Utilization Review Process
Policies and Procedures

Allied Managed Care
April 1, 2026

Utilization Review Process, Policies and Procedures

Table of Contents

Definitions 2

§9792.6.1 Utilization Review Standards – Definitions 2

§9792.20 Medical Treatment Utilization Schedule – Definitions 6

§9792.27.1 Medical Treatment Utilization (MTUS) Drug Formulary – Definitions 7

Utilization Review Standards – Applicability 10

Medically Based Criteria 14

Utilization Review Process 14

Prior Authorization 16

Utilization Review Plan 16

Financial Incentive Policy 16

Timeframes, Procedures, and Notice of Content: 17

Utilization Review – Receipt of Request for Authorization, Acceptance of Incomplete Request 17

Utilization Review – Dispute of Liability; Deferral 18

Utilization Review – Timeframes 19

Decisions to Approve a Request for Authorization 20

Decisions to modify or deny a request for authorization 21

Utilization Review – Extension of Timeframe for Decision 24

§9792.9.7 Utilization Review – Medical Treatment – First 30 Days of the Date of Injury 25

Utilization Review – MTUS Drug Formulary 27

Dispute Resolution & Appeal Process: 29

AMC Medical Confidentiality Policy 32

URAC Accreditation 33

Definitions

§9792.6.1 Utilization Review Standards – Definitions

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

(a) “Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed “Request for Authorization,” as defined in this section, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, sections 9792.9.1 through 9792.12.

(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 14006.1, or on the applicable physician reporting forms authorized by section 9785.

(e) Reserved.

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

(g) “Dispute liability” means an assertion by the claims administrator that a factual, medical, or legal basis exists, other than medical necessity, that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.

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

(i) “Emergency health care services” means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

(j) “Expedited review” means utilization review or independent medical review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

(k) “Expert reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, whose consultation for a specialized review has been requested by the claims administrator or utilization review organization, necessitating an extension of time, under section 9792.9.6, prior to the determination of medical necessity.

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

(m) “Immediately” means within one business day.

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

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

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

(q) “Medical Treatment Utilization Schedule” means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20.
(r) “Modification” means a decision by a physician reviewer that part of the requested treatment or service is not medically necessary.

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

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

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

(1) Unless accepted by a claims administrator under section 9792.9.1(b), a request for authorization must be set forth on a “Request for Authorization (DWC Form RFA),” as contained in California Code of Regulations (CCR), title 8, section 9785.5, completed by a treating physician and as further outlined in this subdivision and in section 9785(h).

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

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

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

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

(2) “Non-physician reviewer” means an individual designated by the claims administrator or utilization review organization to assist in determining the medical necessity of the requested treatment. A non-physician reviewer may not modify or deny a treatment request.

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

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

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

(aa) “Utilization review process” means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section

3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. The utilization review process begins when a completed request for authorization, or a request for authorization accepted as complete under section 9792.9.1(b), is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

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

(cc) “Normal business day” or “business day” does not include Saturday, Sunday, or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website.

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

§9792.20 Medical Treatment Utilization Schedule – Definitions

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

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

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

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

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

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

(g) “Medical treatment guidelines” means the most current version of written recommendations which are systematically developed by a multidisciplinary process through a comprehensive literature search to assist in decision-making about the appropriate medical treatment for specific clinical circumstances reviewed and updated within the last five years
(h) “Nationally recognized” means published in a peer-reviewed medical journal; or developed, endorsed and disseminated by a national organization with affiliates based in two or more U.S. states and is the most current version.

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

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

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

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

§9792.27.1 Medical Treatment Utilization (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. The 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” where OTC stands for over-the-counter, 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 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.

Utilization Review Standards – Applicability

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 Professional Code.

Alan E. Randle, M.D.,
CA License G27961
Medical Director, Allied Managed Care
P.O. Box 269120
Sacramento, CA 95826-9120
(916) 563-1911 ext. 336

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 1:00 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
- 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 Managed Care utilizes non physician reviewers (Utilization Review Nurses), consisting of licensed nurses. 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 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, PBMM 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.

Medically Based Criteria

§9792.8 Utilization Review Standards – Medically-Based Criteria

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

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

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

Utilization Review Process

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 include 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 Receipt of Request for Authorization. (*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).

- 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 section §9792.9.3 and 9792.9. Any time beyond the time specified in these sections is subject to the provisions of section §9792.9.6

- 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 Peer Review Department 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 per §9792.9.5(a)(1)(2)

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 Addendum 1 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 an approved utilization review plan on file with the Administrative Director which also identifies the claims administrator client(s) on whose behalf it performs any utilization review functions.

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.

The files and other records, whether electronic or paper, that pertain to the utilization review process shall be retained for at least three (3) years following either: (1) the most recent utilization review decision for each injured employee, or (2) the date on which any appeal from the assessment of penalties for violations of Labor Code section 4610 or sections 9792.6 through 9792.12 is final, whichever date is later.

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.

Timeframes, Procedures, and Notice of Content:

Utilization Review – Receipt of Request for Authorization, Acceptance of Incomplete Request

(a) (1) A request for authorization shall be deemed to have been received by the claims administrator or by AMC by facsimile, electronic mail, or by electronic data interchange on the date the form was received if the receiving facsimile or electronic mail address or clearinghouse 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 claim's administrator or the claims administrator's utilization review organization. A request for authorization transmitted by facsimile, electronic mail, or electronic data interchange after 5:30 PM Pacific Time shall be deemed to have been received by the claim's administrator or AMC on the following business day, except in the case of an expedited or concurrent review. The copy of the request for authorization or the cover sheet accompanying the form transmitted by a facsimile transmission, electronic mail, or electronic data interchange shall bear a notation of the date, time and place of transmission and the facsimile telephone number, electronic mail address, or identity of the payor's clearinghouse 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, electronic mail, or electronic data interchange transmission report, which shall display the facsimile telephone number, electronic mail address, or clearinghouse to which the form was transmitted. The requesting physician must indicate if there is the need for an expedited review on the request for authorization.

(2) (A) Where the request for authorization is sent by mail, the form, absent documentation of receipt, shall be deemed to have been received by the claim's administrator five (5) business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.

(B) Where the request for authorization 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.

(C) In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the request for authorization shall be deemed to have been received by the claims administrator five days after the latest date the sender wrote on the document.

(3) AMC and/or the claims administrator shall maintain telephone access and have a representative personally available by telephone (916) 563-1911 and/or by fax (916) 362- 3043 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.

(b) Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a claims administrator, non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it "not complete" and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt. A request for authorization accepted as complete shall be subject to investigation under section 9792.11 and the assessment of administrative penalties under section 9792.12.

The AMC UR process begins when a request for authorization is first received either by the claim's administrator or AMC. The UR timeframes will begin with the date of receipt of the request for authorization– 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 request for authorization, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the request for authorization.

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 claim's administrators on any referrals from the claims organization as the confirmed date of receipt. If the date of receipt stamped by the claim's 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 – Dispute of Liability; Deferral

(a)(1)Utilization review of 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.

(2)(A) If AMC or the claims administrator determines that Labor Code section 4610(k) precludes the need for utilization review, AMC or the claims administrator shall comply with the requirements under this section

(B) A request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred 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.

(b) If the claims administrator disputes liability as allowed under subdivision (a), it may, no later than five (5) business days from the receipt of the request for authorization, 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:

(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 the 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 (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 or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

(c) 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 request for authorization after the final determination of liability.

Utilization Review – Timeframes

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

(b) Prospective or concurrent decisions to approve, modify, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed request for authorization.

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

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

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

Decisions to Approve a Request for Authorization

(a) (1) All written decisions to approve a request for authorization shall specify the date the complete, or accepted as complete, request for authorization was first received, the specific 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 was requested, and the date the information was received.

(2) For approvals of a request for authorization of a drug where the request for authorization did not indicate "Do Not Substitute" or "Dispense as Written," the written decision approving the request in generic form shall indicate, "generic substitute authorized" or words to that effect and meaning.

(3) For approvals of a request for authorization of a drug that is exempt on the Drug Formulary, the written decision approving the request shall indicate, "Exempt per MTUS Drug Formulary" or words to that effect and meaning.

(4) For approvals of a request for authorization of non-drug treatment that are exempt under section 9792.9.7 (i.e., the 30-day exemption), the written decision approving the request shall identify the exempt treatment as, "30-day exemption" or words to that effect and meaning.

(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 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 be followed be issued to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.

(c) (1) 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.

(2) 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 communication expressly acknowledging the retrospective approval.

Decisions to modify or deny a request for authorization

(a) The review and decision to deny or modify a request for medical treatment will be conducted by 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.

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

(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 be issued to the requesting physician where the initial communication of the decision to the physician was by telephone.

(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 this determination as to whether the treatment was medically necessary.

(e) The written decision modifying or denying treatment authorization shall be provided to the requesting physician, the injured worker, and, if applicable, the injured worker’s representative and/or 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:

(1) The date on which the completed or accepted request for authorization was first received.

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

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

(4) A description of the specific course of medical treatment set forth on the request for authorization.

(5) A list of all medical records reviewed.

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

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

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

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

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

(10) The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee, must be completed by the 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.

(11) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed

Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application1

(12) 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 (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.”

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

(14) The written decision modifying or denying treatment authorization provided to the requesting physician will also contain the name and specialty of the reviewer or, if applicable, 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.

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

(1) 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.

(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

Utilization Review – Extension of Timeframe for Decision

(a) (1) The timeframe for utilization review decisions specified in §9792.9.3 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.

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

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

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

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

(d)(1) Upon receipt of information requested pursuant to subdivision (a)(1) (A), (B), or (C), 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 in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5

(2) Upon receipt of the information requested pursuant to subdivisions (a)(1) (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 in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5.

(3) Upon receipt of information requested pursuant to subdivisions (a)(1) (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 in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5..

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 5th 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

§9792.9.7 Utilization Review – Medical Treatment – First 30 Days of the Date of Injury

(a) Notwithstanding the requirements of sections 9792.9.1 through 9792.9.6, a treating physician specified in Labor Code section 4610(b), may render medically necessary treatment or services to an injured worker without prospective utilization review for the first thirty (30) days after the date of injury, provided that:

(1) The treatment or service is for a body part or condition that has been accepted as compensable by the claims administrator.

(2) The treatment or service is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director under Section 5307.27.

(3) The initial treating physician timely submits the “Doctor's First Report of Occupational Injury or Illness,” DIR Form 5021, to the claims administrator as required by section 9785, subdivision (e), setting forth in detail the anticipated treatment plan for the injured worker.

(4) All treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, are set forth in a request for authorization provided to the claims administrator in accordance with section 9785(h). The form shall be submitted to the 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.

(5) The treating physician's medical treatment bill for the non-emergency treatment rendered or services provided under this section is submitted to the claims administrator within thirty (30) days of the date the service was provided. Medical treatment bills for emergency treatment services shall be submitted within 180 days of the date that the treatment was provided.

(b) The following medical treatment services, unless previously authorized by the claims administrator or rendered as emergency medical treatment, cannot be provided under subdivision (a) and shall require prospective utilization review under section 9792.9.1 or 9792.9.3:

(1) Pharmaceuticals, to the extent they are not expressly exempt from prospective review under the MTUS Drug Formulary.

(2) Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician’s office. This includes all necessary and routine pre-operative, intra-operative, and post-operative services performed for the purpose of surgery including, but not limited to, related diagnostic tests or procedures, rehabilitation services, durable medical equipment or supplies, and routine post-surgical pain management treatment or services. For the purpose of this section, "surgery" means: 1) any procedure set forth in the Surgery section of the American Medical Association’s *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.

(3) Psychological or psychiatric treatment services, which includes diagnostic services, psychotherapy, and other services or procedures to an individual or group in all care settings provided by a physician or other qualified health care provider, and including psychiatric pharmaceuticals, to the extent they are not expressly exempt from prospective utilization review under the MTUS Drug Formulary.

(4) Home health care services, including health care and other medically necessary services provided to the injured worker in the residential setting.

(5) Imaging and radiology services, excluding X-rays.

(6) All durable medical equipment, prosthetics, orthotics, and supplies where the purchase or rental cost of the item with necessary supplies, if any, for the expected course of treatment is greater than $250.00 as determined by the DWC Official Medical Fee Schedule (OMFS), or, for an unlisted item, where the billed amount will be greater than $250.00.

(7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies. For the purpose of the subdivision, electrodiagnostic medicine is a medical specialty where the physician uses neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic, neuromuscular, and/or muscular systems. This includes, but is not limited to, procedures set forth in the American Medical Association's *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.

(8) Spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections.

Utilization Review – MTUS Drug Formulary

(a) This subdivision governs review of Exempt Drugs listed on the MTUS Drug List.

(1) Notwithstanding sections 9792.9.1 through 9792.9.7, the following drugs can be dispensed to an injured worker without obtaining authorization through prospective review:

(A) Drugs identified on the MTUS Drug List as exempt under section 9792.27.15;

(B) Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Special Fill policy under section 9792.27.12; and

(C) Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Perioperative Fill policy under section 9792.27.13.

(2) Exempt drugs identified in subsection (1) must still be set forth in a request for authorization as required under section 9792.6.1(u), or in a manner agreed upon by the treating physician and the claims administrator.

(b) This subdivision governs review of Non-Exempt Drugs that are listed on the MTUS Drug List. For a drug not covered under subdivision (a) of this section, regardless of whether a drug is prescribed and dispensed within 30 days from the date of injury, the treating physician must request authorization through prospective utilization review by submitting a request for authorization in the manner set forth in section 9792.6.1(u), or in a manner agreed upon by the treating physician and the claims administrator.

(1) Prospective decisions to approve, modify, or deny a request for authorization for a drug not covered under subdivision (a) of this section shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the request

for treatment. The reviewer or non-physician reviewer may request the treating physician to provide additional information reasonably necessary to make a determination as follows:

(A) The reviewer or non-physician reviewer shall request the information from the treating physician within four (4) business days from the date of receipt of the request for authorization.

(B) If the information is not received within five (5) business days from the date of the request for authorization of treatment, a physician reviewer may deny the request in accordance with section 9792.9.5, subdivision (e).

(2) The decision shall be communicated in the manner set forth in sections 9792.9.4 and 9792.9.5.

(3) The extension of time as set forth in section 9792.9.6 is not applicable to a request for authorization of a drug covered under this subdivision.

(c) This subdivision governs review of drugs that are not listed on the MTUS Drug List. A treating physician must request authorization through prospective review for a drug not listed on the MTUS Drug List by submitting a request for authorization in the manner set forth in section 9792.6.1(u) or in a manner agreed upon by the treating physician and the claims administrator, regardless of whether a drug is prescribed or dispensed within 30 days from the date of injury. Prospective decisions to approve, modify, or deny a request for authorization of a drug not listed on the MTUS Drug List shall be made in a timely fashion in accordance with section 9792.9.3 and section 9792.9.6. The decision shall be communicated in the manner set forth in sections 9792.9.4 and 9792.9.5.

(d) Notwithstanding subdivision (b), a request for authorization that requests both drugs and non-pharmaceutical treatment related to the same injury or illness shall be reviewed under the timeframes set forth in section 9792.9.3 and section 9792.9.6 and the requirements of sections 9792.9.4 and 9792.9.5.

(e) Except for drugs that fall under 9792.9.7(a), a utilization review decision to deny a request for authorization of a drug which falls under subdivision (a) of this section based on the failure of the treating physician to prescribe or dispense the medication consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule, can be grounds for the denial of payment for the medication.

(f) (1) A decision to modify or deny a request for authorization under this section based on medical necessity shall be reviewed only through the claims administrator's voluntary internal utilization review appeals process, or the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

(2) A dispute regarding a decision to modify or deny a request for authorization under this section based on a reason other than medical necessity shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

(3) If a decision is made to modify or deny a request for authorization under this section based on both medical necessity and a reason other than medical necessity, the non-medical necessity dispute shall be resolved first.

(g) The following rules apply when a treating physician prescribes or dispenses a drug to treat an injured worker under the provisions of section 9792.9.7(a).

(1) The injured worker's initial treating physician shall describe in the treatment plan on the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, all drugs that are being prescribed or dispensed to treat the injured worker, and list on the request for authorization required under section 9792.9.7(a)(4), all drugs that are being prescribed or dispensed. Subsequent primary treating physicians shall submit a request for authorization following their first visit with the injured worker indicating all drugs that are being prescribed or dispensed for treatment.

(2) The treating physician may prescribe or dispense a drug identified under subdivision (a) of this section without the need to obtain authorization through prospective utilization review.

(3) For a drug not covered under subdivision (a) of this section, the treating physician must request authorization through prospective utilization review by submitting a request for authorization in the manner set forth in section 9792.9.1, or in a manner agreed upon by the treating physician and the claims administrator.

(4) The claims administrator may conduct retrospective review of a drug prescribed or dispensed to the injured worker under subdivision (a) of this section only for the purpose of determining whether the use of the drug is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director under Section 5307.27.

(A) Payment for an exempt drug dispensed under the provisions of section 9792.9.7(a) shall not be denied based on a determination that use of the drug was not consistent with the applicable guideline.

(B) Use of an exempt drug that is not consistent with the applicable guideline may be used as a basis to find that the physician, under section 9792.9.7(c), has a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule.

Dispute Resolution & Appeal Process:

Utilization Review – Dispute Resolution

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

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

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

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

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

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

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

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

(d) If expedited review is requested for a 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).

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

(2) If the claims administrator (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 9792.9.5I(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.

(f) (1) AMC does provide a voluntary internal utilization review appeal process. The 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
FDAdminShare@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.

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

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.

(3) 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 9792.9.5(e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.5(e)(7) must indicate that the decision is a modification after appeal.

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.

URAC Accreditation

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CERTIFICATE OF AWARD

in recognition of

Allied Managed Care Incorporated
10445 Old Placerville Road
Sacramento, California 95827

for compliance with

Workers' Compensation Utilization Management 8.1
Accreditation Program

is awarded

Full Accreditation

Effective from 12/01/2025 through 12/01/2028

Shawn Griffin MD

Shawn Griffin, MD
President & Chief Executive Officer

Certificate Number: WUM010042

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ACCREDITED

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

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

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