Status Medical Management

Modesto CA 95352

Utilization Review Plan 2020

UR Plan Revised 10/21/2020

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Utilization Review Definitions

1. “ACOEM Practice Guidelines”: the American College of Occupational and Environmental Medicine’s Occupational Practice Guidelines, Second Edition.
2. “Approval” or “Approve” means a decision that the requested treatment or service is Authorized as Medically Appropriate to cure or relieve the effects of a compensable industrial injury.
3. “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 section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on either a completed “Request for Authorization for Medical Treatment,” DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2) 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, section 9792.9.1, and may be provided by utilizing the indicated response section of the “Request for Authorization for Medical Treatment,” DWC Form RFA if that form was initially submitted by the treating physician.
4. "Claims Administrator" is a self-administered workers' compensation insurer, subject to labor code section 4610. The “Claims Administrator” may utilize an entity contacted to conduct its utilization review responsibilities.
5. "Concurrent review" means utilization review conducted during an inpatient stay.
6. "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," Form DLSR 5021, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.
7. “Denial” means a decision by a physician reviewer that the requested treatment or service is not authorized.
8. “Dispute liability” means an assertion by the claims administrator that a factual, medical or legal basis exists 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.
9. “Disputed medical treatment” means medical treatment that has been modified or denied by a utilization review decision on the basis of medical necessity.
10. "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.
11. “Employer” (unless otherwise indicated by context) means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.
12. "Expedited review" means utilization 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.
13. "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, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.

14. "Health care provider" means a provider of medical services, as well as 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 section 4616.
15. “Immediately” means within one business day.
16. "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.
17. "Medical services" means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.
18. “Medical Treatment Utilization Schedule” means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27; updated as of December 2017 (CA MTUS).
19. “Medical Treatment Utilization Schedule (MTUS Drug Formulary)” means the current version of the CA drug formulary adopted by the Administrative Director pursuant to Title 8, of the California Code of Regulations beginning with sections 9792.27.1.
20. “Medically necessary” and “medical necessity” mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied as set forth in the medical treatment utilization schedule, including the drug formulary, adopted by the administrative director pursuant to Section 5307.27:
    a. The guidelines, including the drug formulary, adopted by the administrative director pursuant to Section 5307.27.b. Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;
    b. Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
    c. Nationally recognized professional standards.
    d. Expert opinion.
    e. Generally accepted standards of medical practice.
    f. Treatments that will likely provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.
21. “Modification” means a decision by a physician reviewer that part of the requested treatment or service is not medically necessary.
22. “Peer Reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractor practitioner licensed by any state or the District of Colombia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer’s practice.
23. "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.
24. "Request for authorization" means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) and 8CCR §9792.6.1(t) or a written request for a specific course of proposed medical treatment .
25. "Retrospective review" means utilization review conducted after medical services have been provided and for which approval has not already been given.
26. “Utilization review decision” means a decision pursuant to Section 4610 to modify or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with, the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402. “Utilization review decision” may also mean a determination, occurring on or after January 1, 2018, by a

physician regarding the medical necessity of medication prescribed pursuant to the drug formulary adopted pursuant to Section 5307.27.

27. "Utilization Review Process" means utilization management (UM) 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. Utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed. The utilization review process begins when the completed DWC Form RFA, or a request for authorization accepted as complete under section 9792.9.1(c)(2), 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.
28. "Written" includes a communication transmitted by facsimile or in paper form. Electronic mail may be used by agreement of the parties within HIPAA requirements.

INTRODUCTION

Status Medical Management is a URAC (Utilization Review Accreditation Commission) accredited Utilization Review Organization (URO) registered with the State of California since 2004.

Status Medical Management provides Utilization Management (UM) services on behalf of their clients. The Utilization Review Plan and Processes were established and are maintained in compliance with Labor Code §4610 et seq and applicable regulations.

Utilization management functions are governed by policies and procedures that meet specified criteria to ensure review decisions are issued timely, the scope of medical material used in the review decision is consistent with MTUS, including the drug formulary (5307.27), peer-to-peer consultations are available, information related to an internal appeal procedure is provided, and a policy preventing financial incentives to doctors and other providers based on utilization review decisions is identified.

Mission Statement

To ensure treatment extended to patients is consistent with evidence-based practice, peer–reviewed guidelines, and National Treatment Standards as outlined by the Administrative Director. The goal is for patients to experience a return to a quality of life through disability management and restoration of function as the result of appropriate and timely medical care.

PROGRAM REQUIREMENTS (9792.9.1)

This Utilization Review process and written policies and procedures are being submitted to the administrative director in compliance with 4610(g)(5) on or before July 1, 2018.

Criteria used in the utilization review process to determine whether to approve, modify, or deny medical treatment services are:

- 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 annually and updated as required
- Disclosed to the physician and patient, if used as the basis of a decision to modify or deny services in a specified case under review.
- The approved utilization review process to include policies and procedures is available to the public upon request through:
  - Electronic means
  - Hard copy for a reasonable copying fee not to exceed 0.25 per page plus actual postage
  - Status Medical Management Web site http://simon-companies.com/medical-management/
- An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested.
- A charge shall not be required for an employee whose physician's request for medical treatment services is under review.

Telephone access is available by telephone (800-647-7079) on normal business days from 9:00 am to 5:30 pm Pacific Coast time of each normal business day (4600.4(a)) for health care providers to request authorization for medical services and/ or to schedule Peer discussion related to specific UR decisions. Should the requesting physician wish to discuss a written UR decision and the original reviewer is unavailable, the case may be discussed with another reviewer who is competent to evaluate the specific clinical issue(s) involved in the medical treatment.

A facsimile (209-574-2840) is maintained to receive communications from health care providers requesting authorization for medical services during and after normal business hours.

Electronic Reporting to State
Status Medical Management shall provide electronic documents for every utilization review performed as required under 4610 (o) in the format prescribed by the DWC.

Financial incentives
Status Medical Management does not provide nor offer financial incentives or consideration to any physician based on the number of Utilization Review modifications or denials made by the physician under this section.

The third party administrator, Pegasus Risk Management has provided written disclosed to their clients/ employers of financial interest in Status Medical Management (see attached) as well as copied the Administrative Director. A copy of the financial interest disclosures is also available at http://simon-companies.com/medical-management/.

PROGRAM STRUCTURE

Designated Medical Director (In compliance with Labor Code §4610(g)(2):

David Rollins, MD
California License Number: G 50655
1524 McHenry, Suite 135
Modesto, CA 95350
P: 209.575.5801

David Rollins, MD, holds an unrestricted medical license to practice medicine in the state of California (section 2050 or 2450 of the Business and Professions Code); medical specialties include general practice, family practice, and occupational medicine. (9792.7(a)(1))

Dr. Rollins is available from 2:00 to 4:00 Tuesday and Thursday to return calls (8 CCR §9792.9.1(e)(5)(K).

Medical Director:

- The medical director oversees and evaluates the process by which the employer or other entity reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services compliant with the requirements of Labor Code 4610 and corresponding regulations.
- The Medical director is responsible for all decisions rendered through the Status Medical Management utilization review program.
- Contributes to the development of overall philosophy and policies of the UR Program as well as the implementation of Best Practices.
- Attends quarterly meetings to review and discuss the use of guidelines as well as UR Policies/ Procedures and program updates
- Reviews all RFAs made at the occupational level for approval, modification, or denial prior to, retrospectively, or concurrently in compliance with Labor Code 4610 (g)(2) and implementing regulations. (9792.7 (b)(1))
- Participates in QA discussions of complex cases
- Provides periodic review to identify trends and opportunities for educational interventions to improve quality and ensure consistency of UR decision-making.

In the event the requested medical treatment falls outside the Medical Director's scope of practice, the requested medical treatment will be referred to a UR vendor partners for Peer Review.

UR vendor partners:
Status Medical Management (SMM) maintains a relationship with several multi-specialty physician groups that are URAC accredited.

All Peer Review Physicians are trained with regards to the ACOEM Guidelines effective December 1, 2017, the Medical Treatment Utilization Schedule (MTUS) and Drug Formulary effective January 1, 2018; The Official Disability Guidelines (ODG) and thereafter other nationally recognized, evidence-based guidelines developed on sound clinical processes and principles by physicians in active clinical practice that are peer-reviewed.

In addition, it is understood by Peer Review Physicians that an RFA may not be denied on the grounds of causation when the requested treatment is otherwise medically appropriate for the presenting condition.

Specialty/ Expert Peer Reviewers are Board Certified in their specialty and maintain unrestricted medical licensure to practice medicine. The **Expert Peer Reviewer** can be a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist or chiropractic practitioner licensed by any state or the District of Columbia. They must be competent to evaluate the specific clinical issues involved in the medical treatment services, the services are within their scope of practice and they are contracted to provide specialized services in strict compliance with California law as well as meet the highest practice standard.

Utilization Review Unit
Status Medical Management works with claims staff for implementation and training related to the utilization review process as well as reviews requirements for compliance with statutory regulations. In addition, Status Medical Management works with the Medical Director and claims staff in the development/ periodic review of Best Practices to streamline medical treatment requests.

UR Coordinator
The UR Coordinator is responsible for the management of the URO referral process, securing medical determines, and disseminating the determinations to all parties within established timelines.

UR Director of Operations Responsibilities**:**

- Works with the Medical Director to ensure the process by which RFA are reviewed.
- Reviews and updates the URO plan under the supervision of the Medical Director
- Contributes to the development and implementation of Best Practices
- Attends quarterly meetings to review and delineate program updates
- Participates in QA discussions of complex cases

Nurse staff:

- Registered Nurses/ Licensed Vocational Nurses who hold unrestricted nursing licenses, will review initial RFA consistent with the Medical Treatment Utilization Schedule, drug formulary, ACOEM Guidelines, ODG, established Best Practices as well as other standard treatment guidelines and peer-reviewed literature.

The Nurses understands that in the event they are unable to issue an authorization, the RFA will be referred for Peer Review. The Nurse understands that only the Peer Review Physician can issue a modification or denial decision (9792.7(b)(2), 9792.9.1(e)(1)).

UTILIZATION REVIEW PROCESS

Status Medical Management (SMM) provides utilization management services that Concurrently, Prospectively, or Retrospectively review and either approve, modify, issue a time extension, or deny a valid RFA based on whether the requested medical treatment is reasonably necessary to cure or relieve the effects of an injury/ illness.

Authorization is required for medical treatment and in the effort to ensure a timely and seamless prior authorization process, Status Medical Management has, through the collaborative efforts of our Medical Director, nurse staff and seasoned claims personnel established Best Practices (attached). The Best Practices delineates treatment that can be authorized without Peer Review.

When a medical treatment request is an outlier to the Best Practices, Medical Treatment Utilization Schedule (MTUS), the Drug Formulary effective January 1, 2018 and other recognized treatment guidelines, the requested treatment is further reviewed to determine the benefit to the patient when compared to the cost effectiveness of the Utilization Review process.

Utilization review is limited to a review on the basis of medical necessity and does not include determinations of the work-relatedness or for the purpose of determining whether the medical services were accurately billed.

A physician providing treatment under Section 4600 shall send any RFA for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer, or other entity according to rules adopted by the administrative director (4610 (g)(2). If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, or deny requests for authorization, that employer, insurer, or other entity shall request only the information reasonably necessary to make the determination.

Clinical Peer review will be conducted for all cases where a clinical determination to certify cannot be made by an initial clinical reviewer. If any portion of requested services is not approved, the RFA under review will be referred for clinical peer review. All clinical peer reviews must be documented and specify the clinical rationale for the determination.

Process

1. An RFA is received by the Claims Examiner initially.
2. The Claims Examiner reviews the RFA against established Best Practices and in the event they are not able to authorize, the RFA is referred for Utilization Review.
3. The nurse will review the RFA, medical documentation against the following to determine whether the RFA is within treatment criteria (It is possible that treatment is within standards but may not be medically necessary):
    A. American College of Occupational and Environmental Medicine's (ACOEM) Practice Guidelines
    B. Medical Disability Advisor by Presley Reed, MD.
    C. Official Disability Guidelines –most current version available.

D. State of California MTUS
E. State of California drug Formulary

4. When an RFA is consistent and within criteria, a certification will be issued.
5. The Initial Clinical Reviewer is encouraged to contact the requesting provider if additional information is needed to complete the review.
6. The Initial Clinical Reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought when it appears inconsistent with the criteria. The requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the initial reviewer may approve the amended RFA.
7. The Initial Clinical Reviewer will utilize clinical judgment to consider the specifics of the RFA and whether a departure from applicable criteria applies.
8. If the Initial Clinical Reviewer determines that authorization cannot be issued, the RFA will be forwarded to a Clinical Peer Reviewer (in the same license category as the original provider) and/or Specialty Consultant Reviewer (same scope of practice).
9. Clinical Peer Reviewer and/or Specialty Consultant Reviewer will hold an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States; and unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting a peer clinical review.
10. The Clinical Peer Reviewer and/or Specialty Consultant Reviewer will:
    a. Review all of the documentation previously considered by the non-physician reviewer and determine if the proposed treatment should be authorized.
    b. Attempt to contact the ordering physician by phone for peer to peer discussion regarding the RFA as well as the treatment plan and rationale.
11. The Medical Director is available to discuss determinations with attending physicians or other ordering providers and to provide opinion about the medical condition, procedures, and treatment under review within his scope of practice.
12. Peer review determinations will be returned to Status, Inc. within timelines referencing clinical rationale for certification or non-certification and cite guidelines referenced.
13. If Certification is rendered, notification will be sent to all parties within timeline.
14. Documentation of all interactions - including date, time, requests, certification status, and rationale – will be completed by Status, Inc. UR staff.
15. When a Non-Certified determination is rendered by the Clinical Peer Reviewer and/or Specialty Consultant Reviewer, the requesting provider will be notified the day of the determination in writing or telephone should a fax is not available (not to exceed 5 business days from receipt of the RFA). The determination notification will include an explanation that written confirmation will be forthcoming.
16. Written correspondence will be forwarded within (2) two business days for prospective reviews to the attending physician or other ordering provider, facility rendering the service, patient, and/ or payer outlining:
    a. Request and Tracking information (reference number)
    b. Certification status
    c. Clinical rationale used in making the non-certification decision will include:
        i. The name of the Clinical Peer Reviewer and/or Specialty Consultant
        ii. A phone number to reach Status, Inc.
        iii. Instructions for initiating the appeal process including timelines

d. Should the attending or ordering physician request peer to peer conversation within (3) three business days, the opportunity to discuss the non-certification determination with the clinical peer reviewer who made the initial determination will be initiated. If the original clinical peer reviewer who made the initial determination is not available arrangements with a different clinical peer will be offered.

17. Should a peer to peer conversation occur and the determination is overturned/ certified, certification will be sent.
18. If peer to peer conversation occurs and the determination remains Non-Certification, the patient or their representative has the right to initiate the Independent Medical Reviewer (IMR) process.
19. Reversal of Certifications
    a. Reversal of a certification status will only be made if new information relevant to the certification is made available to the reviewer.
20. In addition, the Initial Clinical Reviewer will assess for potential safety issues during prospective reviews to include but not limited to contraindicated treatment, conservative treatment not addressed or ruled out, adverse drug interactions, or inappropriate treatment.
21. The Initial Clinical Reviewer will communicate to the claims examiner and document the case file in the event a potential safety concern is identified.

Request for Authorization:
The request for authorization for a course of treatment as defined in section 9792.6.1(d) must be in written form set forth on the "Request for Authorization (DWC Form RFA)," as contained in California Code of Regulations, title 8, section 9785.5.

The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA.

The DWC RFA and/ or cover sheet will be deemed received by the claims administrator or URO via:

1. Facsimile or electronic mail on the date the form was electronically date stamped.

a. The DWC RFA or the cover sheet accompanying the form transmitted by facsimile transmission or electronic mail shall:
   a. Bear a notation of the date, time and place of transmission
   b. The facsimile telephone number or the electronic mail address to which the form was transmitted
   c. Or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission
   d. Or by a fax or electronic mail transmission report which displays the facsimile telephone number to which the form was transmitted
   e. When no electronic stamp is recorded, the date the form was transmitted shall be the date received.

2. A DWC Form RFA transmitted by facsimile 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 requesting physician must indicate if there is the need for an expedited review on the DWC Form RFA 9792.9.1 (a)(1).
3. Mail, absent documentation of receipt, shall be deemed to have been received five (5) business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service 9792.9.1 (a)(2)(A).

4. Certified mail with return receipt mail, the form, absent documentation of receipt, shall be deemed to have been received on the receipt date entered on the return receipt 9792.9.1 (a)(2)(B).
5. In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the DWC RFA shall be deemed to have been received five days after the latest date the sender wrote on the document 9792.9.1 (a)(2)(C).

The RFA must identify:

- The Injured worker
- The requesting provider
- The recommended treatment
- Signed by the requesting physician
- Be accompanied by documentation substantiating medical necessity on one of the following
    - **DFR** (Doctor's Fist Report)
    - **PR2** (Primary Treating Physician's Progress Report) form contained in Section 9785.2
    - Narrative report entitled "**Primary Treating Physician's Progress Report**" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2.
- Incomplete DWC Form RFA (as defined in section 9792.9.1(c)(2)(A): will be either treated as complete or returned to the requesting physician marked "not complete" specifying the reasons for the return of the RFA no later than five (5) business days from receipt.
- The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.
- The claims administrator may accept a request for authorization for medical treatment that does not utilize the DWC Form RFA, provided that:
  (1) "Request for Authorization" is clearly written at the top of the first page of the document;
  (2) All requested medical services, goods, or items are listed on the first page; and
  (3) The request is accompanied by documentation substantiating the medical necessity for the requested treatment.
- A response to a request for additional information may be submitted in letter format.
- A narrative report or response letter to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2:
  "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code §139.3."

UR DECISION TIMEFRAMES

The initial 30 days following injury:

Labor Code 4610 (b): For all dates of injury occurring on or after January 1, 2018:

- Emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer
- Addressed by the medical treatment utilization schedule (MTUS) adopted pursuant to Section 5307.7
- Treated by a member of the medical provider network (MPN) or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600
- Within the 30 days following the initial date of injury

Treatment shall be authorized without prospective utilization review, except as provided in subdivision (c):

- The services rendered under this subdivision shall be consistent with MTUS.
- In the event that the employee is not subject to treatment with a MPN, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the

employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer.

Treatment rendered by a MPN physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer-selected physician, **the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.**

In the event a physician fails to submit the report required under Section 6409 and a complete request for authorization, the employer may remove the physician's ability to provide further medical treatment to the employee that is exempt from prospective utilization review 4610(e).

An employer may perform retrospective utilization review for any treatment provided pursuant to subdivision (b) solely for the purpose of determining if the physician is prescribing treatment consistent with the schedule for medical treatment utilization, including, but not limited to, the drug formulary adopted pursuant to Section 5307.27, 4610(f).

Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, rendered within the 30 days following the initial date of injury, shall be subject to prospective utilization review:

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

Emergency Health Care Services: 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 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 a employees' 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 employee's life or health or could jeopardize the employee's ability to regain maximum function.

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 (c)(3) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (c)(3).

Concurrent Review is a utilization review conducted during an inpatient stay.
Decisions to Certify, Modify, Deny, or request additional information must be made **within 5 business days** from the date of receipt of the RFA including supporting information reasonably necessary to make the determination, but in **no event more than 14 days** from the date of the medical treatment recommendation by the physician.

Medical care shall not be discontinued nor denied until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician. The care plan must be appropriate for the medical needs of the Injured Employee and consistent with the Medical Treatment Utilization Schedule (MTUS), the Drug Formulary effective January 1, 2018 and other recognized treatment guidelines. The Insurance carrier will be liable only for those services determined medically necessary to cure and relieve. If there is a disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute will be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062.

If appropriate information which is necessary to render a decision was not provided with the RFA, a written request for additional information shall be sent on at least 2 separate dates within 5 business days from the date of receipt of the RFA to the requesting provider. Requests for additional information, notifications of Time Extensions and utilization reviews conducted upon receipt of the requested information shall comply with 8 CCR 9792.9.1(f)(4)–(6).

Prospective Review: Utilization Review conducted prior to the delivery of requested medical treatment/ services unless the patient is hospitalized.

Decisions to approve, modify, deny or request additional information for non-formulary medical treatment/ services must be made in a timely fashion that is appropriate for the patient's condition, **not to exceed 5 business days** from the date of receipt of the RFA including supporting information reasonably necessary to make a determination.

If appropriate information which is necessary to render a decision was not provided with the RFA, a written request for additional information shall be sent on at least 2 separate dates within 5 business days from the date of receipt of the RFA to the requesting provider. Requests for additional information, notifications of Time Extensions and utilization reviews conducted upon receipt of the requested information shall comply with 8 CCR 9792.9.1(f)(4)–(6).

Decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of receipt of the medical treatment request. The request for authorization and supporting documentation may be submitted electronically under rules adopted by the administrative director.

Retrospective Review is a utilization review conducted after Medical Services have been provided and for which certification has not already been given.

Decisions to Certify, Modify or Deny must be completed within **30 calendar days** of receipt of the request for authorization and medical information that is reasonably necessary to make a

determination. In the event payment for the service is made within the time prescribed by Section 4603.2, a Retrospective Review decision to approve the service need not be otherwise communicated.

Extended time frame for decisions:
The time frame for decisions may only be extended under one or more of the following circumstances:

1. The claims administrator or reviewer is not in receipt of all of the information reasonably necessary to make a determination.

   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 RFA. The request shall be made on 2 separate days in writing and documented.

   In the event, information requested by the reviewer or non-physician reviewer that is reasonably necessary to make a determination is not received within fourteen (14) days from receipt of the completed RFA for a prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

2. The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice and/ or the reviewer needs a specialized consultation and review of medical information by an expert reviewer.

   The reviewer shall within five (5) business days from the date of receipt of the RFA 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 the specialty of the expert reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered.

   Should the results of the additional examination, test or the specialized consultation that was requested by the reviewer is not received within thirty (30) days from the date of the RFA, the reviewer shall deny the treating physician's request with the stated condition that the request will be reconsidered upon receipt of the results of the additional examination or test or the specialized consultation.

Documentation of Lack of Information Requests and Denial:
All attempts to obtain necessary medical information from the requesting physician will be made in writing (fax, mail or email) and documented on 2 separate dates prior to a Reviewer issuing a URO denial.

Applicability of Utilization Review Decision
A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the 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.

Neither the employee nor the employer shall have any liability for medical treatment furnished without authorization if the treatment is Modified, or Denied by a utilization review decision unless the utilization review decision is overturned by independent medical review pursuant to Labor Code §§ 4610.5 and 4610.6.

NOTIFICATON OF UTILIZATION REVIEW DECISIONS:
Authorizations
Prospective, concurrent, or expedited reviews:
Decisions to approve a request for authorization (within appropriate timeframes):
1. Communicated to the requesting physician within 24 hours of the decision
2. Initially by telephone, facsimile, or electronic mail
3. Written notice to the requesting physician, the patient, their attorney/designee, if applicable
   a. Within 24 hours of the decision for concurrent review
   b. Within two (2) business days for prospective review
   c. Within 72 hours of the decision for an expedited review
4. Shall only contain the following information specific to the request
   a. Specify the date the complete RFA was received
   b. A description of the specific course of proposed medical treatment requested
   c. A specific description of the medical treatment service approved
   d. Note the date of the decision
   e. The written decision shall be signed by either the claims administrator or the reviewer

Retrospective reviews:
Written notice of approval within 30 days of RFA:
1. Be sent to the physician who provided the medical services
2. Be sent to the individual who received the medical services
3. Be sent to his or her attorney/designee, if applicable.
4. Specify the date the complete RFA was received
5. A description of the specific course of proposed medical treatment requested
6. A specific description of the medical treatment service approved
7. Note the date of the decision
8. The written decision shall be signed by either the claims administrator or the reviewer

Payment, or partial payment consistent with the provisions of California Code of Regulations, title 8, section 9792.5, of a medical bill for services requested on the DWC Form RFA, within the 30-day timeframe set forth in subdivision (c)(5), shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete. A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured employee who received the medical services, and his or her attorney/ designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

MODIFICATIONS OR DENIALS:
The review and decision to modify or deny a request for medical treatment must be conducted by a Peer Review Physician, 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

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

Prospective, concurrent, or expedited reviews:
Decision to modify, extend time, or deny an RFA (within appropriate timeframes):
1. Communicated to the requesting physician within 24 hours of the decision
2. Initially by telephone, facsimile, or electronic mail
3. Written notice to the requesting physician, the patient, their attorney/designee, if applicable
   a. Within 24 hours of the decision for concurrent review
   b. Within two (2) business days for prospective review
   c. Within 72 hours of the decision for an expedited review

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

Retrospective
Decisions to modify, extend time, or deny treatment (within 30 days):
1. Written decisions provided to:
   a. The requesting physician
   b. The injured worker
   c. The injured worker's representative
   d. If the injured worker is represented by counsel, the injured worker's attorney.

Written decisions will contain the following information specific to the request:
The written decision modifying, or denying treatment 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:
(A) The date on which the DWC Form RFA was first received.
(B) The date on which the decision is made.
(C) A description of the specific course of proposed medical treatment for which authorization was requested.
(D)) A list of all medical records reviewed.
(E) A specific description of the medical treatment service approved, if any.
(F) A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section 9792.8. If a utilization review decision to modify or deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.
(G) 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. Prior to March 1, 2014, any version of the DWC Form IMR adopted by the Administrative Director under section 9792.10.2 may be used by the claims administrator in a written decision modifying or denying treatment authorization.

(H) 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 30 calendar days after service of the decision.
(I) Include the following mandatory language advising the injured employee:
"You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's 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."
(J) Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a clear statement that the internal appeals process is 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.
(K) The written decision modifying, or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision 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 or an agreed upon scheduled time to discuss the decision with the requesting physician. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

VOLUNTARY APPEALS PROCESS

Standard Appeal Process- Non-Urgent Cases

1. When a modification or denial for certification has been issued for a Request for Authorization (RFA) and further review is desired by the patient, requesting provider or facility, the following will occur:
   a. The requesting party may submit a request for appeal verbally or in writing to the UM Staff within 10 days of receipt of the original UR determination.
   b. Indicate the grounds for appeal and submit any supporting documentation.
2. Upon receipt of an appeal the UM Staff:
   a. The appeal letter, attached supporting documentation, with the original information/ determination will be reviewed by UM staff.
   b. In the event the UM denial determination cannot be overturned, the appeal letter, attached supporting documentation, and the original documentation/ determination will be forwarded to a Clinical Peer Reviewer/Specialty Consultant (MD) (not the initial Clinical Peer Reviewer) of the same discipline as the requesting provider.
   c. Further medical information and/or supporting documentation may be requested or required from the requesting provider by the Clinical Peer Reviewer.
   d. Within 20 days of receipt of the Appeal request, the Clinical Peer Reviewer will make a determination.
   e. All parties (requesting physician, patient and attorney if applicable) will be informed of the decision by letter to include the principal reason for the determination. A statement of the clinical

rationale used in the appeal decision will be provided in writing with the determination as well as options for the IMR Process.

3. A decision by the appeal reviewer to overturn a previous denial of certification must be honored, although the Claims Examiner has the option to pay treatment even if the reviewer upholds the denial.

Expedited Appeals Process – Urgent Cases

4. If a denial certification has been issued and the requesting provider believes the decision warrants immediate determination, they shall:
   a. Submit request for expedited appeal verbally or by fax to the UM Staff.
   b. Indicate the grounds for appeal and any supporting documentation.
5. Upon receipt of an expedited appeal, the UM staff will:
   a. Review the Appeal determine/ documents to assess whether certification can be made.
   b. In the event the UM denial determination cannot be overturned, the appeals letter, attached supporting documentation, and the original determination will be forwarded to a Clinical Peer Reviewer/Specialty Consultant (MD) (not the initial Clinical Peer Reviewer) of the same discipline as the requesting provider.
   c. The requesting party will be notified within 48 hours of the Expedited Appeal determination.
   d. In the event the original denial certification is upheld, the determination will include clinical rationale for the denial determination.
6. All parties (requesting physician, patient and attorney if applicable) will be informed of the decision by letter to include the principal reason for the determination. A statement of the clinical rationale used in making the appeal decision will be provided in writing with the determination as well as options for the IMR process.
7. All appeals will be tracked on an appeal log. The appeal log will include:
   a. The original UR date, date the Appeal was received, and the date the final determination is made.
   b. Name of the claim #, requesting provider/ facility/ initial Peer Reviewer.
   c. Documentation Appeal resolution.
   d. Copies of all correspondence between the above parties and organization.
   e. Minutes or transcripts of appeal proceedings, if any.
   f. Name and credential of the Clinical Peer Reviewer meeting qualifications per policy.
   g. Dispute Resolution - Independent Medical Review

DISPUTE RESOLUTION - Independent Medical Review

You have the right to disagree with decisions affecting your claim. If you have questions about the information regarding this notice, please contact [claims examiner] at (209) [ ]. However, if you are represented by an attorney, please contact your attorney instead.

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 list of offices, call toll-free 1-800-736-7401.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

You have the right to disagree with the utilization review decision and can dispute it by requesting an independent medical review. All utilization review disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

This utilization review decision is final unless you request an independent medical review.
Failure to request an independent medical review timely will result in the loss of the right.

An objection to the utilization review decision must be submitted by the Injured Employee, the Injured Employee's representative, or the Injured Employee's attorney on behalf of the Injured Employee on the enclosed Application for Independent Medical Review, DWC Form within the following applicable time frame:

1. For Formulary Disputes: within ten (10) calendar days after the service of the utilization review decision to the Injured Employee; and
2. For All Other Medical Treatment Disputes: within thirty (30) calendar days after service of the decision to the Injured Employee.

In the event the employer is disputing liability for treatment for any reason besides medical necessity, the time for the employee to submit a request for independent medical review to the administrative director or administrative director's designee is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

The enclosed DWC Form IMR-1 must be signed and a copy of the written decision modifying or denying a request for authorization of medical treatment must be mailed, faxed, or sent via electronic transmission to:

DWC-IMR, c/o MAXIMUS Federal Services, Inc.
625 Coolidge Drive, Suite 100
Folsom, CA 95630
Fax#: (916) 364-8134

The employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf. A designation of an agent executed prior to the utilization review decision shall not be valid. The requesting physician may join with or otherwise assist the employee in seeking an independent medical review, and may advocate on behalf of the employee.

When the employee 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, a provider of emergency medical treatment, may submit a request for independent medical review on its own behalf. A request submitted by a provider pursuant to this paragraph shall be submitted to the administrative director or administrative director's designee within the time limitations applicable for an employee to submit a request for independent medical review.

In the event the IMR form is not provided to the employee at the time of utilization review decision, the time limitations for the employee to submit a request for independent medical review shall not begin to run until the employer provides the required notice to the employee.

A utilization review decision may only be reviewed or appealed by Independent Medical Reviewer (IMR).

Neither the employee nor the employer will have any liability for medical treatment furnished without authorization by the employer if the treatment is modified, or denied by utilization review decision unless that decision is overturned by the IMR (4610.5(e)).

The independent medical review process may be terminated at any time upon the employer's written authorization of the disputed medical treatment. Notice of the authorization, any settlement or award that may resolve the medical treatment dispute, or the requesting physician withdrawing the request for treatment, shall be communicated to the independent medical review organization by the employer within five days.

A signed consent by the employee is necessary to obtain medical records from the employer or insurer and from any medical provider the employee may have consulted on the matter.

You have right to provide information or documentation, either directly or through the employee's physician, regarding the following:

(A) The treating physician's recommendation indicating that the disputed medical treatment is medically necessary for the employee's medical condition.

(B) Medical information or justification that a disputed medical treatment, on an urgent care or emergency basis, was medically necessary for the employee's medical condition.

(C) Reasonable information supporting the employee's position that the disputed medical treatment is or was medically necessary for the employee's medical condition, including all information provided to the employee by the employer or by the treating physician, still in the employee's possession, concerning the employer's or the physician's decision regarding the disputed medical treatment, as well as any additional material that the employee believes is relevant.

DEFERRED FOR DISPUTE OF LIABILITY

Medical treatment requests may be deferred if the claims administrator disputes liability for either the occupational injury for which treatment is recommended or the recommended treatment itself on ground other than medical necessity 9792.9.1 (b)

The claims administrator may, no later than five (5) business days from receipt of the DWC RFA, issue a written decision deferring utilization review of the requested treatment.

The written decision must be sent to:

- The requesting physician
- The injured worker
- The injured worker's attorney, if represented by counsel

The written decision shall only contain 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 course of 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 or parts, 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.

(E) The following mandatory language advising the injured employee:

"You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert

telephone number). However, if you are represented by an attorney, please contact your attorney instead.
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.”

If utilization review is deferred pursuant to this subdivision, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, 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 DWC Form RFA after the final determination of liability 9792.9.1(b)(2).

POLICY TITLE: Information Confidentiality and Security Policy

PURPOSE: To Assess the potential risks and vulnerabilities to the confidentiality, integrity and availability of information systems

HIPAA Awareness Training is required for all Staff
Staff are required to read and accept company's Code of Conduct and Non-Disclosure Agreement (NDA) as a component of the new hire onboarding process

POLICY
Implementation and enforcement of privacy and security policies designed to maximize the protection of consumer, customer, and employee information.
Status, Inc. controls user access to confidential information based on user roles. Roles are defined by operations management.

Integrity: All User activity processed through Status, Inc. is traced from entry to final processing to ensure transactions are processed completely, accurately, and timely.

Availability: Status, Inc. utilizes monitoring software to ensure production environment effectiveness, timeliness, and availability. The software is configured to send alerts to authorized individuals when specified predefined thresholds are met.

Risk assessments on vendor data platforms are completed on an annual basis per contract.

Status, Inc. determines the organizational structure and personnel roles sufficient to address business requirements
Organizational & operational threats are identified through risk assessment
Threats are assigned risk ratings
Mitigation strategies will be created upon identification of risk

Employee Access Levels: access to the information and various company systems is enforced by username.
Certain levels of access may be granted or restricted by roles.

Employee Exit Checklist: on termination, review of the exit checklist including cancelling any user access to Email, or any other systems; reassign any work to other
employees.

Intrusion Protection System:

- Daily, monitoring of the system that checks users on the servers against the list of authorized users.
- Each week a log of any suspicious activity on the Firewall is reviewed. In the event of a breach, the Security Incident Response Plan is activated.
- Firewall restricts access to network services
- New employees must agree to a confidentiality agreement.
- Policies to require employees to use good practices with confidential documents.
- Each desktop computer terminal, personal computers, and any portable media devices is login and password protected

Intrusion detection system monitors network for suspicious activity. Logs are reviewed on a weekly basis.

If breach was a result of employee misconduct, appropriate progressive disciplinary action is taken by HR.
See Policy on how to handle a breach

The above Policy and Procedure has been approved by the CEO/ CFO and is reported to the Board of Directors. Signatures of approval are on file.

Review or Revision
This policy and procedures is to be reviewed annually and revised as necessary.

Initiated 6/15/2017/ Reviewed 1/20/2020