AmTrust North America
An AmTrust Financial Company

CALIFORNIA
UTILIZATION REVIEW PLAN

Utilization Review ("UR") Plan

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I. Definitions[1]

American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines ("ACOEM"): guidelines containing evidence-based medical treatment guidelines for conditions commonly associated with the workplace; can be accessed via www.acoem.org.

Administrative Director: the Administrative Director of the California Division of Workers' Compensation (DWC).

Administrative Staff: non-clinical staff including managed care assistants who support the initial phase of Level 1 UR and perform clerical duties, as directed by clinical staff members.

Approve (or Approval): a determination that a specific course of proposed medical treatment is medically necessary.

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.

Business Day: day(s) of the week not including Saturday, Sunday, or any day that is declared by the Governor of California to be an official state holiday or holiday listed on the Department of Human Resources internet website per California Labor Code §4600.4(b) and §9 of the Civil Code. This term has the same meaning as "Normal Business Day" or "Working Day."

Calendar Day: day(s) of the week including Saturdays, Sundays and days declared as holidays.

Claims Administrator: AmTrust North America, Inc. on behalf of itself and its U.S. workers' compensation insurers (collectively, "AmTrust") and any independent review organization under contract to conduct AmTrust's UR responsibilities.

Concurrent Review: UR conducted during an inpatient hospital stay.

Deny (or Denial): a decision by a physician reviewer that the requested treatment or service is not authorized.

Dispute Liability: an assertion by AmTrust that a factual, medical, or legal basis exists, other than medical necessity, which precludes compensability on the part of AmTrust for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.

Disputed Medical Treatment: medical treatment that has been modified or denied by a utilization review decision.

[1] Definitions herein are in accordance with Title 8 of the California Code of Regulations, Article 5.5.1. and California Labor Code § 4610

Emergency Health Care Services: health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

Expedited Review: UR or Independent Medical Review (IMR) 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.

Health Care Provider: 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 (MPN) as provided in Labor Code § 4616.

Immediately: within one (1) business day.

Independent Review Organization (IRO): independent organization accredited by the Utilization Review Accreditation Commission (URAC) that is under contract with AmTrust to provide initial clinical review (as needed) and conduct physician review (second level clinical review) services. AmTrust's contracted, URAC-accredited IRO's are listed in Section III. of this Plan.

Initial Clinical Review: a review conducted by an initial clinical reviewer (non-physician reviewer) of a treatment request and supporting documentation against clinical review criteria to render a determination to approve the request, issue a request for additional information, or escalate to second level review (physician review).

Internal Appeal: a voluntary process, pursuant to §9792.10.1(f), that may be pursued on an optional basis to conduct an internal utilization review appeal of an original UR decision to modify or deny requested treatment, provided the injured worker and, if the injured worker is represented by counsel, the injured worker's attorney, have been notified of the timeframes in which to file an application for independent medical review, pursuant to §9792.10.1(a).

Material Modification: when the claims administrator changes utilization review vendor(s); makes a change to the utilization review standards as specific in section 9792.7; or changes its Medical Director, address, company name or corporate structure.

Medical Director: 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 and is responsible for all decisions made in the UR process. AmTrust's medical director is designated in Section III. Overview.

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

Medical Necessity/Medically Necessary: medical treatment or services reasonably required to cure or relieve the injured worker of the effects of his or her work-related injury or illness as consistent with the MTUS, including the drug formulary (medication), adopted by the administrative director.

Medical Services: goods and services provided in accordance with Article 2 (commencing with Labor Code § 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

Medical Treatment Utilization Schedule (MTUS): the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2, beginning with section 9792.20. MTUS recommendations are presumptively correct on the issue of extent and scope of medical treatment.

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

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

Non-Physician Reviewer: an individual designated by the claims administrator or utilization review organization to conduct initial clinical review to assist in determining the medical necessity of requested treatment. A non-physician reviewer may not modify or deny a treatment request. At AmTrust, the terms "Initial Clinical Reviewer" or "Clinical Review Nurse" have the same meaning as "Non-Physician Reviewer."

Official Disability Guidelines ("ODG"): medical treatment and return-to-work guidelines and drug formulary for workers' compensation combining evidence-based medical literature ("evidence-based medicine") with claims data analytics. Used as a secondary guideline source when conducting utilization review on California requests for authorization, including but not limited to, scenarios where the treatment request or condition under review is not addressed by MTUS.

Physician Reviewer(s): 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 physician reviewer's practice. The term "clinical peer reviewer" has the same meaning as physician reviewer within AmTrust's UR program.

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

Request for Authorization (RFA): a written request for a specific course of proposed medical treatment that meets all of the following criteria:

- Set forth on a completed "Request for Authorization (DWC Form RFA[2])", unless accepted by the claims administrator under section 9792.9.1(b)
- Signed by the treating physician in compliance with §9792.6.1(u)(3). By agreement of the

[2] The current DWC Form RFA can be found online at https://www.dir.ca.gov/dwc/forms.html.

parties, the treating physician may submit the request for authorization with an electronic signature.

- "Completed," for the purpose of this section and for purposes of investigations and penalties, means that the RFA must identify 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 thirty (30) calendar 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.
- The request for authorization may be mailed, faxed, or sent electronically by encrypted email in accordance with section 9792.6.1(u)(3) to the address, fax number or email address designated by the claims administrator under section 9781(d)(5) for this purpose. AmTrust does not utilize an electronic data interchange (EDI) or clearinghouse for purposes of receiving requests for authorization. AmTrust's designated points of entry for submission of requests for authorization can be found in Section IV. Subsection C. of this Plan.

Retrospective Review: UR conducted after medical services have been provided, and for which approval has not already been given.

Second Level Review: a review conducted by a clinical peer reviewer (physician reviewer) employed or under contract with AmTrust's contracted, URAC-accredited IRO, where the treatment request could not be approved at initial clinical review. A second level review may result in a need for additional information, or may result in a UR decision to approve, modify or deny the requested treatment. Decisions to modify or deny requested treatment may only be rendered by clinical peer reviewers.

URAC: 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.

UR Decision: decision pursuant to Labor Code §4610 to approve, modify, or deny a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code §§ 4600 or 5402(c) or a determination by a physician regarding the medical necessity of medication prescribed pursuant to the drug formulary adopted by Labor Code §5307.27.

UR Staff: personnel responsible for supporting the UR process; includes administrative staff, non-physician reviewers (e.g., Initial Clinical Reviewers or Clinical Review Nurses), medical director, physician reviewers (employed by AmTrust's contracted IRO), and UR manager(s).

UR Plan: Written plan filed with the administrative director pursuant to Labor Code §4610, setting forth the policies and procedures, and a description of the UR process.

UR Process: utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code §3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code §4600. The UR process begins when the completed DWC Form RFA, or an RFA accepted as complete under §9792.9.1(b), is first received by AmTrust.

Written: 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.

II. Roles, Responsibilities, and Oversight

A. The oversight process ensures all UR decisions are completed in accordance with §§ 9792.6.1 - 9792.15 of Title 8, California Code of Regulations, involve review of all necessary medical records, and guarantee proper retention of documentation for AmTrust's records.

B. Role Descriptions:

i. Vice President (VP) – Claims Managed Care
- Responsible for overall Managed Care program including medical case management, UR, and quality assurance within the workers' compensation claim department

ii. Director – Utilization Review
- Responsible for development, implementation, and compliance with AmTrust's Utilization Review plan within the workers' compensation claims department

iii. Medical Director
- Responsible for consultation to AmTrust UR staff in design and development of a robust and high-impact UR plan including process flows, training materials, training sessions (telephonic and in-person webinars)
- Oversee communication with health care providers to negotiate and authorize appropriate treatment plans
- Review of IRO treatment guidelines and make recommendations regarding applicability to AmTrust UR best practices and workflows
- Conduct quality assurance reviews of AmTrust-contracted clinical peer reviewers
- Unrestricted physician licensed by the Medical Board of California
- Board certified in Occupational Medicine with experience in UR and case management
- Working knowledge and understanding of the application of MTUS and other evidence-based guidelines in UR including, but not limited to, ACOEM or ODG
- 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 §4610 and the Utilization Review Standards within Title 8 CCR, pursuant to § 9792.7(b)(1)

iv. Director – Managed Care
- Responsible for development, implementation, and compliance with AmTrust's case management program within the workers' compensation claims department

v. Manager – UR
- Responsible for coaching, mentoring, and training Clinical Review Nurses, and monitoring productivity and compliance with all UR best practices and procedures
- Certified medical professional

vi. Manager –Utilization Review Operations
- Responsible for supporting the Director of Utilization Review in the development and implementation of the internal Utilization Review program

vii. Clerical Supervisor, Operations

- Responsible for monitoring and managing the daily RFA processing workload, workflows, and productivity of the Managed Care Claim Assistants Non-clinical administrative manager

viii. Initial Clinical Reviewer

- A non-physician reviewer, licensed as a health professional in a state or territory of the United States, responsible for conducting Level 1 medical necessity reviews including approvals and requests for additional information of the RFA's received by AmTrust
- The initial clinical reviewer does not issue modifications or denial determinations. If unable to approve at initial level review, the initial clinical reviewer must refer the RFA for review by a clinical peer reviewer with AmTrust's contracted IROs
- May issue deferral notices due to reasons other than medical necessity pursuant to Labor Code §4610(k) and §9792.9.2 at the direction of the claim adjuster
- May issue notice that a request for authorization is not complete, pursuant to §9792.9.1(b)
- The term "clinical review nurse" has the same meaning as initial clinical reviewer within AmTrust's UR program

ix. Managed Care Claim Assistant

- A non-clinical staff member, responsible for screening and data entry of incoming RFA's and assignment to the Initial Clinical Reviewer. The Managed Care Claim Assistant is not involved in the clinical aspects of conducting utilization review
- May issue deferral notices due to reasons other than medical necessity pursuant to Labor Code §4610(k) and §9792.9.2 at the direction of the claim adjuster
- May issue administrative approval notices to approve treatment based on structured screening criteria, or to approve non-drug treatment that is exempt from utilization review under §9792.9.7 and in compliance with the notice requirements of §9792.9.4

x. Managed Care Quality Assurance and Quality Control Committee (QAQC)

- Responsible for identifying problems, responding to trends, discussing solutions for identified Utilization Review plan deficiencies and ensuring compliance with applicable regulations
- Meets quarterly
- Committee Members: Medical Director, UR Director, UR Managers, AmTrust's designated regulatory staff, and select legal members

xi. URO

- Responsible for the oversight of vended services and vendor's compliance with applicable regulations and timeframes

xii. IRO

- URAC-accredited review organization under contract with AmTrust to provide overflow Level 1 review (as needed) and performs all Level 2 and appeal level reviews
- IRO clinical peer reviewers have the ability to non-certify UR requests that do not meet clinical review criteria following Level 1 review
- IRO clinical peer reviewers are available at a minimum of four (4) hours per week during normal business hours.

III. Overview

AmTrust as claims administrator establishes this policy as a Utilization Review Organization (URO) to determine the appropriateness of completed, proposed, or requested medical services and/or procedures for workers' compensation claimants.

AmTrust's UR Program does not issue modified or denied UR decisions on the basis of medical necessity. AmTrust's UR staff issue approvals, UR deferrals due to disputes of liability, notices of RFAs deemed as not complete, or requests for additional information and identifies cases that would benefit from, or require, Level 2 review and defers these cases to AmTrust's contracted, URAC-accredited IRO's.

AmTrust strives to work collaboratively with health care providers to certify care that is consistent with the MTUS, and other applicable guidelines including, but not limited to, ACOEM or ODG. Each injured worker's medical treatment is evaluated on an individual basis related to their diagnosis and the receipt of a complete RFA outlining requesting provider, employee, proposed treatment, and medical care with appropriate supporting documentation.

AmTrust intends to perform UR at the highest industry standards to:

- assure appropriate medical care is provided in the appropriate setting consistent with adopted treatment guidelines
- assess the level of medical services provided, the duration of such services, and the continued need for treatment
- identify potential alternative treatment plans, settings, and modalities, and avoid medically unnecessary treatment
- assist in timely discharge planning; and
- identify and escalate cases that require Level 2 review

AmTrust's Medical Director:

Alan E. Randle, MD
Board Certified in Occupational Medicine
1655 Grant St, 6th Floor
Concord, CA 94520
Medical License # G27961
(888) 488-3241

AmTrust's Contracted IROs:

Arbicare, LLC
1175 Peachtree Street
NE Suite 1000
Atlanta, GA, 30361

Genex Services, LLC
440 E Swedesford Rd
Suite 1000
Wayne, PA, 19087

IV. Accessibility

A. Health Care Provider Access to UR Staff**:**

UR staff is available between the hours of 9:00 A.M. and 5:30 P.M. Pacific Time each business day and is accessible by toll-free telephone number 888-488-3241, by e-mail, or by facsimile.

B. After Hours Protocols:

After 5:30 P.M. Pacific Time or on non-business days, telephone callers will hear a pre-recorded message with the following information:

i. Normal hours of operation
ii. Information on how to submit a written RFA
iii. That, in the event of an emergency, the caller should seek and/or provide necessary medical care and contact AmTrust on the next business day
iv. Disclaimer that any provided treatment will be subject to applicable UR
v. That, if the caller elects to leave a message, they can expect a return call before the end of the next business day.

C. Dedicated Points of Entry for RFAs: AmTrust has dedicated points of entry for submission of requests for authorization (RFA). If the RFA is received by AmTrust outside of the dedicated points of entry, the request is re-directed to the UR department.

Health care providers should submit a complete RFA via e-mail, facsimile, or postal mail to one of the following points of entry:

E-mail:	CaliforniaRFA@amtrustgroup.com
Facsimile:	+1 (888) 941-4218
Postal Mail:	AmTrust North America, Inc. P.O. Box 6717 Cleveland, OH 44101

D. Health Care Provider Outreach:

In the event that UR staff needs to contact health care providers, UR staff will attempt to contact during normal business hours, unless otherwise indicated by the health care provider.

E. Request by the Public:

Upon request, AmTrust will make the UR plan electronically available to the public. If a hard copy is requested, AmTrust may charge reasonable copying and postage expenses to provide the UR plan. Such charge shall not exceed $0.25 per page plus actual postage costs.

V. Request for Authorization (RFA)

A. Determination of the Date of RFA Receipt:

Mode of transmission	Date of receipt
RFA received by mail	If received by regular mail: deemed to have been received on the date stamped as received by AmTrust; if there is no date stamped by AmTrust deemed to have been received by AmTrust **five (5) business days after the latest date sender wrote the document.** If received by certified mail: deemed to have been received on the receipt date entered on the return receipt. If received with a proof of service by mail: deemed to have been received **five (5) business days after the deposit in the mail** at a facility regularly maintained by the United States Postal Service.
RFA transmitted by electronic mail	• Deemed to have been received **on the date the RFA was received** if the receiving electronic mail address electronically date stamps the transmission when received. If there is no electronic stamp date recorded, then the date the form was transmitted is deemed the date AmTrust received the form. • Deemed received by AmTrust **the following business day** if the RFA is (i) transmitted after 5:30 PM Pacific Time, or (ii) received on a non-business day, unless the request is for an expedited or concurrent review.
RFA transmitted by facsimile	• Deemed to have been received **on the date the RFA was received** if the receiving facsimile address electronically date stamps the transmission when received. If there is no electronic stamp date recorded, then the date the form was transmitted is deemed the date AmTrust received the form. • Deemed received by AmTrust **the following business day** if the RFA is (i) transmitted after 5:30 PM Pacific Time, or (ii) received on a non-business day, unless the request is for an expedited or concurrent review.

B. Alternate Form of RFA: AmTrust may, in its discretion, accept an alternate form of RFA containing all the following:
   i. "Request for Authorization" is clearly written at the top of the first page;
   ii. All requested medical services are listed on the first page; and
   iii. Request is accompanied by documentation substantiating the medical necessity for the requested treatment.

C. Utilization Review of Medical Treatment in First 30 Days of the Date of Injury

   i. Pursuant to §9792.9.7, a treating physician specified in Labor Code §4610(b) may render medically necessary treatment or services to an injured worker without prospective utilization review for the first thirty (30) calendar days after the date of injury, provided that:
      a. The treatment or service is for a body part or condition that has been accepted as compensable by the claims administrator
      b. The treatment or service is consistent with the recommendations set forth in the

applicable guideline of the medical treatment utilization schedule (MTUS)

c. The initial treating physician timely submits the “Doctor’s First Report of Occupational Injury or Illness,” DIR Form 5021, to the claims administrator as required by §9785(e), setting forth in detail the anticipated treatment plan for the injured worker.
d. 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 RFA provided to the claims administrator in accordance with section 9785(h). The form shall be submitted to the claims 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
e. 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

ii. Pursuant to §9792.9.7(b), the following medical treatment services, unless previously authorized by the claims administrator or rendered as emergency medical treatment, are not exempt from utilization review under §9792.9.7(a) and shall require prospective utilization review:

a. Pharmaceuticals, to the extent they are not expressly exempt from prospective review under the MTUS Drug Formulary
b. Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician’s office. This includes all necessary and routine pre-operative, intra-operative, and post-operative services performed for the purpose of surgery including, but not limited to, related diagnostic tests or procedures, rehabilitation services, durable medical equipment or supplies, and routine post-surgical pain management treatment or services. For the purpose of this section, "surgery" means: 1) any procedure set forth in the Surgery section of the American Medical Association’s *Current Procedural Terminology (CPT®)* which is incorporated by reference at section 9789.31(h), and any updates pursuant to section 9789.36; or 2) any procedure code defined as “surgery” in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule found in the Healthcare Common Procedure Coding System (HCPCS), which is incorporated by reference at section 9789.31(i), and any updates pursuant to section 9789.36
c. 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
d. Home health care services, including health care and other medically necessary services provided to the injured worker in the residential setting
e. Imaging and radiology services, excluding X-rays
f. 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

g. Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies. For the purpose of the subdivision, electrodiagnostic medicine is a medical specialty where the physician uses neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic, neuromuscular, and/or muscular systems. This includes, but is not limited to, procedures set forth in the American Medical Association's *Current Procedural Terminology (CPT®)* Medicine section, under the subheading "Neurology and Neuromuscular Procedures," and any test that measures the speed and degree of electrical activity in the muscles and nerves in order to make a diagnosis
h. Spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections

VI. RFA Response Timeframes Based on Type of Review

NON-EXPEDITED REVIEW OF RFA	
RFA Type	**Mandatory Timeframes for Claims Administrator Response**
Prospective Review	**Five (5) business days** from the date of receipt of the complete RFA or accepted alternate form of submission, and supporting documentation reasonably necessary to make the determination, but, in the event that additional information is requested under §9792.9.6 (a-d) no more than fourteen (14) calendar days from initial receipt of the complete RFA. For RFAs pursuant to the drug formulary for non- exempt drugs, a UR decision must be made within five (5) business days from receipt of the complete RFA.
Concurrent Review	**Five (5) business days** from the date of receipt of the complete RFA or accepted alternate form of submission, and supporting documentation reasonably necessary to make the determination, but, in the event that additional information is requested under §9792.9.6 (a-d) no more than fourteen (14) calendar days from initial receipt of the complete RFA. For RFAs pursuant to the drug formulary for non- exempt drugs, a UR decision must be made within five (5) business days from receipt of the complete RFA.
Retrospective Review	**Within thirty (30) days** of receipt of the complete RFA, or accepted alternate form of submission, and supporting documentation reasonably necessary to make the determination.

EXPEDITED REVIEW OF RFA Requesting physician must certify in writing and document the need for an expedited review	
RFA Type	**Mandatory Timeframes for Claims Administrator Response**
Prospective Review	**Not to exceed 72 hours** after receipt of the complete RFA, accepted alternate form of submission, or written information reasonably necessary to make the determination if additional information is requested under §9792.9.6 (a-d).
Concurrent Review	**Not to exceed 72 hours** after receipt of the complete RFA, accepted alternate form of submission, or written information reasonably necessary to make the determination if additional information is requested under §9792.9.6 (a-d).

AmTrust's system automatically generates the appropriate due date in accordance with the RFA response timeframes in the above charts.

In accordance with §9792.9.3(c), if the requesting provider fails to certify in writing and document the need for an expedited review upon submission of the RFA, and where the RFA 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 UR would be detrimental to the injured worker's condition, then such finding will be documented and the review will be completed within the timeframe for a non-expedited prospective or concurrent review, whichever is applicable to the RFA.

AmTrust cannot refuse to pay for medical services on the basis that the requesting health care provider did not obtain prior authorization for emergency health care services. Such services may be subject to retrospective review. Documentation for emergency health care services must be made available to AmTrust upon request.

In accordance with §9792.9.5(f)(1), medical care shall not be discontinued with regards to a concurrent review 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.

VII. UR Deferral - Dispute of Liability:

A. UR of an RFA may be deferred by AmTrust if it disputes liability for either the occupational injury for which treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

B. In the event of a dispute of liability, AmTrust will issue a written decision deferring UR of the requested treatment with an explanation for the deferral no later than five (5) business days from receipt of the RFA. If the requesting physician has been previously notified of such dispute of liability and an explanation for the deferral of utilization review for a specific course of treatment in accordance with §9792.9.2(b), no additional written communication is required.

C. In accordance with §9792.9.2(a)(2)(B), if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change. 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. AmTrust will send the RFA to a contracted IRO for Level 2 review.

D. The written decision in accordance with the information requirements listed in §9792.9.2(b) see Schedule B) must be sent to the requesting physician, the injured worker, and the injured worker's attorney (if applicable).

E. If UR is deferred, and it is ultimately determined that AmTrust is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, AmTrust will commence retrospective review on the date the determination of the AmTrust's liability becomes final. The time for AmTrust to conduct prospective review shall commence from the date of AmTrust's receipt of an RFA after the final determination of liability.

VIII. Requests for Additional Information

A. If additional information is needed for a determination of medical necessity, such information must be requested in accordance with §9792.9.6 (b) (1) or (2), or §9792.9.8(b)(1)(A), whichever is applicable. Except for RFAs requesting only drug treatment where at least one of the drugs is classified as Non-Exempt on the MTUS Drug List pursuant to §9792.9.8(b), the timeframe for decisions may be extended under one or more of the following circumstances:

TIMEFRAME EXTENSION	
Circumstance	**Mandatory Timeframes for Claims Administrator Response**
The Initial Clinical Reviewer is not in receipt of all information reasonably necessary to make a determination.	**Submission of Requests for Additional Information**: (1) For **non-drug formulary requests or requests that include both drug and non-drug treatment**, the Initial Clinical Reviewer shall request the information from the requesting physician within **five (5) business days** from the date of receipt of the RFA in accordance with §9792.9.6(b)(1) by sending the letter titled "AmTrust – Request for Additional Information" (see Schedule D) (2) For RFAs requesting **drug-only treatment** subject to utilization review under §9792.9.8(b), **pertaining to Non-Exempt Drugs on the MTUS Drug List**, the Initial Clinical Reviewer will request the information within **four (4) business days** from the date of receipt of the RFA by sending the "Request for Additional Information" letter (see Schedule D). The extension of time set forth in §9792.9.6 is not applicable to a request for authorization of a drug subject to §9792.9.8(b). **Once Requested Information is Received**: (1) For prospective or concurrent review, the Initial Clinical Reviewer shall make a decision to approve or escalate the RFA to a Level 2 reviewer for a determination to be rendered within five (5) business days of receipt of the requested information. (2) For retrospective review, the Initial Clinical Reviewer shall make a decision to approve or escalate the RFA to a Level 2 review for a final determination to be rendered within thirty (30) calendar days of receipt of the requested information. (3) For expedited review, the Initial Clinical Reviewer shall make a decision to approve or escalate the RFA to a Level 2 review for a final determination to be rendered within 72 hours of receipt of the requested information. (4) For **RFAs containing only drugs**, where at least one of the drugs is

	subject to §9792.9.8(b), pertaining to drugs **classified as Non-Exempt on the MTUS Drug List**, the Initial Clinical Reviewer shall make a decision to approve or escalate the RFA to a Level 2 review for a final determination to be rendered within **five (5) business days** from the date of receipt of the RFA. (5) For RFAs that contain **both non-exempt drug and non-pharmaceutical treatment**, the timeframes for response corresponds to the type of review (prospective, concurrent, retrospective or expedited) as defined in (1), (2) and (3) of this subsection. **If Requested Information is Not Received**: (1) Pursuant to §9792.9.6(c)(1), for **non-drug treatment requests, or for RFAs containing both drug and non-drug treatment**, if the requested information is not received within fourteen (14) calendar days from receipt of the RFA for prospective or concurrent review, or within thirty (30) calendar days from the date of the receipt of the RFA for retrospective review, the Initial Clinical Reviewer must escalate the request to a physician reviewer who shall deny the request in accordance with §9792.9.6(c)(1) and the written notification denying the request must comply with content requirements in §9792.9.5(e). (2) Pursuant to §9792.9.6(c)(2), if the results of the additional examination or test required under §9792.9.6(a)(1)(B), or the specialized consultation under §9792.9.6(a)(1)(C), and where the RFA is for **non-drug treatment, or where the RFA contains both drug and non-drug treatment**, is not received within thirty (30) calendar days from receipt of the RFA for prospective, concurrent or retrospective review, the Initial Clinical Reviewer must escalate the request to a physician reviewer who shall deny the request in accordance with §9792.9.6(c)(2) and the written notification denying the request must comply with content requirements in §9792.9.5(e). (3) Pursuant to §9792.9.8(b) relating to **drugs classified on the MTUS Drug List as Non-Exempt Drugs**, the extension of time set forth in §9792.9.6 is not applicable to an RFA of a Non-Exempt Drug. For RFAs that contain both non-exempt drug and non-pharmaceutical treatment, the extension of time set forth in section §9792.9.6 applies. (4) For RFAs containing **only drug treatment** where it includes one or more **non-exempt drugs**, if the information requested under §9792.9.8(b)(1)(A) is not received within **five (5) business days** from the date of receipt of the RFA, the RFA must be escalated to a physician reviewer who may deny the RFA in accordance with §9792.9.8(b)(1)(B) and the written notice requirements of §9792.9.5(e). (5) An RFA denied by a physician reviewer due to a failure to respond to a request for information within the required timeframes shall be reconsidered upon receipt of the requested information with a completed request for authorization (RFA).
The physician reviewer has asked for an additional examination or test to be performed upon the injured worker that is reasonably necessary to make a determination; or The physician reviewer needs a specialized consultation and review of medical information by an expert reviewer.	(1) AmTrust's Initial Clinical Reviewers do not make requests for additional information pursuant to §9792.9.6(a)(1)(B) or (C). (2) For RFAs escalated to a physician review where the physician reviewer requires additional information pursuant to §9792.9.6(a)(1)(B) or (C), AmTrust requires that the IRO's physician reviewer follows the procedures outlined in §9792.9.6(b), (c), and (d).

IX. UR Process

The criteria for UR decisions are:

- Developed with involvement from actively practicing physicians,
- Consistent with the MTUS,
- Evaluated for compliance with California law and regulations at least annually, and
- Disclosed to the requesting physician and the injured worker, if used as the basis of a decision to modify or deny services in a specified case under review.

Level 1:

A. Initial Screening: administrative staff screens and collects structured data from the RFA in accordance with the criteria below:
   i. Duplicate Submission: determine whether the RFA was previously submitted on the same form and request date, from the same requesting provider, based on the same date of service with an identical treatment request and identical medical documentation. In this circumstance, the RFA will be marked as a duplicate. AmTrust will not proceed with further review and is not required by law to communicate such status to the requesting physician.
   ii. Eligibility: determine whether the RFA involves a dispute of liability in accordance with Section VII.
      a. If there is a dispute of liability regarding the RFA, the administrative staff sends the letter titled "AmTrust – Disputed Liability" (template attached as Schedule B) to the requesting physician, the injured worker, and his or her legal representative (if applicable).
   iii. Medical Provider Network (MPN) Participation: Unless the non-participating provider is authorized to treat, AmTrust may defer RFAs received from providers that are not part of the AmTrust California MPN. The requesting provider will be informed with the letter titled "AmTrust – Disputed Liability" (template attached as Schedule B).
   iv. Completed:
      a. A complete RFA pursuant to §9792.6.1(u)(2) and (3) contains the following:
         1. Identification of injured worker
         2. Identification of requesting provider
         3. 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. Specificity means a narrative description of the recommended treatment and, as applicable to the specific request, includes quantity, frequency, dosage, and expected duration of treatment that is being requested
         4. Supporting documentation, issued or created no earlier than thirty (30) calendar days before the date of submission of the request for authorization, that substantiates need for the requested treatment
         5. Signature of requesting physician. Electronic signature of the requesting physician is accepted pursuant to §9792.6.1(u)(3).
      b. If the RFA is incomplete, the administrative staff or Initial Clinical Reviewer will return it to the requesting physician within five (5) business days of receipt with the letter titled "AmTrust – RFA Not Complete" (template attached as Schedule C) indicating the RFA is

"Not Complete" and articulating the reason(s) for return.

c. If the RFA is returned as incomplete, the timeframe for UR will start anew upon receipt of a complete RFA.

v. For retrospective or concurrent review: If the RFA is complete, there is no dispute of liability, and the request is from an MPN provider or non-participating provider that is authorized to treat, then the RFA is assigned to an Initial Clinical Reviewer.

vi. For prospective review: if the RFA is complete, there is no dispute of liability, and the request is from an MPN provider or non-participating provider that is authorized to treat, then the RFA is evaluated in accordance with Section IX. Level 1.B (Initial Clinical Review by Non-Physician Reviewer).

vii. If the top of the request for authorization indicates expedited review, then the administrative staff will communicate the priority status to the Initial Clinical Reviewer via AmTrust's system.

a. If the request for authorization indicates "Change of material facts," then the RFA will be escalated to Level 2 to be reviewed by a physician reviewer with contracted IRO.

B. Administrative Processing and Assignment for Initial Clinical Review

i. The administrative staff will determine if the RFA is received within thirty (30) days following the initial date of injury.

ii. If the RFA is submitted within the thirty (30) calendar days following the initial date of injury, then administrative staff will review each requested medical service to see if any of the requested treatments require prospective utilization review in accordance with section V.C.ii. of this Plan pertaining to treatment within the first thirty (30) days of injury.

iii. If the RFA contains any of the treatments that require prospective utilization review as outlined in section V.C.ii. of this Plan, or if the RFA is submitted after thirty (30) calendar days of the date of injury, the RFA is entered into the system by the administrative staff and the case is assigned to an Initial Clinical Reviewer.

iv. If the RFA is submitted within the first thirty (30) days of the date of injury, contains none of the treatments or services listed in section V.C.ii. of this Plan, is completed as defined in section IX.A.iv. of this Plan, does not warrant issuance of a deferral due to a dispute of liability, and the requesting provider is within the MPN or otherwise authorized to treat, the administrative staff will send the letter titled "AmTrust - Certification" (template attached as Schedule A) within five (5) business days of receipt of the RFA.

v. If the top of the RFA indicates expedited review, then the administrative staff will communicate the priority status to the Initial Clinical Reviewer via AmTrust's system.

C. Initial Clinical Reviewer Review Process:

i. If the Initial Clinical Reviewer determines that the RFA involves a dispute of liability, is a duplicate submission, involves a requesting provider that is outside of the MPN or not otherwise authorized to treat, or is not a complete RFA, then the Initial Clinical Reviewer will follow the applicable procedure in accordance with section IX.A. of this Plan.

ii. Repeat Request for Authorization:

a. Pursuant to §9792.9.5(g), a utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical

necessity shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

b. Where the requesting provider has provided information claiming to substantiate a material change in facts has occurred, the Initial Clinical Reviewer shall not interpret whether or not that claim is sufficient to substantiate a material change and must escalate the case to an IRO physician reviewer to make that determination, pursuant to §9792.9.2(a)(2)(B).

iii. Evaluation for Approval: The Initial Clinical Reviewer will review the submitted clinical information and request any additional information that will support the medical necessity of the request in accordance with §9792.9.6(a)(1)(A). The Initial Clinical Reviewer will review the RFA against MTUS (or other applicable medical treatment guidelines including, but not limited to, ACOEM or ODG) and will either:

a. Approve and communicate such approval within twenty-four (24) hours of the decision for concurrent or prospective review, or, for retrospective review within thirty (30) days of receipt of the RFA. Such communication will be with written notice to the requesting physician by facsimile or electronic mail as outlined in section X. of this Plan.

b. Refer the RFA to the IRO for Level 2 physician review, if unable to approve.

Level 2:

A. If the Initial Clinical Reviewer cannot approve the RFA, and the RFA is not subject to deferral, then the RFA is escalated to the IRO physician reviewer for Level 2 Review or internal appeal review, as applicable to the request.

B. AmTrust does not issue modified or denied determinations on the basis of medical necessity. Only physicians reviewers can deny or modify.

C. AmTrust requires that it's contracted IRO's maintain current URAC accreditation, comply with the utilization review provisions and timeframes of the California Labor Code and Article 5.5.1 Utilization Review Standards within Title 8, California Code of Regulations, and maintain a current California Utilization Review Plan approved by the Division of Workers' Compensation.

X. Written Utilization Review Notices

For utilization review determinations rendered by AmTrust staff, AmTrust issues written notifications as described in this section, as applicable to the type of review and determination outcome, and as shown in Schedules A, B, C, and D of this Plan.

For utilization review determinations rendered by AmTrust's contracted IRO physician reviewers, or for overflow first level review UR determinations issued by the IRO's initial clinical reviewers, the IRO issues their letter template in accordance with §9792.9.4, §9792.9.5, §9792.9.6, §9792.9.8, §9792.9.10,

and the IRO's approved California Utilization Review Plan.

A. Approval of Request for Authorization

i. Pursuant to §9792.9.4, 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 §9792.9.6(a)(1)(A), (B), or (C) was requested, and the date the information was received.

   a. 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.

   b. 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.

   c. For approvals of a request for authorization of non-drug treatment that are exempt under §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.

ii. Pursuant to §9792.9.4(b), 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 twenty-four (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 twenty-four (24) hours of the decision for concurrent review and within two (2) business days for prospective review.

iii. Pursuant to §9792.9.4(c), regarding approvals related to retrospective review:

   a. For retrospective review, a written decision to approve shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.

   b. Payment, or partial payment, of a medical bill for services requested on a request for authorization shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete. A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured employee who received the medical services, and his or her attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

iv. For approval determinations rendered by the AmTrust Initial Clinical Reviewer, AmTrust issues the "AmTrust – Certification Notice" (see Schedule A).

v. For approval determinations rendered by AmTrust's contracted IRO physician reviewers, or for overflow first level review approval determinations issued by the IRO's initial clinical reviewers, the IRO issues their approval letter template in accordance with §9792.9.4 and the IRO's approved California Utilization Review Plan.

B. Modification or Denial of a Request for Authorization

i. AmTrust's UR staff do not issue modified or denied utilization review determinations and, as such, does not issue written notices of modified or denied requests for authorization. Upon initial clinical review of a complete RFA that is not subject to UR deferral, if the Initial Clinical Reviewer cannot approve the request for authorization, the case is referred to AmTrust's contracted, URAC-accredited IROs to perform second level review or internal appeal review, as applicable to the request.

ii. Pursuant to §9792.9.5(c), 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 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.

iii. Pursuant to §9792.9.5(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.

iv. Pursuant to §9792.9.5(e)(1-14), the written decision modifying or denying treatment authorization, shall be provided to the requesting physician, the injured worker, and, if applicable, 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:

a. The date on which the completed or accepted request for authorization was first received.

b. 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.

c. The date on which the decision is made.

d. A description of the specific course of medical treatment set forth on the request for authorization.

e. A list of all medical records reviewed.

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

g. 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.

h. 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.

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

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

k. 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.

l. 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.

m. Include the following mandatory language advising the injured employee:
"You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me."

and

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

n. Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, including with respect to disputes over the necessity of or availability of the requested information, and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

o. 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.

C. UR Deferral - Dispute of Liability Notice

i. In accordance with §9792.9.2 and Labor Code section 4610(k), a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

ii. A claims administrator shall issue a written decision deferring utilization review of the requested treatment no later than five (5) business days from receipt of the request for authorization unless the requesting physician has been previously notified of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment.

a. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.

b. The written decision shall contain the following information specific to the request:

(1) The date on which the request for authorization was first received.
(2) A description of the specific course of proposed medical treatment for which authorization was requested.
(3) A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.
(4) A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.
(5) The following mandatory language advising the injured employee:

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

iii. For RFAs that require deferral under section VII. of this Plan, AmTrust's staff issue the "AmTrust – Disputed Liability" letter (see Schedule B).

D. RFA Not Complete Notice

i. A claims administrator or non-physician reviewer, pursuant to §9792.9.1(b), and according to the process outlined in section IX.A.iv. of this Plan, will mark the RFA "not complete" if the RFA does not meet the definition of a complete request for authorization under §9792.6.1(u), 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.

ii. For RFAs that are deemed "not complete," AmTrust's staff issue the "AmTrust – RFA Not Complete" letter, specifying the reasons for the return of the request (see Schedule C).

E. Request for Additional Information Notice

i. When the Initial Clinical Reviewer is not in receipt of all of the information reasonably necessary to make a determination pursuant to the process and timeframes outlined in section VIII. of this Plan and pursuant to §9792.9.6 and §9792.9.8 (pertaining to non-exempt drug requests), the Initial Clinical Reviewer must issue the "AmTrust – Request for Additional Information" letter, specifying the information needed (see Schedule D).

ii. For RFAs delegated for overflow initial clinical review to AmTrust's IROs, or for RFAs escalated to the IRO physician reviewer for second level review or internal appeal review, if the IRO reviewer determines that additional information is necessary to render a determination, the IRO issues their Request for Additional Information letter template, specifying the information needed, according to the procedures and timeframes in and §9792.9.6 and §9792.9.8 (pertaining to non-exempt drug requests), and in accordance with the IRO's approved California Utilization Review Plan.

XI. Voluntary Internal Utilization Review Appeal Process

AmTrust participates in the process of voluntary internal appeal outlined in §9792.10.1(f). Participation in the internal appeal process is voluntary and neither triggers nor bars use of the dispute resolution procedures of the Labor Code §4610.5 and §4610.6 but may be pursued on an optional basis.

A. Initiation of voluntary appeal: An internal voluntary appeal must be submitted in writing within ten (10) calendar days of receipt of the adverse determination to one of the following points of entry:

E-mail: CaliforniaRFA@amtrustgroup.com
Facsimile: 888-941-4218
Postal Mail:
AmTrust North America, Inc.
P.O. Box 6717
Cleveland, OH 44101

B. An Initial Clinical Reviewer may issue an approval of an internal utilization review appeal when the information submitted with the appeal clearly refutes the basis of the rationale for the original UR determination and provides sufficient, evidence-based support under the Medical Treatment Utilization Schedule (MTUS) for the requested treatment.

C. If the Initial Clinical reviewer is unable to approve the request, the appeal is sent to the IRO for appeal-level physician review.

D. Internal appeal timeframes shall be in accordance with §9792.10.1 (f)(1-2):

i. A request for an internal utilization review appeal shall be completed, and a determination

issued within thirty (30) calendar days after receipt of the request.

ii. Denials or modifications, rendered by the IRO's physician reviewers, of a medical treatment request for a drug listed on the MTUS Drug List, the internal utilization review appeal shall be completed, and a determination issued, within ten (10) calendar days after receipt of the request.

E. Written notifications of internal appeal determinations to approve by the AmTrust Initial Clinical Reviewer, or to approve, modify or deny by the IRO physician reviewer are issued in accordance with the procedures outlined in section X. of this Plan.

F. An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under §9792.10.6(e) that determines the medical necessity of the disputed treatment.

G. For determinations rendered by the IRO's physician reviewer in response to an internal utilization review appeal, the IRO's letter template is issued by the IRO in accordance with §9792.9.4, §9792.9.5, §9792.9.6, §9792.9.8, §9792.9.10, and the IRO's approved California Utilization Review Plan.

XII. Dispute Resolution: Independent Medical Review (IMR)

All UR decision letters to modify or deny, issued by AmTrust's contracted IROs, are accompanied by the Independent Medical Review (IMR) application form (DMC Form IMR), which can be submitted by the employee or their applicable designee to dispute the UR decision.

The IMR process is handled by an AmTrust claim professionals in accordance with Labor Code §§ 4610.5 and 4610.6. The injured worker is advised that any dispute shall be resolved in accordance with the IMR provisions of Labor Code §§ 4610.5 and 4610.6 and 9792.10.1 (a)(1-2), 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, within the timeframe indicated on the last page of the application.

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.

Neither the employee nor AmTrust shall have any liability for the completed medical treatment without the authorization of AmTrust if the treatment is modified or denied by a UR decision, unless the UR decision is overturned by IMR.

XIII. Confidentiality and Record Retention

Confidential information, including, but not limited to, individual medical records, received during the UR process may only be used for case management purposes to evaluate the claim for benefits and assess return-to-work initiatives. Such confidential information is maintained in accordance with all applicable state and federal laws and regulations. All claimant-specific information is only shared with those departments, vendors, or agencies necessary to complete UR. Confidentiality requirements and security procedures apply to all UR staff and vendors. In addition, AmTrust shall retain all utilization review records for at least three (3) years in accordance with §9792.7(n).

AmTrust maintains effective information security policies and procedures including administrative, technical, and physical safeguards designed to:

a. ensure the security of confidential information
b. protect against anticipated threats or hazards to the security or integrity of confidential information
c. protect against unauthorized access or use of confidential information
d. ensure the proper maintenance of confidential information.

XIV. Ethics & Compliance

This UR plan is filed with the Administrative Director and is in accordance with Labor Code §4610, Title 8 of the California Code of Regulations, Article 5.5.1, and DWC regulations.

AmTrust and all AmTrust employees involved with the UR process hold the necessary licenses, certifications, accreditations, and/or registrations required to perform UR. All AmTrust employees involved in the UR process are required to comply with this UR plan, applicable California laws, and California regulations. AmTrust requires our IROs to maintain the required licenses and applicable accreditations and to comply with California requirements applicable to the services they provide in connection with AmTrust's UR process. AmTrust will ensure that the UR staff is adequately staffed to support UR volume.

AmTrust's California Medical Director provides oversight and supervision of AmTrust's California Utilization Review Plan, as well as all supporting policies and procedures. The Medical Director oversees the Physician Peer Review Panel that meets quarterly for the purpose of review and discussion of quality assurance assessments of UR determinations that approve, modify, or deny requests for the provision of medical services. The Medical Director also provides advice and direction to the UR Staff in support of the UR process.

AmTrust does not offer or provide any financial incentive or consideration based on the number of modifications or denials made in performing UR. AmTrust shall also train employees and contractors on recognizing conflicts of interest situations and the appropriate recusal process per AmTrust policies and procedures.

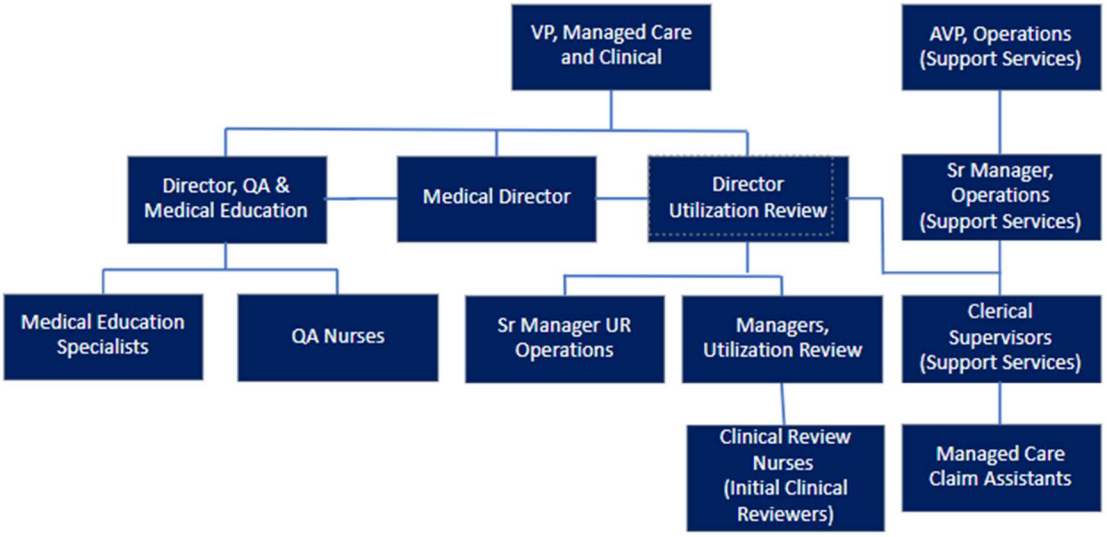
At minimum, the QAQC reviews this UR plan annually. To ensure regulatory compliance, additional review may occur when there are changes to Federal and/or applicable California laws, recommendations from URAC and/or California agencies, and/or directives from the Administrative Director. If AmTrust determines that changes are needed, AmTrust will file a modified UR plan with the Administrative Director within thirty (30) calendar days of making the change.

XV. Consumer Complaint Process

AmTrust's consumer complaints process includes a process to respond to and resolve complaints for consumers in a timely fashion. In that regard, all UR complaints will be maintained in a complaint log and managed by the UR Manager. Reporting of consumer complaints is provided quarterly and reviewed by the QAQC Committee.

Exhibit A

Managed Care & Clinical – Utilization Review Organizational Chart



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AmTrust North America
PO Box 6717 • Cleveland, OH 44101
(p) 888.488.3241 • (f) 888.941.4218

< Letter date >

< Recipient >
< Street address>
< City, State, Postal Code>

Employee:	[Employee]
Claim No.:	[Claim #]
Date of Injury:	[DOI]
Employer:	[Employer]
Request:	[Treatment Request]
Date RFA First Received:	[Received Date]
Date Add. Info. Requested:	[RFI Request Date]
Date Add. Info. Received:	[RFI Received Date]
Decision Date:	[Decision Date]
Treatment ID:	[TRID]

Notice: Utilization Review Certification

Dear < Requesting Provider >,

This letter serves as notification that the following requested treatment is certified as medically necessary:

< Requested Service(s)/Treatment(s)>

UR Determination: Certified

Certification Dates: < Treatment Service Dates>

If the Employee requires continued services beyond the certified number of services or length of stay, the ordering physician or servicing facility's representative should contact the AmTrust Utilization Review Department on or before the approved services have expired. Benefits for services not approved in advance may be denied.

Authorized ancillary services, such as therapy, diagnostics, and durable medical equipment, should be coordinated through our AmTrust preferred vendors.

Authorized specialty consultations must be coordinated through a provider within the AmTrust California MPN. The MPN directory can be found online at www.talispoint.com/amtrust/campn.

For approvals of a request for authorization of a drug where the request for authorization does not indicate "Do Not Substitute" or "Dispense as Written," and where a generic substitute of the drug is available, this authorization is for the generic substitute pursuant to 9792.9.4(a)(2).

Please feel free to contact us at 888-488-3241 Monday through Friday 9:00 a.m. – 5:30 p.m. (PST), should you have any additional questions regarding this claim.

Sincerely,

Utilization Review Department
AmTrust North America, Inc.

Schedule B
AmTrust – Disputed Liability

AmTrust North America, Inc.
PO Box 6717 • Cleveland, OH 44101
(p) 888.488.3241 • (f) 888.941.4218

AmTrust North America
An AmTrust Financial Company

< Letter date >

< Recipient >
< Street address>
< City, State, Postal Code>

RE:	Employee:	[Employee]
	Claim No.:	[Claim #]
	Date of Injury:	[DOI]
	Employer:	[Employer]
	Request:	[Treatment Request]
	Date RFA First Received:	[Received Date]
	Treatment ID:	[TRID]

Notice: Disputed Liability – Utilization Review Deferred

Dear < Requesting Provider >,

AmTrust has received a Request for Authorization (RFA) for the following medical treatment:

< Requested Service(s)/Treatment(s)>

Pursuant to the provisions of California Code of Regulations §9792.9.2, AmTrust is deferring utilization review on this RFA for the following reason:

☐ Liability of the claim in its entirety has been denied or is currently disputed.

☐ Liability for the body part(s) for which treatment is being requested is disputed.

☐ Liability for the diagnosis for which treatment is recommended is disputed.

☐ You do not participate in the AmTrust California Medical Provider Network and are not an authorized treating physician. Please see https://www.talispoint.com/amtrust/campn/ for a listing of physicians within the MPN.

Any dispute concerning this decision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

Notification to the Injured Worker:

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 Adjuster name) at (insert claim adjuster phone #). 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.

Sincerely,

< Claims Adjuster Name >
Claims Examiner

CC: Employee:
Employee's attorney, if represented:
Defense Counsel:

Schedule C
AmTrust – RFA Not Complete

AmTrust North America
An AmTrust Financial Company

AmTrust North America, Inc.
PO Box 6717 • Cleveland, OH 44101
(p) 888.488.3241 • (f) 888.941.4218

< Letter date >

< Recipient >
< Street address>
< City, State, Postal Code>

RE: Employee: [Employee]
Claim No.: [Claim #]
Date of Injury: [DOI]
Employer: [Employer]
Request: [Treatment Request]
Date RFA First Received: [Received Date]
Decision Date: [Decision Date]
Treatment ID: [TR ID]

Notice: Request for Authorization Not Complete

Dear < Requesting Provider >,

AmTrust has received a Request for Authorization (RFA) for the following medical treatment:

< Requested Service(s)/Treatment(s)>

Pursuant to §9792.6.1(u)(2) and 9792.9.1(b), your RFA has been deemed "not complete" for the following reason(s):

☐ The Employee and/or requesting provider has not been clearly identified

☐ The recommended course of treatment has not been identified with specificity (Ex: frequency, duration, quantity, dosage) in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used

☐ There is no accompanied medical report or other documentation, issued or created no earlier than 30 days before the date of submission of the request for authorization, to substantiate the medical necessity of the requested course of treatment

☐ The RFA has not been signed by the requesting physician

The timeframe for a utilization review decision on this request will begin anew upon receipt of a new RFA inclusive of the information noted above as necessary to consider the request "complete." Please submit all RFAs by fax to 888-941-4218 email to CaliforniaRFA@amtrustgroup.com or mail to AmTrust Financial Services Inc., P.O. Box 6717 Cleveland, OH 44101.

The DWC form RFA is available on the California Division of Workers' Compensation's form page: www.dir.ca.gov/dwc/forms.html.

Sincerely,
Utilization Review Department
AmTrust North America, Inc.

Schedule D
AmTrust – Request for Additional Information

AmTrust North America
An AmTrust Financial Company

AmTrust North America, Inc.
PO Box 6717 • Cleveland, OH 44101
(p) 888.488.3241 • (f) 888.941.4218

< Letter date >

< Recipient >
< Street address>
< City, State, Postal Code>

RE: Employee: [Employee]
Claim No.: [Claim #]
Date of Injury: [DOI]
Employer: [Employer]
Request: [Treatment Request]
Date RFA First Received: [Received Date]
Treatment ID: [TR ID]

Notice: Request for Additional Information

Dear < Requesting Provider >,

AmTrust North America, Inc. performs utilization review (UR) to determine medical necessity and appropriateness of requested treatment for your patient's worker's compensation injury. We have received your request for the following:

Treatment Requested: <Original Treatment Requested>

After reviewing the documents submitted, we have determined that we are not in receipt of all necessary information required to continue to the UR process. Please provide the following additional information necessary to render a determination.

<Manually enter missing information>

RFI due date: <<Complete by Date>>

Pursuant to 9792.9.6(a)(1)(A), the claims administrator or reviewer is not in receipt of all of the information reasonably necessary to make a determination.

Pursuant to 9792.9.6(b)(1), 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.

Pursuant to 9792.9.6(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).

Please submit the requested information to 888-941-4218 by <Actual Due Date>. Pursuant to the above UR Standards, if the requested information is not received by this date, authorization shall be denied.

Such denial will be reconsidered upon receipt of the requested information.

Sincerely,

AmTrust North America, Inc.
Utilization Review Department

CC: Injured Worker
Injured Worker's attorney, if represented

Review #«Id»

«CurrentDate»

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

Recommendation: NON-CERTIFY

RE: Claimant: «claim.patient.FullName»
Claim: «claim.claimnumber»
Date request was first received by «claim.organization.clientname»:
«receivedbyclienttimestamp_string»
Date request received by Genex: «DateReceivedByUR_string»
Date additional information Requested: «GetOldestAmiStatusDate»
Manner request was made: Fax, if applicable
Date additional information received, if applicable: «DateAdditionalInfoReceived»
Decision date: «enddate{short}»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if the requested health care services are medically necessary and appropriate for this claim. This letter is to notify you that the following health care services did not meet the established criteria for medical necessity:

UR Determination
«authorizedtreatmentplan_no_dates_for_adv»

Specific Treatment Plan Requested
«OrderedTreatmentPlansWithoutDates»

Provider Requesting Authorization
«physician.FullName»
«physician.address.street1»«physician.address.street2»
«physician.address.city», «physician.address.state» «physician.address.postalcode»
Phone: «physician.telephone» Fax: «physician.fax»

«Expedited_Downgrade»

Clinical Rationale
«clinical_rationale»

Peer to Peer Call Details (If Applicable):
«PeerToPeerCallsTT»

Documents Reviewed
«DocumentsReviewed»

Criteria/Guidelines Applied
«guidelines»

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact Genex at «project.doc_phone» so that a convenient time may be arranged for this discussion. All reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. PST. Additionally, please feel free to contact us should you have any additional questions regarding this claim.

Respectfully,

«signoff_user.FullQualifiedPathOfSignatur»

«signoff_user.FullName»
«signoff_user.StateLicensesDisplayString»
«signoff_user.BoardCertificationDisplaySt»

Enclosures: IMR form sent to: injured worker; requesting provider; applicant attorney, if applicable.

«cc_withDelivery_noFaxNumber»

Utilization Review strictly analyzes the medical necessity of treatment requests.
Genex Services does not affirm the acceptance of this workers compensation claim.

Genex Services is URAC Accredited for Workers' Compensation Utilization Management.

urac®
ACCREDITED
Workers' Compensation
Utilization Management
Expires: 04/01/2027

Genex Grievance Process

Non-clinically related oral or written complaints may be submitted to Genex at «project.doc_phone» or mailed to the address provided in this letter. A written response will be provided within 30 calendar days. More information about the grievance process can be found on our website.

Genex Optional Internal UR Appeals Process

If the provider has not previously submitted an appeal for any treatment request which was ***modified*** or ***denied*** in this review, the claimant or requesting provider has the option of submitting a request for an internal appeal on a voluntary basis. Participation in this optional appeals process neither triggers nor bars the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6. The request for the optional internal appeal must:

1. Be in writing; and
2. Be received by Genex within 10 days after the receipt of the original determination; and
3. Indicate if the appeal warrants an expedited review*; and
4. Contain either:
    a. Additional information supporting the request; or
    b. The basis or rationale for disagreement with the denial.

Appeal requests which do not match the above requirements will not be considered.

Appeals and information may be faxed to (888) 941-4218 or may be submitted via mail to «project.doc_address», «project.doc_city», «project.doc_state» «project.doc_zip».

** Expedited appeals shall only be granted if:*

1) *the timeline for making a determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or*
2) *the claimant would be in severe pain that could not be adequately managed without the care or treatment under review.*

Additional Language required by California Labor Code and Regulations:

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.

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-1, 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.

Review #«Id»

«CurrentDate»

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

Recommendation: MODIFIED

RE: Claimant: «claim.patient.FullName»
Claim: «claim.claimnumber»
Date request was first received by «claim.organization.clientname»:
«receivedbyclienttimestamp_string»
Date request received by Genex: «DateReceivedByUR_string»
Date additional information first requested: «GetOldestAmiStatusDate»
Manner request was made: Fax, if applicable
Date additional information received, if applicable: «DateAdditionalInfoReceived»
Decision date: «enddate{short}»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if the requested health care services are medically necessary and appropriate for this claim. This letter is to notify you of our determination regarding medical necessity:

Specific Treatment Plan Requested
«OrderedTreatmentPlansWithoutDates»

Provider Requesting Authorization
«physician.FullName»
«physician.address.street1»«physician.address.street2»
«physician.address.city», «physician.address.state» «physician.address.postalcode»
Phone: «physician.telephone» Fax: «physician.fax»

UR Determination
«authorizedtreatmentplan_no_dates_for_adv»

Authorized ancillary services, such as therapy, diagnostics, and durable medical equipment, should be coordinated through our partners at One Call Care Management by calling (866) 672-3064 or emailing AmTrust@oncecallcm.com. Authorized specialty consultations must be coordinated through a provider within the AmTrust California MPN. The MPN directory can be found online at www.talispoint.com/amtrust/campn.

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".

«Expedited_Downgrade»

Clinical Rationale
«clinical_rationale»

Peer to Peer Call Details (If Applicable):
«PeerToPeerCallsTT»

Criteria/Guidelines Applied
«guidelines»

Information regarding our optional internal appeals and reconsiderations processes is attached to this determination letter.

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact Genex at «project.doc_phone» so that a convenient time may be arranged for this discussion. All reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. PST. Please feel free to contact us should you have any additional questions regarding this claim.

Respectfully,

«signoff_user.FullQualifiedPathOfSignatur»

«signoff_user.FullName»
«signoff_user.StateLicensesDisplayString»
«signoff_user.BoardCertificationDisplaySt»

Enclosures: IMR form sent to: injured worker; requesting provider; applicant attorney, if applicable.

«cc_withDelivery»

A certification is for medical necessity only and does not guarantee payment under Workers' Compensation coverage. If you have any questions related to this claim, please contact your local Claims office.

Genex Services is URAC Accredited for Workers' Compensation Utilization Management.

Genex Grievance Process

Non-clinically related oral or written complaints may be submitted to Genex at «project.doc_phone» or mailed to the address provided in this letter. A written response will be provided within 30 calendar days. More information about the grievance process can be found on our website.

Genex Reconsiderations Process

For any treatment request which was ***denied – Lack of information***, the treatment request will be reconsidered upon receipt of the requested information.

Genex Optional Internal UR Appeals Process

If the provider has not previously submitted an appeal for any treatment request which was ***modified*** or ***denied*** in this review, the claimant or requesting provider has the option of submitting a request for an internal appeal on a voluntary basis. Participation in this optional appeals process neither triggers nor bars the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6. The request for the optional internal appeal must:

1. Be in writing; and
2. Be received by Genex within 10 days after the receipt of the original determination; and
3. Indicate if the appeal warrants an expedited review*; and
4. Contain either:
    a. Additional information supporting the request; or
    b. The basis or rationale for disagreement with the denial.

Appeal requests which do not match the above requirements will not be considered.

Appeals and/or Reconsiderations may be faxed to (888) 941-4218 or may be submitted via mail to «project.doc_address», «project.doc_city», «project.doc_state» «project.doc_zip».

** Expedited appeals shall only be granted if:*

1. *the timeline for making a determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or*
2. *the claimant would be in severe pain that could not be adequately managed without the care or treatment under review.*

Additional Language required by California Labor Code and Regulations:

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.

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-1, 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.

Medical Records Reviewed

The following is a list of documents reviewed:
«DocumentsReviewed»

ARBICARE

Review completed by **Arbicare**
on behalf of **{{Client Name}}**

Utilization Review Determination

Dear Injured Worker Name,

With the intent of maintaining a high standard of care, Arbicare has been requested by {{Client Name}} to perform utilization review of the appropriateness and necessity of the below listed health care treatments.

Claimant	Treating Provider	Review Type
Claim #	**Address**	**Client**
Case #	**City**	**Referrer**
Birth Date	**State**	**RFA First Received**
Injury Date	**Zip**	**Decision Date**
Jurisdiction		

Request Determination(s)

Certified:
- Request #1

Modified:
- Request #2

Non-Certified:
- Request #3

Diagnosis

- **Diagnosis #1**

Clinical History

{{Clinical History Summary}}

Determination Summary

- Request #1 is Non-Certified

[[Determination Summary]]

Determination Rationale

- Request #1 is Non-Certified

{{Full Determination_Rationale}}

Peer to Peer / Outreach Summary

For concurrent review denials or discontinuation of ongoing treatment, this section shall document discussion or attempted discussion of reasonable care plan options with the requesting physician.

Date / Time	Respondent / Role	Dialogue

Extension of Review Summary (If Applicable)

- Additional information / test / exam / consultation needed: [insert]
- Date(s) and time(s) requested: [insert]
- Manner of request(s): [telephone / fax / email / other]
- Date information / results first received: [insert]

Records Reviewed

Date	Type	Source

Conflict of Interest Attestation

I certify that no material professional, familial, or financial conflict of interest exists regarding the determination made in review of this case. Further, no conflict of interest exists between myself or any of the following: the referring entity; any prior involvement with the case; the insurance issuer or group health plan/carrier for the case under review; a management role in a health plan of an insurance issuer or group health plan that is the subject of a review which includes participation on the board of directors or any sub-committee of that board and in advisory groups that provide guidance to a provider network, including credentialing, medical policy and quality management committees; the covered person or the covered person's authorized representative; any officer, director, or management employee of an insurance issuer; the group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the review.

I attest that I have a scope of licensure or certification and professional experience that typically manages the medical condition, procedure, treatment, or issue under review.

Clinical Reviewer

Reviewer Signature
Reviewer Name
Reviewer Specialty
Licenses:
Date

CC:

Requesting Provider
Injured Worker Name
Applicant Attorney
Defense Attorney
Claims Examiner

Decision Effective Dates

Pursuant to applicable California workers' compensation utilization review law and regulation, a utilization review decision to modify or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician 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.

Reviewer Availability

Should discussion concerning the decision be needed, Arbicare will make a consulting reviewer available for follow-up discussion during normal business hours (between 9:00am and 5:30pm Pacific Time) for at least four (4) hours over the course of the subsequent five (5) business days of the request for discussion. Within this conversation the consulting reviewer will contemplate any new information presented and either uphold or overturn the determination. Please contact Arbicare at (800) 716-8295 to schedule physician availability.

Conditional Denial

When a determination is made to deny or modify the request because insufficient medical information was available, Arbicare provides the opportunity for the ordering provider, within 1 business day of receiving the denial or modification, to discuss the determination with the peer reviewer that made the determination; or with a different peer reviewer, if the original peer reviewer is unavailable. A reconsideration will be accepted by Arbicare from the ordering provider through a discussion or written response.

Internal Appeals Process

Arbicare maintains an internal appeals process for the requesting physician that is entirely voluntary 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 expedited basis. Any additional appeal request after completion of the voluntary Internal Appeals process must be made by using the Independent Medical Review process detailed in Labor Code section 4610.5 and 4610.6.

Standard Appeal

Per Title 8, CCR §9792.10.1(d)(1-3), Arbicare has in place procedures for internal appeals of decisions to deny or modify a utilization review determination. If you wish to appeal this decision, please submit your request for appeal to Arbicare with any supporting documentation and/or a written statement by the attending physician within ten (10) days of receipt of the decision. Any request for an appeal of the utilization review decision must be submitted either by telephone or in writing to the address, phone number, fax number, or email listed below. Participating in this process is entirely voluntary. Any appeal request will be completed as soon as is practicable but will be completed no later than thirty (30) days upon receipt of request and all applicable medical documentation. The appeal will be completed by a different reviewer of at least the same qualifications as the initial reviewer. As part of the appeal process please provide any additional medical records that are relevant to the completion of the reconsideration. Notification of the completed appeal determination will be delivered in writing to the patient or representative and the attending provider. In the event that the determination remains to deny, the written notification will include an explanation of the principal reason(s) for the determination.

Expedited Appeal

Arbicare has in place procedures for expedited appeals of decisions to deny a utilization review determination. If you wish to appeal this decision on an expedited basis, please submit your request for appeal to Arbicare with any supporting documentation and/or a written statement to be submitted either by telephone or in writing to the address, phone number, fax number, or email listed below. Participating in this process is entirely voluntary. Any expedited appeal request will be completed as soon as is practicable but will result in verbal notification of determination to the attending physician no later than 72 hours following receipt of the expedited appeal request. The verbal notification will be followed by written confirmation of the notification delivered to the patient and attending physician within three (3) calendar days. In the event that the determination remains to deny, the written notification will include an explanation of the principal reason(s) for the determination.

Address	Arbicare 235 Ponce de Leon Place Ste M - #316 Decatur, GA 30030-3258
Email	support@arbicare.com
Phone	(800) 716-8295
Fax	(404) 631-6387

If you have any questions about this determination, the reconsideration process, or need further information concerning available next steps, please contact our support staff by calling our Toll-Free number 1-800-716-8295 or by emailing us at support@arbicare.com.

Dispute Resolution Procedures

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code sections 4610.5 and 4610.6. An objection to this 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 applicable timeframe below:

- 10 days from the mailing date of the utilization review decision for disputes involving only a drug or drugs on the MTUS Drug Formulary.
- 30 calendar days from the mailing date of the utilization review decision for all other medical treatment disputes.

The voluntary appeal process neither triggers nor bars the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6.

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 {{!Case.Examiner__r.FirstName}} {{!Case.Examiner__r.LastName}} at {{!Case.Examiner__r.Phone}}. 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.

ARBICARE

Review completed by **Arbicare**
on behalf of **{{Client Name}}**

Utilization Review Appeal Determination

Dear Injured Worker Name,

With the intent of maintaining a high standard of care, Arbicare has been requested by {{Client Name}} to perform utilization review of the appropriateness and necessity of the below listed health care treatments.

Claimant	Treating Provider	Review Type
Claim #	**Address**	**Client**
Case #	**City**	**Referrer**
Birth Date	**State**	**RFA First Received**
Injury Date	**Zip**	**Decision Date**
Jurisdiction		

Request Determination(s)

Certified:
- Request #1

Modified:
- Request #2

Non-Certified:
- Request #3

Diagnosis

- **Diagnosis #1**

Clinical History

{{Clinical History Summary}}

Determination Summary

- Request #1 is Non-Certified

[[Determination Summary]]

Determination Rationale

- Request #1 is Non-Certified

{{Full Determination_Rationale}}

Peer to Peer / Outreach Summary

Date / Time	Respondent / Role	Dialogue

Extension of Review Summary (If Applicable)

- Additional information / test / exam / consultation needed: [insert]
- Date(s) and time(s) requested: [insert]
- Manner of request(s): [telephone / fax / email / other]
- Date information / results first received: [insert]

Records Reviewed

Date	Type	Source

Conflict of Interest Attestation

I certify that no material professional, familial, or financial conflict of interest exists regarding the determination made in review of this case. Further, no conflict of interest exists between myself or any of the following: the referring entity; any prior involvement with the case; the insurance issuer or group health plan/carrier for the case under review; a management role in a health plan of an insurance issuer or group health plan that is the subject of a review which includes participation on the board of directors or any sub-committee of that board and in advisory groups that provide guidance to a provider network, including credentialing, medical policy and quality management committees; the covered person or the covered person's authorized representative; any officer, director, or management employee of an insurance issuer; the group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the review.

I attest that I have a scope of licensure or certification and professional experience that typically manages the medical condition, procedure, treatment, or issue under review.

Clinical Reviewer

Reviewer Signature
Reviewer Name
Reviewer Speciality
Licenses:
Date

CC:

Requesting Provider
Injured Worker Name
Applicant Attorney
Defense Attorney
Claims Examiner

Decision Effective Dates

Pursuant to applicable California workers' compensation utilization review law and regulation, a utilization review decision to modify or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician 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.

Reviewer Availability

Should discussion concerning the decision be needed, Arbicare will make a consulting reviewer available for follow-up discussion during normal business hours (between 9:00am and 5:30pm Pacific Time) for at least four (4) hours over the course of the subsequent five (5) business days of the request for discussion. Within this conversation the consulting reviewer will contemplate any new information presented and either uphold or overturn the determination. Please contact Arbicare at (800) 716-8295 to schedule physician availability.

Conditional Denial

When a determination is made to modify or deny a request because the requesting physician did not provide sufficient information to reasonably determine medical necessity, the decision letter shall identify the missing information and shall state that the requested treatment will be reconsidered upon receipt of a new Request for Authorization containing the missing information, examination or test results, or specialized consultation. Arbicare shall also provide the ordering provider the opportunity, within 1 business day of receiving the determination, to discuss the decision with the peer reviewer who issued it, or with another peer reviewer if the original reviewer is unavailable. Reconsideration may occur through that discussion or through a written response submitted by the ordering provider.

Notice of Appeal Decision

This appeal determination was made by a clinical reviewer with appropriate licensure, scope of practice, and clinical expertise relevant to the treatment or condition under review and was completed in accordance with applicable California workers' compensation

utilization review requirements. If any dispute remains concerning the utilization review decision, please pursue the Independent Medical Review process outlined below.

Address	Arbicare 235 Ponce de Leon Place Ste M - #316 Decatur, GA 30030-3258
Email	support@arbicare.com
Phone	(800) 716-8295
Fax	(404) 631-6387

If you have any questions about this determination, the reconsideration process, or need further information concerning available next steps, please contact our support staff by calling our Toll-Free number 1-800-716-8295 or by emailing us at support@arbicare.com.

Dispute Resolution Procedures

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code sections 4610.5 and 4610.6. An objection to this 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 applicable timeframe below:

- 10 days from the mailing date of the utilization review decision for disputes involving only a drug or drugs on the MTUS Drug Formulary.
- 30 calendar days from the mailing date of the utilization review decision for all other medical treatment disputes.

The voluntary appeal process neither triggers nor bars the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6.

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 {{!Case.Examiner__r.FirstName}} {{!Case.Examiner__r.LastName}} at {{!Case.Examiner__r.Phone}}. 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.

ARBICARE

Review completed by **Arbicare**
on behalf of **{{Client Name}}**

Conditionally Non-Certified (CNC)

Arbicare received a Request for Authorization for the treatment identified below. Based on the information submitted, the requesting physician did not provide sufficient information to reasonably make a medical necessity determination for one or more requested treatment items.

Claimant	Treating Provider	Review Type
Claim #	**Address**	**Client**
Case #	**City**	**Referrer**
Birth Date	**State**	**RFA First Received**
Injury Date	**Zip**	**Decision Date**
Jurisdiction		

Request Determination(s)

Non-Certified:

- Request #1

Based on the clinical documentation submitted, there is insufficient information to reasonably determine medical necessity for the request identified above. The records provided do not include all information reasonably necessary to evaluate the request under applicable treatment guidelines.

Insufficient Information / CNC Determination

The requesting physician did not provide sufficient information to reasonably make a medical necessity determination for the following request(s):

- Request #1

Missing information:

- [insert specific missing information, examination or test results, or specialized consultation needed]

The requested treatment will be reconsidered upon receipt of a new Request for Authorization containing the missing information, examination or test results, or specialized consultation.

Extension of Review Summary (If Applicable)

- Additional information / test / exam / consultation needed: [insert]
- Date(s) and time(s) requested: [insert]
- Manner of request(s): [telephone / fax / email / other]
- Date information / results first received: [insert]

Peer to Peer / Outreach Summary

For concurrent review denials or discontinuation of ongoing treatment, this section shall document discussion or attempted discussion of reasonable care plan options with the requesting physician.

Date / Time	Respondent / Role	Dialogue

Records Reviewed

Date	Type	Source

Conflict of Interest Attestation

I certify that no material professional, familial, or financial conflict of interest exists regarding the determination made in review of this case. Further, no conflict of interest exists between myself or any of the following: the referring entity; any prior involvement with the case; the insurance issuer or group health plan/carrier for the case under review; a management role in a health plan of an insurance issuer or group health plan that is the subject of a review which includes participation on the board of directors or any sub-committee of that board and in advisory groups that provide guidance to a provider network, including credentialing, medical policy and quality management committees; the covered person or the covered person's authorized representative; any officer, director, or management employee of an insurance issuer; the group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the review.

I attest that I have a scope of licensure or certification and professional experience that typically manages the medical condition, procedure, treatment, or issue under review.

Clinical Reviewer

Reviewer Signature

Reviewer Name
Reviewer Specialty
Licenses:
Date

CC:

Requesting Provider
Injured Worker Name
Applicant Attorney
Defense Attorney

Claims Examiner

Reviewer Availability

Should discussion concerning the decision be needed, Arbicare will make a consulting reviewer available for follow-up discussion during normal business hours (between 9:00am and 5:30pm Pacific Time) for at least four (4) hours over the course of the subsequent five (5) business days of the request for discussion. Within this conversation the consulting reviewer will contemplate any new information presented and either uphold or overturn the determination. Please contact Arbicare at (800) 716-8295 to schedule physician availability.

Conditional Denial

When a determination is made to modify or deny a request because the requesting physician did not provide sufficient information to reasonably determine medical necessity, the decision letter shall identify the missing information and shall state that the requested treatment will be reconsidered upon receipt of a new Request for Authorization containing the missing information, examination or test results, or specialized consultation. Arbicare shall also provide the ordering provider the opportunity, within 1 business day of receiving the determination, to discuss the decision with the peer reviewer who issued it, or with another peer reviewer if the original reviewer is unavailable. Reconsideration may occur through that discussion or through a written response submitted by the ordering provider.

Internal Appeals Process

Arbicare maintains a voluntary internal appeals process for the requesting physician that neither triggers nor bars use of the dispute resolution procedures set forth in Labor Code sections 4610.5 and 4610.6. Any additional appeal request after completion of the voluntary Internal Appeals process must be made by using the Independent Medical Review process detailed in Labor Code section 4610.5 and 4610.6. Participation in Arbicare's voluntary internal appeals process does not extend, toll, or replace the timeframe for filing an Application for Independent Medical Review.

Standard Appeal

Arbicare maintains a voluntary internal appeal process as permitted under applicable California workers' compensation utilization review regulations. If you wish to appeal this decision, please submit your request for appeal to Arbicare with any supporting documentation and/or a written statement by the attending physician within ten (10) days of receipt of the decision. Any request for an appeal of the utilization review decision must be submitted either by telephone or in writing to the address, phone number, fax number, or email listed below. Participating in this process is entirely voluntary. Any appeal request will be completed as soon as is practicable but will be completed no later than thirty (30) days upon receipt of request and all applicable medical documentation. The appeal will be completed by a different reviewer of at least the same qualifications as the initial reviewer. As part of the appeal process please provide any additional medical records that are relevant to the completion of the reconsideration. Notification of the completed appeal determination will be delivered in writing to the patient or representative and the attending provider. In the event that the determination remains to deny, the written notification will include an explanation of the principal reason(s) for the determination.

Expedited Appeal

Arbicare has in place procedures for expedited appeals of decisions to deny a utilization review determination. If you wish to appeal this decision on an expedited basis, please submit your request for appeal to Arbicare with any supporting documentation and/or a written statement to be submitted either by telephone or in writing to the address, phone number, fax number, or email listed below. Participating in this process is entirely voluntary. Any expedited appeal request will be completed as soon as is practicable but will result in verbal notification of determination to the attending physician no later than 72 hours following receipt of the expedited appeal request. The verbal notification will be followed by written confirmation of the notification delivered to the patient and attending

physician within three (3) calendar days. In the event that the determination remains to deny, the written notification will include an explanation of the principal reason(s) for the determination.

Address	Arbicare 235 Ponce de Leon Place Ste M - #316 Decatur, GA 30030-3258
Email	support@arbicare.com
Phone	(800) 716-8295
Fax	(404) 631-6387

If you have any questions about this determination, the reconsideration process, or need further information concerning available next steps, please contact our support staff by calling our Toll-Free number 1-800-716-8295 or by emailing us at support@arbicare.com.

Dispute Resolution Procedures

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code sections 4610.5 and 4610.6. An objection to this 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 applicable timeframe below:

- 10 days from the mailing date of the utilization review decision for disputes involving only a drug or drugs on the MTUS Drug Formulary.
- 30 calendar days from the mailing date of the utilization review decision for all other medical treatment disputes.

The voluntary appeal process neither triggers nor bars the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6.

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 {{!Case.Examiner__r.FirstName}} {{!Case.Examiner__r.LastName}} at {{!Case.Examiner__r.Phone}}. 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.

DWC DIVISION OF WORKERS' COMPENSATION
CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers' Compensation
Department of Industrial Relations
State of California

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) 605-4270
- **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 Formulary Drug List ☐ | Retrospective for Exempt Treatment (Non-Drug) ☐ | Retrospective for Exempt 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.