



**Broadspire Utilization Management
Program Plan
#006**

April 2026

March 27, 2026

Material Modification Statement

Re: Broadspire UR Plan #006

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

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INTRODUCTION

This document contains the Broadspire Utilization Management Program including the following:

- (a) The utilization review program plan containing:
 - A medical director with an unrestricted license to practice medicine in California;
 - A description of the UM Process;
 - A description of the specific criteria utilized routinely in the review and decision-making process
 - The Medical Department P&Ps
- (b) Compliance with Labor Code section 4610 including:
 - A description of the qualifications and functions of the personnel
- (c) The utilization review:
 - Policies and Procedures - The documented policies are global in nature and are used in conjunction with the state specific Jurisdictional Guidelines (JuD) for state specific requirements;
 - Pre-certification process P&P;
 - Notification of Certification (Approval) process P&P
 - Notification of Non-Certification process P&P
 - Appeals procedure P&P
 - CA Jurisdictional Guidelines Database (JuD)
 - Utilization review plan availability P&P;
- (d) Independent Medical Review
- (e) *this plan is submitted pursuant to revised regulations effective April 1, 2026.*

PROGRAM PLAN

The Broadspire Utilization Management Program is overseen by the full time Medical Director Eddie Sassoon, MD, CA license number 43258. (See exhibit 1.); mailing address - 1391 N.W. 136th Avenue, Sunrise, FL 33323; phone - 954-693-1746. The Medical Director, Dr. Sassoon, is responsible for all decisions made in Broadspire's utilization review process.

The Broadspire Utilization Management Program includes the following components:

PROSPECTIVE REVIEW:

Request for treatment prior to the delivery of treatment. 8 C.C.R. §9792.6.1 (t) & (u) – Evaluation and determination regarding the medical necessity and appropriateness for projected treatment/admissions.

CONCURRENT REVIEW: Request for treatment during a hospital stay 8 C.C.R. §9792.6.1 (c)-Ongoing review of the medical necessity and appropriateness of continued services during inpatient hospitalization. Reviews are conducted based on the severity or complexity of the patient's condition and in treatment or discharge planning activities. Inpatient reviews are not conducted on a daily basis but are usually conducted at least every three days. Medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee. 8 C.C.R. §9792.9.5(f)(1)

RETROSPECTIVE REVIEW: Request for treatment after delivery of treatment (8 C.C.R §9792.6.1 (v) - A review of complete medical records following discharge to determine appropriate utilization of services. Retrospective reviews may be conducted after inpatient or outpatient services are rendered.

EXPEDITED REVIEW: means utilization review or independent review conducted when the injured worker's condition is such that the injured worker faces 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. 8 C.C.R. §9792.6.1(j)

Broadspire physician reviewers are available via telephone at 800-800-7660 (select Option 4), or faxing your request to 770-777-6447 Monday through Friday from 8am to 5:30pm Pacific time. After hours, weekend and holiday calls are handled by a voice mail system. Broadspire quality standards require that all phone messages be returned by the following business day.

Emergency care does not need to be approved in advance. Injured workers with an emergency condition are to proceed to the nearest emergency facility. "Emergency health care services" is defined in California laws as; 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. §9792.6.1 (i) 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 claim administrator upon request. §9792.9.5 (b)

During the Utilization Review process, **Broadspire applies and utilizes the California Medical Treatment Utilization Schedule (MTUS) as its primary source of criteria.** In the event that the utilization review request is not addressed by the MTUS, Broadspire applies and utilizes other evidence-based medical treatment guidelines that are generally recognized by the national medical community

and are scientifically based such as ACOEM and other state treatment guidelines where applicable. Internally developed criteria consistent with MTUS may be developed through comprehensive study of nationally accepted standards of practice, literature research, networking, consultation and contribution by actively practicing providers certified in their areas of expertise. Criteria are reviewed on an annual and as needed basis.

The *Medical Disability Advisor* (MDA) by the Reed Group is utilized to evaluate disability duration during the case management and disability management processes.

Utilization Management staff include full-time registered nurse reviewers and a physical therapist. A diverse range of peer review physician consultants are routinely available to render utilization review determinations and ensure specialty matching with providers rendering care. Additionally, there are supervisory and training personnel plus the full-time Medical Director.

Professional review staff are evaluated initially through the Human Resources Department. Licenses and references are verified using primary source verification. Each professional applicant must undergo an interview process and demonstrate appropriate experience within their area of clinical expertise. Physicians are board certified in their area of specialty and have undergone a formal credentialing process which includes contacting the individual state boards to verify licensure. (See exhibit 3.)

Cases are initially reviewed by a nurse reviewer utilizing the aforementioned clinical criteria. If the case meets criteria, a certification (approval) recommendation will be made then concurrent review will be conducted as needed for ongoing treatment. In accordance with section §9792.6.1 (a) "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed "Request for Authorization" that has been transmitted by the treating physician to the claims administrator under section §9792.9.1 (a)(1). Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section §9792.9.1 through 9792.12.

Note: Prospective or 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 date of receipt of the completed "Request for Authorization". Upon receipt of a request for authorization as described in subdivision §9792.9.1, that does not identify the employee or provider, does not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity for the requested treatment, or is not signed by the requesting physician, a non-physician reviewer as allowed by section §9792.7 or physician reviewer must either regard the request as a complete request for authorization and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete," specifying the reasons for the return of the request no later than five (5) business days from receipt. The first day in counting any timeframe is the first normal business or working day after receipt of the completed or accepted as complete request for authorization.
§9792.9.3(a)

Prospective or concurrent decisions to approve, modify, or deny a request for authorization 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 date of receipt of the completed request for authorization.

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, shall be reviewed by the claim administrator within 5 business days.

Retrospective decisions to approve, modify, or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination. In the event that a case does not meet the established criteria, a referral is made to the appropriate Physician Reviewer. If it is determined that the case still does not meet criteria after contact with the prescribing provider and review by the Physician Reviewer*, a non-certification recommendation will be issued. Only Physician Reviewers may recommend modification, or denial (non-certification) of services based on clinical rationale. (See exhibit 5.)

Verbal notification of a certification recommendations will be given to the provider(s) in accordance with the more stringent of URAC and/or state specified time frames. For California UR, prospective, concurrent, or expedited review, approvals shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.

For prospective, concurrent, or expedited review, a decision to modify, or deny, shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request.

For retrospective review, 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 30 days of receipt of request for authorization and medical information that is reasonably necessary to make this determination.

Written notification to the provider(s) and patient/representative will follow the verbal notification. Any written non-certification recommendation will include a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Written notification letters include instructions for initiating the appeals process and state mandated language.

§9792.9.5 Decisions to modify, or deny a request for authorization.

(e) The written decision modifying, or denying treatment authorization shall be provided to the requesting physician, the injured worker, and, if applicable, the injured worker is representative and/or attorney. The written decision shall be signed by either the claims administrator or the physician reviewer, and shall only contain the following information specific to the request:

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

(5) A list of all medical records reviewed.

(6) A specific description of the medical treatment service approved, if any.

(7)(A) A clear, concise, and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity or, if applicable, that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation.

(B) Where the requesting physician has expressly opined that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician shall provide an explanation for why the requesting physician's explanation is insufficient.

(8) For decisions based on medical necessity, a citation to and description of the relevant medical criteria or guidelines used to reach the decision.

(9) Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.

(10) 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 claim 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.

(11) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

(12) 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 claim 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."

(13) Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, including with respect to disputes over the necessity of or availability of the requested information, and a clear statement that the internal appeals process is 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.

(14) The written decision modifying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or, if applicable, expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the reviewer, the expert reviewer, or the medical director for the treating physician to discuss the decision which shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time. In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

All decisions to approve a request for authorization shall specify the specific the date the complete request for authorization was received, medical treatment service requested, the specific medical treatment service approved, and the date of the decision.

Broadspire provides a voluntary appeals process to the provider and patient in the event of a non-certification decision. In California an appeal may be requested within ten (10) days after the receipt of the utilization review decision. (See exhibit 6.) §9792.10.1 (f)(1)

§9792.9.6. Utilization Review — Extension of Timeframe for Decision.

(a)(1) The timeframes for decisions specified in section 9792.9.3 may only be extended under one or more of the following circumstances:

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

(B) 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.

(C) The reviewer needs a specialized consultation and review of medical information by an expert reviewer.

(b)(1) If the circumstance under subdivision (a)(1)(A) applies, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization.

(2) If any of the circumstances set forth in subdivisions (a)(1)(B) or (C) are deemed to apply following the receipt of a complete or accepted request for authorization, the physician reviewer shall within five (5) business days from the date of receipt of the request for authorization notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or indicate that a consultation by an expert reviewer is needed, in which case, the specialty of the expert reviewer to be consulted must be identified.

(c) (1) If the information reasonably necessary to make a determination under subdivision (a)(1)(A) that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed or accepted request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, a physician reviewer shall deny the request in accordance with applicable rules in section 9792.9.5(e).

(2) If the results of the additional examination or test required under subdivision (a)(1)(B), or the specialized consultation under subdivision (a)(1)(C), that is requested by the physician reviewer under this subdivision is not received within thirty (30) days from the date of the request for authorization, the reviewer shall deny the treating physician's request in accordance with the applicable requirements under section 9792.9.5(e).

(d)(1) Upon receipt of the information requested pursuant to subdivisions (a)(1)(A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent review, shall make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information.

(2) Upon receipt of the information requested pursuant to subdivisions (a)(1)(A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent decisions related to an expedited review, shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5.

(3) Upon receipt of the information requested pursuant to subdivisions (a)(1)(A), (B), or (C), the claims administrator or reviewer, for retrospective review, shall make the decision to approve, modify or deny the request for authorization within thirty (30) calendar days of receipt of the information requested in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5.

Hours of operation are from 9:00a.m. To 5:30p.m. PST, Monday through Friday. Broadspire Utilization Management's physician reviewers are available via telephone at 800-800-7660 (select Option 4). After hours, weekend and holiday calls are handled by a voice mail system. Broadspire quality standards require that a" phone messages be returned by the following business day. (See exhibit 8.) Requests may also be faxed at any time to 770-777-6447.

In accordance with Labor Code 4610 (B)(i); (ii)(I)(11), Broadspire does not offer nor provide any financial incentive or consideration to a physician based on the number of modifications or denials made.

Broadspire does not refer utilization review services to an entity in which Broadspire has a financial interest, unless prior written disclosure has been provided to the employer and administrative director.

(Exhibit 10)

The Broadspire Utilization Review Department monitors its performance regarding review procedures according to its policies or documented procedures. At least annually, oversight of the utilization management program includes summary reporting and analysis of the monitoring conducted for the following areas of performance. (Exhibit 11)

Broadspire Services, Inc., a division of Crawford & Company, recognizes that a claimant has a fundamental right to privacy and should be assured adequate protection from the unauthorized dissemination of non-public, personally identifiable information. Broadspire has adopted the following practices under our corporate policies to ensure the privacy and security of consumer information. And thus, Broadspire has established written policies and procedures to protect the confidentiality of individually identifiable health information (IIHI).

IIHI will be used by the case management/claim staff and physician review consultants. The case management/claim staff and physician review consultants will acquire and use information solely for the purposes of case management, claims administration, utilization review, quality assessment, discharge planning and/or independent review.

Individuals, employees, contractors, or others that work or are present in the vicinity of such information, but whose functions or services do not involve use of confidential information or personal health information will not have access to IIHI. Examples of such individuals or entities that may be in the vicinity of confidential information may include (but are not limited to): janitorial staff, installation/repair technicians, financial auditors, etc.

In most cases, information will be input into designated computer systems. Access to computerized information is limited solely to clinical medical management/claim staff and physician review consultants, authorized data processing, authorized users, and administrative personnel. Security measures are taken to assure that unauthorized personnel are not afforded access to information.

Information will be disclosed only to those agencies that have authority to receive such Information. These agencies include but are not necessarily limited to: Independent review agents, claims adjusters, benefits administrators, employers, state agencies, and/or a medical provider quality improvement department if an issue related to quality of care is presented. The case/claim staff and physician review consultants are not to disclose information in any manner except to the extent necessary to properly conduct case management, claims administration, utilization review, quality assessment, discharge planning and/or independent review or in communication with other authorized agents. Subpoenas for medical records received will be routed through the Legal Department for approval prior to producing documentation. Broadspire acknowledges that certain Information may be disclosed for data processing and administrative services. The case management/claim management staff and physician review consultants and board members will be continuously updated on issues concerning confidential disclosure of Information through policy updates and periodic in-service sessions.

It is the responsibility of all Broadspire employees, committee members and board members to preserve the confidentiality of IIHI. Broadspire will only acquire or distribute Information with the express consent of the claimant or provider, or where permitted under state or federal. Broadspire acknowledges that the responsibility for obtaining consent of the claimant, if necessary, rests with the treating physician, the institution, and/or the payor.

Broadspire Services, Inc. requires that all employees and contractors, including those VitalCheck committee members, complete our required annual training which covers data privacy and protection of IIHI. The courses require that participants achieve a passing score and complete an attestation indicating their understanding the course material and agreement to abide by the Company's policies pertaining to the privacy and security of consumer information.

Additionally, all Broadspire Services, Inc. board members and VitalCheck program committee members sign an annual attestation specifically agreeing to abide by the Company's policies pertaining to the privacy and security of consumer information that they may have access to as part of their duties.

Training on Anti-Corruption Data Protection & Privacy, Code of Business Conduct & Ethics, Cyber Security, and IIHI are assigned by the Global Compliance Office designee globally to required staff members on an annual basis. Staff members have a defined amount of time to complete the assigned courses. Periodic reminders are sent to the staff members and their supervisor until the course has been completed successfully. Failure to complete the required training by staff will result in corrective action up to and including termination of employment.

* Note: For all California cases as per regulation AB 435, Labor Code Section 3762: Only the medical diagnosis for which workers' compensation is being claimed, the treatment provided for this condition, and medical information regarding the injury for which workers' compensation is claimed that is necessary for the employer to have for the employer to modify the employee's work duties may be released, with specific allowances made for self-insured employer's designated WC administrators.

The Broadspire utilization review plan is available at upon request. The UM Program Plan may be released via electronic means at no fee. If a hard copy of the UM Program Plan is requested, a charge not to exceed \$0.25 per page plus postage costs would be applied.

DWC Administrative Rules § 9792. 7(a)(6)(A)

The Broadspire Utilization Management Program is accredited by URAC for Worker's Compensation Utilization Management. (Exhibit 15).

*Note: A referral may be made to an outside peer review agency in order to ensure that a peer with appropriate licensure renders the determination when applicable.

§ 9792.6.1. Utilization Review Standards—Definitions.

The following definitions apply to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the decision on the request for authorization of medical treatment is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(a) "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed "Request for Authorization," as defined in this section, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, sections 9792.9.1 through 9792.1

(b) "Claims Administrator" is a 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 claims administrator or other entity subject to Labor Code section 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). "Claims Administrator" includes any utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.

(c) "Concurrent review" means utilization review conducted during an inpatient stay.

(d) "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 California Code of Regulations, title 8, section 14006.1, or on the applicable physician reporting forms authorized by section 9785.

(e) Reserved.

(f) "Denial" means a decision by a physician reviewer that the requested treatment or service is not authorized.

(g) "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.

(h) "Disputed medical treatment" means medical treatment that has been modified, or denied by a utilization review decision.

(i) "Emergency health care services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could

reasonably be expected to place the patient's health in serious jeopardy.

(j) "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.

(k) "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 section 9792.9.6, prior to the determination of medical necessity.

(l) "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.

(m) "Immediately" means within one business day.

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

(o) "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.

(p) "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.

(q) "Medical Treatment Utilization Schedule" means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20.

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

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

(t) "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.

(u) "Request for authorization" means a written request for a specific course of proposed medical treatment that meets all of the following criteria:

(1) 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 California Code of Regulations (CCR), title 8, section 9785.5, completed by a treating physician and as further outlined in this subdivision and in section 9785(h).

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

(3) The request for authorization must be signed by the treating physician and may be mailed, faxed, or, if available, sent electronically through the use of an encrypted email system or via electronic data interchange (EDI) to the address, fax number, e-mail address, or clearinghouse designated by the claims administrator under section 9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

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

(w)(1) "Reviewer" or "physician reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's or physician reviewer's practice.

(2) "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.

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

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

(z) "Utilization review plan" means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.

(aa) "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.

(bb) "Written" includes a communication transmitted by facsimile or in paper form. Electronic mail or electronic data interchange (EDI) may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail or by EDI, unless sent through the use of an encrypted electronic mail or EDI system.

(cc) "Normal business day" or "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

(dd) "Working day" as used in this article is the same as "business day" or "normal business day."

Authority cited: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 3209.3, 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

EXHIBIT 1
Medical Director's California License
License Details (State website - updated January 5, 2026)

SASSOON, EDDIE ELIE

LICENSE NUMBER: C 43258 LICENSE TYPE: PHYSICIAN AND SURGEON C

LICENSE STATUS: LICENSE RENEWED & CURRENT ⓘ EXPIRATION DATE: NOVEMBER 30, 2026

SECONDARY STATUS: N/A

CITY: TAMARAC STATE: FLORIDA COUNTY: BROWARD ZIP: 33321



THE FOLLOWING INFORMATION IS SELF-REPORTED BY THE LICENSEE AND HAS NOT BEEN VERIFIED BY THE BOARD.

ARE YOU RETIRED?

NO

ACTIVITIES IN MEDICINE

ADMINISTRATION - 1-9 HOURS

TELEMEDICINE - NONE

PATIENT CARE - 20-29 HOURS

PATIENT CARE PRACTICE LOCATION

ZIP - 33024

COUNTY - NOT IDENTIFIED

PATIENT CARE SECONDARY PRACTICE LOCATION

NOT IDENTIFIED

TELEMEDICINE PRACTICE LOCATION

NOT IDENTIFIED

TELEMEDICINE SECONDARY PRACTICE LOCATION

NOT IDENTIFIED

CURRENT TRAINING STATUS

NOT IDENTIFIED

AREAS OF PRACTICE

PHYSICAL MEDICINE AND REHABILITATION - PRIMARY

BOARD CERTIFICATIONS

AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION - PHYSICAL MEDICINE AND REHABILITATION

POSTGRADUATE TRAINING YEARS

EXHIBIT 2

Medical Department Policies and Procedures

IRO POLICY/PROCEDURE

Org Issue Date 09/26/2018

Id.-No. IRO 5.0 Standard IR-Int 1-Reviewer Credentialing Program

IR-Int 2-Reviewer Credentials Verification

IR-Int 3-Credential Status Changes

IR-Int 4-Reviewer Qualifications

Form No. IRO 050-01-003

1. SCOPE

- 1.1 The scope is defined as all Broadspire Services departments which are within the scope of the URAC accredited services.
- 1.2 To establish criteria for qualifications applicable to all utilization review staff.

2. DEFINITIONS

- 2.1 Organization is a business entity that seeks accreditation under the URAC standards.
- 2.2 Licensure is a license or permit to practice medicine or a health profession that is issued by any state or jurisdiction in the U.S. and is required for the performance of the job.
- 2.3 Certification is a professional credential granted by a national organization signifying that an individual has met the qualifications established by the organization.
- 2.4 Clinical peer is a physician or other health professional who holds an unrestricted license by any state or the District of Columbia and is in the same or similar specialty that typically manages the medical condition, procedure or treatment under review.
- 2.5 Primary source verification is verification of a practitioner's credentials based upon evidence obtained from the issuing source of the credential.
- 2.6 Reviewer is an individual(s) selected by the organization to consider a case. Reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice. §9792.6.1 (w)

3. POLICY

It is a condition of participation that medical providers desiring to do reviews for Broadspire be credentialed before they contract and, thereafter, on a triennial basis. IR-Int 1 (a), (b)(ii) Referrals will not be assigned to reviewers who have not been credentialed by Broadspire's Credentialing Committee or whose credentialed status has been lost for any reason. IR-Int 1 (b) (i), (c)

Bro

Initial credentialing requires an application that must be completed, attested to and signed by the Applicant. Once this completed application package is received by Broadspire, the Company will verify the submitted information through a primary source verification process. IR-Int 1 (b) This step may be delegated to a third party at Broadspire's discretion.

Once primary source verification has been completed, the Credentialing Committee will review the application and data collected during the verification process. The Committee will make a credentialing decision, and its determination shall be communicated in writing to the applicant.

An appeals process is available to an applicant who is denied credentialing or recredentialing. Ongoing credentialing is undertaken every three years and involves the verification of license status and review of disciplinary actions and other standards as required by the Committee.

Broadspire California Utilization Management Plan

Consultants and Applicants must notify Broadspire of any changes in their credentialing eligibility (referred to here as "adverse development") including, but not limited to: IR-Int 3 (a)

3. Loss of licensure or certification;
4. Loss of board certification;
5. Medicare, Medicaid or hospital sanctions or loss of privileges;
6. Criminal conviction;
7. Presence of any medical condition, including alcohol or substance abuse that may interfere with the ability to practice.

Such notification must be received in writing by the AA within 3 business days of occurrence and the Committee will review the facts before making a decision, which may be the loss of credentialing.

STANDARDS

Minimum credentialing standards are set by the Committee and may be changed from time to time at its discretion:
 IR-Int 2 (a-d)

ITEM	STANDARD
Licensure or Certification	<ul style="list-style-type: none"> • At least one valid, current and unrestricted license or certification as required for clinical practice in the Applicant's profession in a State of the United States IR-Int 4(a) • Any sanctions or restrictions on current or former licenses or certifications must be acceptable to the Committee
Physical Location	<ul style="list-style-type: none"> • Consultants must be located in the United States or one of its territories
Board certification	<ul style="list-style-type: none"> • Active board certification by one or more of the following, if a physician, podiatrist or dentist: <ol style="list-style-type: none"> 1. Any of the member boards of the American Board of Medical Specialties 2. Any of the member boards of the American Osteopathic Association 3. American Board of Podiatric Surgery 4. American Board of Podiatric Orthopedics and Primary Podiatric Medicine 5. American Dental Association 6. American Board of General Dentistry
Experience and employment history	<ul style="list-style-type: none"> • Minimum of five years of full time equivalent experience providing direct clinical care to patients IR-Int 4(b) Employment history, including gaps in employment to the Committee

Malpractice history	• Must be acceptable to the Committee
Medicare/Medicaid sanctions	• If present, must be acceptable to the Committee
Hospital sanctions	• If present, must be acceptable to the Committee
Criminal convictions / felonies	• If present, must be acceptable to the Committee
Alcohol or substance abuse	• No current substance abuse or misuse • If history, must be acceptable to the Committee

CREDENTIALING COMMITTEE

Broadspire's Chief Medical Officer ("CMO") is the Moderator of the Committee. Two other Broadspire-credentialed physicians shall serve on the Committee, by invitation of the CMO. A quorum of two (one of whom must be the CMO) shall be necessary to review credentials. Each member shall have one vote and a majority of members shall be necessary to reach a credentialing determination. The Committee may meet and vote in person, by telephone or electronically (synchronously or asynchronously), as determined by the CMO. An Administrative Assistant (UAA) will assist in the process of credentialing.

CREDENTIALING PROCESS

Initial Credentialing

1. Once Broadspire has identified an applicant, he or she will be required to provide the following completed and signed documents:
 - a. Broadspire obtains attestation statements from those Physician Consultants in active practice to validate active practice status
 - b. Physician Consultants who perform peer review in Massachusetts must sign an affidavit of active practice attesting to a minimum of 8 hours per week
 - c. Application
 - d. W-9 form
 - e. Contact information form
 - f. Service Agreement (1 copy), signed
2. Incomplete applications, including those that are not signed, will not be reviewed. The candidate will be sent written (email or regular mail) notification of the deficiency.
3. Broadspire, or its delegate (DE), will perform primary and secondary source verification of the candidate's information and produce a Credentialing Verification Report. IR-Int 2 (a)
4. The DE will provide to the AA the following: IR-Int 2 (a-d)
 - a. Primary source verification of the requisite licensure or certification required for clinical or legal practice
 - b. Primary source verification of the reviewer's board certification
 - c. Primary source verification of history of sanctions or disciplinary actions (from state licensing boards)
 - d. Information regarding professional experience including length of time providing direct patient care and dates indicating when the direct patient care occurred
 - e. Secondary source verification of individual malpractice insurance policy certificate

- f. Secondary source verification of professional experience (CV and application)
 - g. Broadspire Provider Credentialing Checklist
5. The AA will notify the Credentialing Committee that the following information is available in Credential Smart, which shall review it in consideration of credentialing:
 - a. CV
 - b. Application
 - c. Credentialing Verification Report
 - d. Malpractice/sanction verification (if applicable)
 6. The Credentialing Committee shall issue a determination of credentialing upon review of the aforementioned documents.
 - a. The Committee may seek more information from the Candidate in order to clarify any questions it may have.
 - b. In such case, a letter or email shall be sent by the AA to the Candidate requesting such information.
 - c. A response must be received by the AA within 30 calendar days of request.
 - d. Failure to receive the requested information within 30 calendar days shall end the credentialing application and the AA will notify the Candidate in writing (email or regular mail).
 7. History of sanctions and/or disciplinary actions is evaluated on a case by case basis by the Committee and final determination for inclusion on the panel is at the discretion of the CMO.
 8. AA notifies the Candidate of the determination in writing (email or regular mail) within 7 business days of decision.

Recredentialing

1. DE is responsible for recredentialing of PRS panel consultants every 3 years:
2. DE generates and sends a recredentialing letter and prepopulated application (for update and signature) to the Consultant.
3. PRS Consultant returns signed prepopulated application to DE.
4. DE repeats the source verification process:
5. DE provides a Recredentialing Verification Report to the AA
6. The AA will notify the Credentialing Committee that the following information is available in Credential Smart, which shall review it in consideration of recredentialing:
 - a. Recredentialing Reverification Report
 - b. Malpractice / sanction verification (if applicable)
7. The Credentialing Committee shall issue a determination of recredentialing upon review of the aforementioned documents:
 - a. The Committee may seek more information from the Consultant in order to clarify any questions it may have
 - b. In such case, a letter or email shall be sent by the AA to the Consultant requesting such information
 - c. A response must be received by the AA within 30 calendar days of request
 - d. Malpractice/sanction verification (if applicable)

8. As with credentialing, a history of sanctions and/or disciplinary actions is evaluated on a case by case basis by the Committee and final determination for inclusion on the panel is at the discretion of the CMO.
9. AA notifies the Consultant of the determination in writing (email or regular mail) within 7 business days of decision.

Appeal Process

Upon receipt of an adverse credentialing decision, the Applicant or Consultant may request a reconsideration of the decision. Such appeal must be made in writing and received by the AA within 30 calendar days of the original decision.

Upon receipt of the appeal, the AA shall send such appeal to the Credentialing Committee which shall have 30 calendar days to review the appeal and issue a final determination.

This determination shall be sent by the AA to the Appellant in writing within 7 business days of the decision. The determination is final and will not be considered for further review.

Review of adverse development IR-Int 3(b)

When a self-report of an adverse development is received by Broadspire:

1. The AA will send such self-report to the Credentialing Committee, which shall review it and any available evidence before making a determination about loss of credentialing:
 - a. The CMO may, at its sole discretion, place a temporary loss of credentialing until such a time as the Committee makes its determination.
 - b. The Committee may seek more information from the Consultant in order to clarify any questions it may have.
 - c. In such case, a letter or email shall be sent by the AA to the Consultant requesting such information
 - d. A response must be received by the AA within 7 business days of request
 - e. Failure to receive the requested information in this time shall result in loss of credentialing
2. The Committee's decision shall be sent to the Consultant by the AA in writing within 7 business days of decision.

When Broadspire discovers a possible or actual adverse development, and the Consultant has not self-reported:

1. The CMO shall, at its own discretion, place a temporary loss of credentialing until such a time as the Committee evaluates the available evidence and issues a final decision.
2. The CMO shall ask, in writing, for a written explanation from the Consultant.
3. This explanation must be received by the CMO within 7 business days of request.
4. Failure to receive the requested information in this time shall result in loss of credentialing.
5. If received timely, the AA will schedule a meeting of the Credentialing Committee, which shall review the Consultant's explanation and any other facts that may be available, before making a determination about loss of credentialing.
6. The Committee may seek more information from the Consultant in order to clarify any questions it may have.
7. In such case, a letter or email shall be sent by the AA to the Consultant requesting such information.
8. A response must be received by the AA within 7 business days of request.
9. The Committee's decision shall be sent to the Consultant by the AA in writing within 7 business days of decision.

RECORD of APPROVAL AND REVISIONS

Revision Level	Action Taken	Authorized Signature	Date
00	APPROVAL	Gaylan Brown, RN, CCM, VP UM and PRS	09/26/2018
01	APPROVAL	Gaylan Brown, RN, CCM, VP UM and PRS	01/14/2019
02	APPROVAL	Gaylan Brown, RN, CCM, VP UM and PRS	01/02/2020
03	APPROVAL	Gaylan Brown, RN, CCM, VP UM and PRS	01/02/2021

EXHIBIT 3

UM P&P Manual

Utilization Management
Regulatory References:
Policies and Procedures

URAC UM 6,17,24,26,27

Subject:

Pre-certification Process

Origination Date:

April 1994

Revision Date:

10/1/97, 11/12/98,4/7/99, 11/3/99, 11/6/02,9/12/03,4/8/05,
5/25/06,3/26/07,8/5/09; 8/5/2011; 8/2012; 8/2013; 8/2014; 6/2015,
11/21/19,2/4/20,8/23/21,

Performed By:

All Utilization Management Services

Policy: The Utilization Management Department receives and reviews requests for pre-certification (prospective) review of proposed treatment within appropriate time frames and in accordance with URAC Standards and relevant state regulations.

Procedure:

1. A request for pre-certification (prospective review) may be received from worker or a representative of the worker, the claims adjuster, the facility rendering the service, the provider, a state regulator, FCM, TCM or SNR, via:
 - a. Electronic referral (from the claims adjuster)
 - b. Telephone
 - c. Facsimile
 - d. Interdepartmental referral
2. When a request for pre-certification is received from a provider, the claims adjuster and case manager are notified of the referral via phone or e-mail at the initiation of each new case except for cases in Texas and Massachusetts. An interdepartmental Communication Service Code (C6500) is entered into the case noting the conversation with the case manager. Notification of the claims technician is not required for continued care requests once the review is initiated.
3. Demographic information is obtained by the Claim Intake Representative and the case set-up is completed. The Claim Intake Representative will forward cases to the case distribution area for timely distribution to review staff.

4. The case is triaged to obtain the necessary medical information* to complete the review, which may include but is not limited to: treatment plan; symptoms; diagnostic studies; past treatment history; and discharge plan. Information may be accepted from any reasonably reliable source that will assist in the certification process.
5. The pre-certification review will be completed within the relevant or appropriate time frame:
 - a. 72 hours of the request *if it is a case involving urgent care* **or
 - b. 5 calendar days of the receipt of the request *if it is a case involving non-urgent care*
 - c. ***State regulatory requirements. (per the Jurisdictional Guidelines Database "JuD"
6. If the proposed treatment meets the accepted criteria, notification is made within the relevant or appropriate timeframe as noted above. Notification timeframes are inclusive of the entire UM process, from receipt of the request for a UM decision to the issuance of the determination both verbal and written. Providers are notified verbally and in writing. Patients are notified as deemed necessary by the state requirements.
7. If the proposed treatment does not meet the criteria, the case is referred to the Peer Reviewer for review. If non-certification is recommended, notification including method of initiating the Appeal process is forwarded to the provider, the injured worker, the injured worker's representative and if the injured worker is represented by counsel, the injured worker's attorney.
8. The claims adjuster/administrator is notified both verbally and in writing of any non-certification recommendations. The case manager is notified of the determination either by phone or electronically.
9. Review determinations are based solely on the medical information obtained at the time of the review determination.
10. When a patient is represented (e.g. attorney) in a workers' compensation claim, written notification will be provided to the attorney or patient representative in accordance with jurisdictional requirements.
11. The nurse will document treatment approvals using a forty five-day window or the specific timeframe requested by the provider not to exceed 45 days. If the treatment is not rendered within the projected time frame, the provider may request a time extension to render the previously approved treatment. A time frame extension can be requested via fax to include an explanation for the extension. The new date range will be documented in the case and the provider will be verbally notified of the extension.

Notes:

2. See Jurisdictional Guidelines Database (JUD) for state regulatory requirements.

EXHIBIT 4

UM P&P Manual
Utilization Management
Regulatory References: URAC UM 17,18,19,20
Policies and Procedures
Subject: Notification of Prospective, Concurrent and Retrospective
Treatment - CALIFORNIA UR
Origination Date: April 1994
Review/Revision Date: 10/1/97,12/18/98,4/7/99,9/28/01,6/23/03,9/12/03,6/16/05,5/17/06,
3/22/07, 4/2008, 4/15/2009, 4/2010, 4/5/2011; 5/2012; 5/2013; 8/2014;
6/2015,1/5/26
Performed By: All Utilization Management Services

Policy:

Utilization Review (UR) Recommendations are conveyed to the appropriate entities in compliance with URAC Standards and relevant state regulations.

In workers' compensation where the patient bears no financial responsibility, patients do not receive copies of notification letters unless required by state regulations. Please refer to the Jurisdictional Guidelines Database ("JuD") for state specific notification requirements.

Procedure

1. The timeframes in which prospective, continued stay/concurrent and retrospective review recommendations for certification of treatment will be made based on the state regulatory requirements (per the jurisdictional guidelines database [JuD]. If no guidelines specified by the State, notification will be made according to URAC guidelines.

A. California Timeframes:

§9792.9.3 The utilization review process shall meet the following timeframe requirements:

(1) The first day in counting any timeframe requirement is the day after the receipt of the request for authorization, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the request for authorization.

(2) The reviewer must either regard the request as a complete request for authorization and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete," specifying the reasons for the return of the request no later than five (5) business days from receipt. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed request for authorization.

(3) The claims administrator may accept a request for authorization for medical treatment 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

(4) Prospective or concurrent decisions to approve, modify, or deny a request for authorization 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 date of receipt of the completed request for authorization.

(5) 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).

(6) Written Retrospective decisions to approve, modify or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and medical information that is sufficient for a reviewer to make a determination as to whether the treatment was medically necessary. For retrospective review, a written decision to approve, modify, or deny shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and, if applicable, the injured worker's representative/attorney.

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

§9792.9.5 Decisions to modify, or deny a request for authorization.

- (a) The review and decision to deny, or modify a request for medical treatment must be conducted by a reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice.
- (b) Failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claim administrator upon request.
- (c) For prospective, concurrent, or expedited review, a decision to modify, or deny a request for authorization shall be initially communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or, if agreed to by the parties, by encrypted electronic mail. Written communication of the decision shall issue to the injured worker, the requesting physician and, if applicable, to the injured worker's representative within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request.
- (d) For retrospective review, a written decision to deny part or all of the requested medical treatment based on medical necessity 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 information that is sufficient for a reviewer to make a determination as to whether the treatment was medically necessary.
- (e) The written decision modifying, or denying treatment authorization shall be provided to the requesting physician, the injured worker, and, if applicable, the injured worker is representative and/or attorney. The written decision shall be signed by either the claims administrator or the physician reviewer, and shall only contain the following information specific to the request:
 - (1) The date on which the request for authorization was first received.

- (2) If the timeframe for decision was extended under section 9792.9.6, a specific description of the information needed to make a medical necessity determination of the treatment request; the date(s) and time(s) the request(s) for information, exam, or consultation under subdivision (a)(1)(A), (B), or (C) of section 9792.9.6 were requested; the manner in which the requests were made; and the date the information was first received.
- (3) The date on which the decision is made.
- (4) A description of the specific course of medical treatment set forth on the request for authorization.
- (5) A list of all medical records reviewed.
- (6) A specific description of the medical treatment service approved, if any.
- (7)(A) A clear, concise, and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity or, if applicable, that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation.
- (B) Where the requesting physician has expressly opined that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician shall provide an explanation for why the requesting physician's explanation is insufficient.
- (14) For decisions based on medical necessity, a citation to and description of the relevant medical criteria or guidelines used to reach the decision.
- (15) Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.
- (16) 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 claim 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.
- (17) 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 and within ten (10) days for formulary disputes ..
- (18) 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 claim 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."
- (19) Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, including with respect to disputes over the necessity of or availability of the requested information, and a clear statement that the internal appeals process is 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.

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

All decisions to approve a request for authorization shall specify the specific the date the complete request for authorization was received, medical treatment service requested, the specific medical treatment service approved, and the date of the decision.

EXHIBIT 5

UM P&P Manual Utilization Management
Regulatory References URAC UM 22, 23
Policies and Procedures
Subject: Notification of Non-Certification Process
Origination Date: May 14, 1997
Review/Revision Date: 11/2/98, 1/29/99, 9/28/01, 3/7/05, 3/22/07, 4/2008,
5/13/09, 4/15/2010, 4/5/11, 9/1/2011, 11/21/19, 1/6/26
Performed By: All Utilization Management Services

Policy: The Utilization Management Department shall provide notification of its non-certification determinations in accordance with URAC standards and relevant regulatory guidelines.

In workers' compensation where the patient bears no financial responsibility, patients do not receive copies of notification letters unless expressly required by state regulations. Please refer to the Jurisdictional Guidelines Database ("JuD") for state specific notification requirements.

Procedure:

1. When a request for treatment or services is received, the treatment request and the clinical information submitted by the provider are compared with appropriate criteria.
2. If the information received does not meet criteria, the UM Reviewer will schedule a peer review using the Physician Review Services Database and complete the process according to the Referral to Peer Consultant P&P.
3. During the review process, prior to a determination being rendered, a peer-to-peer contact will be offered to the provider. If the provider has requested contact with the peer, the peer will contact the provider during the review to discuss the case and obtain additional clinical information.
4. The UM reviewer will follow Notification of Certification Process for certification of treatment or services.
5. When a determination is made not to certify a requested treatment, procedure or service, the requesting provider and/or other provider/facility rendering services shall be notified by telephone and in writing within the appropriate notification timeframes based on type of review or State guidelines. These timeframes are inclusive of the entire UM process, from the receipt of the request for a UM decision to issuance of both the verbal and written documentation.
6. Verbal notification shall include the principal reason for the non-certification determination and will inform the provider of the option to appeal the determination. The offer of a peer-to-peer contact is documented in the Physician Review database/General Service Code (R1026).

7. Written notification shall include the principal reason for the non-certification and instructions for initiating an appeal. The patient & provider shall be notified where written notification is required by state regulation or rule.

For California Reviews

A description of the medical criteria or guidelines used pursuant to section 9792.8, shall be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.

Nothing in section 9792.8 precludes authorization of medical treatment beyond what is covered in the medical treatment utilization schedule or supported by the best available medical evidence in order to account for medical circumstances warranting an exception in accordance with section 9792.21.1(e).

8. When a patient is represented (e.g. attorney) in a workers' compensation claim, written notification will be provided to the attorney or patient representative as required by state regulation or rule.

9. For Group Health, patients will receive written copies of all determination letters.

When a denial is made due to lack of information or due to lack of test, exam or special consultation results, the denial states that the decision will be reconsidered once the requested information or requested results are received. 8 C.C.R. §9792.9.5(e)(7)(A)

10. Efforts to obtain information (including request for test, exam or specialty consultation) from the requesting physician must be documented before issuing a denial due to lack of reasonable and necessary information. 8 C.C.R. §9792.9.5 (e)

When additional test, exams or specialty consultation is required and requested, the decision will be made within 30 days of the receipt of the initial request for authorization. See §9792.9.6(c)(1)

***Notes:**

See Jurisdictional Guidelines Database for state regulatory requirements.

EXHIBIT 6

UM P&P Manual Utilization Management

Regulatory References URAC UM 30, 31, 32, 33, 34, 35, 36
Policies and Procedures
Subject: Internal Appeals Procedure - CALIFORNIA UR
Origination Date: April 1993
Review/Revision Date: 3/20/96, 11/12/98,4/6/99,4/21/99,7/26/99,2/13/02,4/1/02,
6/26/02, 10/1/02, 06/19/03, 2/9/05, 5/18/06, 3/9/07, 3/2008,
8/12/09,12/01/09,1/12/2011,11/21/19,8/23/21, 1/6/26
Performed By: All Utilization Management Services

Policy: Broadspire provides an internal appeal procedure, upon request, to the attending physician, health care facility or patient/enrollee if a non-certification or modification recommendation is made for medical treatment/services. The following guidelines were constituted on behalf and for the rights of the above referenced parties. Broadspire will comply with all Federal and State regulatory guidelines. Refer to the Jurisdictional Guidelines Database for state regulatory guidelines. *

Appeal reviews will be conducted by clinical peers who:

- o Are Health Professionals
- o Are qualified, as determined by the medical director, to render a clinical opinion about the medical condition, procedures, or treatment under review
- o Hold a current, unrestricted and valid license in the same licensure category as the ordering provider or as a doctor of medicine or osteopathy
- o Are Board certified (if applicable) by a specialty board approved by American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists
- o Are in the same profession and in a similar specialty that typically manages the medical condition
- o Are neither the individual who made the original non-certification nor the subordinate of such an individual

Procedure:

California UR Internal APPEALS:

(f)(1) Nothing in this section precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the employee and, if the employee is represented by counsel, the employee's attorney, have been notified of the timeframes in subdivision (a) in which to file an application for independent medical review. Any request by the injured worker or treating physician for an internal utilization review appeal process conducted under this subdivision must be submitted to the claim administrator within ten (10) days after the receipt of the utilization review decision. §9792.10.1

- a. A request for an internal utilization review appeal must be completed, and a determination issued by the claim administrator within thirty (30) days after receipt of the request under

subdivision (f)(1). If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the internal utilization review appeal must be completed, and a determination issued by the claim administrator within ten (10) days after receipt of the request under subdivision (f)(1). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6(e) that determines the medical necessity of the disputed treatment.

b. Any determination by the claims administrator following an internal utilization review appeal that results in a modification of the requested medical treatment 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 section 9792.9.5 (e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.5(e)(7) must indicate that the decision is a modification after appeal.

1. The provider, facility and/or patient may submit written comments, documentation, records, or other information relating to the case with the appeal request.
2. The Utilization Management department will take into account all information submitted without regard to whether such information was submitted or considered on the initial review of the case. Information may be transmitted via fax, telephone, or other means. If no additional information is received from the provider, the determination is rendered based on existing medical information.
3. Case documentation for all appeals will contain:
 - The name of the patient, provider and facility rendering service;
 - Date of appeal reviews, documentation of actions taken, and final resolution;
 - Copies of all correspondence from the patient, provider or facility rendering service and information related to the appeal determination.
4. The expedited and standard appeals processes are described below:

EXPEDITED APPEALS (Urgent, Imminent or Ongoing Care)

After an initial adverse determination, the attending physician or other ordering provider, facility, or patient/enrollee may assert his/her right for an expedited appeal verbally or in writing for any urgent, imminent or ongoing services.

- An Urgent request is defined as any request for utilization management determination with respect to which their application of the time periods for making non-urgent care determinations
 - a. could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function, or
 - b. in the opinion of a physician with knowledge of the consumer's medical condition, would subject the consumer to severe pain that cannot be managed without the requested care or treatment.
- Examples of imminent or ongoing care may include but are not limited to such services as inpatient hospitalization, work hardening, work condition, and chronic pain program.
 - c. Verbal notification of the determination is provided to the attending physician or other ordering provider or facility rendering service, within 72 hours of initiating the expedited appeal process.
 - d. The expedited appeal is completed (i.e. written notification of the determination is issued) as soon as possible, but no later than 72 hours after the initiation of the appeal process.

- e. Written notification shall be sent to the patient/enrollee and attending physician or other ordering provider and facility rendering service (if applicable.)
- f. In the event an expedited appeal is not resolved or if the treating provider disputes the result, the treating provider or patient may request an appeal through the Standard Appeal process.

STANDARD APPEAL (Non-imminent Ongoing Care)

Decision(s) of the Physician Reviewer may be appealed by the attending physician or other ordering provider, facility, or patient/enrollee may assert his/her right for a standard appeal by verbal or written request.

- The Standard Appeals process may be used in the event that an Expedited Appeal is not resolved (as appropriate) or after a non-certification decision has been made for non-imminent ongoing services.
- An appeal of a retrospective review will be conducted as a Standard Appeal.
 - a. Verbal notification of the determination is provided to the attending physician or other ordering provider or facility rendering service, within thirty (30) days of the initiation of the appeal request
 - b. Standard appeal determinations are completed (Le. written notification of the appeal decision is issued) within thirty (30) days of the initiation of the appeal request.
 - c. Written notification shall be sent to the patient/enrollee and attending physician or other ordering provider and facility rendering service (if applicable.)

WRITTEN NOTIFICATION of appeal determinations includes the following information:

- a. The treatment requested and the party requesting the appeal;
- b. The determination relating to the treatment reviewed;
- c. The principal reasons for the determination to uphold the non-certification;
- d. The appeal letter templates include:
 - A statement indicating a standard appeal may be requested after an expedited appeal adverse determination.
 - A statement indicating the clinical rationale used to make the determination will be made available in writing upon request.

Notes:

Broadspire **Jurisdictional Guidelines**

State: CALIFORNIA

Section: Law and Regulations
Utilization Management Requirements

<p>UM Required For:</p>	<p>For injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 physical therapy and 24 occupational therapy visits per industrial injury, unless carrier authorizes additional visits in writing. <i>(Note: This limit shall not apply to visits for postsurgical physical medicine and postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule.</i> Cal. Lab. Code § 5307.27 (Deering). Cal. Lab. Code § 4604.5(d) (Deering).</p> <p>Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. Cal. Lab. Code § 4600(a) (Deering).</p> <p style="padding-left: 40px;">4610. (a) "utilization review" means functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600. (above)</p> <p>If physician is pre-designated: the insurer may require prior authorization of any nonemergency treatment or diagnostic service and may conduct reasonably necessary utilization review. Cal. Lab. Code § 4600(d)(5) (Deering).</p> <p>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 and is addressed by the medical treatment utilization schedule adopted pursuant to Cal. Lab. Code § 5307.27, by a member of the medical provider network or health care organization, or by a physician pre-designated pursuant to subdivision (d) of Cal. Lab. Code § 4600 (Deering), within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or pre-designated physician pursuant to subdivision (d) of Cal. Lab. Code § 4600 (Deering), 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.</p> <p>(c) Unless authorized by the employer or rendered as emergency medical treatment, the following medical</p>
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	<p>treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:</p> <ul style="list-style-type: none">(1) Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Cal. Lab. Code § 5307.27 (Deering).(2) Nonemergency inpatient and outpatient surgery, including all presurgical 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, whose combined total value exceeds two hundred fifty dollars (\$250), as determined by the official medical fee schedule.(7) Electrodiagnostic 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. L.C. 4610 (b) & (c). <p>Effective 4/1/2026: §9792.9.7 UR-Medical Treatment First 30 Days of the Date of Injury</p> <p>(a) Notwithstanding the requirements of sections 9792.9.1 through 9792.9.6, a treating physician specified in Labor Code section 4610(b), may render medically necessary treatment or services to an injured worker without prospective utilization review for the first thirty (30) days after the date of injury, provided that:</p> <ul style="list-style-type: none">(1) The treatment or service is for a body part or condition that has been accepted as compensable by the claims administrator.(2) The treatment or service is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director under Section 5307.27.(3) The initial treating physician timely submits the “Doctor’s First Report of Occupational Injury or Illness,” DIR Form 5021, to the claims
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	<p>administrator as required by section 9785, subdivision (e), setting forth in detail the anticipated treatment plan for the injured worker.</p> <p>(4) All treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, are set forth in a request for authorization provided to the claims administrator in accordance with section 9785(h). The form shall be submitted to the claim administrator concurrent with the Doctor's First Report of Occupational Injury or Illness. Subsequent treating physicians during the 30-day period shall submit a request for authorization following their first visit with the injured worker indicating all treatment being rendered.</p> <p>(5) The treating physician's medical treatment bill for the non-emergency treatment rendered or services provided under this section is submitted to the claims administrator within thirty (30) days of the date the service was provided. Medical treatment bills for emergency treatment services shall be submitted within 180 days of the date that the treatment was provided.</p> <p>(b) The following medical treatment services, unless previously authorized by the claims administrator or rendered as emergency medical treatment, cannot be provided under subdivision (a) and shall require prospective utilization review under section 9792.9.1 or 9792.9.3:</p> <p>(1) Pharmaceuticals, to the extent they are not expressly exempt from prospective review under the MTUS Drug Formulary.</p> <p>(2) Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician's office. This includes all necessary and routine pre-operative, intra-operative, and post-operative services performed for the purpose of surgery including, but not limited to, related diagnostic tests or procedures, rehabilitation services, durable medical equipment or supplies, and routine post-surgical pain management treatment or services. For the purpose of this section, "surgery" means: 1) any procedure set forth in the Surgery section of the American Medical Association's <i>Current Procedural Terminology (CPT®)</i> which is incorporated by reference at section 9789.31(h), and any updates pursuant to section 9789.36; or 2) any procedure code defined as "surgery" in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule found in the Healthcare Common Procedure Coding System (HCPCS), which is incorporated by reference at section 9789.31(i), and any updates pursuant to section 9789.36.</p>
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	<p>(3) Psychological or psychiatric treatment services, which includes diagnostic services, psychotherapy, and other services or procedures to an individual or group in all care settings provided by a physician or other qualified health care provider, and including psychiatric pharmaceuticals, to the extent they are not expressly exempt from prospective utilization review under the MTUS Drug Formulary.</p> <p>(4) Home health care services, including health care and other medically necessary services provided to the injured worker in the residential setting.</p> <p>(5) Imaging and radiology services, excluding X-rays.</p> <p>(6) All durable medical equipment, prosthetics, orthotics, and supplies where the purchase or rental cost of the item with necessary supplies, if any, for the expected course of treatment is greater than \$250.00 as determined by the DWC Official Medical Fee Schedule (OMFS), or, for an unlisted item, where the billed amount will be greater than \$250.00.</p> <p>(7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies. For the purpose of the subdivision, electrodiagnostic medicine is a medical specialty where the physician uses neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic, neuromuscular, and/or muscular systems. This includes, but is not limited to, procedures set forth in the American Medical Association's <i>Current Procedural Terminology (CPT®)</i> Medicine section, under the subheading "Neurology and Neuromuscular Procedures," and any test that measures the speed and degree of electrical activity in the muscles and nerves in order to make a diagnosis.</p> <p>(8) Spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections.</p> <p>(c) (1) If the claims administrator determines, after retrospective review, that a physician providing treatment under subdivision (a) of this section has a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, the claims administrator may:</p> <p>(A) Remove the ability of the physician to render treatment exempt from prospective review to any injured worker whose claim is adjusted or administered by the claims administrator. The claims administrator must provide written notice to the physician that: (1) documents, based on retrospective review, the physician's pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary; (2) advises</p>
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	<p>that based on the documented failure the physician can no longer render exempt treatment to any injured worker whose claims are adjusted or administered by the claims administrator; and (3) advises of the requirement of prospective utilization review for all subsequent medical treatment.</p> <p>(B) Remove the physician as the injured worker's primary treating physician by filing a petition for change of primary treating physician under section 9786.</p> <p>(C) Terminate the physician from the claims administrator's or employer's medical provider network or health care organization.</p> <p>(2) For the purpose of this section, "pattern and practice" means when treatment has been rendered inconsistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, for twenty (20) separate and unrelated recommended medical services or goods with ten (10) or more injured workers over the course of three (3) months; or for eight (8) separate and unrelated medical services or goods with two (2) or less injured workers within a month.</p> <p>(d) If a physician renders treatment under this section without timely submitting the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, to the claims administrator as required by section 9785(e), or without timely submitting a complete request for authorization as required by section 9792.6.1(u), the claims administrator may remove the physician's ability to provide further medical treatment that is exempt from prospective review to the employee for the remainder of the thirty-day time period referenced at subdivision (a) by issuing written notice to the physician. The written notice must identify that the physician either failed to timely submit the DIR Form 5021 or failed to timely submit a complete request for authorization, advise that the physician can no longer render exempt treatment to the injured worker for the remainder of the thirty days, and advise that any such treatment is subject to prospective utilization review.</p>
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<p>UM may be requested by:</p>	<p>A request for authorization for a course of treatment must be in written form. An oral request for authorization must be followed with a written confirmation of the request within seventy-two (72) hours.</p> <p>Note: The clock starts upon receipt by the organization either the UM department or the claims adjuster.</p> <p>A request for authorization (RFA) transmitted after 5:30 PM Pacific Time shall be deemed to be received on the following business day as defined in Cal. Lab. Code § 4600.4 and in, except in the case of an expedited or concurrent review. §9792.9 (a)(1)</p> <p>Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a claims administrator, non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it “not complete” and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt.</p> <p>https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR_FormRFAClean.pdf</p>
<p>Emergency Treatment Provisions:</p>	<p><u>Emergency care does not need to be approved in advance.</u> Injured workers with an emergency condition are to proceed to the nearest emergency facility. Emergency health care services, however, may be subjected to retrospective review.</p> <p>See “UR Required” section above concerning Medications RFA within the first 30 days of injury.</p> <p>Expedited review - 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. <u>The requesting physician must indicate the need for an expedited review upon submission of the request.</u> A decision 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.</p> <p>Cal. Lab. Code § 4610(3) https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=LAB&division=4.&title=&part=2.&chapter=2.&article=2</p> <p>Cal. Code Regs., tit. 8, § 9792.6.1.</p>

<p>UM Decision Turnaround Time:</p>	<p>Broadspire at a minimum will meet jurisdictional guidelines(see below) and will strive to meet the more stringent URAC guidelines.</p> <p>The first day in counting any timeframe requirement is the first normal business or working day after receipt of the completed, or accepted as complete request for authorization, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the request for authorization. 9792.9.3 (a)</p> <p>For prospective, concurrent, or expedited review, a decision to approve a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. If the initial communication is by telephone, written communication shall issue to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.</p> <p>Prospective or concurrent decisions to approve, modify, or deny a request for prior authorization shall be made within five (5) business days from the date of receipt of the written request for authorization. If appropriate information necessary to render a decision is not provided with the original request for authorization, the information will be requested within the five (5) working days from the date of receipt of the written request. In no event shall the determination be made more than 14 calendar days from the date of receipt of the original request for authorization by the health care provider. If 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 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 request for authorization notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or 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. 9792.9.6</p> <p>If the reasonable information requested by the claims administrator is not received within 14 calendar days of the date of the original written request by the requesting physician, a reviewer (i.e. physician reviewer) may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested. If the results of the additional examination or test required or the specialized consultation that is requested by the reviewer under this subdivision is not received within thirty (30) days from the date of the request for authorization, 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. 9792.9.6</p> <p>UR-Dispute of Liability-Deferral</p> <p>A request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred if the</p>
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	<p>requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change. Such a request must be reviewed by a physician reviewer and any modification or denial of the request must comply with applicable requirements as set forth at section 9792.9.5.</p> <p>UR-Decision to Modify or Deny a Request for Authorization</p> <p>For prospective, concurrent, or expedited review, a decision to modify, or deny a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision, by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. Written communication of the decision shall be issued to the injured worker, and, if applicable, to the injured worker's representative within 24 hours of the decision for concurrent review, within two (2) business days for prospective review, and, for expedited review, within 72 hours of receipt of the request. Written communication in accordance with this paragraph shall also issue to the requesting physician where the initial communication of the decision to the physician was by telephone. 9792.9.5 (c).</p> <p>For retrospective review, a written decision to deny part or all of the requested medical treatment based on medical necessity 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 the receipt of the request for authorization and information that is sufficient for a reviewer to make a determination as to whether the treatment was medically necessary. 9792.9.5 (d)</p> <p>§9792.9.8 UR-MTUS Drug Formulary</p> <p>(a) This subdivision governs review of Exempt Drugs listed on the MTUS Drug List.</p> <p>(1) Notwithstanding sections 9792.9.1 through 9792.9.7, the following drugs can be dispensed to an injured worker without obtaining authorization through prospective review:</p> <p>(A) Drugs identified on the MTUS Drug List as exempt under section 9792.27.15;</p> <p>(B) Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Special Fill policy under section 9792.27.12; and</p> <p>(C) Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Perioperative Fill policy under section 9792.27.13.</p> <p>(2) Exempt drugs identified in subsection (1) must still be set forth in a request for authorization as required under section 9792.6.1(u), or in a manner agreed upon by the treating physician and the claims administrator.</p> <p>(b) This subdivision governs review of Non-Exempt Drugs that are listed on the MTUS Drug List. For a drug not covered under subdivision (a) of this</p>
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	<p>section, regardless of whether a drug is prescribed and dispensed within 30 days from the date of injury, the treating physician must request authorization through prospective utilization review by submitting a request for authorization in the manner set forth in section 9792.6.1(u), or in a manner agreed upon by the treating physician and the claims administrator.</p> <p>(1) Prospective decisions to approve, modify, or deny a request for authorization for a drug not covered under subdivision (a) of this section 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 date of receipt of the request for treatment. The reviewer or non-physician reviewer may request the treating physician to provide additional information reasonably necessary to make a determination as follows:</p> <p>(A) The reviewer or non-physician reviewer shall request the information from the treating physician within four (4) business days from the date of receipt of the request for authorization.</p> <p>(B) If the information is not received within five (5) business days from the date of the request for authorization of treatment, a physician reviewer may deny the request in accordance with section 9792.9.5, subdivision (e).</p> <p>(2) The decision shall be communicated in the manner set forth in sections 9792.9.4 and 9792.9.5.</p> <p>(3) The extension of time as set forth in section 9792.9.6 is not applicable to a request for authorization of a drug covered under this subdivision.</p> <p>(c) This subdivision governs review of drugs that are not listed on the MTUS Drug List. A treating physician must request authorization through prospective review for a drug not listed on the MTUS Drug List by submitting a request for authorization in the manner set forth in section 9792.6.1(u) or in a manner agreed upon by the treating physician and the claims administrator, regardless of whether a drug is prescribed or dispensed within 30 days from the date of injury. Prospective decisions to approve, modify, or deny a request for authorization of a drug not listed on the MTUS Drug List shall be made in a timely fashion in accordance with section 9792.9.3 and section 9792.9.6. The decision shall be communicated in the manner set forth in sections 9792.9.4 and 9792.9.5.</p> <p>(d) Notwithstanding subdivision (b), a request for authorization that requests both drugs and non-pharmaceutical treatment related to the same injury or illness shall be reviewed under the timeframes set forth in section 9792.9.3 and section 9792.9.6 and the requirements of sections 9792.9.4 and 9792.9.5.</p> <p>(e) Except for drugs that fall under 9792.9.7(a), a utilization review decision to deny a request for authorization of a drug which falls under subdivision (a) of this section based on the failure of the treating physician to prescribe or dispense the medication consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule, can be grounds for the denial of payment for the medication.</p>
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	<p>(f) (1) A decision to modify or deny a request for authorization under this section based on medical necessity shall be reviewed only through the claims administrator's voluntary internal utilization review appeals process, or the independent medical review provisions of Labor Code section 4610.5 and 4610.6.</p> <p>(2) A dispute regarding a decision to modify or deny a request for authorization under this section based on a reason other than medical necessity shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.</p> <p>(3) If a decision is made to modify or deny a request for authorization under this section based on both medical necessity and a reason other than medical necessity, the non-medical necessity dispute shall be resolved first.</p> <p>(g) The following rules apply when a treating physician prescribes or dispenses a drug to treat an injured worker under the provisions of section 9792.9.7(a).</p> <p>(1) The injured worker's initial treating physician shall describe in the treatment plan on the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, all drugs that are being prescribed or dispensed to treat the injured worker, and list on the request for authorization required under section 9792.9.7(a)(4), all drugs that are being prescribed or dispensed. Subsequent primary treating physicians shall submit a request for authorization following their first visit with the injured worker indicating all drugs that are being prescribed or dispensed for treatment.</p> <p>(2) The treating physician may prescribe or dispense a drug identified under subdivision (a) of this section without the need to obtain authorization through prospective utilization review.</p> <p>(3) For a drug not covered under subdivision (a) of this section, the treating physician must request authorization through prospective utilization review by submitting a request for authorization in the manner set forth in section 9792.9.1, or in a manner agreed upon by the treating physician and the claims administrator.</p> <p>(4) The claims administrator may conduct retrospective review of a drug prescribed or dispensed to the injured worker under subdivision (a) of this section only for the purpose of determining whether the use of the drug is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director under Section 5307.27.</p> <p>(A) Payment for an exempt drug dispensed under the provisions of section 9792.9.7(a) shall not be denied based on a determination that use of the drug was not consistent with the applicable guideline.</p>
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	<p><u>EXPEDITED REVIEW:</u> The requesting physician must indicate the need for an expedited review upon submission of the request. (See above Emergency Treatment Provisions discussion for the definition of an Expedited Review.)</p> <p>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, and to the individual's designee, within 30 calendar days of receipt of information that is reasonably necessary to make this determination.</p> <p>Cal. Lab. Code § 4610(c) https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=LAB&division=4.&title=&part=2.&chapter=2.&article=2.</p>
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<p>State Treatment Guidelines:</p>	<p>The Administrative Director adopts the Medical Treatment Utilization Schedule (MTUS) ACOEM consisting of Cal. Code Regs., tit. 8, § 9792.20 through Cal. Code Regs., tit. 8, § 9792.27.23.</p> <p>The MTUS, based on the principals of Evidenced-Based Medicine (EBM), shall be the primary source of guidance for treating physicians and physician reviewers for the evaluation and treatment of injured workers.</p> <p>https://www.dir.ca.gov/dwc/MTUS/MTUS.html</p> <p>DRAFT TO BE EDITED 8/20/2015 NM</p> <p>Medical Evidence Search Sequence:</p> <p>(2) In the limited situation where a medical condition or injury is not addressed by the MTUS or if the MTUS' presumption of correctness is being challenged, then:</p> <p>A) Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in Cal. Code Regs., tit. 8, § 9792.25.1. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then</p> <p>(B) Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in Cal. Code Regs., tit. 8, § 9792.25.1. Medical treatment guidelines can be found in the National Guideline Clearinghouse that is accessible at the following website address: www.guideline.gov/. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then</p> <p>(C) Search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury.</p> <p>Treatment shall not be denied on the sole basis that the condition or injury is not addressed by the MTUS. There are two limited situations that may warrant treatment based on recommendations found outside of the MTUS:</p> <p>(1) First, if a medical condition or injury is not addressed by the MTUS, medical care shall be in accordance with other medical treatment guidelines or peer-reviewed studies found by applying the Medical Evidence Search Sequence set forth in Cal. Code Regs., tit. 8, § 9792.21.1.</p> <p>(2) Second, if the MTUS' presumption of correctness is successfully challenged. The recommended guidelines set forth in the MTUS are</p>
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	<p>presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof. Therefore, the treating physician who seeks treatment outside of the MTUS bears the burden of rebutting the MTUS' presumption of correctness by a preponderance of scientific medical evidence.</p> <p>The guideline/criteria order/sequence of authority for UR is:</p> <ol style="list-style-type: none"> 1. MTUS Special or Clinical Topic 2. ACOEM 3. Other nationally recognized guideline/criteria (ODG, ELOS) <p>NOTE: Please see Clinical Content Prioritization document below for questions regarding guideline v. criteria sequencing use for UR determinations.</p> <p></p> <p>Clinical Content Prioritization.doc</p> <p>During the Utilization Review process, Broadspire applies and utilizes the California Medical Treatment Utilization Schedule (MTUS) ACOEM guidelines as its primary source of criteria. For all conditions or injuries not addressed by the MTUS, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based.</p> <p>Broadspire applies and utilizes other evidence-based medical treatment guidelines that are scientifically based and generally recognized by the national medical community, such as ACOEM and other state treatment guidelines where applicable. Internally developed criteria consistent with MTUS, are developed through comprehensive study of the accepted standards of practice, literature research, networking, consultation and contribution by actively practicing providers certified in their areas of expertise. Criteria are reviewed on an annual and as needed basis. Cal. Code Regs., tit. 8, § 9792.8.</p> <p><u>Medical Treatment Utilization Schedule (MTUS)</u> Effective 10/26/200</p> <ul style="list-style-type: none"> • Antiemetics Guideline (ACOEM March 27, 2020) <p><u>Medical Treatment Utilization Schedule (MTUS)</u> Effective 6/1/25 Cannabis Guidelines https://www.dir.ca.gov/dwc/DWCPPropRegs/2025/MTUS-Evidence-Based-Update/Cannabis-Guideline.pdf</p> <p>Effective 6/1/25 Chronic Pain Guidelines https://www.dir.ca.gov/dwc/DWCPPropRegs/2025/MTUS-Evidence-Based-Update/Chronic-Pain-Guideline.pdf</p> <p>Effective 10/7/19 Hip & Groin Disorders Guidelines https://www.dir.ca.gov/dwc/DWCPPropRegs/MTUS-Evidence-Based-Updates-August2019/Hip-Groin-DisordersGuidelines.pdf</p>
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	<p>Effective 11/23/21 Low Back Disorders Guideline (ACOEM February 13, 2020)</p> <p>Introduction to Workplace Mental Health https://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Evidence-Based-Updates-April2019/Mental-Health.pdf</p> <p>Effective 4/18/19 MTUS ACOEM Guidelines Updates: https://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Evidence-Based-Update/MTUS-Evidence-Based-Update.htm Ankle & Foot Disorders Cervical & Thoracic Spine Disorders Elbow Disorders Hand, Wrist & Forearm Disorders Workplace Mental Health: PTSD, Acute Stress Guidelines</p> <p>Effective 10/31/18 MTUS ACOEM Guidelines https://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Evidence-Based-Updates/Final-Regulations/Traumatic-Brain-Injury.pdf https://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Evidence-Based-Updates/Final-Regulations/Prevention.pdf https://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Evidence-Based-Updates/Final-Regulations/General-Approach-to-Initial-Assessment-and-Documentation.pdf https://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Evidence-Based-Updates/Final-Regulations/Cornerstones-of-Disability-Prevention-and-Management.pdf</p> <p>Link: https://www.dir.ca.gov/dwc/mtus/MTUS-Formulary-Orders.html</p> <p>Effective 12/1/17 MTUS ACOEM Guidelines: http://www.dir.ca.gov/dwc/DWCPropRegs/Medical-Treatment-Utilization-Schedule/Medical-Treatment-Utilization-Schedule.htm</p> <p>Effective July 18, 2009: The MTUS includes new sections effective on 7-18-09. The Post-surgical Treatment Guidelines sets forth an exception to the 24-visit limit for physical therapy and chiropractic care for postsurgical physical medicine and rehabilitation services. Link: http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS_Regulations/MTUS_Regulations.htm</p> <p>(You may search for a criteria by ICD or diagnosis in the Post Surgical Guidelines and by recommended treatment in the Chronic Pain Guideline using CTRL-F to find a key word.)</p> <p>MTUS Clinical Topics & MTUS Special Topics: Acupuncture & Postsurgical MTUS Special Topic: Chronic Pain</p>
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MTUS RegulationsFinalCleanCopy.pdf



MTUS_ChronicPainMedicalTreatmentGuidelines[1].pdf

[American College of Occupational and Environmental Medicine ACOEM Practice Guidelines](#)

Healthcare providers treating, evaluating, or performing utilization review in the California workers' compensation system may access the MTUS (ACOEM) Guidelines and MTUS Drug List at no cost by registering at www.mdguidelines.com/mtus/login.

ACOEM Practice Guidelines - 2nd Edition

<https://www.acoempracguides.org/Default.aspx>
userid: **broadspire**
password: **acoem**

Link to Medical Dept. Database: ACOEM Summary Documents for Chapters *6, 8, 9, 10, 11, 12, 13, 14, 15: -->Notes Link

(* NOTE: ACOEM Chapter 6 is not currently used for Chronic Pain California UR; Use MTUS Guideline as directed below.)

---> Broadspire MTUS FAQs for UM and CM <-----



California MTUS FAQ v1-7-28-2009.doc

Cal. Code Regs., tit. 8, § 9792.20 (re)adopts ACOEM guidelines and **adds** Acupuncture guidelines which supercede the text of ACOEM related to acupuncture except shoulder injuries. These guidelines also address acupuncture for areas not addressed by ACOEM.

UR DOCUMENTATION: How to Reference MTUS in UR Letters (examples):

Cal. Code Regs., tit. 8, § 9792.24.1. Acupuncture Medical Treatment Guidelines.

Cal. Code Regs., tit. 8, § 9792.24.2. Chronic Pain Medical Treatment Guidelines, *Trigger point injections* (include the specific guideline referenced)

Cal. Code Regs., tit. 8, § 9792.24.3. Postsurgical Treatment Guidelines, *Achilles tendon rupture* (include the specific guideline referenced)

Individual treatment guidelines and the California UM Program Plan may be released upon request. The UM Program Plan may be released via electronic means at no fee. If a hard copy of the UM Program Plan is requested, a charge not to exceed \$0.25 per page plus postage costs would be applied.

Cal. Code Regs., tit. 8, § 9792.7(d)(1).

THE DOCUMENT BELOW MAY BE USED IF OUR UM PROGRAM IS REQUESTED BY A MEMBER OF THE PUBLIC, ATTORNEY, ETC.

REVISED 12/12/07 (URAC Updated 12/6/06; Dr. Lazarovic license updated 12/12/07); 5/2008; 11/2009 Dr. Lazarovic license updated.; 6/2010 BSI Sunrise office address updated; 7/15/2010 Authorization definition added at state's request; 8/25/2011 State recommended revisions added. 3/1/2012 Post audit UR Plan posted here. 6/2015 Post audit updated UR Plan posted. 6/30/17 UR Plan updated with new CMO information. 8/9/19 UR Plan updated with new CMO information.



CA UR Plan
006.2025.approved.

<p>Special Determination Procedures:</p>	<p>UR- Decisions to Approve A RFA</p> <p>(a) (1) All written decisions to approve a request for authorization shall specify the date the complete, or accepted as complete, request for authorization was first received, the medical treatment service requested, the specific medical treatment service approved, and the date of the decision. If applicable, the written decision shall also include the date the request for information, exam, or consultation under section 9792.9.6, subdivision (a)(1)(A), (B), or (C) was requested, and the date the information was received.</p> <p>(2) For approvals of a request for authorization of a drug where the request for authorization did not indicate “Do Not Substitute” or “Dispense as Written,” the written decision approving the request in generic form shall indicate, “generic substitute authorized” or words to that effect and meaning.</p> <p>(3) For approvals of a request for authorization of a drug that is exempt on the Drug Formulary, the written decision approving the request shall indicate, “Exempt per MTUS Drug Formulary” or words to that effect and meaning.</p> <p>(4) For approvals of a request for authorization of non-drug treatment that are exempt under section 9792.9.7 (i.e., the 30-day exemption), the written decision approving the request shall identify the exempt treatment as, “30-day exemption” or words to that effect and meaning.</p> <p>UR- Decisions to Modify or Deny A RFA</p> <p>For prospective, concurrent, or expedited review, a decision to modify, delay, or deny a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. Written communication of the decision shall issue to the injured worker, and, if applicable, to the injured worker’s representative within 24 hours of the decision for concurrent review within two (2) business days for prospective review, and, for expedited review, within 72 hours of receipt of the request. Written communication in accordance with this paragraph shall also issue to the requesting physician where the initial communication of the decision to the physician was by telephone.</p> <p>(d) For retrospective review, a written decision to deny part or all of the requested medical treatment based on medical necessity 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 the receipt of the request for authorization and information that is sufficient for a reviewer to make a determination as to whether the treatment was medically necessary.</p> <p>(e) The written decision modifying or denying treatment authorization shall be provided to the requesting physician, the injured worker, and, if applicable, if the injured worker’s representative and/or attorney. The written decision shall be signed by either the claims administrator or the physician reviewer, and shall only contain the following information specific to the request:</p>
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	<p>(1) The date on which the completed or accepted request for authorization was first received.</p> <p>(2) If the timeframe for decision was extended under section 9792.9.6, a specific description of the information needed to make a medical necessity determination of the treatment request; the date(s) and time(s) the request(s) for information, exam, or consultation under subdivision (a)(1)(A), (B), or (C) of section 9792.9.6 were requested; the manner in which the requests were made; and the date the information was first received.</p> <p>(3) The date on which the decision is made.</p> <p>(4) A description of the specific course of medical treatment set forth on the request for authorization.</p> <p>(5) A list of all medical records reviewed.</p> <p>(6) A specific description of the medical treatment service approved, if any.</p> <p>(7) (A) A clear, concise, and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity or; if applicable, that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation.</p> <p>(B) Where the requesting physician has expressly opined that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician shall provide an explanation for why the requesting physician's explanation is insufficient.</p> <p>(8) For decisions based on medical necessity, a citation of and a description of the relevant medical criteria or guidelines used to reach the decision.</p> <p>(9) Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.</p> <p>(10) 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.</p> <p>(11) 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,</p>
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	<p>DWC Form IMR, within the timeframe indicated on the last page of the application.</p> <p>(12) Include the following mandatory language advising the injured employee:</p> <p>“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.”</p> <p>and</p> <p>“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.”</p> <p>(13) Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, including with respect to disputes over the necessity of or availability of the requested information, and a clear statement that the internal appeals process is <u>a</u> 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.</p> <p>(14) The written decision modifying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or, if applicable, expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the reviewer, the expert reviewer, or the medical director for the treating physician to discuss the decision, which shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time. In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.</p>
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	<p>In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker. (Note: concurrent review includes inpatient rehab.)</p> <p>In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request but shall not include the rationale, criteria or guidelines used for the decision.</p> <p>Cal. Code Regs., tit. 8, § 9792.10(b)(1).</p> <p>Authorization requests may only be modified, or denied by a physician with education, training, expertise and experience pertinent to evaluating the specific clinical services under review. The reviewer must be licensed by any state or the District of Columbia.</p> <p>Responses regarding decisions to modify, or deny medical treatment services requested by physicians must include clear and concise explanation of reasons for the determination, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.</p> <p>Cal. Lab. Code § 4610(i)(5) (Deering) Cal. Code Regs., tit. 8, § 9792.9.5(7)(A).</p>
<p>Special Licensure Requirements:</p>	<p>ACUPUNCTURE: Acupuncture requests for CA must be reviewed by a L.Ac., MD or DO licensed in any US state (or the District of Columbia). (1/29/10 per Sara K Scully, RN, NCH, DWC Medical Unit-UR) 2/04/10 RS</p> <p>The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in the state of California. Broadspire's medical director is licensed in the state of California.</p> <p>Only a physician competent to evaluate the specific clinical issues of the treatment request may modify or deny authorization requests for reasons of medical necessity to cure and relieve the workers compensation injury. Physician reviewers do not require California licensure but must be licensed in any state or the District of Columbia.</p>
<p>Direct Access to PT:</p>	<p>CA is a direct access state, but workers' comp law requires a physician referral for PT.</p> <div data-bbox="592 1497 646 1560" data-label="Image"> </div> <p>apta_direct_access_by_state9.4.2024.pd</p> <p>CA Business and Professions Code for PT (Added 9/14/2005)</p> <p>2630. It is unlawful for any person or persons to practice, or offer to practice, physical therapy in this state for compensation received or expected, or to hold himself or herself out as a physical therapist, unless at the time of so doing the person holds a valid, unexpired, and unrevoked license issued under this chapter.</p>

<p>Notification Requirements:</p>	<p>(i)(4)(B)Emergency rules adopted, effective 1/1/13: http://www.dir.ca.gov/DWC/DWCPropRegs/IMR/FinalRegulations/IMR_URCleanRegulations.pdf</p> <p>All prospective and concurrent UR determinations will be <u>reported</u> to the requesting/treating provider(s) <u>via verbal or fax notification</u> on the <u>same business day</u> that the determination is rendered. (**Although the California regulations stipulate a 24 hour window for the verbal/fax notification, it is <u>Broadspire's business policy decision to notify providers "same day."</u>)</p> <p>**Per Regulation: UM decisions must be communicated to the physician initially via telephone or fax within 24 hours of the decision to approve, modify, delay, or deny requests for authorization.</p> <p>A written decision modifying or denying treatment authorization shall be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. Cal. Code Regs., tit. 8, § 9792.9.1(d). Cal. Code Regs., tit. 8, § 9792.9.1.(e).</p> <p>https://www.dir.ca.gov/t8/9792_9_1.html</p> <p>Written notification of a modification or denial of requests by physicians for authorization must be provided to the <u>claimant and the physician</u> within 24 hours <u>of the decision</u> for concurrent review and <u>within 2 business days of the decision</u> for prospective review. Please refer to the UM decision turn around time referenced above. (Note: concurrent review includes inpatient rehab and hospitalization.) Cal. Lab. Code § 4610(i)(4)(B) (Deering) Cal. Code Regs., tit. 8, § 9792.9.1(e)(3).</p> <p>In cases where the review is retrospective, the decision shall be communicated to the individual who <u>received services, or to the individual's designee</u>, within 30 calendar days of receipt of information that is reasonably necessary to make this determination. Cal. Lab. Code § 4610(i)(2) (Deering). Cal. Code Regs., tit. 8, § 9792.9.1(d).</p> <p>Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment services requested, specific services approved and the date of the decision. Responses regarding decisions to modify or deny medical treatment services requested by physicians must include:</p> <ul style="list-style-type: none"> • date the DWC form RFA was received;(effective for decisions rendered on or after 7/1/13, regardless of date of injury) • the date on which the decision is made; • a description of the specific course of proposed medical treatment for which authorization was requested; • a list of all medical records reviewed;(effective for decisions rendered on or after 7/1/13, regardless of date of injury) • a specific description of the medical treatment service approved, if any; • clear and concise explanation of reasons for the reviewing physician's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity pursuant to 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 information that is needed. Authorization denied for lack of information
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	<p>must have documentation of attempts to obtain the necessary information. (effective for decisions rendered on or after 7/1/13, regardless of date of injury).</p> <ul style="list-style-type: none">• the Application for Independent Medical Review, DWC Form IMR, with all fields, except for the signature of the employee, completed, an addressed envelope for mailing to the DWC Administrative Director. (effective for decisions rendered on or after 7/1/13, regardless of date of injury).• https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR_Form_Application.pdf <p>Letters modifying, or denying services must include:</p> <ul style="list-style-type: none">- the full name of the peer reviewer, their licensure category (MD, DO, etc.) and their specialty;- phone # and hours of availability (this is included in the standard letter template);- medical criteria upon which the denial is based; <i>(A description of the medical criteria or guidelines used pursuant to Cal. Code Regs., tit. 8, § 9792.8(a)(3) shall be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. Cal. Code Regs., tit. 8, § 9792.9(k)(5).</i>- state specific dispute statement (this is included in the standard letter template)- the required mandatory language- Details of internal review process <p>Cal. Lab. Code § 4610(i)(5) (Deering) Cal. Code Regs., tit. 8, § 9792.9.1(e)(5)(A) through Cal. Code Regs., tit. 8, § 9792.9.1(e)(5)(K).</p> <p>The California Notice of Non-Certification and Exception UR letter contains language directly from the UR regulations describing the claimant's responsibilities. This letter is utilized for denials on retrospective & concurrent reviews as well as exceptions, reconsiderations, and appeals.</p> <p>https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm</p>
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<p>Appeals:</p>	<p>A patient and/or provider has the right to appeal process outlined in Cal. Lab. Code § 4610.5(f) (Deering) through Cal. Lab. Code § 4610.5(i) (Deering) & Cal. Lab. Code § 4610.6 (Deering).</p> <p>http://www.leginfo.ca.gov/cgi-bin/displaycode?section=lab&group=04001-05000&file=4600-4614.1 An appeal or dispute must be requested within 30 calendar days of receipt of the UR decision.</p> <p>Cal. Code Regs., tit. 8, § 9792.10.1, effective 7/1/13. http://www.dir.ca.gov/t8/9792_10_1.html A request for an internal utilization review appeal must be completed, and a determination issued, by the claims administrator within thirty (30) days after receipt of the request under subdivision (d)(1). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6(e) that determines the medical necessity of the disputed treatment</p>
<p>Notes:</p>	<p>CA Division of Workers Comp Frequently Asked Questions</p> <p>UR FAQs: http://www.dir.ca.gov/dwc/UtilizationReview/UR_FAQ.htm</p> <p>===== =====</p> <p>Link to CA DWC UR Complaint Form: (Form updated: 4/14/2014) Medical providers, injured workers or others who find that UR has not been performed as it is required by statute or regulations can file a complaint with the DWC. The attached form may be used to register a complaint regarding UR services connected with workers' compensation injuries and treatment. http://www.dir.ca.gov/dwc/forms/utilizationreviewcomplaintform.pdf</p>

<p>Authority Source:</p>	<p>Administrative Code/Rule, Division of Workers Compensation</p>	<p>Cal. Lab. Code § 4600 through Cal. Lab. Code § 4614.1 https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?awCode=LAB&division=4.&title=&part=2.&chapter=2.&article=2</p> <p>Cal. Lab. Code § 4060-4068 https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?awCode=LAB&division=4.&title=&part=1.&chapter=7.&article=2</p> <p>DWC Administrative Rules - UR Standards: https://www.dir.ca.gov/t8/ch4_5sb1a5_5_1.html</p> <p>UR Main: https://www.dir.ca.gov/dwc/UR_Main.htm</p> <p>DWC Administrative Rule - UR Violations & Penalties: https://www.dir.ca.gov/t8/9792_11.html</p> <p>Reference to InterQual removed 2/16/12. Revised: 2/16/12cb, 12/19/12cb, 2/28/14cb, 4/25/16cb, 8/15/16cb, 2/20/17cb, 11/2/17cb, 12/11/17cb, 2/16/18cb, 4/18/18cb, 9/10/18cb, 10/2/18cb, 1/11/19cb, 2/5/19cb, 3/20/19 cb, 7/12/19cb, 7/18.19cb, 8/9/19 cb, 9/5/19cb, 11/21/19cb, 12/18/19cb, 2/14/20cb, 7/2/21cb, 9/29/21cb, 11/29/21cb, 9/29/22cb, 8/6/25cb, 12/31/25cb, 1/6/26cb</p> <p>Reviewed 8/11/06da, 11/22/06da; 6/22/2007 nm; 7/2/2009 rs, 10/27/09rs, 1/06/10rs, 9/15/10s, 3/3/11cb, 8/25/2011 nm, 2/9/12cb; 2/2013nm; 1/8/2015nm; 1/12/2016nm, 6/9/16cb, 11/21/19cb, 3/30/23cb, 3/20/23cb, 3/20/25cb</p>
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Broadspire Jurisdictional Guideline Database

Status: Complete

Created On: by: Modified On:2/14/2020 by: Cindy N. Buxton

Cal Lab Code 5307.27

Deering's California Codes are current through Chapter 3 of the 2020 Regular Session.

- Deerings California Codes Annotated
- LABOR CODE (1 12001)
- Division 4 Workers Compensation and Insurance (Pts. 1 4)
- Part 4 Compensation Proceedings (Chs. 1 7)
- Chapter 1 Jurisdiction (5300 5318)

5307.27. Adoption of medical treatment utilization schedule; Evidence-based updates; Inclusion of drug formulary

(a) The administrative director, in consultation with the Commission on Health and Safety and Workers Compensation, shall adopt, after public hearings, a medical treatment utilization schedule, that shall incorporate the evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission pursuant to Section 77.5, and that shall address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers compensation cases. Evidence-based updates to the utilization schedule shall be made through an order exempt from Sections 5307.3 and 5307.4, and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), but the administrative director shall allow at least a 30-day period for public comment and a public hearing. The administrative director shall provide responses to submitted comments prior to the effective date of the updates. All orders issued pursuant to this subdivision shall be published on the Internet Web site of the Division of Workers Compensation.

(b) On or before July 1, 2017, the medical treatment utilization schedule adopted by the administrative director shall include a drug formulary using evidence-based medicine. Nothing in this section shall prohibit the authorization of medications that are not in the formulary when the variance is demonstrated, consistent with subdivision (a) of Section 4604.5.

(c) The drug formulary shall include a phased implementation for workers injured prior to July 1, 2017, in order to ensure injured workers safely transition to medications pursuant to the formulary.

(d) This section shall apply to all prescribers and dispensers of medications serving injured workers under the workers compensation system.

History

Added Stats 2003 ch 639 41 (SB 228). Amended Stats 2015 ch 525 4 (AB 1124), effective January 1, 2016; Stats 2016 ch 868 10 (SB 1160), effective January 1, 2017.

Deerings California Codes Annotated
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Cal Lab Code 4604.5

Deering's California Codes are current through Chapter 3 of the 2020 Regular Session.

- Deerings California Codes Annotated
- LABOR CODE (1 12001)
- Division 4 Workers Compensation and Insurance (Pts. 1 4)
- Part 2 Computation of Compensation (Chs. 1 2)
- Chapter 2 Compensation Schedules (Arts. 1 7)
- Article 2 Medical and Hospital Treatment (4600 4615)

4604.5. Medical treatment utilization schedule and recommended guidelines; Rebuttable presumption of correctness; Limit on chiropractic, occupational and physical therapy visits

(a) The recommended guidelines set forth in the medical treatment utilization schedule adopted by the administrative director pursuant to Section 5307.27 shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof.

(b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices that are evidence and scientifically based, nationally recognized, and peer reviewed. The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.

(c)

(1) Notwithstanding the medical treatment utilization schedule, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury.

(2)

(A) Paragraph (1) shall not apply when an employer authorizes, in writing, additional visits to a health care practitioner for physical medicine services. Payment or authorization for treatment beyond the

limits set forth in paragraph (1) shall not be deemed a waiver of the limits set forth by paragraph (1) with respect to future requests for authorization.

(B) The Legislature finds and declares that the amendments made to subparagraph (A) by the act adding this subparagraph are declaratory of existing law.

(3) Paragraph (1) shall not apply to visits for postsurgical physical medicine and postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27.

(d) For all injuries not covered by the official utilization schedule adopted pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are recognized generally by the national medical community and scientifically based.

History

Added Stats 2003 ch 639 27 (SB 228). Amended Stats 2004 ch 34 25 (SB 899), effective April 19, 2004; Stats 2007 ch 621 1 (AB 1073), effective January 1, 2008; Stats 2008 ch 179 175 (SB 1498), effective January 1, 2009; Stats 2012 ch 363 41 (SB 863), effective January 1, 2013.

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Cal Lab Code 5307.7

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- Deerings California Codes Annotated
- LABOR CODE (1 12001)
- Division 4 Workers Compensation and Insurance (Pts. 1 4)
- Part 4 Compensation Proceedings (Chs. 1 7)
- Chapter 1 Jurisdiction (5300 5318)

5307.7.Vocational expert fees

(a) On or before January 1, 2013, the administrative director shall adopt, after public hearings, a fee schedule that shall establish reasonable fees paid for services provided by vocational experts, including, but not limited to, vocational evaluations and expert testimony determined to be reasonable, actual, and necessary by the appeals board.

(b) A vocational expert shall not be paid, and the appeals board shall not allow, vocational expert fees in excess of those that are reasonable, actual, and necessary, or that are not consistent with the fee schedule adopted by the administrative director.

History

Added Stats 2011 ch 555 1 (AB 1168), effective January 1, 2012. Amended Stats 2012 ch 363 75 (SB 863), effective January 1, 2013.

Cal Lab Code 4600.4

Deering's California Codes are current through Chapter 3 of the 2020 Regular Session.

- Deerings California Codes Annotated
- LABOR CODE (1 12001)
- Division 4 Workers Compensation and Insurance (Pts. 1 4)
- Part 2 Computation of Compensation (Chs. 1 2)
- Chapter 2 Compensation Schedules (Arts. 1 7)
- Article 2 Medical and Hospital Treatment (4600 4615)

4600.4.Availability during normal business day

(a) A workers compensation insurer, third-party administrator, or other entity that requires, or pursuant to regulation requires, a treating physician to obtain either utilization review or prior authorization in order to diagnose or treat injuries or diseases compensable under this article, shall ensure the availability of those services from 9 a.m. to 5:30 p.m. Pacific standard time of each normal business day.

(b) For purposes of this article, 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 internet website.

History

Added Stats 1999 ch 124 1 (AB 775). Amended Stats 2019 ch 647 4 (SB 537), effective January 1, 2020.

Cal Civ Code 9

Deering's California Codes are current through Chapter 3 of the 2020 Regular Session.

- Deerings California Codes Annotated
- CIVIL CODE (1 7021)
- PRELIMINARY PROVISIONS (2 21)

9.Business days

All other days than those mentioned in Section 7 are business days for all purposes; provided, that as to any act appointed by law or contract, or in any other way, to be performed by, at, or through any bank organized under the laws of or doing business in this state, any optional bank holiday as defined in Section 7.1 is not a business day; and provided, that any act appointed by law or contract, or in any other way, to be performed on any day which is an optional bank holiday as defined in Section 7.1, by, at, or through any bank or branch or office thereof, whether acting in its own behalf or in any other capacity whatsoever, may be performed on that optional bank holiday if the bank or branch or office by, at, or through which the act is to be performed is open for the transaction of business on that optional bank holiday, or, at the option of the person obligated to perform the act, it may be performed on the next succeeding business day.

History

Enacted 1872. Amended Stats 1905 ch 17 2; Stats 1939 ch 414 1; Stats 1955 ch 198 1, ch 599 1; Stats 1973 ch 285 1; Stats 1979 ch 159 1; Stats 1981 ch 67 1, effective June 16, 1981; Stats 1982 ch 1203 1, effective September 22, 1982; Stats 1985 ch 147 1, effective July 8, 1985; Stats 1994 ch 668 2 (SB 1405).

Article 5.5.1 Utilization Review Standards

§ 9792.6.1. Utilization Review Standards—Definitions.

The following definitions apply to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the decision on the request for authorization of medical treatment is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

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

(x) "Claims Administrator" is a 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 claims administrator or other entity subject to Labor Code section 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). "Claims Administrator" includes any utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.

(y) "Concurrent review" means utilization review conducted during an inpatient stay.

(z) "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 California Code of Regulations, title 8, section 14006.1, or on the applicable physician reporting forms authorized by section 9785.

(aa) Reserved.

(bb) "Denial" means a decision by a physician reviewer that the requested treatment or service is not authorized.

(cc) "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.

(dd) "Disputed medical treatment" means medical treatment that has been modified, or denied by a utilization review decision.

(ee) "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.

(ff) "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.

(gg) "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 section 9792.9.6, prior to the determination of medical necessity.

(hh) "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.

(ii) "Immediately" means within one business day.

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

(kk) "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.

(ll) "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.

(mm) "Medical Treatment Utilization Schedule" means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20.

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

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

(pp) "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.

(qq) "Request for authorization" means a written request for a specific course of proposed medical treatment that meets all of the following criteria:

(1) 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 California Code of Regulations (CCR), title 8, section 9785.5, completed by a treating physician and as further outlined in this subdivision and in section 9785(h).

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

(3) The request for authorization must be signed by the treating physician and may be mailed, faxed, or, if available, sent electronically through the use of an encrypted email system or via electronic data interchange (EDI) to the address, fax number, e-mail address, or clearinghouse designated by the claims administrator under section 9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

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

(w)(1) "Reviewer" or "physician reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's or physician reviewer's practice.

(2) "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.

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

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

(cc) "Utilization review plan" means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.

(aa) "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.

(bb) "Written" includes a communication transmitted by facsimile or in paper form. Electronic mail or electronic data interchange (EDI) may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail or by EDI, unless sent through the use of an encrypted electronic mail or EDI system.

(cc) "Normal business day" or "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 internet website.

(dd) "Working day" as used in this article is the same as "business day" or "normal business day."

Authority cited: Sections 133, 4603.5, and 5307.3, Labor Code.

Reference: Sections 3209.3, 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

8 CCR 9792.20

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- ARTICLE 5.5.2. MEDICAL TREATMENT UTILIZATION SCHEDULE

9792.20. Medical Treatment Utilization Schedule--Definitions

As used in this Article:

(a) "ACOEM" means means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines published by the Reed Group containing evidenced-based medical treatment guidelines for conditions commonly associated with the workplace. ACOEM guidelines may be obtained from the Reed Group (<http://go.reedgroup.com/mtus>).

(b) "Chronic pain" means pain lasting three or more months from the initial onset of pain.

(c) "Claims administrator" is a self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator, or the California Insurance Guarantee Association.

(d) "Evidence-Based Medicine (EBM)" means a systematic approach to making clinical decisions which allows the integration of the best available research evidence with clinical expertise and patient values.

(e) "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the medical evaluation and treatment; and a reduction in the dependency on continued medical treatment.

(f) "Medical treatment" is care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26.

(g) "Medical treatment guidelines" means the most current version of written recommendations which are systematically developed by a multidisciplinary process through a comprehensive literature search to assist in decision-making about the appropriate medical treatment for specific clinical circumstances reviewed and updated within the last five years

(h) "Nationally recognized" means published in a peer-reviewed medical journal; or developed, endorsed and disseminated by a national organization with affiliates based in two or more U.S. states and is the most current version.

(i) "ODG" means the Official Disability Guidelines published by the Work Loss Data Institute containing evidenced-based medical treatment guidelines for conditions commonly associated with the workplace. ODG guidelines may be obtained from the Work Loss Data Institute, 169 Saxony, #101, Encinitas, California 92024 (

www.ODG@worklossdata.com

).

(j) "Peer reviewed" means that a study's content, methodology and results have been evaluated and approved prior to publication by an editorial board of qualified experts.

(k) "Scientifically based" means based on scientific literature, wherein the body of literature is identified through performance of a literature search, the identified literature is evaluated, and then used as the basis to support a recommendation.

(l) "Strength of Evidence" establishes the relative weight that shall be given to scientifically based evidence.

Statutory Authority

AUTHORITY:

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

History

HISTORY:

1. New article 5.5.2 (sections 9792.20-9792.23) and section filed 6-15-2007; operative 6-15-2007 pursuant to Government Code section 11343.4 (Register 2007, No. 24).
2. Amendment of subsection (b), new subsection (c), subsection relettering and amendment of newly designated subsection (g) filed 6-18-2009; operative 7-18-2009 (Register 2009, No. 25).

3. Editorial correction of operative date in 2 (Register 2009, No. 30).
4. Amendment filed 4-20-2015; operative 4-20-2015 pursuant to Government Code section 11343.4(b)(3) (Register 2015, No. 17).
5. Amendment of subsection (a) filed 1-11-2018; operative 12-1-2017. Submitted to OAL for filing and printing only pursuant to Labor Code section 5307.27(a) (Register 2018, No. 2).

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8 CCR 9792.27.23

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- ARTICLE 5.5.2. MEDICAL TREATMENT UTILIZATION SCHEDULE

9792.27.23.MTUS Drug List Updates

(a) The Administrative Director shall consult with the P&T Committee as needed on updates to the MTUS Drug List, which may be adopted by the Administrative Director on a quarterly or more frequent basis in order to allow provision for all appropriate medications.

(b) The P&T Committee is responsible for reviewing and consulting with the Administrative Director on available evidence of the relative safety, efficacy, and effectiveness of drugs within a class of drugs. In carrying out these duties the P&T Committee may provide consultation on a variety of relevant issues, including but not limited to the following:

- (1) Recommendations on prospective review requirements for drugs;
- (2) Recommendations on Special Fill and Perioperative Fill designation and policies;
- (3) Review of drug treatment changes adopted into the MTUS Treatment Guidelines to identify needed additions or deletions of drugs from the MTUS Drug List;
- (4) Recommendations on establishing a therapeutic interchange program in order to promote safe and appropriate cost effective care.

(c) The P&T Committee serves in an advisory role only. P&T Committee recommendations are not binding on the Administrative Director.

(d) Updates to the MTUS Drug List will be adopted by issuance of an Administrative Director's order specifying the changes and the effective date, and shall be posted on the division's website pursuant to Labor Code section 5307.29.

Statutory Authority

AUTHORITY:

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 4600, 4604.5, 5307.27 and 5307.29, Labor Code.

History

HISTORY:

1. New section filed 12-7-2017; operative 1-1-2018 pursuant to Government Code section 11343.4(b)(3) (Register 2017, No. 49).

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8 CCR 9792.25.1

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9792.25.1.MTUS Methodology for Evaluating Medical Evidence

(a) When competing recommendations are cited to guide medical care, Utilization Review and Independent Medical Review physicians shall apply the MTUS Methodology for Evaluating Medical Evidence to evaluate the quality and strength of evidence used to support the recommendations that are at variance with one another. The MTUS Methodology for Evaluating Medical Evidence provides a process to evaluate studies, not guidelines. Therefore, the reviewing physician shall evaluate the underlying study or studies used to support a recommendation found in a guideline. Medical care shall be in accordance with the recommendation supported by the best available evidence. The MTUS Methodology for Evaluating Medical Evidence shall be applied as follows:

(1) The reviewing physician shall determine if different guidelines or studies were cited to guide the injured worker's medical care by the treating physician, the Utilization Review physician and/or the Independent Medical Review physician that contain recommendations that are at variance with one another.

(2) If different guidelines or studies were cited to guide the injured worker's medical care containing recommendations that are at variance with one another, the reviewing physician shall evaluate the quality of evidence by determining if the studies used to support the recommendations are applicable to the injured worker and his or her medical condition or injury. Applicability refers to the extent to which the individual patients, subjects, settings, interventions, and outcome measures of studies used to support a recommendation are similar to the worker and his or her medical condition or injury. A recommendation supported by inapplicable studies should not be used as the source to support, deny, delay or modify an RFA. Reviewing physicians shall provide an explanation of their rationale in the Utilization Review or Independent Medical Review decision if they conclude a recommendation is supported by studies inapplicable to the worker and his or her medical condition or injury.

(A) The evaluation of medical evidence can end after this step if a citation to a guideline or a study contains a recommendation supported by inapplicable studies and the other citation contains a recommendation that is supported by studies applicable to the injured worker's medical condition or injury.

(3) If the guidelines or studies cited contain recommendations supported by studies applicable to the worker and his or her medical condition or injury, then the reviewing physician shall continue to evaluate the quality of evidence by determining what factors, if any, bias may have had in the studies used to support the recommendations. Factors to consider include, but are not limited to, vested interests such as financial interests, academic interests, industry influence, and the methodological safeguards to protect against biases related to the generation of the randomization sequence, concealment of allocation, blinding, selective outcome reporting, early stopping, intention to treat, and confounding bias. A recommendation supported by studies determined to be of poor quality due to the presence of bias should not be used as the source to support, deny, delay or modify an RFA. Reviewing physicians shall provide an explanation of their rationale in the Utilization Review or Independent Medical Review decision if they conclude a recommendation is supported by studies determined to be of poor quality due to the presence of bias.

(A) The evaluation of medical evidence can end after this step if a citation to a guideline or a study contains a recommendation supported by studies determined to be of poor quality due to the presence of bias and the other citation contains a recommendation that is supported by studies determined to be of good quality due to the absence of bias.

(4) If the guidelines or studies cited contain recommendations supported by studies applicable to the worker and his or her medical condition or injury and if the recommendations are supported by studies that are determined to be of good quality due to the absence of bias, then the reviewing physician shall determine the strength of evidence used to support the differing recommendations by applying the Hierarchy of Evidence for Different Clinical Questions set forth in 9792.25.1(b). To apply the Hierarchy of Evidence for Different Clinical Questions, the following steps shall be taken:

(A) Determine the design of the study used to support the recommendation. Study designs are categorized as one of the following categories:

1. Systematic Review of:

(aa) Randomized Controlled Trials

(bb) Prospective or Cohort Studies

2. Randomized Controlled Trials

3. Observational studies:

(aa) Prospective study or Cohort Study

(bb) Cross-sectional study

(cc) Case-control study

(ee) Uncontrolled or observational study

(ff) Case report

4. Published expert opinion

(B) Determine which of the four clinical questions in the MTUS Hierarchy of Evidence for Different Clinical Questions as set forth in Section 9792.25.2(b) the study is answering and then apply the corresponding hierarchy(ies) of evidence. The sequence to be followed for each of the four clinical questions is as follows:

1. If the original study answers the question "How useful is Treatment X in treating patients with Disease Y?" then the hierarchy of evidence set forth under Treatment Benefits shall apply.
2. If the original study answers the question "How useful is Test X in diagnosing patients with Disease Y?" then the hierarchy of evidence set forth under Diagnostic Test shall apply.
3. If the original study answers the question "What will happen to a patient with Disease Y if nothing is done?" then the hierarchy of evidence set forth under Prognosis shall apply.
4. If the original study answers the question "What are the harms of intervention (treatment or diagnostic test) X in patients with Disease Y?" then the hierarchy of evidence set forth under Treatment Harms shall apply.

(C) In each Clinical Question category, the levels of evidence are listed from highest to lowest, as defined by the principles of Evidence-Based Medicine. Levels of evidence shall be applied in the order listed. Recommendation for or against medical treatment based on a lower level of evidence shall be permitted only if every higher ranked level of evidence is inapplicable to the employee's medical condition.

1. The level of evidence for each published study (e.g. 1a, 1b, 2, etc.) shall be documented and included with the citation in the Utilization Review or Independent Medical Review decisions.
2. When relying on lower levels of evidence, a written statement shall be provided that states higher levels of evidence are absent.

(b) MTUS Hierarchy of Evidence for Different Clinical Questions shall apply:

MTUS Hierarchy of Evidence for Different Clinical Questions

[SEE ILLUSTRATION IN ORIGINAL]

Statutory Authority

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5, 4610.5 and 5307.27, Labor Code.

History

HISTORY:

1. New section filed 4-20-2015; operative 4-20-2015 pursuant to Government Code section 11343.4(b)(3) (Register 2015, No. 17).

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8 CCR 9792.21.1

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- ARTICLE 5.5.2. MEDICAL TREATMENT UTILIZATION SCHEDULE

9792.21.1. Medical Evidence Search Sequence

(a) Treating physicians and medical reviewers shall conduct the following medical evidence search sequence for the evaluation and treatment of injured workers.

(1) Search the recommended guidelines set forth in the current MTUS to find a recommendation applicable to the injured worker's medical condition or injury.

(2) In the limited situation where a medical condition or injury is not addressed by the MTUS or if the MTUS' presumption of correctness is being challenged, then:

(A) Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then

(B) Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1. Medical treatment guidelines can be found in the National Guideline Clearinghouse that is accessible at the following website address: www.guideline.gov/. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then

(C) Search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured

available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1. A search for peer-reviewed published studies may be conducted by accessing the U.S. National Library of Medicine's database of biomedical citations and abstracts that is searchable at the following website: www.ncbi.nlm.nih.gov/pubmed. Other searchable databases may also be used.

(b) After conducting the medical evidence search in the sequence specified above:

(1) Treating Physicians

(A) If the medical condition or injury is not addressed by the MTUS, then the treating physician may provide in the Request for Authorization (RFA) or in an attachment to the RFA a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

1. The citation provided by the treating physician shall be the primary source relied upon which he or she believes contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

2. If the treating physician provides more than one citation, then a narrative shall be included by the treating physician in the RFA or in an attachment to the RFA explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

(B) If the medical condition or injury is addressed by the MTUS but the treating physician is attempting to rebut the MTUS' presumption of correctness, then the treating physician shall provide in the RFA or in an attachment to the RFA the following: a clear and concise statement that the MTUS' presumption of correctness is being challenged; a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury; and a copy of the entire study or the relevant sections of the guideline containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

1. The citation and copy of the study or copy of the relevant sections of the guideline provided by the treating physician shall be the primary source relied upon which he or she believes contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

2. If the treating physician provides more than one citation, then a copy of the additional study(ies) or copy of the additional relevant sections of the guideline(s) along with a narrative shall be included by the treating physician in the RFA or in an attachment to the RFA explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

(2) Utilization Review Physicians

(A) If the RFA is being modified, delayed or denied, then the Utilization Review physician shall provide in the Utilization Review decision, in addition to the requirements set forth in section 9792.9.1(e), a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

1. The citation provided by the Utilization Review physician shall be the primary source relied upon which he or she believes contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

2. If the Utilization Review physician provides more than one citation, then a narrative shall be included by the reviewing physician in the Utilization Review decision explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

(3) Independent Medical Review Physicians

(A) If the Utilization Review Decision delays, denies or modifies an injured worker's request for treatment and review of that decision is requested through Independent Medical Review, then the Independent Medical Review physician shall provide in the Independent Medical Review decision, in addition to the requirements set forth in section 9792.10.6(d), a citation to the guideline or study containing the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

1. The citation provided by the Independent Medical Review physician shall be the primary source he or she relied upon which contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

2. If the Independent Medical Review physician provides more than one citation, then a narrative shall be included by the reviewing physician in the Independent Medical Review decision explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

(c) If the treating physician and/or the Utilization Review physician and/or the Independent Medical Review physician cited different guidelines or studies containing recommendations that are at variance with one another, the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1 shall be applied by the reviewing physician to determine which one of the recommendations is supported by the best available evidence.

(d) The format of the citations provided by the treating physician, Utilization Review physician, and Independent Medical physician, shall include the following

(1) When citing the MTUS:

(A) Indicate the MTUS is being cited and the effective year of the guideline;

(B) Title of chapter (e.g., Low Back Complaints); and

(C) Section of chapter (e.g., Surgical Considerations).

(2) When citing other medical treatment guidelines:

(A) Title of organization publishing the guideline (e.g., ACOEM or ODG);

(B) Year of publication;

(C) Title of chapter; and

(D) Section of chapter.

(3) When citing a peer-reviewed study:

(A) First author's last name and first name initial;

(B) Published article title;

(C) Journal title (standard abbreviations may be used);

(D) Volume number;

(E) Year published; and

(F) Page numbers.

(e) Employers and their representatives, at their discretion, may approve medical treatment beyond what is covered in the MTUS or supported by the best available medical evidence in order to account for medical circumstances warranting an exception. The treating physician should provide clear documentation of the clinical rationale focusing on expected objective functional gains afforded by the requested treatment and impact upon prognosis.

Statutory Authority

AUTHORITY:

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5, 4610.5 and 5307.27, Labor Code.

History

HISTORY:

1. New section filed 4-20-2015; operative 4-20-2015 pursuant to Government Code section 11343.4(b)(3) (Register 2015, No. 17).

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8 CCR 9792.24.1

This document is current through Register 2020, No. 16, April 17, 2020

- CA - Barclays Official California Code of Regulations
- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 4.5. DIVISION OF WORKERS' COMPENSATION
- SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -- ADMINISTRATIVE RULES
- ARTICLE 5.5.2. MEDICAL TREATMENT UTILIZATION SCHEDULE

9792.24.1.Acupuncture Medical Treatment Guidelines

Guidance for acupuncture treatment and evaluation are contained in the applicable Clinical Topics guidelines, and/or Chronic Pain Guideline, and/or Opioid Guideline.

Statutory Authority

AUTHORITY:

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

History

HISTORY:

1. Renumbering and amendment of former section 9792.21, subsections (a)(2)-(a)(2)(E) to new section 9792.24.1 filed 6-18-2009; operative 7-18-2009 (Register 2009, No. 25).
2. Editorial correction of operative date in 1 (Register 2009, No. 30).
3. Amendment of subsection (d) filed 4-20-2015; operative 4-20-2015 pursuant to Government Code

section 11343.4(b)(3) (Register 2015, No. 17).

4. Repealer and new section filed 1-11-2018; operative 12-1-2017. Submitted to OAL for filing and printing only pursuant to Labor Code section 5307.27(a) (Register 2018, No. 2).

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8 CCR 9792.24.2

This document is current through Register 2020, No. 16, April 17, 2020

- CA - Barclays Official California Code of Regulations
- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 4.5. DIVISION OF WORKERS' COMPENSATION
- SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -- ADMINISTRATIVE RULES
- ARTICLE 5.5.2. MEDICAL TREATMENT UTILIZATION SCHEDULE

9792.24.2.Chronic Pain Guidelines

The Administrative Director adopts and incorporates by reference the Chronic Pain Guideline (ACOEM May 15, 2017) into the MTUS from the ACOEM Practice Guidelines for the treatment and evaluation of patients who have chronic pain as defined in section 9792.20. This guideline addresses a general approach to patients with chronic pain and the psychological and behavioral aspects of chronic pain. This guideline also addresses a few specific chronic pain disorders (i.e., complex regional pain syndrome, fibromyalgia, neuropathic pain). Guidance for treatment and evaluation of chronic pain disorders not specifically addressed in this guideline are contained in the Clinical Topics guidelines and/or Opioid Guideline.

Statutory Authority

AUTHORITY:

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

History

HISTORY:

1. New section filed 6-18-2009; operative 7-18-2009 (Register 2009, No. 25).
2. Editorial correction of operative date in 1 (Register 2009, No. 30).
3. Amendment filed 7-28-2016; operative 7-28-2016 pursuant to Government Code section 11343.4(b)(3) (Register 2016, No. 31).
4. Amendment of section heading and repealer and new section filed 1-11-2018; operative 12-1-2017. Submitted to OAL for filing and printing only pursuant to Labor Code section 5307.27(a) (Register 2018, No. 2).

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8 CCR 9792.24.3

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- CA - Barclays Official California Code of Regulations
- TITLE 8. INDUSTRIAL RELATIONS
- DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS
- CHAPTER 4.5. DIVISION OF WORKERS' COMPENSATION
- SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -- ADMINISTRATIVE RULES
- ARTICLE 5.5.2. MEDICAL TREATMENT UTILIZATION SCHEDULE

9792.24.3. Postoperative Rehabilitation Guidelines

Guidance for postoperative rehabilitation treatment and evaluation are contained in the Clinical Topics guidelines, and/or Chronic Pain Guideline and/or Opioid Guideline. The post-operative rehabilitation treatment recommendations apply to visits during the post-operative period only and to surgeries as defined in those guidelines. At the conclusion of the post-operative period, treatment reverts back to the applicable 24-visit limitation for chiropractic, occupational therapy, and physical therapy pursuant to Labor Code section 4604.5(c)(1).

Statutory Authority

AUTHORITY:

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code. Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

History

HISTORY:

1. New section filed 6-18-2009; operative 7-18-2009 (Register 2009, No. 25).
2. Editorial correction of operative date in 1 (Register 2009, No. 30).
3. Amendment of subsection (d)(1) filed 4-20-2015; operative 4-20-2015 pursuant to Government Code section 11343.4(b)(3) (Register 2015, No. 17).
4. Amendment of section heading and repealer and new section filed 1-11-2018; operative 12-1-2017. Submitted to OAL for filing and printing only pursuant to Labor Code section 5307.27(a) (Register 2018, No. 2).

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§9792.7. Utilization Review Standards--Applicability

(a) Every claims administrator shall establish and maintain a utilization review process for medically necessary treatment in compliance with Labor Code section 4610. Each utilization review process shall be set forth in a utilization review plan which shall contain:

(1) The name, address, phone number, and medical license number of the employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.

(2) A description of the process whereby requests for authorization are reviewed, and decisions on such requests are made, and a description of the process for handling expedited reviews.

(3) A description of the specific criteria utilized routinely in the review and throughout the decision-making process, including treatment protocols or standards used in the process. The treatment protocols or standards governing the utilization review process shall be consistent with the Medical Treatment Utilization Schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27.

(4) A description of the qualifications and functions of the personnel involved in decision-making and implementation of the utilization review plan.

(5) A description of the claims administrator's practice, if applicable, of any prior authorization process, including but not limited to, where authorization is provided without the submission of the request for authorization.

(6)(A) For utilization review plans that modify or deny treatment requests, proof of accreditation through the Workers' Compensation Utilization Management Accreditation program administered by URAC.

(B) A public sector internal utilization review plan that modifies or denies treatment requests need not obtain URAC accreditation under subdivision (a)(6) if it provides in its plan submission to the Administrative Director a statement under penalty of perjury by the plan's medical director that the plan meets or exceeds the standards established by URAC's Workers' Compensation Utilization Management Accreditation program.

(b)(1) The medical director shall ensure that the process by which the claims administrator reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with Labor Code section 4610 and these implementing regulations.

(2) A reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the reviewer's scope of practice, may, except as indicated below, modify or deny requests for authorization of

medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

(3) A non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. A non-physician reviewer may approve requests for authorization of medical services. A non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization. Additionally, a non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision but in no event shall this exceed the time limitations imposed in section 9792.9.3 and 9792.9.4. Any time beyond the time specified in these sections is subject to the provisions of section 9792.9.6.

(c) (1) The complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process, shall be filed by the claims administrator, or by the external utilization review organization contracted by the claims administrator to perform the utilization review, with the Administrative Director. In lieu of filing the utilization review plan, the claims administrator may submit a letter identifying the external utilization review organization which has been contracted to perform the utilization review functions, provided that the utilization review organization has an approved utilization review plan on file with the Administrative Director, which also identifies the claims administrator client(s) on whose behalf it performs any utilization review functions.

(2) Utilization review plans that modify or deny treatment requests shall submit with their plan a completed DWC Form UR-01, "Utilization Review Plan Application or Modification," set forth in section 9792.7.1, with an original signature by the applicant's medical director. The utilization review plan shall be submitted in compact discs or flash drives, or other electronic format agreed to by the Administrative Director and the applicant, in word-searchable PDF format. The hard copy of the completed, signed original shall be maintained by the applicant and made available for review by the Administrative Director upon request. Electronic signatures in compliance with California Labor Code section 110.5 or 3206.5 are acceptable.

(3) A utilization review plan that submits an application for approval thereby releases URAC from any obligation it may have, contractual or other, regarding nondisclosure of any of its files relating to the utilization review plan's accreditation or audits with URAC. Accordingly, the Division of Workers' Compensation may obtain such documents from URAC for the purpose of ensuring or enforcing compliance with the rules governing utilization review at sections 9792.6.1 through 9792.12.

(4) All utilization review plan entities shall file a material modification of its utilization review plan with the Administrative Director within 30 calendar days of the material modification. The material modification shall include a DWC Form UR-01 set forth in

section 9792.7.1, completed as applicable with an original signature by the applicant's medical director, and an attached statement certifying that the utilization review plan, as modified, continues to be in compliance with the rules governing utilization review at sections 9792.6.1 through 9792.12. The modified utilization review plan shall be submitted in compact discs or flash drives, or other electronic format agreed to by the Administrative Director and the applicant, in word searchable PDF format. Electronic signatures in compliance with California Labor Code section 110.5 or 3206.5 are acceptable.

(d) Within 30 days after receipt of the utilization review plan or plan modification submitted under subdivision (c), the Administrative Director shall notify the organization in writing that the plan is complete and has been accepted for filing or that the plan is not complete. If the plan is not complete, the Administrative Director shall specify in the notice what additional information or documents are needed from the organization in order for the plan to be deemed complete. Notice that a utilization review plan submission is complete does not preclude the Administrative Director from later requesting additional documentation or records necessary for determining a utilization review plan's compliance with the law.

(e) (1) For utilization review plans that deny or modify treatment requests, the Administrative Director shall approve or deny the plan or plan modification within 60 days following the issuance of the Administrative Director's notice that a utilization review plan filing or filing of plan modification is complete.

(A) The Administrative Director may extend the time for review for another 60 days by notifying the plan in writing that an extension is required. If the Administrative Director takes no action after the 60-day extension has elapsed, the utilization review plan shall be deemed to be provisionally approved until a final determination to approve, conditionally approve, or deny the plan is made.

(B) If specific deficiencies are identified but the applicant substantially complies with the requirements of Labor Code section 4610 and this Article, a conditional approval may be granted for a period not to exceed six (6) months to permit the applicant the opportunity to correct those deficiencies. If the deficiencies are not corrected after the first period of conditional approval, or the condition upon which an approval may be granted is not satisfied, the conditional authorization to operate may be extended for a period not to exceed six (6) months if the applicant demonstrates a good faith effort and ability to correct the deficiencies.

(C) A conditional authorization to operate shall expire at the end of its stated period and the application shall be deemed denied, unless the deficiencies are removed prior to its expiration and an approval has been granted before that date.

(2) The Administrative Director shall notify a utilization review plan applicant of a denial under subdivision (e) in writing and shall state the reasons for non-approval. The denial shall be transmitted to the plan by certified mail and shall be in effect for 12 months unless a lesser timeframe is agreed upon for good cause by the Administrative Director.

(f) A utilization review plan applicant may appeal the Administrative Director's denial under subdivision (e) by filing, within twenty-five (25) days of the issuance of the denial, a petition with the Workers' Compensation Appeals Board pursuant to California Code of Regulations, title 8, section 10560. A copy of the petition shall be concurrently served on the Administrative Director.

(g) The Administrative Director may require an organization to update its approved plan if it is determined that a change in the plan is required in order to bring the plan into compliance with the law. An organization that receives a Notice of Required Update shall have 30 days from the receipt of the notice to bring its plan into compliance. Failure to adopt and implement required changes may result in the probation or suspension of a plan or revocation of plan approval.

(h) (1) The Administrative Director may place on probation, suspend, or revoke approval of a utilization review plan for any one or more of the following reasons:

- (A) The UR program is operating out of compliance with the terms of its approved plan or the law;
- (B) The plan fails to timely adopt and implement updates to its UR plan as specified by the Administrative Director;
- (C) The plan knowingly makes false statements or representations to the Administrative Director or fails to submit plan modifications or updates as required by this Article;
- (D) The plan fails to respond to at least two or more repeated requests or inquiries by the Administrative Director concerning plan compliance.

(2) If the Administrative Director determines that one or more of the circumstances in subdivision (h)(1) applies, the Administrative Director shall issue written notice of the violation(s). Upon receipt of such notice, the organization shall have 14 days to correct the violation or respond with a plan of action to timely correct the violation.

(3)(A) If the Administrative Director determines that the violations have not been remediated in a timely manner, a Findings and Notice of Action shall issue to the organization specifying the time period for which probation, suspension, or revocation will take effect. A plan whose approval has been revoked shall be barred from applying again for approval for 12 months following the date of revocation, unless a lesser timeframe is agreed upon for good cause by the Administrative Director.

(B) Where the Findings and Notice of Action are for the suspension or revocation of a UR plan, the UR plan shall issue a copy of the Findings and Notice of Action to all organizations for which it performs utilization review.

(i)(1) Within 14 days of the issuance of the Findings and Notice of Action, a UR plan may request a re-evaluation of the probation, suspension or revocation by submitting to the Administrative Director, under penalty of perjury, a written explanation accompanied by documentary evidence supportive of the request for re-evaluation.

(2) Within 45 days of the request for re-evaluation, the Administrative Director shall issue a Decision and Order affirming, modifying, or rescinding the Notice of Action,

which shall include an explanation for the decision. The Administrative Director may extend the time for issuing a Decision and Order for a period of 30 days. At any time during re-evaluation, the Administrative Director may order a plan to submit additional documentation or information.

(j) A utilization review plan entity may, as an alternative to requesting re-evaluation under subdivision (i), appeal a Notice of Action to the Workers' Compensation Appeals Board by filing a petition within 20 days of the issuance of such notice under California Code of Regulations, title 8, section 10560. A copy of the petition shall be concurrently served on the Administrative Director.

(k) Nothing in this section shall prevent the Administrative Director from imposing penalties as applicable under section 9792.12.

(l) The Administrative Director shall post on the Division's website a list of all entities who have filed a complete utilization review plan under this section, indicating the plans' statuses as they evolve including, but not limited to, approved, denied, inactive, probation, suspended, or revoked. Utilization review plan entities who cease to perform utilization review under its own name for a period of 12 consecutive months following the last UR activity performed under its own name may be marked as inactive.

(m) (1) Upon request by the public, the claims administrator shall make available the complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process.

(2) The claims administrator may make available the complete utilization review plan, consisting of the 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. Such charge shall not exceed \$0.25 per page plus actual postage costs.

(n) For utilization review organizations: The files and other records, whether electronic or paper, that pertain to the utilization review process shall be retained for at least three (3) years following either: (1) the most recent utilization review decision for each injured employee, or (2) the date on which any appeal from the assessment of penalties for violations of Labor Code section 4610 or sections 9792.6 through 9792.12 is final, whichever date is later. Claims administrators shall retain their claim files as set forth in section 10102 of Title 8 of the California Code of Regulations.

Authority cited: Sections 133, 4603.5, 4610 and 5307.3, Labor Code. Reference: Sections 4062, 4600, 4600.4, 4604.5 and 4610, Labor Code.

§ 9792.10.1. Utilization Review--Dispute Resolution

(a)(1) A request for independent medical review of a utilization review decision that denies or modifies a medical treatment request must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days of service of the written utilization review determination issued by the claims administrator under section 9792.9.5(e).

(2) If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the request for independent medical review must be filed by the eligible party within 10 days of service of the written utilization review decision.

(b) A request for independent medical review must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision denying or modifying the request for authorization of medical treatment. At the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision denying, or modifying the request for authorization of medical treatment, to the claims administrator.

(c) A party eligible to file a request for independent medical review includes:

(1) The employee or, if the employee is represented, the employee's attorney. If the employee's attorney files the DWC Form IMR, the form must be accompanied by a notice of representation or other document or written designation confirming representation.

(A) A parent, guardian, conservator, relative, or other designee of the employee pursuant to Labor Code section 4610.5(j).

(B) The physician whose request for authorization of medical treatment was denied or modified may join with or otherwise assist the employee in seeking an independent medical review. The physician may submit documents on the employee's behalf pursuant to section 9792.10.5 (b) and may respond to any inquiry by the independent review organization.

(2) A provider of emergency medical treatment pursuant to Labor Code section 4610.5(h)(4).

(d) If expedited review is requested for a utilization review decision eligible for independent medical review, the Application for Independent Medical Review, DWC Form IMR, shall include, unless the initial utilization review decision was made on an expedited basis, written certification from the employee's treating physician with documentation confirming that the employee faces an imminent and serious threat to his or her health as described in section 9792.6.1(j).

(e) (1) If, at the time of a utilization review decision, the claims administrator is also disputing liability for the treatment for any reason besides medical necessity, the time limitation for the employee to submit an application for independent medical review under subdivision (a) shall not begin to run until the claims administrator serves a notice to the employee stating that the dispute of liability has been resolved.

(2) If the claims administrator provides the employee with a written utilization review determination modifying or denying a treatment request that does not contain the required elements set forth in section 9792.9.5(e) at the time of notification of its utilization review decision, the time limitations for the employee to submit an application for independent medical review under subdivision (a) shall not begin to run until the claims administrator provides the written decision, with all required elements, to the employee.

(f)(1) Nothing in this section precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the employee and, if the employee is represented by counsel, the employee's attorney, have been notified of the timeframes in subdivision (a) in which to file an application for independent medical review. Any request by the injured worker or treating physician for an internal utilization review appeal process conducted under this subdivision must be submitted to the claims administrator within ten (10) days after the receipt of the utilization review decision.

(2) A request for an internal utilization review appeal must be completed, and a determination issued, by the claims administrator within thirty (30) days after receipt of the request under subdivision (f)(1). If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the internal utilization review appeal must be completed, and a determination issued, by the claims administrator within ten (10) days after receipt of the request under subdivision (f)(1). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6(e) that determines the medical necessity of the disputed treatment.

(3) Any determination by the claims administrator following an internal utilization review appeal that results in a modification of the requested medical treatment 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 section 9792.9.5(e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.5(e)(7), must indicate that the decision is a modification after appeal.

Authority: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

Cal Lab Code 4610

Deering's California Codes are current through Chapter 3 of the 2020 Regular Session.

- Deerings California Codes Annotated
- LABOR CODE (1 12001)
- Division 4 Workers Compensation and Insurance (Pts. 1 4)
- Part 2 Computation of Compensation (Chs. 1 2)
- Chapter 2 Compensation Schedules (Arts. 1 7)
- Article 2 Medical and Hospital Treatment (4600 4615)

4610. Employers to establish utilization review process; Criteria; Administrative penalties

(a) For purposes of this section, utilization review means utilization review or 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 and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(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 and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network 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, shall be authorized without prospective utilization review, except as provided in subdivision

(c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, 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. For treatment rendered by a medical provider network 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 employees initial visit and evaluation.

(c) Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a

predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

(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 presurgical 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, whose combined total value exceeds two hundred fifty dollars (\$250), as determined by the official medical fee schedule.

(7) Electrodiagnostic 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.

(d)

(1) Except for emergency treatment services, any request for payment for treatment provided under subdivision (b) shall comply with Section 4603.2 and be submitted to the employer, or its insurer or claims administrator, within 30 days of the date the service was provided.

(2)

(A) In the case of emergency treatment services, any request for payment for treatment provided under subdivision (b) shall comply with Section 4603.2 and be submitted to the employer, or its insurer or claims administrator, within 180 days of the date the service was provided.

(B) For the purposes of this subdivision, emergency treatment services means treatment for an emergency medical condition defined in subdivision (b) of Section 1317.1 of the Health and Safety Code and provided in a licensed general acute care hospital, as defined in Section 1250 of the Health and Safety Code.

(e) If a physician fails to submit the report required under Section 6409 and a complete request for authorization, as described in subdivision (b), an employer may remove the physician's ability under this subdivision to provide further medical treatment to the employee that is exempt from prospective utilization review.

(f) 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.

(1) If it is found after retrospective utilization reviews that there is a pattern and practice of the physician or provider failing to render treatment consistent with the schedule for medical treatment utilization, including the drug formulary, the employer may remove the ability of the predesignated physician, employer-selected physician, or the member of the medical provider network or health care organization under this subdivision to provide further medical treatment to any employee that is exempt from prospective utilization review. The employer shall notify the physician or provider of the results of the retrospective utilization review and the requirement for prospective utilization review for all subsequent medical treatment.

(2) The results of retrospective utilization review may constitute a showing of good cause for an employers petition requesting a change of physician or provider pursuant to Section 4603 and may serve as grounds for termination of the physician or provider from the medical provider network or health care organization.

(g) Each employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(1) Each utilization review process that modifies or denies requests for authorization of medical treatment shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.

(2)

(A) Unless otherwise indicated in this section, a physician providing treatment under Section 4600 shall send any request for authorization 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. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or 2450 of the Business and Professions Code. The medical director shall ensure that 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 complies with the requirements of this section. This section does not limit the existing authority of the Medical Board of California.

(B) A request for authorization, including its supporting documentation, shall not be altered or amended by any entity other than the requesting physician or provider prior to the submission of the request to the claims administrator in accordance with subparagraph (A). This subparagraph is declaratory of existing law.

(3)

(A) A person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, if these services are within the scope of the physicians practice, requested by the physician, shall not modify or deny requests for authorization of medical

treatment for reasons of medical necessity to cure and relieve or due to incomplete or insufficient information under subdivisions (i) and (j).

(B)

(i) The employer, or any entity conducting utilization review on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications or denials made by the physician under this section.

(ii) An insurer or third-party administrator shall not refer utilization review services conducted on behalf of an employer under this section to an entity in which the insurer or third-party administrator has a financial interest as defined under Section 139.32. This prohibition does not apply if the insurer or third-party administrator provides the employer and the administrative director with prior written disclosure of both of the following:

(I) The entity conducting the utilization review services.

(II) The insurer or third-party administrators financial interest in the entity.

(C) The administrative director has authority pursuant to this section to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting utilization review on behalf of the employer, and the utilization review physician. Any information disclosed to the administrative director pursuant to this paragraph shall be considered confidential information and not subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Disclosure of the information to the administrative director pursuant to this subdivision shall not waive the provisions of the Evidence Code relating to privilege.

(4) A utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review services, by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical material used in issuing a utilization review decision, peer-to-peer consultation, internal appeal procedure, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The administrative director shall adopt rules to implement the selection of an independent, nonprofit organization for those accreditation purposes. Until those rules are adopted, the administrative director shall designate URAC as the accrediting organization. The administrative director may adopt rules to do any of the following:

(A) Require additional specific criteria for measuring the quality of a utilization review process for purposes of accreditation.

(B) Exempt nonprofit, public sector internal utilization review programs from the accreditation requirement pursuant to this section, if the administrative director has adopted minimum standards applicable to nonprofit, public sector internal utilization review programs that meet or exceed the accreditation standards developed pursuant to this section.

(5) On or before July 1, 2018, each employer, either directly or through its insurer or an entity with which an employer or insurer contracts for utilization review services, shall submit a description of the

utilization review process that modifies or denies requests for authorization of medical treatment and the written policies and procedures to the administrative director for approval. Approved utilization review process descriptions and the accompanying written policies and procedures shall be disclosed by the employer to employees and physicians and made available to the public by posting on the employers, claims administrators, or utilization review organizations internet website.

(h) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, or deny medical treatment services shall be all of the following:

- (1) Developed with involvement from actively practicing physicians.
- (2) Consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.
- (3) Evaluated at least annually, and updated if necessary.
- (4) Disclosed to the physician and the employee, if used as the basis of a decision to modify or deny services in a specified case under review.
- (5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. A charge shall not be required for an employee whose physicians request for medical treatment services is under review.

(i) In determining whether to approve, modify, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees, all of the following requirements shall be met:

- (1) Except for treatment requests made pursuant to the formulary, prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employees condition, not to exceed five normal business days from the receipt of a request for authorization for medical treatment and 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. Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five normal business 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.
- (2) In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individuals designee, within 30 days of the receipt of the information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.
- (3) If the employees condition is one in which the employee faces an imminent and serious threat to the employees health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would

be detrimental to the employees life or health or could jeopardize the employees ability to regain maximum function, decisions to approve, modify, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employees condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(4)

(A) Final decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, secure email.

(B) Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated in writing to the employee, and to the physician if the initial communication under subparagraph (A) was by telephone, within 24 hours for concurrent review, or within two normal business days of the decision for prospective review, as prescribed by the administrative director. If the request is modified or denied, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(C) In the case of concurrent review, medical care shall not be discontinued until the employees physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. A compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in a way that minimizes reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. Fees shall not be levied upon insurers or self-insured employers making reports required by this section.

(5) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employers decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny a medical service is due to incomplete or insufficient information, the decision shall specify all of the following:

(A) The reason for the decision.

(B) A specific description of the information that is needed.

(C) The date and time of attempts made to contact the physician to obtain the necessary information.

(D) A description of the manner in which the request was communicated.

(j)

(1) Unless otherwise indicated in this section, a physician providing treatment under Section 4600 shall send any request for authorization 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. 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.

(2) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i) because the employer or other entity is not in receipt of, or in possession of, all of the information reasonably necessary to make a determination, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information that must be provided by the physician for a determination to be made. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i).

(k) A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a further recommendation by the same physician, or another physician within the requesting physicians 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.

(l) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(m) If utilization review is deferred pursuant to subdivision (l), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (2) of subdivision (i) shall begin on the date the determination of the employers liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employers receipt of a treatment recommendation after the determination of the employers liability.

(n) Each employer, insurer, or other entity subject to this section shall maintain telephone access during California business hours for physicians to request authorization for health care services and to conduct peer-to-peer discussions regarding issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity decision.

(o) The administrative director shall develop a system for the mandatory electronic reporting of documents related to every utilization review performed by each employer, which shall be administered by the Division of Workers Compensation. The administrative director shall adopt regulations specifying the documents to be submitted by the employer and the authorized transmission format and timeframe

for their submission. For purposes of this subdivision, employer 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.

(p) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers Compensation Administration Revolving Fund.

(q) The administrative director shall contract with an outside, independent research organization on or after March 1, 2019, to evaluate the impact of the provision of medical treatment within the first 30 days after a claim is filed, for a claim filed on or after January 1, 2017, and before January 1, 2019. The report shall be provided to the administrative director, the Senate Committee on Labor and Industrial Relations, and the Assembly Committee on Insurance before January 1, 2020.

History

Added Stats 2016 ch 868 4.5 (SB 1160), effective January 1, 2017, operative January 1, 2018. Amended Stats 2017 ch 240 1 (SB 489), effective January 1, 2018; Stats 2019 ch 647 6 (SB 537), effective January 1, 2020.

Deerings California Codes Annotated
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§ 9792.10.1. Utilization Review--Dispute Resolution

(a)(1) A request for independent medical review of a utilization review decision that denies or modifies a medical treatment request must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days of service of the written utilization review determination issued by the claims administrator under section 9792.9.5(e).

(2) If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the request for independent medical review must be filed by the eligible party within 10 days of service of the written utilization review decision.

(b) A request for independent medical review must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision denying or modifying the request for authorization of medical treatment. At the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision denying, or modifying the request for authorization of medical treatment, to the claims administrator.

(c) A party eligible to file a request for independent medical review includes:

(1) The employee or, if the employee is represented, the employee's attorney. If the employee's attorney files the DWC Form IMR, the form must be accompanied by a notice of representation or other document or written designation confirming representation.

(A) A parent, guardian, conservator, relative, or other designee of the employee pursuant to Labor Code section 4610.5(j).

(B) The physician whose request for authorization of medical treatment was denied or modified may join with or otherwise assist the employee in seeking an independent medical review. The physician may submit documents on the employee's behalf pursuant to section 9792.10.5 (b) and may respond to any inquiry by the independent review organization.

(2) A provider of emergency medical treatment pursuant to Labor Code section 4610.5(h)(4).

(d) If expedited review is requested for a utilization review decision eligible for independent medical review, the Application for Independent Medical Review, DWC Form IMR, shall include, unless the initial utilization review decision was made on an expedited basis, written certification from the employee's treating physician with documentation confirming that the employee faces an imminent and serious threat to his or her health as described in section 9792.6.1(j).

(e) (1) If, at the time of a utilization review decision, the claims administrator is also disputing liability for the treatment for any reason besides medical necessity, the time limitation for the employee to submit an application for independent medical review under subdivision (a) shall not begin to run until the claims administrator serves a notice to the employee stating that the dispute of liability has been resolved.

(2) If the claims administrator provides the employee with a written utilization review determination modifying or denying a treatment request that does not contain the required elements set forth in section 9792.9.5(e) at the time of notification of its utilization review decision, the time limitations for the employee to submit an application for independent medical review under subdivision (a) shall not begin to run until the claims administrator provides the written decision, with all required elements, to the employee.

(f)(1) Nothing in this section precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the employee and, if the employee is represented by counsel, the employee's attorney, have been notified of the timeframes in subdivision (a) in which to file an application for independent medical review. Any request by the injured worker or treating physician for an internal utilization review appeal process conducted under this subdivision must be submitted to the claims administrator within ten (10) days after the receipt of the utilization review decision.

(2) A request for an internal utilization review appeal must be completed, and a determination issued, by the claims administrator within thirty (30) days after receipt of the request under subdivision (f)(1). If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the internal utilization review appeal must be completed, and a determination issued, by the claims administrator within ten (10) days after receipt of the request under subdivision (f)(1). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6(e) that determines the medical necessity of the disputed treatment.

(3) Any determination by the claims administrator following an internal utilization review appeal that results in a modification of the requested medical treatment 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 section 9792.9.5(e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.5(e)(7), must indicate that the decision is a modification after appeal.

Authority: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5, 4610, and 4610.5, Labor Code.

§ 9792.8. Utilization Review Standards – Medically-Based Criteria.

(a) The criteria for a physician reviewer to determine the medical necessity of requested treatment shall be consistent with the medical treatment utilization schedule adopted pursuant to Labor Code section 5307.27, including the methodology for evaluating medical evidence under section 9792.25.1.

(b) Nothing in this section precludes authorization of medical treatment beyond what is covered in the medical treatment utilization schedule or supported by the best available medical evidence in order to account for medical circumstances warranting an exception in accordance with section 9792.21.1(e).

Authority cited: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.

Reference: Sections 4062, 4600, 4600.4, 4604.5 and 4610, Labor Code.

§9792.9.3. Utilization Review — Timeframes.

(a) The first day in counting any timeframe requirement is the first normal business or working day after receipt of the completed or accepted as complete request for authorization, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the request for authorization.

(b) Prospective or concurrent decisions to approve, modify, or deny a request for authorization 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 date of receipt of the completed request for authorization.

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

(d) Retrospective decisions to approve, modify, or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and information regarding rendered medical treatment that is sufficient for a reviewer to make a determination as to whether the treatment was medically necessary.

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

Authority: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.

Reference: Sections 4600, 4603, 4600.4, 4604.5, 4610, and 5307.27, Labor Code.

Cal Lab Code 4610.5

Deering's California Codes are current through Chapter 3 of the 2020 Regular Session.

- Deerings California Codes Annotated
- LABOR CODE (1 12001)
- Division 4 Workers Compensation and Insurance (Pts. 1 4)
- Part 2 Computation of Compensation (Chs. 1 2)
- Chapter 2 Compensation Schedules (Arts. 1 7)
- Article 2 Medical and Hospital Treatment (4600 4615)

4610.5.Review of utilization review decision

(a) This section applies to the following disputes:

(1) Any dispute over a utilization review decision regarding treatment for an injury occurring on or after January 1, 2013.

(2) Any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(3) Any dispute occurring on or after January 1, 2018, over medication prescribed pursuant to the drug formulary adopted pursuant to Section 5307.27.

(b) A dispute described in subdivision (a) shall be resolved only in accordance with this section.

(c) For purposes of this section and Section 4610.6, the following definitions apply:

(1) Disputed medical treatment means medical treatment that has been modified or denied by a utilization review decision on the basis of medical necessity.

(2) 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.

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(3) 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.

(4) Unless otherwise indicated by context, employer 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.

(d) If a utilization review decision denies or modifies a treatment recommendation based on medical necessity, the employee may request an independent medical review as provided by this section.

(e) A utilization review decision may be reviewed or appealed only by independent medical review pursuant to this section. Neither the employee nor the employer shall have any liability for medical treatment furnished without the authorization of the employer if the treatment is modified or denied by a utilization review decision, unless the utilization review decision is overturned by independent medical review in accordance with this section.

(f) As part of its notification to the employee regarding an initial utilization review decision based on medical necessity that denies or modifies a treatment recommendation, the employer shall provide the employee with a one-page form prescribed by the administrative director, and an addressed envelope, which the employee may return to the administrative director or the administrative directors designee to initiate an independent medical review. The employee may also request independent medical review electronically under rules adopted by the administrative director. The employer shall include on the form any information required by the administrative director to facilitate the completion of the independent medical review. The form shall also include all of the following:

(1) Notice that the utilization review decision is final unless the employee requests independent medical review.

(2) A statement indicating the employees consent to obtain any necessary medical records from the employer or insurer and from any medical provider the employee may have consulted on the matter, to be signed by the employee.

(3) Notice of the employees right to provide information or documentation, either directly or through the employees physician, regarding the following:

(A) The treating physicians recommendation indicating that the disputed medical treatment is medically necessary for the employees medical condition.

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

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

(g) The independent medical review process may be terminated at any time upon the employers 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.

(h)

(1) The employee may submit a request for independent medical review to the division. The request may be made electronically under rules adopted by the administrative director. The request shall be made no later than as follows:

(A) For formulary disputes, 10 days after the service of the utilization review decision to the employee.

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

(2) If at the time of a utilization review decision the employer is also disputing liability for the 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 directors designee is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

(3) If the employer fails to comply with subdivision (f) at the time of notification of its 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.

(4) A provider of emergency medical treatment when the employee faced 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, 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 directors designee within the time limitations applicable for an employee to submit a request for independent medical review.

(i) An employer shall not engage in any conduct that has the effect of delaying the independent review process. Engaging in that conduct or failure of the employer to promptly comply with this section is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five

thousand dollars (\$5,000) for each day that proper notification to the employee is delayed. The administrative penalties shall be paid to the Workers Compensation Administration Revolving Fund.

(j) For purposes of this section, an 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.

(k) The administrative director or his or her designee shall expeditiously review requests and immediately notify the employee and the employer in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the employer agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred if at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity.

(l) Upon notice from the administrative director that an independent review organization has been assigned, the employer shall electronically provide to the independent medical review organization under rules adopted by the administrative director a copy and list of all of the following documents within 10 days of notice of assignment:

(1) A copy of all of the employees medical records in the possession of the employer or under the control of the employer relevant to each of the following:

(A) The employees current medical condition.

(B) The medical treatment being provided by the employer.

(C) The request for authorization and utilization review decision.

(2) A copy of all information provided to the employee by the employer concerning employer and provider decisions regarding the disputed treatment.

(3) A copy of any materials the employee or the employees provider submitted to the employer in support of the employees request for the disputed treatment.

(4) A copy of any other relevant documents or information used by the employer or its utilization review organization in determining whether the disputed treatment should have been provided, and any statements by the employer or its utilization review organization explaining the reasons for the decision to deny or modify the recommended treatment on the basis of medical necessity. The employer shall concurrently provide a copy of the documents required by this paragraph to the employee and the requesting physician, except that documents previously provided to the employee or physician need not be provided again if a list of those documents is provided.

(m) Any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The employer shall concurrently provide a

copy of medical records required by this subdivision to the employee or the employees treating physician, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

(n) If there is an imminent and serious threat to the health of the employee, as specified in subdivision (c) of Section 1374.33 of the Health and Safety Code, all necessary information and documents required by subdivision (l) shall be delivered to the independent medical review organization within 24 hours of approval of the request for review.

(o) The employer shall promptly issue a notification to the employee, after submitting all of the required material to the independent medical review organization, that lists documents submitted and includes copies of material not previously provided to the employee or the employees designee.

(p) The claims administrator who issued the utilization review decision in dispute shall notify the independent medical review organization if there is a change in the claims administrator responsible for the claim. Notice shall be given to the independent medical review organization within five working days of the change in administrator taking effect.

History

Added Stats 2012 ch 363 45 (SB 863), effective January 1, 2013. Amended Stats 2013 ch 287 5 (SB 375), effective January 1, 2014; Stats 2014 ch 217 2 (AB 2732), effective January 1, 2015; Stats 2016 ch 868 5 (SB 1160), effective January 1, 2017.

Deerings California Codes Annotated
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Cal Lab Code 4610.6

Deering's California Codes are current through Chapter 3 of the 2020 Regular Session.

- Deerings California Codes Annotated
- LABOR CODE (1 12001)
- Division 4 Workers Compensation and Insurance (Pts. 1 4)
- Part 2 Computation of Compensation (Chs. 1 2)
- Chapter 2 Compensation Schedules (Arts. 1 7)
- Article 2 Medical and Hospital Treatment (4600 4615)

4610.6.Independent medical review organization to conduct review of utilization review decision; Procedure upon final determination of review

(a) Upon receipt of a case pursuant to Section 4610.5, an independent medical review organization shall conduct the review in accordance with this article and any regulations or orders of the administrative director. The organizations review shall be limited to an examination of the medical necessity of the disputed medical treatment.

(b) Upon receipt of information and documents related to a case, the medical reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the employee, provider reports, and any other information submitted to the organization or requested from any of the parties to the dispute by the reviewers. If the reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (c).

(c) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the employee and the standards of medical necessity as defined in subdivision (c) of Section 4610.5.

(d)

(1) The organization shall complete its review and make its determination in writing, and in laypersons terms to the maximum extent practicable, and the determination shall be issued, as follows:

(A) For a dispute over medication prescribed pursuant to the drug formulary submitted under subdivision (h) of Section 4610.5, within five working days from the date of receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director.

(B) For all other medical treatment disputes submitted for review under subdivision (h) of Section 4610.5, within 30 days of receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director.

(C) If the disputed medical treatment has not been provided and the employees provider or the administrative director certifies in writing that an imminent and serious threat to the health of the employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the employee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information.

(2) Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

(e) The medical professionals analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the employees medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (c) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(f) The independent medical review organization shall provide the administrative director, the employer, the employee, and the employees provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewers analyses and determinations.

(g) The determination of the independent medical review organization shall be deemed to be the determination of the administrative director and shall be binding on all parties.

(h) A determination of the administrative director pursuant to this section may be reviewed only by a verified appeal from the medical review determination of the administrative director, filed with the appeals board for hearing pursuant to Chapter 3 (commencing with Section 5500) of Part 4 and served on all interested parties within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:

(1) The administrative director acted without or in excess of the administrative directors powers.

(2) The determination of the administrative director was procured by fraud.

(3) The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.

(4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.

(5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion.

(i) If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent medical review by a different independent review organization. In the event that a different independent medical review organization is not available after remand, the administrative director shall submit the dispute to the original medical review organization for review by a different reviewer in the organization. In no event shall a workers compensation administrative law judge, the appeals board, or any higher court make a determination of medical necessity contrary to the determination of the independent medical review organization.

(j) Upon receiving the determination of the administrative director that a disputed health care service is medically necessary, the employer shall promptly implement the decision as provided by this section unless the employer has also disputed liability for any reason besides medical necessity. In the case of reimbursement for services already rendered, the employer shall reimburse the provider or employee, whichever applies, within 20 days, subject to resolution of any remaining issue of the amount of payment pursuant to Sections 4603.2 to 4603.6, inclusive. In the case of services not yet rendered, the employer shall authorize the services within five working days of receipt of the written determination from the independent medical review organization, or sooner if appropriate for the nature of the employees medical condition, and shall inform the employee and provider of the authorization.

(k) Failure to pay for services already provided or to authorize services not yet rendered within the time prescribed by subdivision (l) is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars (\$5,000) for each day the decision is not implemented. The administrative penalties shall be paid to the Workers Compensation Administration Revolving Fund.

(l) The costs of independent medical review and the administration of the independent medical review system shall be borne by employers through a fee system established by the administrative director. After considering any relevant information on program costs, the administrative director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews and the cost of administering the independent medical review system, which may vary depending on the type of medical condition under review and on other relevant factors.

(m) The administrative director may publish the results of independent medical review determinations after removing individually identifiable information.

(n) If any provision of this section, or the application thereof to any person or circumstances, is held invalid, the remainder of the section, and the application of its provisions to other persons or circumstances, shall not be affected thereby.

History

Added Stats 2012 ch 363 46 (SB 863), effective January 1, 2013. Amended Stats 2016 ch 868 6 (SB 1160), effective January 1, 2017.

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Cal Bus & Prof Code 4999

Deering's California Codes are current through Chapter 3 of the 2020 Regular Session.

- Deerings California Codes Annotated
- BUSINESS & PROFESSIONS CODE (1 30047)
- Division 2 Healing Arts (Chs. 1 16)
- Chapter 15 Telephone Medical Advice Services (4999 4999.9)

4999.Telephone medical advice service

Telephone medical advice service means any business entity that employs, or contracts or subcontracts, directly or indirectly, with, the full-time equivalent of five or more persons functioning as health care professionals, whose primary function is to provide telephone medical advice, that provides telephone medical advice services to a patient at a California address. Telephone medical advice service does not include a medical group that operates in multiple locations in California if no more than five full-time equivalent persons at any one location perform telephone medical advice services and those persons limit the telephone medical advice services to patients being treated at that location.

History

Added Stats 1999 ch 535 1 (AB 285). Amended Stats 2000 ch 857 2.1; Stats 2002 ch 107 22 (AB 269); Stats 2006 ch 659 29 (SB 1475), effective January 1, 2007; Stats 2016 ch 799 28 (SB 1039), effective January 1, 2017.

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Cal Lab Code 4600

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- Deerings California Codes Annotated
- LABOR CODE (1 12001)
- Division 4 Workers Compensation and Insurance (Pts. 1 4)
- Part 2 Computation of Compensation (Chs. 1 2)
- Chapter 2 Compensation Schedules (Arts. 1 7)
- Article 2 Medical and Hospital Treatment (4600 4615)

4600. Medical treatment provided by employer; Liability for reasonable expense; Medical provider network; Predesignation of personal physician; Expenses incurred in submitting to examination; Qualified interpreter

(a) Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of the workers injury shall be provided by the employer. In the case of the employers neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.

(b) As used in this division and notwithstanding any other law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of the workers injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27.

(c) Unless the employer or the employers insurer has established or contracted with a medical provider network as provided for in Section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of the employees own choice or at a facility of the employees own choice within a reasonable geographic area. A chiropractor shall not be a treating physician after the employee has received the maximum number of chiropractic visits allowed by subdivision (c) of Section 4604.5.

(d)

(1) If an employee has notified the employees employer in writing prior to the date of injury that the employee has a personal physician, the employee shall have the right to be treated by that physician from the date of injury if the employee has health care coverage for nonoccupational injuries or illnesses

on the date of injury in a plan, policy, or fund as described in subdivisions (b), (c), and (d) of Section 4616.7.

(2) For purposes of paragraph (1), a personal physician shall meet all of the following conditions:

(A) Be the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(B) Be the employee's primary care physician and has previously directed the medical treatment of the employee, and who retains the employee's medical records, including the employee's medical history. Personal physician includes a medical group, if the medical group is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries.

(C) The physician agrees to be predesignated.

(3) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the employer is notified pursuant to paragraph (1), all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code. Disputes regarding the provision of medical treatment shall be resolved pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(4) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a group health insurance policy as described in Section 4616.7, all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by the applicable provisions of the Insurance Code.

(5) The insurer may require prior authorization of any nonemergency treatment or diagnostic service and may conduct reasonably necessary utilization review pursuant to Section 4610.

(6) An employee is entitled to all medically appropriate referrals by the personal physician to other physicians or medical providers within the nonoccupational health care plan. An employee is entitled to treatment by physicians or other medical providers outside of the nonoccupational health care plan pursuant to standards established in Article 5 (commencing with Section 1367) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(e)

(1) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers compensation administrative law judge, the employee submits to examination by a physician, the employee is entitled to receive, in addition to all other benefits herein provided, all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination.

(2) Regardless of the date of injury, reasonable expenses of transportation includes mileage fees from the employees home to the place of the examination and back at the rate of twenty-one cents (\$0.21) a mile or the mileage rate adopted by the Director of Human Resources pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time the employee is given notification of the time and place of the examination.

(f) When at the request of the employer, the employers insurer, the administrative director, the appeals board, or a workers compensation administrative law judge, an employee submits to examination by a physician and the employee does not proficiently speak or understand the English language, the employee shall be entitled to the services of a qualified interpreter in accordance with conditions and a fee schedule prescribed by the administrative director. These services shall be provided by the employer. For purposes of this section, qualified interpreter means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.

(g) If the injured employee cannot effectively communicate with the employees treating physician because the employee cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during medical treatment appointments. To be a qualified interpreter for purposes of medical treatment appointments, an interpreter is not required to meet the requirements of subdivision (f), but shall meet any requirements established by rule by the administrative director that are substantially similar to the requirements set forth in Section 1367.04 of the Health and Safety Code. The administrative director shall adopt a fee schedule for qualified interpreter fees in accordance with this section. Upon request of the injured employee, the employer or insurance carrier shall pay for interpreter services. An employer shall not be required to pay for the services of an interpreter who is not certified or is provisionally certified by the person conducting the medical treatment or examination unless either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code.

(h) Home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the effects of the employees injury and prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and subject to Section 5307.1 or 5307.8. The employer is not liable for home health care services that are provided more than 14 days prior to the date of the employers receipt of the physicians prescription.

History

Added Stats 2009 ch 565 2 (SB 186), effective January 1, 2010. See this section as modified in Governors

Reorganization Plan No. 1 199 of 2011. Amended Stats 2012 ch 363 35 (SB 863) (ch 363 prevails), effective January 1, 2013, ch. 665 179 (SB 1308), effective January 1, 2013; Stats 2013 ch 793 1 (AB 1376), effective October 13, 2013; Stats 2014 ch 71 111 (SB 1304), effective January 1, 2015, ch 217 1 (AB 2732), effective January 1, 2015 (ch 217 prevails); Stats 2019 ch 497 188 (AB 991), effective January 1, 2020.

Deerings California Codes Annotated

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Cal Lab Code 4614.1

Deering's California Codes are current through Chapter 3 of the 2020 Regular Session.

- Deerings California Codes Annotated
- LABOR CODE (1 12001)
- Division 4 Workers Compensation and Insurance (Pts. 1 4)
- Part 2 Computation of Compensation (Chs. 1 2)
- Chapter 2 Compensation Schedules (Arts. 1 7)
- Article 2 Medical and Hospital Treatment (4600 4615)

4614.1.Acceptance of payment on fee-for-service basis

Notwithstanding subdivision (f) of Section 1345 of the Health and Safety Code, a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act and certified by the administrative director pursuant to Section 4600.5 to provide health care pursuant to Section 4600.3 shall be permitted to accept payment from a self-insured employer, a group of self-insured employers, or the insurer of an employer on a fee-for-service basis for the provision of such health care as long as the health care service plan is not both the health care organization in which the employee is enrolled and the plan through which the employee receives regular health benefits.

History

Added Stats 1993 ch 121 42 (AB 110), effective July 16, 1993. Amended Stats 1993 ch 1242 35 (SB 223).

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Cal Lab Code 4060

Deering's California Codes are current through Chapter 3 of the 2020 Regular Session.

- Deerings California Codes Annotated
- LABOR CODE (1 12001)
- Division 4 Workers Compensation and Insurance (Pts. 1 4)
- Part 1 Scope and Operation (Chs. 1 11)
- Chapter 7 Medical Examinations (Arts. 1 2)
- Article 2 Determination of Medical Issues (4060 4068)

4060.Liability for medical-legal evaluation performed by other than treating physician; Procedure; Notice

(a) This section shall apply to disputes over the compensability of any injury. This section shall not apply where injury to any part or parts of the body is accepted as compensable by the employer.

(b) Neither the employer nor the employee shall be liable for any comprehensive medical-legal evaluation performed by other than the treating physician, except as provided in this section. However, reports of treating physicians shall be admissible.

(c) If a medical evaluation is required to determine compensability at any time after the filing of the claim form, and the employee is represented by an attorney, a medical evaluation to determine compensability shall be obtained only by the procedure provided in Section 4062.2.

(d) If a medical evaluation is required to determine compensability at any time after the claim form is filed, and the employee is not represented by an attorney, the employer shall provide the employee with notice either that the employer requests a comprehensive medical evaluation to determine compensability or that the employer has not accepted liability and the employee may request a comprehensive medical evaluation to determine compensability. Either party may request a comprehensive medical evaluation to determine compensability. The evaluation shall be obtained only by the procedure provided in Section 4062.1.

(e) The notice required by subdivision (d) shall be accompanied by the form prescribed by the administrative director for requesting the assignment of a panel of qualified medical evaluators.

History

Added Stats 1993 ch 121 29 (AB 110), effective July 16, 1993. Amended Stats 1993 ch 1242 27 (SB 223); Stats 2004 ch 34 12 (SB 899), effective April 19, 2004; Stats 2011 ch 544 3 (AB 335), effective January 1, 2012.

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EXHIBIT 8

Utilization Management Policies and Procedures CORE POLICY/PROCEDURE

- Id.-No. WCUM Standard 1 Review Criteria Requirements,
 2 Access to Review Staff,
 3 Review Service Communication and Time Frames

Form No. WCUM 07.2-01-03
07.2-02-03
07.2-03-03

1. SCOPE

- 1.1 The scope is defined as all Broadspire Services departments which are within the scope of the URAC accredited services.
- 1.2 To establish criteria for qualifications applicable to all utilization review staff.

2. REFERENCE DOCUMENTS/RESOURCES/EXHIBITS

- 2.1 Core Standards 3, 27, 28, 29, 30, 34

3. DEFINITIONS

- 3.1 A Policy is the overall intention and direction of the organization related to a specific topic.
- 3.2 A procedure is a specified way to carry out an activity or a process established by the organization.
- 3.3 An organization is a business entity, program or department that seeks accreditation under the URAC Standards.
- 3.4 Clinical Review Criteria are the written screens, decision rules, medical protocols or guidelines used by the organization as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures and services under the auspices of the applicable regulatory agency.

4. POLICY

- 4.1 Broadspire's Utilization Management Program incorporates all regulatory requirements as mandated by each state or regulatory agency in all states or territories of the United States in which Broadspire conducts Utilization Management.

5. PROCEDURE

- 5.1 Broadspire utilizes nationally recognized clinical review criteria including ODG, ACOEM/MTUS and State Treatment Guidelines. All criteria are maintained on the Crawford Intranet, via the Quick Links > 00 Guidelines. State Treatment guidelines are updated in real time by each state. Updates for ODG/ACOEM/MTUS are communicated by the Utilization Management Managers to PeersHealth to be updated upon notification.
- 5.2 Broadspire provides access to its review staff by a toll free or collect telephone line at a minimum from 9:00 am to 5:30 pm of each normal business day in each time zone where the organization conducts review activities.
 - 5.2.1 CA only: Physician reviewers are available to providers at least four (4) hours each week. §9792.9.5 (14)
- 5.3 Broadspire maintains processes to:
 - 5.3.1 Receive communications from providers and patients during the business day and after business hours;
 - 5.3.2 Respond to communications within one business day; and
 - 5.3.3 Conduct its outgoing communications related to utilization management during providers' reasonable and normal business hours, unless otherwise mutually agreed.
- 5.4 The Broadspire Utilization Management Program includes the following components:
 - 5.4.1 PRE-ADMISSION/PRE-CERTIFICATION REVIEW - Evaluation and determination regarding the medical necessity and appropriateness for projected treatment/admissions.
 - 5.4.2 CONCURRENT REVIEW - Ongoing review of the medical necessity and appropriateness of continued services during inpatient hospitalization or outpatient treatment. Reviews are conducted based on the

severity or complexity of the patient's condition and in treatment or discharge planning activities. Inpatient reviews are not conducted on a daily basis; however the frequency of conducting concurrent inpatient reviews is based on evidenced based medicine and Length of Stay criteria applicable on a case-by-case basis.

- 5.4.3 **RETROSPECTIVE REVIEW** - A review of complete medical records following discharge or completion of outpatient treatment to determine appropriate utilization of services. Retrospective reviews may be conducted after inpatient or outpatient services are rendered.
- 5.4.4 During the Utilization Review process, Broadspire applies and utilizes commercially available criteria by American College of Occupational and Environmental Medicine (ACOEM) guidelines, Official Disability Management Guidelines (ODG), state treatment guidelines where applicable, and internally developed criteria. Internally developed criteria are based on current clinical principles/processes and developed through comprehensive study of the accepted standards of practice, literature research, networking, consultation and contribution by actively practicing providers certified in their areas of expertise. Criteria are approved by the medical director and reviewed on an annual and as needed basis.
- 5.4.5 The Medical Disability Advisor (MDA) by Presley Reed, M.D. is utilized to evaluate disability duration during the case management and disability management processes.
- 5.5 Utilization Management staff include full-time registered nurse reviewers and a physical therapist. A diverse range of peer review physician consultants are routinely available to render utilization review determinations and ensure specialty matching with providers rendering care. Additionally, there are supervisory, quality assessment, and training personnel plus a full-time Chief Medical Officer.
- 5.6 Professional review staff are evaluated initially through the Broadspire Human Resources Department. Licenses and references are verified. Each professional applicant must undergo an interview process and demonstrate appropriate experience within their area of clinical expertise. Physicians are board certified in their area of specialty and have undergone a formal credentialing process.
- 5.7 All Utilization Review staff go through a formal orientation and training process with the Utilization Management trainer followed by daily work with a preceptor. Periodic evaluations are conducted until the reviewer demonstrates proficiency with the review process. Upon successful completion of the orientation program, routine performance evaluations are conducted by the designated supervisor with feedback provided to the reviewer at three months, six months and at least annually thereafter.
- 5.8 Cases are initially reviewed by a nurse reviewer utilizing the aforementioned clinical criteria. If the case meets criteria, a certification recommendation will be made and the case will be followed at pre-established intervals (as noted above) until discharge from treatment.
- 5.8.1 In the event that a case does not meet the established criteria, a referral is made to the appropriate Broadspire peer reviewer. If it is determined that the case still does not meet criteria after contact with the prescribing provider and review by the Broadspire peer consultant*, a non-certification or modification recommendation will be issued. Only peer reviewers may recommend non-certification or modification of services based on clinical rationale.
- 5.8.2 Notification of all certification recommendations will be given to the provider(s) within the more stringent of URAC or state specific time frames. Written notification to the provider(s) will follow. Any non-certification or modification recommendation will include the rationale for the determination. Written notification letters include instructions for initiating the appeals process.
- 5.8.3 Broadspire provides an appeals process to the provider and patient in the event of a non-certification or modification decision. An appeal may be requested within sixty days** of the original determination through the reconsideration, expedited and/or standard appeal procedures.
- 5.9 Hours of operation are from 8:00a.m. to 8:30p.m. EST. (9:00 a.m - 5:30 p.m. PST) Monday through Friday. After hours, weekend and holiday calls are handled by a voice mail system. Broadspire quality standards require that all phone messages be returned by the following business day. All messages are logged and maintained on file for future reference.
- 5.10 The Broadspire Utilization Management Program is accredited by URAC for Worker's Compensation as well as Independent Review Organization Standards. Broadspire will submit in writing any material change in the information set forth in an application submitted to a national or state accrediting body within thirty (30) days after the change as required by the state or organization**.

*Note: A referral may be made to an outside peer review agency to ensure that a peer with appropriate state licensure renders the determination when applicable, or in accordance with state specific time frames

EXHIBIT 9 Independent Medical Review - Overview FAQs & Forms

What is independent medical review? Independent medical review (IMR) is a quick, non-judicial way to resolve disputes about the medical treatment of injured employees. If a request by a treating physician for a specific course of medical treatment is denied or modified by a claims administrator for the reason that the treatment is not medically necessary, the injured employee can ask for a review of that decision by physician-conducted IMR.

What is a medical necessity treatment dispute? A medical necessity treatment dispute is a request by a treating physician for a specific course of medical treatment that has been modified or denied by a utilization review (UR).

Who performs IMR? The administrative director (AD) has designated Maximus as the independent medical review organization to conduct all IMR. Maximus contracts with medical professionals to perform IMR, and each medical professional must meet rigorous qualification and conflict of interest standards.

When does IMR become effective? IMR is available as of July 1, 2013 to resolve medical necessity treatment disputes for all dates of industrial injury.

Who can request IMR? Only the injured employee or his or her designee can request IMR.

- If the injured employee is represented, the employee's representative or attorney can request IMR.
- If the injured employee is unrepresented, he or she can designate a parent, guardian, conservator, relative or other person as an agent to act on his or her behalf to request IMR.
- The physician whose request for authorization of medical treatment was denied or modified may join with or assist the injured employee in seeking IMR.
- If the injured employee required emergent medical treatment because of an imminent and serious threat to his or her health, the provider of emergency medical treatment can submit an application for IMR.

How is IMR requested? To request IMR, the worker must submit an application for IMR and mail the following information within 10 calendar days after the service of the utilization review decision to the employee for formulary disputes, and 30 calendar days after the service of the utilization review decision to the employee for all other medical treatment disputes to the address below:

- Original signed Application for Independent Medical Review:
<http://www.dir.ca.gov/dwC/DWCPPropReqs/IMRIIMRFormApplication.pdf>
- A copy of the utilization review denial of treatment

Mail the above information to:
DWC -IMR
c/o Maximus Federal Services,
Inc.
PO Box 138009
Sacramento, CA 95813-8009

Is there a deadline to request IMR?

- Yes. IMR must be requested within 10 calendar days after the service of the utilization review decision to the employee for formulary disputes, and 30 calendar days after the service of the utilization review decision to the employee for all other medical treatment disputes. A copy of the IMR application must be sent to the claims administrator.
- If the request for IMR is made by a provider of emergency medical treatment, the deadline for filing the application for IMR is within 30 days after the service of the UR decision concerning the provider's retrospective request for authorization of the emergency medical treatment.
- If at the time of the UR decision the claims administrator is also disputing liability for the treatment for any reason besides medical necessity, the request for IMR is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved. IMR Frequently Asked Questions:
<https://www.dir.ca.gov/dwcliIMRIIMRFAQs.htm>



Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- Sign and date this application and consent to obtain medical records.
- Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:
Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 606-4270
- Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. **THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

- Regular Expedited Modification after Appeal
- Medication Only – MTUS Retrospective for Exempt Retrospective for Exempt
Formulary Drug List Treatment (Non-Drug) Treatment (Drug)

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:
Fax Number: Specialty:

Claims Administrator Information:

Employer Name:
Name of Administrator: Contact Name:
Address: Number/Unit:
State: Zip Code: Telephone Number:
Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter:

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? Yes No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

1.

2.

3.

4.

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

- 30 days from the mailing date of the written determination letter.
- 10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" determination letter) that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review ("IMR") of the medical treatment request by a physician who is not connected to your Claims Administrator. If the IMR is decided in your favor, your Claims Administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your Claims Administrator.

- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.
- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

**DWC-IMR, c/o Maximus Federal Services, Inc.
PO Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270**

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days

from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.



CORE POLICY/PROCEDURE

Org Issue Date

07/17/2018

Id.-No. **CORE 3.2/IR-Standard 16/1-8 Confidentiality of Individually-Identifiable Health Information****CORE 5.2****Form No. CORE 003-016-07****1. SCOPE**

- 1.1 The scope is defined as all Broadspire Services departments which are within the scope of Kentucky MBR-UR Plan certification.

2. REFERENCE DOCUMENTS/RESOURCES/EXHIBITS

- 2.1 Documentation of HIPAA training script; documentation of data privacy script; documentation of annual required training; signed BOD attestation statements, Form CORE 003-015-00

3. DEFINITIONS

- 3.1 A policy is the overall intention and direction of the organization related to a specific topic.
- 3.2 A procedure is a specified way to carry out an activity or a process established by the organization.
- 3.3 Organization is defined as a business entity that seeks certification under Kentucky Statutes & Regulations.

4. POLICY

- 4.1 Broadspire recognizes that a claimant has a fundamental right to privacy and should be assured adequate protection from the unauthorized dissemination of non-public, personally identifiable information ("Information"). Broadspire has adopted the following Best Practice in an effort to provide this protection. And thus, Broadspire has established written policies and procedures to protect the confidentiality of individually-identifiable health information.
- 4.2 According to the Center for Medicare and Medicaid Services (CMS), the activities in the normal course of business are not considered information which is classified under HIPAA. CMS specifies that the following types of insurance are not covered under HIPAA: long/short term disability; workers' compensation; automobile liability that includes coverage for medical payments as they are not health plans. The HIPAA Administrative Simplification regulations specifically exclude from the definition of a "health plan" any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits, which are listed in section 2791(c)(1) of the Public Health Service Act, 42 U.S.C. 300gg-91(c)(1). See 45 CFR 160.103. As described in the statute, excepted benefits are one or more (or any combination thereof) of the following policies, plans or programs: Coverage only for accident, or disability income insurance, or any combination thereof; Coverage issued as a supplement to liability insurance; Liability insurance, including general liability insurance and automobile liability insurance; Workers' compensation or similar insurance; Automobile medical payment insurance; Credit-only insurance; Coverage for on-site medical clinics; Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- 4.3 Individually-identifiable health information will be used by the case management/claim staff and physician review consultants. (Core 16a)

- 4.4 The case management/claim staff and physician review consultants will acquire and use information solely for the purposes of case management, claims administration, utilization review, quality assessment, discharge planning and/or independent review (Core 16b)
- 4.5 In most cases, information will be input into the appropriate computer system. Access to computerized Information is limited solely to clinical medical management/claim staff and physician review consultants, authorized data processing, authorized users, and administrative personnel. Security measures are taken to assure that unauthorized personnel are not afforded access to Information. (Core 16c)
- 4.6 Information will be disclosed only to those agencies that have authority to receive such Information. These agencies include but are not necessarily limited to: Independent review agents, claims adjusters, benefits administrators, employers, state agencies, and/or a medical provider QI department if an issue related to quality of care is presented. The case/claim staff and physician review consultants shall not disclose information in any manner except to the extent necessary to properly conduct case management, claims administration, utilization review, quality assessment, discharge planning and/or independent review or in communication with other authorized agents. All subpoenas for medical records received will be routed through the Legal Department for approval prior to producing documentation. Broadspire acknowledges that certain Information may be disclosed for data processing and administrative services. However, no information is disclosed in any way that would violate this policy. The case management/claim management staff and physician review consultants and board members will be continuously updated on issues concerning confidentiality disclosure of Information through policy updates and periodic in-service sessions. (Core 16d)
- 4.7 It is the responsibility of all Broadspire employees, committee members and board members to preserve the confidentiality of individually-identifiable health information. Broadspire will neither acquire nor distribute Information without the express consent of the claimant or provider, or if state or federal law will allow such acquisition and disclosure of Information without consent. Broadspire acknowledges that the responsibility of obtaining consent of the claimant, if necessary, rests with the treating physician, the institution and the payor. (Core 16e)
- 4.8 Broadspire requires that all staff members, which includes committee members, to complete annual online training courses in both data privacy and HIPAA which requires employees, which at the conclusion of training, participants must obtain an established passing score and will be required to acknowledge their agreement to maintain confidentiality through the online system. Broadspire board members sign an annual attestation to meet this requirement. (Core 16f)
- 4.9 Crawford & Company Data Privacy Policy - See Core 15 Policy & Procedure, Form No. CORE 003-015-00 for details.

5. PROCEDURE

- 5.1 Training on Anti-Corruption Data Protection & Privacy, Code of Business Conduct & Ethics, CyberSecurity, and HIPAA are assigned by the Ethics & Compliance Department designee globally to all staff members on an annual basis. Staff members have a period of 60 days to complete the assigned courses. Periodic reminders are sent to the staff members and their supervisor until the course has been completed successfully. Failure to complete the required training by staff will result in corrective action up to and including termination of employment.
- 5.2 Details pertaining to the UR procedures will be found in the documents associated with UR Retrospective Case Review and UR Preauthorization Process.
- 5.3 In the scenario of Workers' Compensation Case Management for a patient with a secondary diagnosis, the case manager may release personal health information to an employer when the secondary diagnosis is expressly impacting the workers' compensation claim or expenses thereof except for California cases (* Please see note below.)
- 5.4 In some scenarios the secondary diagnosis may have an impact on costs associated with the claim, e.g. the impact can be either as a complicating factor or a factor that impacts the employee's ability to heal from the injury. In such a case, the secondary diagnosis impacts the benefits paid to the employee. For example, an

employee has an injury that in the absence of the secondary diagnosis should result in the employee returning to work in 4 weeks. Because of the secondary diagnosis, however, the employee's absence is extended up to 8 weeks. In this case, the secondary diagnosis is a complicating factor and thus subject to disclosure.

- 5.5 If the case manager has any uncertainty regarding the impact of a secondary diagnosis they may inquire with the treating physician to determine whether a secondary diagnosis is impacting the workers' compensation claim. Broadspire may also disclose the secondary diagnosis if it is permitted to do so by a valid patient authorization/consent.
- 5.6 * Note: For all California cases as per regulation AB 435, Labor Code Section 3762: Only the medical diagnosis for which workers' compensation is being claimed, the treatment provided for this condition, and medical information regarding the injury for which workers' compensation is claimed that is necessary for the employer to have in order for the employer to modify the employee's work duties may be released.

RECORD of APPROVAL AND REVISIONS

Revision Level	Action Taken	Authorized Signature	Date
00	APPROVAL	Meredith Brogan Signature on file	09/19/2018
01	Reviewed	Cindy Buxton	6/17/19
02	Reviewed	Puran Sampat	2/25/20
03	Reviewed	Missie Mills	06/09/2020
04	Reviewed	Alan Morris/Bob Jett	06/21
05	Revised	Alan Morris	08/21
06	Reviewed	Missie Mills	06/22
07	Reviewed	Jemin Thakkar	06/23

Citations

Standard Element	Document Location
CORE 16a	Page 1, Section 4.3-4.4
CORE 16b	Page 2, Section 4.4
CORE 16c	Page 2, Section 4.5
CORE 16d	Page 2, Section 4.6
CORE 16e	Page 2, Section 4.7
CORE 16f	Page 2, Section 4.8
IR-CORE 1-8ai	Page 1, Section 4.3-4.4
IR-CORE 1-8aii	Page 2, Section 4.4
IR-CORE 1-8aiii	Page 2, Section 4.5
IR-CORE 1-8aiv	Page 2, Section 4.6
IR-CORE 1-8av	Page 2, Section 4.7
IR-CORE 1-8avi	Page 2, Section 4.8

Exhibit 11

The organization is responsible for monitoring and reporting elements of the review process. The Broadspire Utilization Review Department monitors its performance regarding review procedures according to its policies or documented procedures. At least annually, oversight of the utilization management program includes summary reporting and analysis of the monitoring conducted for the following areas of performance: (UM 01-2)

- a. Consistent application of clinical review criteria across reviewers. At least quarterly, Broadspire conducts review of application of clinical review criteria across reviewers to ensure consistency and includes a summary reporting and analysis against acceptable levels of performance and criteria to be applied. (UM 01-2(a))
- b. At least quarterly, the organization generates reports to determine the rate of each of the following regarding each service, device and pharmaceutical that requires certification, determine the rate of each of the following: (UM 01-2(b))
 - i. Certifications (i.e., approvals). The certification rate is determined by Total UM Cases Certified out of the Total UM Cases Closed. (UM 01-2(b)(i))
 - ii. Non-certifications (i.e., denials) The non-certification rate is determined by Total UM Cases Non-Certified out of the Total UM Cases Closed. (UM 01-2(b)(ii))
 - iii. First-level appeals overturned. The first-level appeals overturned rate is determined by Total UM Cases Overturned out of the Total UM Cases Appealed. (UM 01-2(b)(iii))
 - iv. First-level appeals upheld. The first-level appeals upheld rate is determined by Total UM Cases Upheld out of the Total UM Cases Appealed. (UM 01-2(b)(iv))

The organization implements action plans to correct identified problems and meet acceptable levels of performance, as applicable.

Revision & Approval Record:

Revision	Action	Record of Change	Approval	Date
UM 01-2 V01	Approved	Original issue of document to standards	Stacey Moncada, RN, VP UM and PRS	08/21/2024

Citations:

Standard	Page	Section	Para	Bullet
UM 1-2	1		1	
UM 1-2 a	1	a	2	
UM 1-2 b	1	b	3	
UM 1-2 b(i)	1	b	3	i
UM 1-2 b(ii)	1	b	3	ii
UM 1-2 b(iii)	1	b	3	lii
UM 1-2 b(iv)	1	b	3	iv

Plan Revisions:

11/2009 Dr. Lazarovic's license renewal date updated.
6/8/2010 Hours of operation policy updated to reflect Sunrise office
7/15/2010 Authorization definition added to Program Plan.
6/28/2011 References to ACOEM replaced with MTUS.
3/1/2012 OWC suggested language added
3/2014 Dr. Lazarovic's license renewal date updated;
6/2015 IMR information added
7/12/16 Dr. Lazarovic's license renewal date updated;
6/26/17 IMR information updated
12/11/17 Dr. Lazarovic's license renewal date updated.
1/11/18 Updated new CMO information to replace Dr. Lazarovic (retirement) Updated for L.C. 4610 effective 1/1/18.
8/9/19 Dr. Iglesias license renewal updated;
11/21/19 MTUS updated
12/5/19 Dr. Sassoon named CMO
1/14/20 DWC Revisions
2/14/20 DWC Revisions
7/8/21 DWC Revisions
8/23/21 DWC Revisions
12/27/23 Dr. Sassoon License renewal date updated. Credentialing P&P reformatted. DWC Revisions
1/23/25 Dr. Sassoon license renewal date updated.
1/5/26 DWC Regulatory Revisions
4/22/26 DWC Revisions



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

Jurisdiction: «claim.Jurisdiction.statename»

State Claim Number: «claim.wcisnumber»

Claim #: «claim.claimnumber»

Case #: «Id»

Patient Name: «claim.patient.FullName»

Provider(s): «physician.FullName»

Date RFA was First Received: «receivedbyclienttimestamp_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Broadspire, as the delegated agent for the insurer, has reviewed the prescribed plan of treatment.

Treatment Requested:

«requestedtreatmentplan_without_dates»

Determination:

«authorizedtreatmentplan»

Rationale:

«clinical_rationale»

Evidence Based Guidelines Used:

«guidelines»

The requested information requested on «MostRecentRequestForMoreInfo.moreinforeq» has not been received. This request will be reconsidered upon receipt of a new request for authorization containing the additional requested information.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me «claim.examiner.FullName» at «claim.examiner.telephone». However, if you are represented by an attorney, please contact your attorney instead of me.

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.

Broadspire internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

Broadspire's utilization process complies with Section 4610 of the California Labor Code.

In accordance with section 9792.9.5(e)(14) of the California Utilization Review Standards, Broadspire Utilization Management's physician reviewers are available via telephone at 800-800-7660 (select Option 4), Monday through Friday from 8am to 5:30pm Pacific time.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative, or your attorney on behalf of you on the enclosed Application for Independent Medical Review, DWC form IMR within the timeframe indicated on the last page of the application.

Enclosed in mailed letters: Application for Independent Medical Review, DWC Form IMR and envelope addressed to Maximus Federal Services Inc

«signoff_user.FullQualifiedPathOfSignatur»

«signoff_user.FullName»

«signoff_user.StateLicensesDisplayString»

«signoff_user.BoardCertificationDisplaySt»

* In accordance with The Commission/URAC, state and federal guidelines.

«CC»

Your opinion matters to us please take the survey via web link <https://www.surveymonkey.com/r/URcustomersurvey> or scan the QR code below on your smartphone.



CA UR License # 006

CA MPN # 2399

URAC Certification # WUM010034

URAC Certification # WUM010034-2

Initial Certification



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

Jurisdiction: «claim.Jurisdiction.statename»

State Claim Number: «claim.wcisnumber»

Claim #: «claim.claimnumber»

Case #: «Id»

Patient Name: «claim.patient.FullName»

Provider(s): «physician.FullName»

Date RFA was First Received: «receivedbyclienttimestamp_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Broadspire, as the delegated agent for the insurer, has reviewed the prescribed plan of treatment. The clinical information received meets standard criteria and guidelines. The prescribed treatment is certified as outlined below.

The certification process is for the purpose of making a recommendation to the claims representative. This certification notice is in effect for 45 days from the date of this notice.

Treatment Requested:

«requestedtreatmentplan_without_dates»

Determination:

«authorizedtreatmentplan»

The request for authorization may include non-drug treatment exempted under section 9792.9.7 and/or a drug(s) Exempt per MTUS Drug Formulary.

While the medical necessity of the requested treatment or service may have been established, generic substitution must be used when clinically appropriate, jurisdictionally mandated, and/or negotiated within the provider network unless specifically stated in the request for authorization "Dispense as Written" or "Do not Substitute".

Rationale:

«clinical_rationale»

Evidence Based Guidelines Used:

«guidelines»

If additional treatment is required beyond what was certified, we should be contacted immediately.

If the injured employee disputes this determination shall resolve the dispute either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me «claim.examiner.FullName» at «claim.examiner.telephone». 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.

Broadspire's utilization process complies with Section 4610 of the California Labor Code.

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«CurrentDate»

«FullName»

«address.street1» «address.street2»
«address.city» «address.state» «address.postalcode»

Jurisdiction: «claim.Jurisdiction.statename»
State Claim Number: «claim.wcisnumber»
Claim #: «claim.claimnumber»
Case #: «Id»
Patient Name: «claim.patient.FullName»
Provider(s): «physician.FullName»
Date RFA was First Received: «receivedbyclienttimestamp_string»
Date additional information received, if applicable: «DateAdditionalInfoReceived»
Decision date: «decisionrendereddate_string»

Broadspire, as the delegated agent for the insurer, has reviewed your request to reconsider the prescribed plan of treatment.

Treatment Requested:
«requestedtreatmentplan_without_dates»

Determination:
«authorizedtreatmentplan»

The request for authorization may include non-drug treatment exempted under section 9792.9.7 and/or a drug(s) Exempt per MTUS Drug Formulary.

While the medical necessity of the requested treatment or service may have been established, generic substitution must be used when clinically appropriate, jurisdictionally mandated, and/or negotiated within the provider network unless specifically stated in the request for authorization "Dispense as Written" or "Do not Substitute".

Rationale:
«clinical_rationale»

Evidence Based Guidelines Used:
«guidelines»

Broadspire's utilization process complies with Section 4610 of the California Labor Code.

The certification process is for the purpose of making a recommendation to the claims representative.

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«signoff_user.StateLicensesDisplayString»

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URAC Certification # WUM010034-2



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

Jurisdiction: «claim.Jurisdiction.statename»

State Claim Number: «claim.wcisnumber»

Claim #: «claim.claimnumber»

Case #: «Id»

Patient Name: «claim.patient.FullName»

Provider(s): «physician.FullName»

Date RFA was First Received: «receivedbyclienttimestamp_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Broadspire, as the delegated agent for the insurer, has reviewed your request for a «AppealType» appeal and the prescribed plan of treatment.

Treatment Requested:

«requestedtreatmentplan_without_dates»

Determination:

«authorizedtreatmentplan»

The request for authorization may include non-drug treatment exempted under section 9792.9.7 and/or a drug(s) Exempt per MTUS Drug Formulary.

While the medical necessity of the requested treatment or service may have been established, generic substitution must be used when clinically appropriate, jurisdictionally mandated, and/or negotiated within the provider network unless specifically stated in the request for authorization "Dispense as Written" or "Do not Substitute".

Rationale:

«clinical_rationale»

Evidence Based Guidelines Used:

«guidelines»

The certification process is for the purpose of making a recommendation to the claims representative.

Broadspire's utilization process complies with Section 4610 of the California Labor Code.

«signoff_user.FullQualifiedPathOfSignatur»

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«address.city» «address.state» «address.postalcode»

Jurisdiction: «claim.Jurisdiction.statename»

State Claim Number: «claim.wcisnumber»

Claim #: «claim.claimnumber»

Case #: «Id»

Patient Name: «claim.patient.FullName»

Provider(s): «physician.FullName»

Date RFA was First Received: «receivedbyclienttimestamp_string»

Date information/exam/consultation requested:

Manner request was made:

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Broadspire, as the delegated agent for the insurer, has reviewed the prescribed plan of treatment.

Treatment Requested:

«requestedtreatmentplan_without_dates»

Determination:

«authorizedtreatmentplan»

Rationale:

«clinical_rationale»

Evidence Based Guidelines Used:

«guidelines»

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 «claim.examiner.FullName» at «claim.examiner.telephone». However, if you are represented by an attorney, please contact your attorney instead of me.

Broadspire internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

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 you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR, within the time frame indicated on the last page of the application. Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Broadspire's utilization process complies with Section 4610 of the California Labor Code.

In accordance with section 9792.9.5(e)(14) of the California Utilization Review Standards, Broadspire Utilization Management's physician reviewers are available via telephone at 800-800-7660 (select Option 4), Monday through Friday from 8am to 5:30pm Pacific time.

You may request an internal appeal of this determination by calling 1-800-800-7660 or faxing your request to 770-777-6447 within 10 days of receipt of the UR decision. If you appeal, the treatment may be reviewed by another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice. The internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

Enclosed in mailed letters: Application for Independent Medical Review, DWC Form IMR and envelope addressed to Maximus Federal Services Inc

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«signoff_user.FullName»

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«address.city» «address.state» «address.postalcode»

Jurisdiction: «claim.Jurisdiction.statename»

State Claim Number: «claim.wcisnumber»

Claim #: «claim.claimnumber»

Case #: «Id»

Patient Name: «claim.patient.FullName»

Provider(s): «physician.FullName»

Date RFA was First Received: «receivedbyclienttimestamp_string»

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Evidence Based Guidelines Used:

«guidelines»

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 «claim.examiner.FullName» at «claim.examiner.telephone». However, if you are represented by an attorney, please contact your attorney instead of me.

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.

Broadspire internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application. Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Broadspire's utilization process complies with Section 4610 of the California Labor Code.

In accordance with section 9792.9.5(e)(14) of the California Utilization Review Standards, Broadspire Utilization Management's physician reviewers are available via telephone at 800-800-7660 (select Option 4), Monday through Friday from 8am to 5:30pm Pacific time.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative, or your attorney on behalf of you on the enclosed Application for Independent Medical Review, DWC form IMR within thirty (30) days from the mailing date of the written determination letter informing you that the medical treatment requested by your treating physician was denied or modified.

«signoff_user.FullQualifiedPathOfSignatur»

«signoff_user.FullName»

«signoff_user.StateLicensesDisplayString»

«signoff_user.BoardCertificationDisplaySt»

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«CC»

Your opinion matters to us please take the survey via web link <https://www.surveymonkey.com/r/URcustomersurvey> or scan the QR code below on your smartphone.



CA UR License # 006

CA MPN # 2399

URAC Certification # WUM010034

URAC Certification # WUM010034-2



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

Jurisdiction: «claim.Jurisdiction.statename»

State Claim Number: «claim.wcisnumber»

Claim #: «claim.claimnumber»

Case #: «Id»

Patient Name: «claim.patient.FullName»

Provider(s): «physician.FullName»

Date RFA was First Received: «receivedbyclienttimestamp_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Broadspire, as the delegated agent for the insurer, has reviewed your request for a «AppealType» appeal and the prescribed plan of treatment.

Treatment Requested:

«requestedtreatmentplan_without_dates»

Determination:

«authorizedtreatmentplan»

Rationale:

«clinical_rationale»

Evidence Based Guidelines Used:

«guidelines»

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Jurisdiction: «claim.Jurisdiction.statename»

State Claim Number: «claim.wcisnumber»

Claim #: «claim.claimnumber»

Case #: «Id»

Patient Name: «claim.patient.FullName»

Provider(s): «physician.FullName»

Date RFA was First Received: «receivedbyclienttimestamp_string»

Date information/exam/consultation requested:

Manner request was made:

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Broadspire, as the delegated agent for the insurer, has reviewed the prescribed plan of treatment.

Treatment Requested:

«requestedtreatmentplan_without_dates»

Determination:

«authorizedtreatmentplan»

The request for authorization may include non-drug treatment exempted under section 9792.9.7 and/or a drug(s) Exempt per MTUS Drug Formulary.

While the medical necessity of the requested treatment or service may have been established, generic substitution must be used when clinically appropriate, jurisdictionally mandated, and/or negotiated within the provider network unless specifically stated in the request for authorization "Dispense as Written" or "Do not Substitute".

Rationale:

«clinical_rationale»

Evidence Based Guidelines Used:

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You may request an internal appeal of this determination by calling 1-800-800-7660 or faxing your request to 770-777-6447 within 10 days of receipt of the UR decision. If you appeal, the treatment may be reviewed by another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice. The internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

Enclosed in mailed letters: Application for Independent Medical Review, DWC Form IMR and envelope addressed to Maximus Federal Services Inc

«signoff_user.FullQualifiedPathOfSignatur»

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Provider(s): «physician.FullName»

Date RFA was First Received: «receivedbyclienttimestamp_string»

Date information/exam/consultation requested:

Manner request was made:

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Broadspire, as the delegated agent for the insurer, has reviewed your request to reconsider the prescribed plan of treatment.

Treatment Requested:

«requestedtreatmentplan_without_dates»

Determination:

«authorizedtreatmentplan»

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Rationale:

«clinical_rationale»

Evidence Based Guidelines Used:

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Client Pgm Name
AEROTEST, INC.
AGRILINK-DEAN FOODS VEGETABLE COMPANY RUNOFF PROG.
ASPLUNDH TREE EXPERT COMPANY (S/I)
Ball Corporation - Takeover (SI)
Ball Corporation - WC - XL Excess Carrier (SI)
Ball Corporation - WC (SI)
BASHAS' INC.-TAKEOVER (SI)
BELO/PRESS (SI)
BENETO INC.
CHEVRON CORPORATION
Chevron Stations WC - COCO (SI)
City of Chico - T/O (SI)
City of Chico (SI)
COCA-COLA ENTERPRISES INC.
COCA-COLA ENTERPRISES INC. (SI)
Contract Freighters, Inc. (SI)
COX COMMUNICATIONS, INC.
CUBIC CORPORATION (S/I)
Davey Tree Expert Company - CA, NC, MN, PA (SI)
Davey Tree Expert Company -CA, NC, MN, PA T/O (SI)
DEL MONTE CORPORATION (SELF INSURED W/C)
Delaware North Co - T/O (SI)
DIEBOLD, INC. SELF-INSURED PROGRAM
DOW CHEMICAL COMPANY, THE (S/I WC)
E. & J. Gallo Winery - CA (SI)
E. & J. Gallo Winery - T/O (SI)
E.I. DUPONT #28106 TO CHEMOURS (SI)
E.I. DuPont De Nemours & Co. TPA SI i Corteva
Eagle Marine Services - T/O (SI)
Employers Insurance Nevada - Subro (IN-ECI)
FMC CORPORATION (CALIFORNIA CASUALTY)
FMC CORPORATION (S/I)
GKN PLC (S/I - PRE-CONTRACT TAKEOVERS ONLY)
GKN PLC (S/I WC)
HCA HEALTHCARE (NEVADA)
HEALTH TRUST, INC.
HERC RENTALS INC. - T/O (SI)
INDIANAPOLIS COLTS, INC. (S/I)
INVALID CLIENT PROGRAM NUMBER - LFMS
J. H. BAXTER & COMPANY
JEFFERSON SMURFIT CORPORATION (S/I)
JELD-WEN, INC. (S/I WC)
JOHN BEAN TECHNOLOGIES CORPORATION
KAISER ALUMINUM (SELF-INSURED)
KAISER CEMENT - CAL
Kiewit - WC AOS (SI)
Kiewit - WC AOS T/O (SI)
Lithia & Driveway - T/O (SI)
MACANDREWS & FORBES HOLDINGS, INC.
MARKSTEIN BEVERAGE COMPANY
MEDIA SERVICES, INC-TAKEOVER (SI)

MONDELEZ (IMIC- 1/1/76-12/31/81)
MONDELEZ INTERNATIONAL, INC.
MV TRANSPORTATION, INC. (SI)
NORTHWEST AIRLINES, INC.
PENN Entertainment - CCSI T/O WC (SI)
PINKERTON SECURITY & INVE (WC, EML, GL)
Preferred Operator Group - Late Rpt No Coverage
Promedica Health System - Late Reported (SI)
Promedica Health System - T/O (SI)
Promedica Health System - WC CA (SI)
ROCKTENN (S/I)
ROMAN CATHOLIC BISHOP OF FRESNO (SI)
RYDER SERVICES CORPORATION (SI)
SEA-LAND SERVICE, INCORPORATED & CSX CORPORATION
SEARS MERCHANDISE
SIMPSON PAPER COMPANY
SMURFIT KAPPA PACKAGING, LLC (SI)
SMURFIT-STONE CONTAINER CORPORATION (TAKEOVERS ONL
STERIS (OHIO PROGRAM)
STONE CONTAINER CORPORATION (S/I)
TEXTRON INC - TAKEOVER
TEXTRON INC.
The Arc of San Diego (SI)
THE BEKINS COMPANY (WC - 1959 TO 1983)
THE FLYING TIGER LINE INC.
The Pennant Group Inc - CALI SIP - (SI)
THE PILLSBURY COMPANY
T-Mobile US, Inc. - Oversight WA (SI)
U.S. FOODSERVICE RUN-OFF
UNILEVER USA - SELF-INSURED STATES (APD, ELS, WC)
UNITED STATES STEEL CORP (SI)
UNITED STATES STEEL CORP-TAKEOVER (SI)
USAIR, INC.
Veolia North America, Inc. - T/O (SI)
Vulcan USC T/O CA (SI)
WESTROCK COMPANY (SI)

Carrier Name
ACE
AIG
ALLIED WORLD ASSUR
AMERICAN CONTRACTORS INSURANCE GROUP
AMERIPRISE FIN GRP
ARCH INS GROUP
ARGONAUT
CHUBB INSURANCE
CINCINNATI FINANCIAL CORP
CITIGROUP
CNA INSURANCE GROUP
DISCOVERRE
EMPLOYERS HOLDINGS GRP
EVEREST REINS HOLDINGS GRP
FAIRFAX FINANCIAL HOLDINGS
FARMERS INS GRP
HARCO
LIBERTY MUTUAL INSURANCE
LUMBERMENS MUTUAL CASUALTY
MARKEL CORP
NATIONWIDE MUTUAL INS CO
OLD REPUBLIC
QBE INS GRP
RELIANCE
SAFETY NATIONAL
SAMSUNG FIRE AND MARINE
SCORRE
SELECTIVE INS GRP
SELF INSURED BUSINESS
SERVICE INSURANCE HOLDINGS, INC.
SOMPO HOLDINGS
ST PAUL/TRAVELERS
STARR GROUP
SWISS RE
THE HARTFORD FIRE & CASUALTY GROUP
THE TRAVELERS GRP
WR BERKLEY CORP GRP
XL INSURANCE COMPANY
ZENITH INS CO
ZURICH INS GRP



CERTIFICATE OF AWARD

in recognition of

**Broadspire Services, Inc.
5335 Triangle Parkway NW
Atlanta, Georgia 30092**

for compliance with

**Workers' Compensation Utilization Management 8.1
Accreditation Program**

is awarded

Full Accreditation

Effective from 05/01/2025 through 05/01/2028

A handwritten signature in black ink that reads "Shawn Griffin MD".

Shawn Griffin, MD
President & Chief Executive Officer

Certificate Number: WUM010034



URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation. URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.



CERTIFICATE OF AWARD

in recognition of

Broadspire Services, Inc.

1391 NW 136th Ave

Sunrise, Florida 33323

For compliance with

**Workers' Compensation Utilization Management 8.1
Accreditation Program**

is awarded

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Effective from 05/01/2025 through 05/01/2028

Shawn Griffin, MD
President & Chief Executive Officer

Certificate Number: WUM010034-1



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CERTIFICATE OF AWARD

in recognition of

**Crawford & Company, Broadspire - Global Business Center
247 McKinley Bldg 27th Street Corner 7th Avenue
Metro Manila, Philippines, 1534**

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Accreditation Program**

is awarded

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Shawn Griffin, MD
President & Chief Executive Officer

Certificate Number: WUM010034-2



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CERTIFICATE OF AWARD

in recognition of

**Broadspire Services, Inc.
5335 Triangle Parkway NW
Atlanta, Georgia 30092**

for compliance with

**Independent Review Organization Accreditation 6.0: Internal Review
Accreditation Program
with Opioid Stewardship Designation**

is awarded

Full Accreditation

Effective from 05/01/2025 through 05/01/2028

A handwritten signature in black ink that reads "Shawn Griffin MD".

Shawn Griffin, MD
President & Chief Executive Officer

Certificate Number: IRI010008



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Sunrise, Florida 33323

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Certificate Number: IRI010008-1



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