



Utilization Review Process  
Policies and Procedures

Allied Managed Care  
February 4, 2022

**Utilization Review Process/Policies and Procedures  
Pursuant to CA Labor Code Section 4610 and  
Utilization Review Standards §9792.6.1, §9792.9.1,  
§9792.10.1**

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## DEFINITIONS

### § 9792.6.1 Utilization Review Standards—Definitions

- (a) “Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on either a completed “Request for Authorization,” DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2), that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the “Request for Authorization,” DWC Form RFA if that form was initially submitted by the treating physician.
- (b) "Claims Administrator" is a self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). “Claims Administrator” includes any utilization review organization under contract to provide or conduct the claims administrator’s utilization review responsibilities.
- (c) "Concurrent review" means utilization review conducted during an inpatient stay.
- (d) "Course of treatment" means the course of medical treatment set forth in the treatment plan contained on the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, found at California Code of Regulations, title 8, section 14006, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.
- (e) “Denial” means a decision by a physician reviewer that the requested treatment or service is not authorized.
- (f) “Dispute liability” means an assertion by the claims administrator that a factual, medical, or legal basis exists, other than medical necessity that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.
- (g) “Disputed medical treatment” means medical treatment that has been modified, or denied by a utilization review decision.
- (h) "Emergency health care services" means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.
- (i) "Expedited review" means utilization review or independent medical review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or

health or could jeopardize the injured worker's permanent ability to regain maximum function.

(k) "Expert reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.

(l) "Health care provider" means a provider of medical services, as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.

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

(n) "Material modification" is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

(o) "Medical Director" is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California. The Medical Director is responsible for all decisions made in the utilization review process.

(p) "Medical services" means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

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

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

(s) "Prospective review" means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services

(t) "Request for authorization" means a written request for a specific course of proposed medical treatment.

(1) Unless accepted by a claims administrator under section 9792.9.1(c)(2), a request for authorization must be set forth on a "Request for Authorization (DWC Form RFA)," completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5. Prior to March 1, 2014, any version of the DWC Form RFA adopted by the Administrative Director under section 9785.5 may be used by the treating physician to request medical treatment.

(2) "Completed" for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization must identify both the employee and the provider, identify with specificity a recommended treatment or treatments, and be accompanied by documentation substantiating the need for the requested treatment.

(3) The request for authorization must be signed by the treating physician and may be mailed, faxed or e-mailed to, if designated, the address, fax number, or e-mail address designated by the claims administrator

(4) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

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

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

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

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

(y) "Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. The utilization review process begins when the completed DWC Form RFA, or a request for authorization accepted as complete under section 9792.9.1(c)(2), is first received by the claims administrator, or in the case of the client's prior authorization protocols, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

(z) "Written" includes a communication transmitted by facsimile or in paper form. Electronic mail may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail.

## § 9792.20. Medical Treatment Utilization Schedule— Definitions

- (a) “ACOEM” means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines published by the Reed Group containing evidenced-based medical treatment guidelines for conditions commonly associated with the workplace. ACOEM guidelines may be obtained from the Reed Group (<http://go.reedgroup.com/mtus>).
- (b) “Chronic pain” means pain lasting three or more months from the initial onset of pain.
- (c) “Claims administrator” is a self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator, or the California Insurance Guarantee Association.
- (d) “Evidence-Based Medicine (EBM)” means a systematic approach to making clinical decisions which allows the integration of the best available research evidence with clinical expertise and patient values.
- (e) “Functional improvement” means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the medical evaluation and treatment; and a reduction in the dependency on continued medical treatment.
- (f) “Medical treatment” is care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.27.
- (g) “Medical treatment guidelines” means the most current version of written recommendations which are systematically developed by a multidisciplinary process through a comprehensive literature search to assist in decision-making about the appropriate medical treatment for specific clinical circumstances reviewed and updated within the last five years.
- (h) “Nationally recognized” means published in a peer-reviewed medical journal; or developed, endorsed and disseminated by a national organization with affiliates based in two or more U.S. states and is the most current version.
- (i) “ODG” means the Official Disability Guidelines published by the Work Loss Data Institute containing evidenced-based medical treatment guidelines for conditions commonly associated with the workplace. ODG guidelines may be obtained from the Work Loss Data Institute, 169 Saxony, #101, Encinitas, California 92024 ([www.ODG@worklossdata.com](http://www.ODG@worklossdata.com)).
- (j) “Peer reviewed” means that a study's content, methodology and results have been evaluated and approved prior to publication by an editorial board of qualified experts.
- (k) “Scientifically based” means based on scientific literature, wherein the body of literature is

identified through performance of a literature search, the identified literature is evaluated, and then used as the basis to support a recommendation.

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

Note: Authority cited: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5 and 5307.27, Labor Code.

## Section 9792.27.1. Medical Treatment Utilization Schedule (MTUS) Drug Formulary – Definitions

(a) “Administer” means the direct application of a drug or device to the body of the patient by injection, inhalation, ingestion, or other means.

(b) “Authorization through prospective review” means authorization for proposed treatment obtained through the utilization review process set forth in section 9792.6.1 et seq.

(c) “Brand name drug” means a drug that is produced or distributed under an FDA original New Drug Application (NDA) or Biologic License Application (BLA) approved by the FDA. It also includes a drug product marketed by any cross-licensed producers or distributors operating under the same NDA or BLA.

(d) “Combination drug” means a fixed dose combination of two or more active drug ingredients into a single dosage form that is FDA-approved for marketing.

(e) “Compounded drug” means any drug subject to:

- (1) Article 4.5 (commencing with section 1735) or article 7 (commencing with section 1751) of division 17 of title 16 of the California Code of Regulations, or
- (2) Other regulation adopted by the State Board of Pharmacy to govern the practice of compounding, or
- (3) Federal law governing compounding, including title 21, United State Code, sections 353a, 353a-1, 353b.

(f) “Dispense” means: 1) the furnishing of a drug upon a prescription from a physician or other health care provider acting within the scope of his or her practice, or 2) the furnishing of drugs directly to a patient by a physician acting within the scope of his or her practice.

(g) “Executive Medical Director” means the medical director of the Division of Workers’ Compensation.

- (h) “Exempt drug” means a drug on the MTUS Drug List which is designated as being a drug that does not require authorization through prospective review prior to dispensing the drug, provided that the drug is prescribed in accordance with the MTUS Treatment Guidelines. The Exempt status of a drug is designated in the column with the heading labeled “Exempt / “Exempt / Non-Exempt”.
- (i) “Expedited review” means the expedited utilization review conducted prior to the delivery of the requested medical services, in accordance with Labor Code section 4610 and title 8, California Code of Regulations section 9792.6.1 et seq.
- (j) “FDA” means the United States Food and Drug Administration within the United States Department of Health & Human Services.
- (k) “FDA-approved drug” means a prescription or nonprescription drug that has been approved by the FDA under the federal Food, Drug, and Cosmetic Act, title 21, United States Code, section 301 et seq.
- (l) “Generic drug” means a drug that is produced or distributed under an FDA Abbreviated New Drug Application (ANDA) approved by the FDA. A generic drug may be substituted for a therapeutic equivalent brand name drug pursuant to applicable state and federal laws and regulations.
- (m) “MTUS Drug Formulary” means the MTUS Drug List set forth in section 9792.27.15 and the formulary rules set forth in sections 9792.27.1 through 9792.27.23.
- (n) “MTUS Drug List” means the drug list and related information in section 9792.27.15, which sets forth the Exempt or Non-Exempt status of drugs listed by active drug ingredient(s).
- (o) “Non-Exempt drug” means a drug on the MTUS Drug List which is designated as requiring authorization through prospective review prior to dispensing the drug. Non-Exempt Drug status of a drug is designated in the column labeled “Exempt / Non-Exempt.”
- (p) “Nonprescription drug” or “over-the-counter drug” (OTC drug) means a drug which may be sold without a prescription and which is labeled for use by the consumer without the supervision of a health care professional.
- (q) “Off-label use” means use of a drug for a condition, or in a dosage or method of administration, not listed in the drug’s FDA-approved labeling for approved use.
- (r) “OTC Monograph” means a monograph established by the FDA setting forth acceptable ingredients, doses, formulations, and labeling for a class of OTC drugs
- (s) “Perioperative Fill” means the policy set forth in section 9792.27. 13 allowing dispensing of identified Non-Exempt drugs without prospective review where the drug is prescribed within the perioperative period and meets specified criteria.

(t) “P&T Committee” means the Pharmacy and Therapeutics Committee established by the Administrative Director pursuant to Labor Code section 5307.29 to review and consult with the administrative director on available evidence of the relative safety, efficacy, and effectiveness of drugs within a class of drugs in the updating of the evidence-based drug formulary.

(u) “Physician”: Notwithstanding the definition in Labor Code section 3209.3, for purposes of the MTUS Drug Formulary, “Physician” means a medical doctor, doctor of osteopathy, or other health care provider whose scope of practice includes the prescription of drugs. However, for purposes of membership on the P&T Committee, “physician” means a medical doctor or doctor of osteopathy licensed pursuant to the California Business and Professions Code.

(v) “Prescription drug” means any drug whose labeling states “Caution: Federal law prohibits dispensing without prescription,” “Rx only,” or words of similar import.

(w) “Prospective review” means the utilization review conducted prior to the delivery of the requested medical services, in accordance with Labor Code section 4610 and title 8, California Code of Regulations section 9792.6.1 et seq.

(x) “Special Fill” means the policy set forth in section 9792.27.12 allowing dispensing of identified Non-Exempt drugs without prospective review where the drug is prescribed or dispensed in accordance with the criteria set forth in subdivision (b) of section 9792.27.12.

(y) A “therapeutic equivalent” is a drug designated by the FDA as equivalent to a Reference Listed Drug if the two drugs are pharmaceutical equivalents (contain the same active ingredient(s), dosage form, route of administration and strength), and are bioequivalent (comparable availability and rate of absorption of the active ingredient(s).) Drugs that the FDA considers to be therapeutically equivalent products are assigned a Therapeutic Equivalence Evaluation Code beginning with the letter “A” in the FDA publication “Orange Book: Approved Products with Therapeutic Equivalence Evaluations” which is available on the FDA website and accessible via a link provided on the department’s website

(z) “Unlisted drug” means a drug that does not appear on the MTUS Drug List and which is one of the following: an FDA-approved drug or a nonprescription drug that is marketed pursuant to an FDA OTC Monograph. An “unlisted drug” does not include a compounded drug but does include a combination drug.

Authority: Sections 133, 4603.5, 5307.3 and 5307.27, Labor Code.

Reference: Sections 4600, 4604.5, 5307.27 and 5307.29, Labor Code.

## Utilization Review Standards - Applicability

Allied Managed Care, Inc. (AMC) is appointed to administer the Utilization Review Program for the Workers' Compensation Claims Administrator.

The following is a description of the qualifications and functions of the personnel involved in decision making and implementation of the utilization review plan:

### **MEDICAL DIRECTOR:**

The Medical Director's qualifications and functions/responsibilities include the following:

#### **Qualifications:**

- California Licensed M.D
- Prior managed care experience.
- Knowledge of and experience in the clinical delivery of medical services.
- Working knowledge of Utilization Review evidence-based guidelines.
- Experience with analysis of data and components of a continuous improvement model
- Strong written and verbal communication skills

#### **Functions/Responsibilities:**

- Responsible for all decisions made in the utilization review process.
- Functions as the clinical partner to AMC executive staff by helping to direct the clinical aspects of the Utilization and Peer Review process.
- Provides direct supervision and leadership to physicians who are performing UR determinations.
- Provides support to AMC staff in facilitating, developing and implementing clinical policies and procedures to improve the delivery of quality managed care services
- Works directly with physicians, nursing staff and health professionals to facilitate and insure the appropriate application of clinical guidelines for the delivery of health care services.
- Assists in developing "best practice" targets for clinical outcomes, and injured workers satisfaction across the continuum of care.
- Provides committee leadership in AMC Quality Assurance Committee.
- Provides oversight and education to physicians, and AMC nurses, managers, and staff.
- Provides education and training to claims examiners to insure proper functioning as part of the UR process
- Maintains current knowledge of and compliance with administrative and clinical policies and procedures, regulatory standards and changes, and accreditation requirements.
- Performs periodic file reviews or UR determinations to insure compliance with the

## UR standards and AMC quality standards

Allied Managed Care, Inc. has designated Alan E. Randle, M.D., as the Medical Director to implement and supervise the UR program, and to ensure that the AMC Utilization Review process is followed. Dr. Randle is physician licensed by the Medical Board of California and holds an unrestricted license to practice medicine in the State of California issued pursuant to Section 2050 of the Business and Professions Code.

Alan E. Randle, M.D, CA License G27961  
Medical Director Allied Managed Care  
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Dr. Randle will:

- Be responsible for all decisions made in the utilization review process.
- Be responsible for the overall Utilization Review program oversight, coordination, and compliance with the applicable UR Standards
- Ensure that the process by which the claims administrator reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with Labor Code Section 4610 and these implementing regulations. This is accomplished by working closely with the UR Manager, Manager of Peer Review, and the Peer Review Panel/Physicians to provide ongoing education to the staff, to identify and address any issues/concerns, and to promote AMC quality standards
- Be available for peer to peer discussion/consultation from 9:00 AM to 12:00 PM on normal business days. This can be scheduled through the AMC Nursing Supervisors or the Manager of Peer Review Services at the above phone number
- Be available to provide consultations to the initial clinical review staff daily during business hours by phone.

## **DIRECTOR, UTILIZATION REVIEW**

### **KEY RESPONSIBILITIES:**

- Assists Medical Director in managing the entire UR process from referral entry to distribution of UR determination, including monitoring of mandated UR timelines.
- Is responsible for responding to all DWC audit inquiries
- Manages UR nursing and non-nurse review assignment and timeliness required by the UR standards
- Quality assurance review of UR determinations
- Oversees responsiveness to provider, vendor, and customer inquiries and appeals

- Attends ongoing UR and peer review training courses to stay current on regulatory requirement and industry changes

### **MANAGER, PEER REVIEW SERVICES**

#### **KEY RESPONSIBILITIES:**

- Manages entire Peer Review process from referral entry to departure from the office, including turnaround time
- Manages Peer Review Physician Scheduling of peer-to-peer
- Manage and review invoicing and communication process between individual Physicians and Vendor Peer panels.
- Manage Peer Review assignment and timelines required by the CA DWC.
- Quality assurance review of Peer Determinations for completeness.
- Assists in establishing and enforcing written procedures for work flows and Peer review processes
- Oversees responsiveness to provider inquiries and appeals
- Attends ongoing Utilization Review and Peer review training courses and stays current on industry changes
- The manager of peer review services will be available to provide consultations to the initial clinical review staff daily during business hours.
- Conducts ongoing review of peer clinical review decisions for consistency of decision making and documentation.

### **ALLIED NON-PHYSICIAN REVIEWERS**

Allied utilizes non-physician reviewers who are RNs and/or LVNs. The non-physician reviewers shall demonstrate the following qualifications:

- Competent medical working knowledge of the UR Standards and Workers' Compensation regulations.
- Working knowledge of MTUS and other nationally recognized medical treatment guidelines as utilized by AMC
- Knowledge of CPT codes and ICD-9-CM
- Excellent typing and keyboard skills
- Proficient computer skills
- Proficiency in written, phone, and verbal skills
- Good organizational skills and demonstrated accuracy in documentation and record keeping
- Ability to portray a professional company image to customers, partners and coworkers

- Non-physician reviewers do not modify or deny requests for medical treatment.

Administrative staff may not conduct any activities that require interpretation of clinical information, including but not limited to, the choosing of a set of criteria to use for handling a request for healthcare services or treatments.

Alan E. Randle, MD and UR Nurse Manager ensure that the AMC non-physician reviewers comply with the review policies and procedures outlined in the CA UR Plan.

### **ALLIED PHYSICIAN REVIEWERS**

AMC physician reviewers are either a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, who is competent to evaluate the specific clinical issues involved in the medical treatment request/services and where the request/services are within the scope of the reviewer's practice.

Allied Managed Care utilizes the physician peer review panel of NMR (Network Medical Review), Dane Street, Claims Eval and independent physicians as necessary.

In addition, physician peer review may be conducted by the Medical Director.

Physician reviewers who are competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the reviewer's scope of Practice, may, except as indicated below, authorize, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

### **UTILIZATION REVIEW PROCESS**

In addition, physician peer review may be conducted by the Medical Director

Physician reviewers who are competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the reviewer's scope of practice, may, except as indicated below, authorize, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

The DWC allows and encourages claims administrators to establish guidelines within their utilization review plans under which certain requests for treatment are not required to go through a formal UR process. The DWC also supports the establishment of "Best Practices" that allow claims administrators to approve appropriate levels of care for injured workers at the lowest levels within the claims organization without having to send those requests through a third party process.

Consistent with the above, the AMC UR process provides for the ability of claims examiner or nurse case manager to authorize a request for services when such request is within specified criteria established by the claims administrator and AMC as outlined below. The authorization process will comply with the appropriate timelines and criteria as outlined below.

The process whereby requests for authorization are reviewed and decisions on such requests are made includes the following:

- An initial screening of the request for authorization is performed by the appointed claims examiner to determine if authorization can be provided based on specified criteria or whether referral to Allied Managed Care Utilization Review is appropriate or necessary. If the request for authorization is determined to be consistent with the specified criteria (*See attachment*) or otherwise medically necessary for the injured worker and is authorized by the claims examiner, notification letters are sent out by the claims examiner in accordance with § 9792.9.1 Utilization Review Standards – Timeframes, Procedures, and Notice Content (see below).

*Note: The Medical Director of AMC maintains supervisory oversight of adjuster-driven approvals through a comprehensive quality review program and feedback to the claims leadership team on specific identifiable trends that indicate both appropriate and timely authorizations as well as areas for improvement. Any corrective action plans are then developed and implemented by the claims management.*

- If the request for authorization cannot be authorized by the claims examiner, the request for authorization is faxed to Allied Managed Care within 24 hours of receipt, with the date of receipt as defined by § 9792.9.1 (a)(1) and (a)(2)(A), (a)(2)(B), (a)(2)(C). (See below)
- Upon receipt of a request for authorization by Allied Managed Care, an initial review is performed by a non-physician, medically trained reviewer under the supervision of the AMC UR Manager to determine if the request for authorization falls within the recommended criteria as contained in the treatment guidelines of the Medical Treatment Utilization Schedule (MTUS) or other nationally recognized, scientifically and evidenced based medical treatment guidelines if applicable. If the proposed treatment is consistent with the applicable guidelines, the non-physician reviewer may approve requests for authorization.
- The non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization. The requesting physician must sign and date the amended request. This documentation must be part of the injured worker's file.

- The non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision, but in no event shall this exceed the time limitations imposed in sections 9792.9.1 subdivisions (c) and (d). Any time beyond the time specified in these sections is subject to the provisions of section 9792.9.1 (f).
- If the non-physician reviewer is unable to approve the request for authorization after following the above steps, the request is submitted to the AMC Manager of Peer Review Services for assignment to a physician reviewer.
- A physician reviewer will then review the case and provide a determination to authorize, modify or deny the request for authorization of medical treatment based on applicable medical criteria and clinical guidelines. Only licensed physicians may modify or deny treatment. As part of the peer review process, the physician reviewer will, when reasonable and appropriate, make at least one attempt to contact the requesting physician in the event of a denial or modification.
- Before issuing a denial due to lack of reasonable and necessary information, efforts to obtain the information from the requesting physician must be documented. 8 CCR 9792.9.1(g).

(Note: in the event of a decision to deny/modify the request for treatment wherein there has been no peer to peer contact, a request for reconsideration of the determination shall be referred back to the initial peer review physician. If a formal appeal is issued by the requesting physician, the appeal process outlined below will be followed.) Refer to the section: Dispute Resolution & Appeal Process.

(Reconsideration is when a physician provides additional information to reconsider the determination or some other type of clarifying document. The appeal request can be initiated without additional information.)

## UTILIZATION REVIEW WITHIN 30 DAYS FOLLOWING THE INITIAL DATE OF INJURY

(Effective 1-1-18)

- a) For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (b). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. For treatment rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer-selected physician, the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.
- b) Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:
- (1) Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.
  - (2) Nonemergency inpatient and outpatient surgery, including all pre-surgical and postsurgical services.
  - (3) Psychological treatment services.
  - (4) Home health care services.
  - (5) Imaging and radiology services, excluding X-rays.
  - (6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars (\$250), as determined by the official medical fee schedule.
  - (7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
  - (8) Any other service designated and defined through rules adopted by the administrative director.

- c) If a physician fails to submit the report required under Section 6409 and a complete request for authorization, as described in subdivision (a), an employer may remove the physician's ability under this subdivision to provide further medical treatment to the employee that is exempt from prospective utilization review.
- d) Retrospective utilization review may be performed for any treatment provided pursuant to subdivision (a) solely for the purpose of determining if the physician is prescribing treatment consistent with the schedule for medical treatment utilization, including, but not limited to, the drug formulary adopted pursuant to Section 5307.27

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

The criteria or guidelines routinely utilized in the AMC Utilization Review Process shall be consistent with the Medical Treatment Utilization Review Schedule (MTUS) adopted pursuant to Sections 9792.20 - 9792.23. These criteria/guidelines shall be reviewed and updated as necessary on a bi-annual basis by the AMC Medical Director.

### **PRIOR AUTHORIZATION**

In addition to the authorization provided under the guidelines for treatment during the first 30 days following the initial date of injury, the AMC Utilization Review Plan provides for client specific prior authorization processes wherein authorization is provided without the need for submission of a request for authorization. When the designated physician or clinic or other provider satisfies the condition described in the parameters of the client prior authorization plan for each specific medical treatment, procedure, or medication, a DWC RFA is not required and authorization is granted. Please see the appendix for the specific criteria of each client's prior authorization plan.

### **UTILIZATION REVIEW PLAN**

The complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process, shall be filed by the claims administrator, or by AMC, with the Administrative Director. In lieu of filing the utilization review plan, the claims administrator may submit a letter identifying AMC as having been contracted to perform the utilization review functions, provided that AMC has filed a complete utilization review plan with the Administrative Director. A modified utilization review plan shall be filed with the Administrative Director within 30 calendar days after the claims administrator makes a material modification to the plan

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

AMC may make available the complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process, through electronic means. If a member of the public requests a hard copy of the utilization review plan, AMC may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed \$0.25 per page plus actual postage costs.

**Financial Incentive Policy:**

Allied Managed care does not have a system for reimbursement, bonuses or incentives to staff or health care providers based directly on consumer utilization of health care services.

# MEDICALLY BASED CRITERIA

(a) The medically based criteria shall be consistent with the Medical Treatment Utilization Schedule adopted by the DWC pursuant to Labor Code Section 5307.27.

## 1) § 9792.22 General Approaches

- (a) Prevention (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 1).
- (b) General Approach to Initial Assessment and Documentation (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 2).
- (c) Initial Approaches to Treatment (ACOEM June 30, 2017).
- (d) Cornerstones of Disability Prevention and Management (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 5).

## 2) § 9792.23 Clinical Topics

- (a) Cervical and Thoracic Spine Disorders Guideline (ACOEM May 27, 2016)
- (b) Shoulder Disorders Guideline (ACOEM August 1, 2016)
- (c) Elbow Disorders Guideline (ACOEM 2013)
- (d) Hand, Wrist, and Forearm Disorders Guideline (ACOEM June 30, 2016)
- (e) Low Back Disorders Guideline (ACOEM February 24, 2016)
- (f) Knee Disorders Guideline (ACOEM October 28, 2015)
- (g) Ankle and Foot Disorders Guideline (ACOEM September 2015)
- (h) Stress Related Conditions - Chronic Pain Guideline (ACOEM May 2017)
  - Note: The above related to psychological treatment and evaluation related to chronic pain. If the injured worker's psychological condition, treatment, or evaluation is unrelated to chronic pain, then medical care and evaluation shall be in accordance with other medical treatment guidelines or peer-reviewed studies found by applying the Medical Evidence Search Sequence as outlined below.
- (i) Eye Disorders Guideline (ACOEM April 1, 2017)
- (j) Hip and Groin Guideline (ACOEM May 1, 2011)
- (k) Occupational/Work-Related Asthma Medical Treatment Guideline (ACOEM January 4, 2016)
- (l) Occupational Interstitial Lung Disease Guideline (ACOEM January 4, 2016)
- (m) Acupuncture Treatment Guidelines - Guidance for acupuncture treatment and evaluation are contained in the applicable Clinical Topics guidelines, and/or Chronic Pain Guideline, and/or Opioid Guideline.
- (n) Chronic Pain Guideline (ACOEM May 15, 2017)
- (o) Postoperative Rehabilitation Guidelines - Guidance for postsurgical operative

- rehabilitation treatment and evaluation are contained in the Clinical Topics guidelines, and/or Chronic Pain Guideline and/or Opioid Guideline. The post-operative rehabilitation treatment recommendations apply to visits during the post-operative period only and to surgeries as defined in those guidelines. At the conclusion of the post-operative period, treatment reverts back to the applicable 24-visit limitation for chiropractic, occupational therapy, and physical therapy pursuant to Labor Code section 4604.5(c)(1).
- 3) § 9792.27.2. MTUS Drug Formulary; MTUS Drug List; Scope of Coverage. (Effective Date 1-1-18).
- (a) Drugs prescribed or dispensed to treat a work related injury or illness fall within Labor Code section 4600's definition of "medical treatment" and are subject to the relevant provisions of the MTUS, including the MTUS Treatment Guidelines, provisions relating to the presumption of correctness, and the methods for rebutting the 7presumption and for substantiating medical necessity where the MTUS Treatment Guidelines do not address the condition or injury.
- (b) Except for continuing drug treatment subject to section 9792.27.3, subdivision (b), a drug dispensed on or after January 1, 2018 for outpatient use shall be subject to the MTUS Drug Formulary, regardless of the date of injury.
- 4) § Section 9792.27.3. MTUS Drug Formulary Transition.
- (a) Except as provided in subdivision (b), the MTUS Drug Formulary applies to drugs dispensed on or after January 1, 2018, regardless of the date of injury.
- (b)
- (1) For injuries occurring prior to January 1, 2018, the MTUS Drug Formulary should be phased in to ensure that injured workers who are receiving ongoing drug treatment are not harmed by an abrupt change to the course of treatment. The physician is responsible for requesting a medically appropriate and safe course of treatment for the injured worker in accordance with the MTUS, which may include use of a Non-Exempt drug or unlisted drug where that is necessary for the injured worker's condition or necessary for safe weaning, tapering, or transition to a different drug.
- (2) If the injured worker with a date of injury prior to January 1, 2018 is receiving a course of treatment that includes a Non-Exempt drug, an unlisted drug, or a compounded drug, the physician shall submit a progress report issued pursuant to section 9785 and a Request for Authorization that shall address the injured worker's ongoing drug treatment plan. The report shall either:
- (A) Include a treatment plan setting forth a medically appropriate weaning, tapering, or transitioning of the worker to a drug pursuant to the MTUS, or
- (B) Provide supporting documentation, as appropriate, to substantiate the medical necessity of, and to obtain authorization for, the Non-Exempt drug, unlisted drug, or compounded drug, pursuant to the MTUS (via guidelines, Medical Evidence Search Sequence, and/or Methodology for Evaluating Medical Evidence.)

(3) The progress report, including the treatment plan and Request for Authorization provided under this subdivision, shall be submitted at the time the next progress report is due under section 9785, subdivision (f)(8), however, if that is not feasible, no later than April 1, 2018.

5) § Section 9792.27.8. Physician-Dispensed Drugs.

(a) Drugs dispensed by a physician must be authorized through prospective review prior to being dispensed, except as provided in subdivision (b), section 9792.27.12 (“Special Fill”), and section 9792.27.13 (“Perioperative Fill”).

(b) A physician may dispense up to a seven-day supply of a one or more drugs that are designated as “Exempt” in the MTUS Drug List without obtaining authorization through prospective review, if the drug treatment is in accordance with the MTUS Treatment Guidelines and the up-to-seven-day supply is dispensed at the time of an initial visit that occurs within 7 days of the date of injury.

6) § Section 9792.27.9. Compounded Drugs.

(a) Compounded drugs must be authorized through prospective review prior to being dispensed.

7) § Section 9792.27.12 MTUS Drug List – Special Fill.

(a) The MTUS Drug List identifies drugs that are subject to the Special Fill policy. Under this policy, a drug that usually requires prospective review because it is “Non-Exempt,” will be allowed without prospective review as specified in subdivision (b).

(b) The drug identified as a Special Fill drug may be dispensed to the injured worker without seeking prospective review if all of the following conditions are met:

(1) The drug is prescribed at the single initial treatment visit following a workplace injury, provided that the initial visit is within 7 days of the date of injury; and

(2) The prescription is for a supply of the drug not to exceed the limit set forth in the MTUS Drug List; and

(3) The prescription for the Special Fill – eligible drug is for:

(A) An FDA-approved generic drug or single source brand name drug, or,

(B) A brand name drug where the physician documents and substantiates the medical need for the brand name drug rather than the FDA-approved generic drug, and

(4) The drug is prescribed in accordance with the MTUS Treatment Guidelines.

(c) When calculating the 7-day period in subdivision (b)(1), the day after the date of injury is “day one.”

8) § Section 9792.27.13. MTUS Drug List – Perioperative Fill.

(a) The MTUS Drug List identifies drugs that are subject to the Perioperative Fill policy. Under this policy, the Non-Exempt drug identified as a Perioperative Fill drug may be dispensed to the injured worker without seeking prospective review if all of the following conditions are met:

(1) The drug is prescribed during the perioperative period; and

(2) The prescription is for a supply of the drug not to exceed the limit set forth in the MTUS Drug List; and

(3) The prescription for the Perioperative Fill - eligible drug is for:

(A) An FDA-approved generic drug or single source brand name drug, or,

(B) A brand name drug where the physician documents and substantiates the medical need for the brand name drug rather than the FDA-approved generic drug, and

(4) The drug is prescribed in accordance with the MTUS Treatment Guidelines.

(b) For purposes of this section, the perioperative period is defined as the period from 4 days prior to surgery to 4 days after surgery, with the day of surgery as “day zero”.

(b) Recommendations found in the Medical Treatment Utilization Schedule are presumptively correct on the issue of extent and scope of medical treatment and diagnostic services for the duration of the medical condition.

(c) The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption of correctness can be rebutted by applying the Medical Evidence Search Sequence and providing a citation to a medical treatment guideline or peer-reviewed study which contains recommendations supported by a higher quality and strength of evidence than the recommendation in the MTUS Treatment Guidelines. The MTUS presumption of correctness affects the burden of proof and the treating physician who seeks treatment outside of the MTUS Treatment Guidelines bears the burden of rebutting the MTUS presumption of correctness by a preponderance of scientific medical evidence

(d) Treatment shall not be denied on the sole basis that the condition or injury is not addressed by the Medical Treatment Utilization Schedule. For all conditions or injuries not addressed in the MTUS Treatment Guidelines, the authorized treatment and diagnostic services shall be in accordance with other scientifically and evidence-based medical treatment guidelines or peer

reviewed scientific studies found by applying the Medical Evidence Search Sequence set forth in section 9792.21.1 as outlined below that are nationally recognized by the medical community. In such instances, AMC will utilize additional guidelines including (but not limited to):

- a. Official Disability Guidelines (ODG)
- b. Milliman and Roberts
- c. Washington State Guidelines
- d. Colorado State Guidelines
- e. Cochrane Guidelines
- f. Clinical Guidelines issued by Anthem Blue Cross, Aetna, and/or Cigna

### § 9792.21.1. Medical Evidence Search Sequence.

- Utilization review physicians shall conduct the following medical evidence search sequence for the evaluation and treatment of injured workers
  - (1) Search the MTUS Treatment Guidelines to find a recommendation applicable to the injured worker's medical condition or injury
  - (2) In the limited situation where a medical condition or injury is not addressed by the MTUS Treatment Guidelines or if the MTUS' presumption of correctness is being challenged, then:
    - (A) Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then
    - (B) Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25. Medical treatment guidelines can be found in the National Guideline Clearinghouse that is accessible at the following website address: [www.guideline.gov/](http://www.guideline.gov/). If no applicable recommendation is found, or if the reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then
    - (C) Search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.4. A search for peer-reviewed published studies may be conducted by accessing the U.S. National Library of Medicine's

database of biomedical citations and abstracts that is searchable at the following website: [www.ncbi.nlm.nih.gov/pubmed](http://www.ncbi.nlm.nih.gov/pubmed). Other searchable databases may also be used.

After conducting the medical evidence search in the sequence specified above:

- If the RFA is being modified or denied, then the Utilization Review physician shall provide in the Utilization Review decision, in addition to the requirements set forth in section 9792.9.1(e), a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.
1. The citation provided by the Utilization Review physician shall be the primary source relied upon which he or she believes contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.
  2. If the Utilization Review physician provides more than one citation, then a narrative shall be included by the reviewing physician in the Utilization Review decision explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

## **TIMEFRAMES, PROCEDURES, AND NOTICE OF CONTENT:**

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

For purposes of this section, the DWC Form RFA shall be deemed to have been received by the claims administrator or by AMC by facsimile on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or the claims administrator’s utilization review organization. A DWC Form RFA transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator or AMC on the following business day, except in the case of an expedited or concurrent review. The copy of the DWC Form RFA or the cover sheet accompanying the form transmitted by a facsimile transmission or by electronic mail shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall display either the facsimile telephone number to which the request was transmitted or the electronic mail address. The requesting physician must indicate if there is the need for an expedited review on the DWC Form RFA.

Where the DWC Form RFA is sent by mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator five (5) business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.

Where the DWC Form RFA is delivered via certified mail, with return receipt mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator on the receipt date entered on the return receipt.

In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the DWC Form RFA shall be deemed to have been received by the claims administrator five days after the latest date the sender wrote on the document.

AMC and/or the claims administrator shall maintain telephone access and have a representative personally available by telephone from 9:00 AM to 5:30 PM Pacific Time, on business days for health care providers to request authorization for medical services. AMC and/or the claims administrator shall have a facsimile number available for physicians to request authorization for medical services. AMC and/or the claims administrator shall maintain a process to receive communications from health care providers requesting authorization for medical services after business hours. For purposes of this section the requirement that AMC and/or the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by

maintaining a voice mail system or a facsimile number or a designated email address for after business hours requests.

The AMC UR process begins when a DWC Form RFA is first received either by the claims administrator or AMC. The UR timeframes will begin with the date of receipt of the RFA— which is the date of receipt of the written request for authorization as outlined above. The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA.

For purposes of this section, “normal business day” means a business day as defined in Labor Code section 4600.4 and Civil Code section 9.

AMC will use the date stamp applied by the claims administrators on any referrals from the claims organization as the confirmed date of receipt. If the date of receipt stamped by the claims administrator is different than the fax date the claims organization received the request from the provider AMC will assume the claims organization has made this adjustment for technical or accuracy reasons.

Utilization review of a medical treatment request made on the DWC Form RFA 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.

If the claims administrator disputes its liability for the requested medical treatment under this subdivision, it may, no later than five (5) business days from receipt of the DWC Form RFA, issue a written decision deferring utilization review of the requested treatment unless the requesting physician has been previously notified under this subdivision of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment. 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. The written decision shall only contain the following information specific to the request:

- (A) The date on which the DWC Form RFA was first received.
- (B) A description of the specific course of proposed medical treatment for which authorization was requested.
- (C) A clear, concise, and appropriate explanation of the reason for the claims administrator’s dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.
- (D) A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers’ Compensation Appeals Board.

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

“You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call (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 the claims examiner.

and

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

If utilization review is deferred pursuant to this subdivision, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers’ Compensation Appeals Board or by agreement between the parties, the time for the claims administrator to conduct retrospective utilization review in accordance with this section shall begin on the date the determination of the claims administrator’s liability becomes final. The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator’s receipt of a DWC Form RFA after the final determination of liability.

Unless additional information is requested necessitating an extension of the timeframe (as defined under subdivision 9792.9.1 (f) – see below), the utilization review process shall meet the following timeframe requirements:

Upon receipt of a request for authorization as described in the paragraph below or a DWC Form RFA that does not identify the employee or provider, does not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity for the requested treatment, or is not signed by the requesting physician, a non-physician reviewer as allowed by section 9792.7 or reviewer must either regard the request as a complete DWC Form RFA and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked “not complete,” specifying the reasons for the return of the request no later than five (5) business days from receipt. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

Except for treatment requests made pursuant to the formulary, prospective, or concurrent, decisions to approve, modify or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker’s condition, not to exceed five (5) working days from the date of receipt of a request for authorization for medical treatment and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of receipt of the medical treatment request. The

request for authorization and supporting documentation may be submitted electronically under rules adopted by the administrative director.

Prospective or concurrent decisions to approve, modify or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under the above paragraph ("not to exceed 5 working days from the date of receipt of the DWC Form RFA") would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in the above paragraph.

Retrospective decisions to approve modify or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination.

Decisions to approve a request for authorization §9792.9.1 (d):

(1) All decisions to approve a request for authorization set forth in a DWC Form RFA shall specify the date the complete request for authorization was received, the specific medical treatment service requested, the specific medical treatment service approved, and the date of the decision.

(2) For prospective, concurrent, or expedited review, approvals shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. Any decision to approve a request shall be communicated to the requesting physician initially by telephone or facsimile. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two business days for prospective review.

(3) 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.

Payment, or partial payment consistent with the provisions of California Code of Regulations, title 8, section 9792.5, of a medical bill for services requested on the DWC Form RFA, within the 30-day timeframe set forth above, 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.

Decisions to modify or deny a request for authorization §9792.9.1 (e):

(1) The review and decision to deny or modify a request for medical treatment will be conducted by a an AMC physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice.

(2) Failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.

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

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

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

(A) The date on which the DWC Form RFA was first received.

(B) The date on which the decision is made (The date of the utilization review report is the date on which the decision was made unless otherwise specified).

(C) A description of the specific course of proposed medical treatment for which authorization was requested.

(D) A list of all medical records reviewed.

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

(F) A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section §9792.8. If a utilization review decision to modify or deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

(G) The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee, to 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. The DWC Form IMR will be provided whenever a treatment request has been denied or modified. A copy of the DWC Form IMR-1 will also be provided to the applicant attorney and the provider requesting the treatment.

(H) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision.

(I) Include the following mandatory language advising the injured employee:

“You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call (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 the claims examiner

and

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

(J) Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a clear statement that the internal appeals process is voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

(The AMC UR process is outlined below – see section titled “Dispute Resolution – Appeal Process”)

The written decision modifying or denying treatment authorization provided to the requesting physician will also contain the name and specialty of the reviewer or expert physician

reviewer, and the telephone number in the United States of the reviewer or expert physician reviewer. The written decision will also disclose the hours of availability of either the reviewer, the expert physician reviewer or the medical director for the treating physician to discuss the decision. This shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time or an agreed upon scheduled time to discuss the Utilization Review determination with the requesting physician. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services or the AMC Medical Director.

The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment:

- (1) In the case of concurrent review, medical care will not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee.
- (2) Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.

The timeframe for utilization review decisions as outlined above [specified in §9792.9.1 (c)] may only be extended by the reviewer under one or more of the following circumstances:

- (A) The claims administrator or AMC is not in receipt of all of the information reasonably necessary to make a determination.
- (B) The AMC reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.
- (C) The AMC reviewer needs a specialized consultation and review of medical information by an expert reviewer.

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

If any of the circumstances set forth in (B) or (C) above are deemed to apply following the receipt of a DWC Form RFA or accepted request for authorization, the reviewer shall within five (5) business days from the date of receipt of the request for authorization notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is

represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered.

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

If the results of the additional examination or test required under (B) above, or the specialized consultation under subdivision (C) above, that is requested by the reviewer under this subdivision is not received within thirty (30) days from the date of the request for authorization, the reviewer shall deny the treating physician's request with the stated condition that the request will be reconsidered upon receipt of the results of the additional examination or test or the specialized consultation.

Upon receipt of information requested pursuant to (A), (B), or (C) above, the claims administrator or reviewer, for prospective or concurrent review, will make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information. The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision. The written decision shall include the date the information was received and the decision shall be communicated in the manner set out in section 9792.9.1(d) (decisions to approve a request for authorization) or (e) (decisions to modify or deny a request for authorization), whichever is applicable.

Upon receipt of the information requested pursuant to subdivisions (A), (B), or (C) above, the claims administrator or AMC physician reviewer, for prospective or concurrent decisions related to an expedited review, shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information. The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision. The written notice of decision shall include the date the requested information was received and be communicated pursuant to subdivisions §9792.9.1 (d)(2) or §9792.9.1 (e)(3) as outlined above, whichever is applicable.

Upon receipt of information requested pursuant to (A), (B), or (C) above, the claims administrator or AMC physician reviewer, for retrospective review shall make the decision to approve, modify, or deny the request for authorization within thirty (30) calendar days of receipt of the information requested. The decision shall include the date it was made and be communicated pursuant to subdivisions §9792.9.1 (d)(3) or §9792.9.1 (e)(4) as outlined above, whichever is applicable.

Whenever an AMC physician reviewer issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the claims administrator's file shall document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-

mail.

If AMC is in receipt of a request for authorization (RFA) as part of a UR referral sent by the claims examiner after 5 business days from the documented date of receipt (or after 30 days from receipt of the information necessary to perform a retrospective review) and it is therefore determined that the referral has exceeded the timeframe for prospective or concurrent (or retrospective) decisions, the following procedure will be followed:

1] The claims examiner will be notified that the UR referral has exceeded the 5 business day timeframe for a prospective determination and 30 days for a retrospective review within the UR Standards.

2] If the claims examiner can document that there has been a request for additional information issued on or before the 5<sup>th</sup> business day after the date of receipt that would appropriately allow an extension of the due date to 14 calendar days, the RFA will be handled in the normal manner as outlined above.

3] If there is no documentation of a prior written request for additional information, the claims examiner will have the option of either

a] Authorizing the treatment request and provide appropriate written notification consistent with the UR Standards

OR

b] Proceeding with the normal UR process for an RFA

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**, 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.

## **DISPUTE RESOLUTION & APPEAL PROCESS:**

If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6. Neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is modified or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review or the Workers' Compensation Appeals Board under this Article.

A request for independent medical review must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, no later than 30 days after service of the written utilization review determination issued by the claims administrator under section 9792.9.1(e)(5). For formulary disputes, the employee may submit a request for independent medical review to the division no later than 10 days after the service of the utilization review decision to the employee. If at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit a request for independent medical review to the administrative director or administrative director's designee is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved. The request must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision denying or modifying the request for authorization of medical treatment. At the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision denying or modifying the request for authorization of medical treatment, to the claims administrator.

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

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

An unrepresented employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf in filing an application for independent medical review under this subdivision. A designation of an agent executed prior to the utilization review decision shall not be valid.

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

A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit an application for independent medical review

under subdivision (a)(2) on its own behalf within 30 days of receipt of the utilization review decision that either denies or modifies the provider's retrospective request for authorization of the emergency medical treatment.

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

If at the time of a utilization review decision the claims administrator is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit an application for independent medical review under the above provisions is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

If the claims administrator (including AMC) provides the employee with a written utilization review determination modifying or denying a treatment request that does not contain the required elements set forth in section 9792.9(l) or section 9792.9.1(e) at the time of notification of its utilization review decision, the time limitations for the employee to submit an application for independent medical review shall not begin to run until the claims administrator provides the written decision, with all required elements, to the employee.

AMC does provide a voluntary internal utilization review appeal process. The requesting provider and/or requesting physician must request an appeal within ten (10) days after receipt of the utilization review decision to modify or deny a proposed treatment. The appeal must be in writing and forwarded along with any supporting documentation to AMC at the following address or fax:

Allied Managed Care, Inc  
P. O. Box 269120  
Sacramento, CA 95826-9120  
Tel 916-563-1911  
Fax 916-362-3043  
[intakeur@alliedmanagedcare.com](mailto:intakeur@alliedmanagedcare.com)

The appeal will be addressed by a different peer review physician than the one providing the initial UR determination. A peer to peer discussion of the appeal will be attempted if warranted and appropriate based on the additional clinical information and/or additional scientifically and evidence-based, peer-reviewed, medical treatment guidelines submitted in conjunction with the appeal.

A request for an internal utilization review appeal will be completed, and a determination issued, by the claims administrator or AMC within ten (10) days after receipt of the request as part of our best practices but in no way shall it exceed thirty (30) days after the date of receipt of the requested appeal. An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section

9792.10.6(e) that determines the medical necessity of the disputed treatment.

In the case of a request for an expedited appeal, the requesting physician must clearly indicate the need for an expedited appeal. The same criteria for an initial expedited review as outlined above must be documented. A determination shall be made in a timely fashion appropriate to the worker's condition, not to exceed 72 hours from the date of receipt of the written request for an expedited appeal.

AMC will not consider appeals issued by the injured worker or the injured worker's attorney.

Any determination by the claims administrator/AMC following an internal utilization review appeal that results in a modification of the requested medical treatment shall be communicated to the requesting physician and the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney according to the requirements set forth in section 9792.9.1(e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.1(e)(5)(G) must indicate that the decision is a modification after appeal.

The Application for Independent Medical Review, DWC Form IMR, will not be provided with any appeal determination which upholds the prior/original denial.

# AMC MEDICAL CONFIDENTIALITY POLICY

It is the policy of AMC to request medical records only when necessary to review the authorization for medical treatment request submitted by the physician. Only the medical records relating to the determination of the appropriateness of the authorization request will be requested. AMC personnel are subject to a confidentiality policy that requires (i) all personnel maintain the confidentiality of information relating to persons covered by any of AMC's products, and (ii) personnel are prohibited from using any such confidential information except as appropriate for the business of AMC. Personnel are required to sign an annual acknowledgement of their understanding and attest compliance with these confidentiality standards.

When the medical records are received and reviewed, they are scanned into a secure database, and hard copies are filed and stored short term in a locked file cabinet, accessible only by AMC personnel involved in the review process. After a designated period of time, hard copy files are shredded and disposed of by a shredding and disposal service.

This Plan is filed with the state of California Department of Industrial Relations, Division of Workers' Compensation, and is reviewed at least annually by the medical director and is updated as necessary. The entire Plan is available for public review upon request.