
iii. If the clinical peer reviewer determines that additional medical information is required to complete the review, they will issue a request for additional information within the required timeframes:
    a. If the request for authorization only includes formulary medication, the request for additional information must be issued within 4 business days from the date of receipt, and the determination must be completed within the normal review timeframes. (8 CCR § 9792.9.8(b)(1)(A))
    b. If the request for authorization includes both formulary medication and non-pharmaceutical treatment, the request for additional information must be issued within 5 business days from the date of receipt, and the determination must be completed no later than 14 calendar days from the initial date of receipt. (8 CCR § 9792.9.6(c)(1))
iv. All prospective, concurrent, retrospective, and expedited requests for authorization require the clinical peer reviewer to attempt good faith peer-to-peer calls with the requesting physician. All peer-to-peer calls must meet the following criteria:
    a. The clinical peer reviewer must place at least 2 phone call attempts on 2 separate business days. All phone calls must be made during business hours.
    b. If the clinical peer reviewer is unable to reach the requesting physician, they must then leave a voicemail.
        i. If the requesting physician's voicemail is full, or if there is no answering service, the clinical peer reviewer is required to wait at least 5 minutes before the attempt can be counted as "completed."
    c. In the case of an approved determination, the clinical peer reviewer will place an Immediate Provider Approval Call (IPAC), notifying them of the approved determination.
    d. In the case of a denied/modified determination, the clinical peer reviewer will communicate the determination to the requesting physician, injured worker, and the injured worker's attorney within the following timeframes:
        i. Within 1 business day for concurrent reviews,

ii. Within 2 business days for prospective reviews, and
iii. Immediately for expedited reviews.

Determination Letters

i. The written decision modifying or denying a request for authorization shall be provided to the requesting physician, the injured worker, and the injured worker's representative. The determination letter will contain the following:
    a. Reviewer/expert reviewer information:
        i. Name and specialty.
        ii. Telephone number.
        iii. Hours of availability, at a minimum of 4 hours per week during normal business hours of 9:00am to 5:30pm PST.
            1. If the clinical peer reviewer is unavailable, the requesting physician may discuss the written decision with another clinical peer reviewer who is competent and qualified to evaluate the specific clinical issues involved in the treatment request.
        iv. The clinical peer reviewer's signature.
    b. Review information:
        i. The date on which the complete, or accepted as complete, request for authorization was first received.
        ii. The date on which the decision was made.
    c. If the timeframe was extended:
        i. A description of the information needed to make a medical necessity determination of the request for authorization.
        ii. The dates and times the information was requested.
        iii. The manner in which the requests for information attempts were made.
        iv. The date the information was first received.
    d. For approvals:
        i. A description of the specific course of proposed medical treatment for which authorization was requested.
        ii. A list of all medical records reviewed.
        iii. A clear, concise, and appropriate explanation of the reasons for the clinical peer reviewer's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria and/or guidelines.
        iv. Identification of the URAC-accredited entity, approved by the DWC, that is liable for the UR determination. (8 CCR § 9792.9.5(e)(9))

e. For denials/modifications, all information listed in section (d) along with the below-indicated additional information listed will include:
    i. If the denial is due to a lack of information, the specific reason for the decision and specification of information required.
    ii. If the requesting physician has expressly opined that the prerequisite treatment or criteria that are recommended under applicable guidelines should be overlooked or are irrelevant to the requested treatment, the clinical peer reviewer will provide an explanation for why the requesting physician's explanation is insufficient.
    iii. A clear and statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provision of Labor Code § 4610.5 and 4610.6, 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 30 calendar days or 10 calendar days after service of the decision.
    iv. The following mandatory language advising the injured worker:
        1. "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."
        2. "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."
    v. Details about MEDEX's internal utilization review process, and a clear statement that the internal appeal is a voluntary process that neither triggers nor bars the use of the dispute resolution procedures of Labor Code § 4610.5 and 4610.6, but may be pursued on an optional basis.

1. Requests for an appeal of a UR determination can either be sent directly to MEDEX or to the Claims Administrator but must be sent within (10) calendar days after receipt of the utilization review decision.
2. A request for an internal utilization review appeal must be completed, and a determination issued, within thirty (30) days of receipt of the request. An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under 8 CCR § 9792.10.6(e) that determines the medical necessity of the disputed treatment.
3. If the appeal results in a modification of the requested medical treatment, that decision shall be communicated to the requesting physician and the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney according to the requirements set forth in 8 CCR § 9792.9.1 (e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under 8 CCR § 9792.9.1 (e)(5)(G) must indicate that the decision is a modification after appeal.

ii. The Independent Medical Review (IMR) form will be:
   a. Completed entirely, except for the injured worker's signature.
   b. Distributed to the requesting physician, the injured worker, and their attorney.
   c. Provided in an addressed envelope with paid postage for mailing.

iii. All electronic/paper files and records that pertain to the UR process shall be retained for at least 3 years following whichever of the following is later (8 CCR § 9792.7 (n)):
   a. The most recent UR decision for each injured worker, or
   b. The date on which any regulatory appeal is fully resolved with a final decision.

Expedited Review Process

i. Referrals are expedited when the RFA is marked as expedited or the physician or claims examiner identifies the referral needs to be reviewed on an expedited, rush, or stat basis.

ii. Expedited RFAs are:
   a. Identified at the intake level based on initial review of the referral documents.

b. Immediately prioritized for review
c. Assigned to a physician reviewer immediately

iii. Determinations for expedited reviews are made within 72 hours. (8 CCR § 9792.9.3 (c))

iv. Notifications of the decision are provided to the requesting provider and other required parties within 24 hours. (8 CCR § 9792.9.4 (b)), (8 CCR § 9792.9.5 (c))

Review Timeframes

When counting any timeframe requirement, the first normal business day after receipt of the completed (or accepted as completed) request for authorization counts as the "first day," unless the timeline is counted in hours. MEDEX follows the below timeframe requirements set by the DWC (8 CCR § 9792.9.3 (a)-(e)), (8 CCR § 9792.9.4 (b)):

- Prospective – decisions not to exceed 5 business days from the date of receipt, with determination letters being issued within 24 hours of completion.
- Concurrent – decisions not to exceed 5 business days from the date of receipt, with determination letters being issued within 24 hours of completion.
- Retrospective – decisions not to exceed 30 calendar days from the date of receipt, with determination letters being issued within 24 hours of completion.
- Expedited – decisions not to exceed 72 hours from the date of receipt, with determination letters being issued within 24 hours of completion.
    - MEDEX will review the expedited referral under normal timeframes if a dedicated clinical staff person determines that the expedited review is not reasonably supported by evidence that established an imminent or serious threat to the injured worker, or that the timeframe is detrimental to the injured worker.
- MTUS Drug Formulary – depending on the treatments requested in the request for authorization, MEDEX will follow the timeframes below:
    - If the request for authorization only includes formulary medication, the determination will be made within 5 business days from the date of receipt, or 72 hours for expedited referrals, with no extension to the timeframe.
    - If the request for authorization includes both drug formulary medications and non-pharmaceutical treatment, the determination will be made within normal prospective, concurrent, retrospective, or expedited timelines, with extensions if additional information is required to render a determination. (8 CCR § 9792.9.8(d))
    - Any initial disputes based on medical necessity for denied or modified treatment requests will be completed using MEDEX's internal appeal processes, or through the Independent Medical Review processes addressed in Labor Code § 4610.5 and 4610.6. Any further disputes not

based on medical necessity will need to be resolved either through an internal agreement or through the WCAB. (8 CCR § 9792.9.8(f)(1-2))

- Requests for Information
    - If the request for authorization is only for formulary medication, the request for information must be issued and closed out within 5 business days of receipt of the referral.
    - If the request for authorization includes a mix of formulary medication and non-formulary treatment, the request for authorization must be issued within 5 business days of receipt, and determinations must be made within 14 calendar days of receipt of the referral.

Review Types

Prospective Review

Prospective Review means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services.

i. Outpatient services include, but are not limited to, doctor visits, physical therapy, chiropractic, acupuncture, and home health services.
ii. Prospective review procedures will be established and conducted to allow for evaluation of proposed treatment, determination of medical necessity, and assessment of care required prior to the delivery of care.
iii. Prospective decisions shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the receipt of the completed DWC Form PR-1 or information reasonably necessary to make the determination, but in no event more than fourteen (14) days from the date of the medical treatment recommendation by the physician. (Labor Code § 4610(i)(1)).
iv. If the injured worker faces an imminent and serious threat to his or her health, or the normal timeframe for decision making process, as described above, would be detrimental to the injured worker's health, decisions to approve, modify or deny requests by physicians prior to, or concurrent with, medical treatment services to injured workers will be made timely, appropriate to the nature of the injured worker's condition, not to exceed seventy-two (72) hours after receipt of the information reasonably necessary to make the determination. (8 CCR § 9792.9.3 (c))

Concurrent Review

Concurrent review means any utilization review conducted during an inpatient stay.

i. Inpatient Services: Admission review is conducted to verify the appropriateness of the medical necessity of the hospitalization. Documentation in the medical record must justify the admission, including a supporting history and physical exam, a plan of care, and medical orders showing a correlation between the necessity of hospitalization and the plan of care.
    - Continued stay review is conducted regularly throughout an injured worker's hospitalization to assess the need for continued inpatient treatment, to evaluate the appropriate level of care, delays in service, complications, and assess the status of discharge planning. Discharge review is conducted to ensure injured workers are discharged only when they are medically stable.
    - Concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the receipt of the information reasonably necessary to make the determination, but in no event more than fourteen (14) days from the date of the medical treatment recommendation by the physician. (8 CCR § 9792.9.3 (b))
    - Medical care provided during concurrent review shall not be discontinued until the injured worker's physician has been notified of the decision, and a care plan has been agreed upon by the physician that is appropriate to the medical needs of the injured worker. (8 CCR § 9792.9.5 (f)(1))

ii. The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment (8 CCR § 9792.9.5 (f)):
    a. Medical care will 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 employee's medical needs.
    b. 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.

Emergency Services

i. Failure to obtain prior authorization for emergency health care services shall not be an acceptable basis for refusal to cover medical services.
ii. Emergency health care services may be subjected to retrospective review.

Retrospective Review

Utilization review conducted after medical services have been provided and for which approval has not already been given.

i. Retrospective review is conducted after discharge or end of treatment to determine trends or patterns in either under-utilization or over-utilization of medical resources and as a performance review of Utilization Management.
ii. In cases where the review is retrospective, the decision shall be communicated to the requesting physician who provided the medical services and to the individual who received services, or to the individual's designee, within thirty (30) days of receipt of information that is reasonably necessary to make this determination.
iii. Retrospective decisions to approve, modify or deny a request for authorization shall be made within thirty (30) days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination. (8 CCR § 9792.9.1(c)(5))

30 Day Exemption Review

MEDEX recognizes that treating physicians may render medically necessary treatment or services to an injured worker without prospective utilization review within the first 30 days after the date of injury if the below conditions are met. (8 CCR § 9792.9.7(a))

- The treatment is for a compensable/accepted body part or condition
- The treatment/service is consistent with MTUS guidelines
- The initial treating physician submits a DIR Form 5021 and a request for authorization outlining all treatment and/or services anticipated to be provided in the first 30 days after the date of injury
- Subsequent treating physicians during the period should submit a request for authorization indicating all treatment being rendered

MEDEX intake staff review every request for authorization for 30 day exemption review eligibility. The 30 day exemption review acts as a retrospective review to ensure that all treatment rendered to the injured worker during the initial 30 days after the date of injury are consistent with MTUS guidelines. Any treatment identified below would not qualify for the 30 day exemption and will be reviewed under the appropriate prospective, concurrent, or retrospective review workflows. (8 CCR § 9792.9.7(b))

- Pharmaceuticals, except exempt medications
- Non-emergency surgery and peri-operative services provided within any setting.
- Psychological and psychiatric treatments, including diagnostics, psychotherapy, and individual/group therapy services.
- Home health care
- Advanced imaging, except x-rays.
- DME, prosthetics, orthotics, and supplies where the purchase or rental price exceeds $250.
- EMG, NCV, NCS studies used to diagnose, evaluate, and treat injured workers.

- Spinal injections including medial branch blocks, facet joint injections, intradiscal injections, epidural injections, and sacroiliac joint injections

Requests for authorization that qualify for the 30 day exemption will be identified with the "30 day exemption review" referral type on all UR determination letters.

Adjuster Authorization

MEDEX manages the distribution of certified letters that have been approved on behalf of the claims administrator. Upon receiving the approved Request for Authorization from the claims administrator, MEDEX provides written certified notice to the requesting physician, the injured worker, and the injured worker's representative. MEDEX maintains a database (log) of the certified notices that can be accessed during regular business hours by phone, mail, email, and fax. Adjuster authorizations can be provided without the submission of a DWC form RFA, and can be based on the client-specific pre-authorization list. (8 CCR § 9792.7(a)(5)).

Appeal

MEDEX coordinates its appeal activities with regulatory appeal processes, which may be available to the worker. MEDEX processes appeals of denials and issues appropriate determination letters in a timely manner. Appeal reviews are available for both non-urgent cases and expedited cases. As part of the appeal process, MEDEX allows the claimant, provider, or rendering facility to submit written comments, documents, records, and other information related to the claim. MEDEX processes the following types of appeals:

i. **Reconsideration**, may be initiated for one of three reasons: after a successful peer-to-peer conversation with the requesting physician, at the request of the nurse case manager or claims examiner with new supporting documentation, or following a conditional denial due to an unanswered request for information. In the case of a conditional denial, if the provider does not respond to a request for additional information within the regulatory timeframe, the treatment may be denied due to lack of information. This means the denial is not final and may be overturned if the required information is submitted within the allowed period, at which point the same clinical peer reviewer will re-evaluate the request.

ii. **Internal Appeal**, which is initiated by the injured worker, their representative, or the requesting physician after an initial denied or modified review determination is issued. The internal appeal must be requested no later than 10 days after receipt of the adverse determination is received. MEDEX will assign to a different reviewer from the original request, and will issue a determination for a valid appeal no later than 30 calendar days after receiving

the appeal request. The appeal determination will be communicated to the requesting physician, the injured worker, and their attorney if represented. The IMR form will be completely filled out and will indicate that the decision is a modification after appeal. (8 CCR § 9792.10.1(f))

Should the initial denial be upheld in the appeal, MEDEX issues a written notification of the adverse appeal determination to all stakeholders. The written notice includes the following information:

a. The principal reason(s) for the determination to uphold the denial.
b. The clinical rationale used in making the denied decision.
c. Information about additional appeal mechanisms available, if any.
d. The unique identifier assigned to the initial request for authorization.

Should the initial denial be overturned in the appeal, MEDEX issues a written notification of the approved appeal determination to all stakeholders. The written notice includes the following information:

a. The principal reason(s) for the determination to overturn the denial.
b. The clinical rationale used in making the approved decision.
c. The unique identifier assigned to the initial request for authorization.

Deferral - Pre-review Screening and Incomplete Referrals

Should necessary elements be missing from the referral during the review creation, MEDEX non-clinical administrative staff may perform pre-review screening. This screening must be completed within one (1) business day of receiving the request for authorization or appeal, but no later than five (5) business days from the date of receipt. MEDEX non-clinical administrative staff shall record all information gathered and communication made during pre-review screening in the claimant's utilization management electronic file.

MEDEX defines pre-review screening as including one or more of the following:

- Collection of structured clinical data, which is precise information that allows for exact matching against specific medical terms, diagnoses, procedure codes, or other explicit choices without requiring interpretation.
- Asking scripted clinical questions.
- Accepting responses to scripted clinical questions.
- Taking specific actions, including amending items in the electronic file, as explicitly linked to each of the possible responses.

MEDEX's non-clinical administrative staff will not deviate, and pre-review screening shall not include any of the following:

- Applying clinical judgment or interpretation.
- Accepting unstructured clinical information.
- Deviating from the scripted clinical questions.
- Engaging in unscripted clinical dialogue.
- Asking follow-up clinical questions
- Issuing determinations of any kind.

For all requests for authorization, if MEDEX non-clinical staff determine that the Request for Authorization is not complete as defined in 8 CCR § 9792.6.1(u)(2), they may either treat the form as complete and initiate review for compliance with the timeframes set forth in 8 CCR § 9792.9.1 (b) within 5 business days of receipt:

- The request for authorization will be marked as "not complete" and returned to the requesting physician, specifying the reasons for the return of the request.

Deferral - Determination of Need for New Reviews Following a Denial

A request for authorization does not need to be reviewed and will be considered a duplicate if the same request from the same provider is received within 12 months of the denial, unless the new request is supported by a documented change in facts material to the basis of the utilization review decision. The 12-month rule does not apply to a repeat treatment request if the request includes an express or unequivocal statement by the requesting physician that indicates or opines that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of the change. (8 CCR § 9792.9.5(g))

MEDEX may choose to take no action on a request for authorization if the following conditions are met:

- The same requested treatment was denied within 12 months from the date of the denial;
- The request is submitted by the same requesting physician or another physician within the requesting physician's practice group; and
- There is no documented change in the facts material to the basis of the original denial.

When determining if there has been a change in the facts material to the basis of the original denial, MEDEX's default assumption will be that such a change has occurred, necessitating a new review. However, if a licensed healthcare professional finds that no such change has taken place, a new review may not be required. This finding must consider whether there has been:

- A relevant supportive change in the claimant's condition;
- Relevant supportive findings from new diagnostic studies or imaging; or

- A relevant supportive change in interval clinical history.

Deferral - Disputes of Liability

The utilization review of a 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, based on reasons other than medical necessity. These reasons may include non-compensable body parts and denied claims. MEDEX will not defer a request for authorization if the requesting physician indicates that there is a change in material fact with documentation of such change included in the request. (8 CCR § 9792.9.2(a)(1), (a)(2)(B))

If MEDEX disputes liability under this subdivision at the claims administrator's request, a written letter deferring utilization review of the requested treatment must be issued no later than five (5) business days from receipt of the request for authorization. This written decision must be sent to the requesting physician, the claimant, and, if represented, the injured worker's attorney. The written decision must include the following information specific to the request:

A. The date on which the request for authorization was first received.
B. A description of the specific proposed medical treatment for which authorization was requested.
C. A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part(s), or the recommended treatment.
D. A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board (WCAB).
E. The following mandatory language advising the claimant:
   "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your claims examiner (Claims examiner name) at (Claims examiner phone number). However, if you are represented by an attorney, please contact your attorney instead of us."
   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 number 1-800-736-7401."

If utilization review is deferred, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, the time

for the claims administrator to conduct retrospective utilization review in accordance with this section shall begin on the date the determination of the claims administrator's liability becomes final. The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a request for authorization after the final determination of liability.

Requests for Additional Information

Following receipt of a completed (or accepted as completed) request for authorization, the Second Level Reviewer may request additional information from the provider to determine medical necessity within 5 business days from the date of receipt of the request for authorization (8 CCR § 9792.9.6(b)(1)). The request for additional information will only be sent if the reviewer is not in receipt of all the information reasonably necessary to make a determination, additional tests or examinations need to be performed, or if the reviewer needs a specialized consultation and review of medical information by an expert reviewer. (8 CCR § 9792.9.6(a)(1)(A-C))

The reviewer will notify all parties, including the requesting physician, the injured worker, and the injured worker's attorney (if represented) within 5 business days that the reviewer cannot make a decision within the required timeframe, and request

The timeframe for the decision will be extended only if the referral contains a mix of formulary and non-formulary treatments, or non-formulary treatments only. The timeframe will be extended up to 14 calendar days. If the requested information is not received after issuing the request for additional information, determinations will be issued within:

- 5 business days of receiving the requested information for prospective and concurrent reviews (8 CCR § 9792.9.6(d)(1))
- 30 calendar days of receiving the requested information for retrospective reviews (8 CCR § 9792.9.6(c)(1))
- 72 hours of receiving the requested information for expedited reviews

If the requested information is received after issuing the request for additional information, determinations will be issued within:

- 14 calendar days of receiving the initial request for authorization for prospective and concurrent reviews (8 CCR § 9792.9.6(d)(1))
- 30 calendar days of receiving the initial request for authorization for retrospective reviews (8 CCR § 9792.9.6(d)(3))
- 72 hours of receiving the requested information for expedited reviews. (8 CCR § 9792.9.6(d)(2))

Decisions shall be made within 14 calendar days of receiving the initial request for authorization when additional information is requested, in accordance with 8 CCR § 9792.9.1(f)(3)(A).

If a Second Level Reviewer determines that a decision cannot be made due to the need for additional examinations, diagnostic tests, or specialty consultation, a written request must be sent to the requesting physician, injured worker, and, if applicable, the injured worker's attorney within 5 business days of receiving the request for authorization, or sooner if required by 8 CCR § 9792.9.1(f)(2)(B). The notice must include the reason a decision cannot be made, the specific additional information or specialty required, and the anticipated date a determination will be issued.

Decisions involving additional tests, exams, or specialty consultations must be made within 30 calendar days of receiving the initial request for authorization, as outlined in 8 CCR § 9792.9.1(f)(3)(B).

If a request is denied due to insufficient information or lack of additional test results, the denial shall state that the decision will be reconsidered upon receipt of the requested information, consistent with 8 CCR § 9792.9.1(f)(3)(A-B).

The system shall generate and deliver required correspondence to stakeholders within the timelines specified in 8 CCR § 9792.9.1. All attempts to obtain additional information shall be documented accordingly.

Types of Reviewers

MEDICAL DIRECTOR

The Medical Director is the 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.

i. Ensures that the process by which the claims administrator or other entity reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services complies with the requirements of Labor Code § 4610.
ii. Serves as Co-Chair of the Utilization Review Committee.
iii. Participates in the annual review of the Utilization Review Plan.
iv. Serves as a resource for MEDEX Utilization Management services.
v. Receives referrals for medical and surgical cases not initially approved during the First Level review process.

vi. Is available by telephone between the hours of 10:00 AM and 2:00 PM Pacific Time to discuss review determinations with physicians.
vii. Is responsible for all decisions made in the utilization review process.
viii. The Medical Director contact information is as follows:

Name: Paul Kim, MD
License No: A114242
Address: MEDEX Healthcare
2618 San Miguel Dr. #477
Newport Beach, CA 92660
Telephone: 949-221-1700 ext. 304
Fax: 949-612-9207
Qualifications:Board Certified, Occupational Medicine
Board Certified, Preventive Medicine

CLINICAL PEER REVIEWERS

Clinical peer reviewers may be licensed, in any state or the District of Columbia, as a doctor of osteopathy, chiropractic practitioner, psychologist, acupuncturist, optometrist, dentist, or podiatrist. The clinical peer reviewers are competent to evaluate the specific clinical issues involved in medical treatment services within the scope of the physician reviewer's practice; they are Board Certified by a specialty board recognized by the American Board of Medical Specialties or its Osteopathic equivalent. (8 CCR § 9792.7(b)(2))

i. May receive referrals, directly from the Medical Director or his designee, for medical and surgical cases not initially approved during the First Level review process.
ii. Currently have an active practice in the major clinical area being reviewed and admitting privileges and direct patient care responsibilities in medical treatment facilities.
iii. Serves as a resource for the MEDEX Case Management Services.
iv. Are available by telephone to discuss determinations with physicians.

INDEPENDENT MEDICAL REVIEW (IMR)

i. Medical treatment disputes for injuries occurring on or after January 1, 2013 will be resolved by a physician through a process known as Independent Medical Review. A request for medical treatment must go through utilization review to confirm that it is medically necessary before it is approved. If utilization review denies or modifies the treating physicians request for medical treatment because the treatment is not medically necessary, the injured employee may request a review of that decision

through the IMR process by completing an Application for Independent Medical Review, DWC Form IMR. Beginning July 1, 2013, IMR became effective for all dates of injury.

ii. When a utilization review decision denies or modifies a treatment recommendation, MEDEX will provide 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, with an Application for Independent Medical Review, DWC Form IMR. A pre-addressed envelope will be provided to the injured worker so they can return the DWC Form IMR to the Administrative Director or the Administrative Director's designee to initiate the IMR process. MEDEX will complete the DWC IMR form on behalf of the claims administrator and include on the form any information required by the Administrative Director to facilitate the completion of the IMR process.

a. The adverse determination will include 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 the 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 (IMR), DWC Form IMR, within the timeframe indicated on the last page of the application.
b. The adverse determination will include the following mandatory language advising the injured worker:
    i. "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 (claims examiner name) at (claims examiner phone number). However, if you are represented by an attorney, please contact your attorney instead of me."
    ii. And
    iii. "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."
c. The IMR form will identify the appropriate timeframes based on the denied/modified treatment requests:

i. Adverse determinations that include only drug formulary medications will have the 10 day timeframe identified on the form. (8 CCR § 9792.10.1(a)(2))
ii. Adverse determinations that include both formulary medications and non-pharmaceutical treatment will have the 30 day timeframe identified on the form. (8 CCR § 9792.10.1(a)(1))
iii. Expedited reviews will be identified on the form. (8 CCR § 9792.10.1(d))

Grievance and Dispute Resolution Procedure

MEDEX has developed and shall implement the following written policy to consider and adjudicate grievances and disputes initiated by providers and injured workers, and to provide for a fair, equitable, and expeditious disposition of such grievances and disputes ("Grievance Procedure"). The Grievance Procedure, as applied to providers and injured workers, shall assure implementation of the following general procedures.

The Chief Executive Officer or his/her designee shall have primary responsibility for the maintenance of the Grievance Procedure, including its operation, the review of any emergent patterns of grievances, and the formulation of any policy changes and procedural improvements in the administration of the Grievance Procedure.

i. A copy of the Grievance Procedure can be made available in writing, as requested. The employer is responsible for communicating the procedure to the injured worker.
ii. MEDEX shall maintain a telephone number for the filing of provider and injured worker complaints and grievances at each of the Primary Treatment Access Sites maintained by MEDEX for the delivery of workers' compensation health care services.
iii. Complaint forms and a copy of the Grievance Procedure shall be available at each of the Primary Treatment Access Sites, through the Claims Administrator, as well as in the office s of each participating provider of worker's compensation health care services. At each of the Primary Treatment Access Sites, an Operations Department representative shall be available to assist injured workers in the preparation of written complaints and the filing of grievances.
iv. In the event a complaint is received by the provider or an injured worker in person or in writing, an Operations Department representative shall promptly enter the substance of the complaint in the Grievance Logbook. The entry shall include the date of the complaint, the name and job title of the person recording the complaint, and, upon resolution, the ultimate disposition of the complaint.
v. A record of the documented complaints and grievances shall be reviewed quarterly by the Governing Body of MEDEX and the Chief Executive Officer, or his/her designee. Minutes of such meetings of the Governing Body shall be maintained and shall document compliance with policies and procedures governing the tabulation of complaints and grievances. Record of complaints will be available upon request to the Administrative Director of the Division of Workers' Compensation.
vi. MEDEX shall advise providers and injured workers in the Disclosure From (entitled HCO Pamphlet) of their right to file written complaints with the

Administrative Director of the Division of Workers' Compensation of the Department of Industrial Relations.

vii. MEDEX shall, for a period of 5 years, maintain records of all written complaints and grievances concerning the provision of occupational health services, including the name of the grievant, the nature of the complaint or grievance, and the manner in which the grievance was resolved or referred for further action.

viii. MEDEX assures that they do not discriminate against an injured worker solely on the grounds that the injured worker filed a complaint or grievance.

Procedure for Disposing of Grievances

MEDEX shall implement the following policies and procedures in resolving complaints and grievances initiated by providers of workers' compensation health care services.

i. All complaints submitted orally or in writing shall be directed to the Chief Executive Officer or his designee, and a representative of Operations Department shall thereafter promptly record the complaint in the Grievance Logbook.

ii. Within 20 days following receipt, the Operations Department shall acknowledge receipt of the complaint and notify the complainant by certified mail of the name of the Operations Department representative to be contacted regarding the complaint and the progress towards resolution.

iii. If the complaint does not concern the medical reasonableness or medical necessity of treatment recommended by a treating physician, the complaint shall be referred to the Quality Assurance Committee for investigation and adjudication. The Operations Department shall notify the complainant by certified mail of the decision of the Quality Assurance Committee, and the complainant's rights of appeal, within thirty (30) days from the date the complaint was filed, unless MEDEX can identify appropriate reasons for an extension of such time period with respect to a particular complaint.

iv. If the complaint concerns the medical reasonableness or medical necessity of treatment recommended by a treating physician, the injured worker, or someone she or he designates may request Independent Medical Review (IMR). The injured worker, within thirty (30) days must send the original signed Application for Independent Medical Review (IMR) and a copy of the utilization review denial of treatment to the Division of Workers' Compensation – IMR, c/o Maximus Federal Services.

Complaints Filed with the Administrative Director

Providers and injured workers have the right to file, at any time, a written complaint regarding MEDEX, with the Administrative Director of the Division of Workers' Compensation of the California Department of Industrial Relations. It is not required to file a complaint with MEDEX before a complaint is filed with the Administrative Director

Forms and procedures for filing a complaint with the Administrative Director are available from the Operations Department. For assistance in preparing and filing a complaint with the Administrative Director, contact the Operations Department or the Division of Workers' Compensation (DWC). The Division of Workers' Compensation can be reached at 1-800-277-1767.

Provision for Disposing of Injured Worker Grievances

MEDEX shall implement the following policies and procedures in resolving complaints and grievances initiated by injured workers receiving workers' compensation health care services.

i. All complaints from injured workers' involving grievances or disputes shall be recorded in the Grievance Log by the Operations Department representative and referred to the appropriate committee or individual for action and disposition.
ii. Within twenty (20) days following receipt, the Operations Department shall acknowledge receipt of the complaint and notify the complainant by certified mail of the name of the Operations Department representative to be contacted regarding the complaint and the progress towards resolution.
iii. Complaints not involving quality of care issues shall be referred to Operations Department for review, investigation, and resolution. Complaints involving quality of care issues shall be referred to the Case Manager for review, investigation, and resolution. The Operation Department and the Case Manager will take action to ensure that the complaint is informally resolved to the complainant's satisfaction. Within thirty (30) days following the filing of a complaint, the complainant shall be notified by the Operations Department by certified mail of the disposition of the complaint.
iv. If the complainant is dissatisfied with the decision of the Operations Department or the Case Manager, the complainant shall have thirty (30) days to appeal such a decision by sending a written notice of appeal by certified mail to MEDEX.
v. An appeal from the decision of the Operations Department or the Case Manager shall be referred to the Quality Assurance Committee for review and adjudication. The Operations Department shall notify the complainant by

certified mail of the decision of the Quality Assurance Committee, and the complainant's right of appeal, within thirty (30) days from the date the complaint was filed, unless MEDEX can identify appropriate reasons for an extension of such time with respect to a particular complaint.

Availability of the UR Plan

i. Upon request of the public, the claims administrator or utilization review organization shall make available the complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process.

ii. The claims administrator may make available the complete utilization review plan consisting of policies and procedures and a description of the utilization review process, 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: charge not to exceed $0.25 per page plus actual postage costs.

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Annual Evaluation of the Utilization Management Program

The Utilization Management (UM) Program evaluation is completed annually to determine the overall effectiveness of the program in meeting the established goals and objectives based on outcome information from the following components:

- Evaluation of the UM Program structure and function
- Review and assessment of UM activities
- Evaluation of reviewer reliability in applying criteria to UM decisions
- Tracking and trending of measures to assess overall UM department performance
- Recommendations on UM program objectives for the next year
- Identifying and revising parts of the program plan that need revision

The UM Program evaluation is conducted by the UM Committee and is approved by the QA Committee. The UM Program is evaluated against DWC and URAC regulatory standards to ensure compliance with all relevant UM standards. The annual program evaluation is designed to:

- Evaluate the overall effectiveness of the UM Program

- Ensure re-evaluation of policies and workflows
- Explore barriers and limitations in meeting the stated goals and objectives
- Identify objectives, activities, and targets for the following year

The UM Program evaluation will be recorded in a separate document annually, and will include a written description of how MEDEX implements and meets the objectives of the UM program from the prior year. The COO and Director of Managed Care sign and date the approved evaluation.

APPENDIX A

Sample Decision Letter Templates

APPENDIX B

Client Vendor List