UTILIZATION MANAGEMENT / UTILIZATION REVIEW PROGRAM

UTILIZATION REVIEW
POLICIES AND PROCEDURES MANUAL

Division of Workers' Compensation
Medical Unit - Utilization Review
P.O. Box 71010
Oakland, CA 94612

Revised on June 16, 2023

Rev. 06-16-2023 GC

Table of Contents **Page**

INTRODUCTION

PROGRAM GOAL

To conduct Workers' Compensation utilization review in accordance with California law, including but not limited to the labor code, regulations and governing case law.

PROGRAM COMPONENTS

Two basic components used to reach the program goal

1. Review of services on a prospective, concurrent, and retrospective basis.
2. Collection and analysis of utilization data within this review organization.

SECTION I

DEFINITIONS

ACOEM: 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.

Authorization: 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.

Claims Administrator: 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

Concurrent Review: Utilization review conducted during an inpatient stay.

Course of Treatment: 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

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

Expedited Review: 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.

Expert Reviewer: 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.

Health Care Professional (HCP); AKA: Non-Physician Reviewer: A non-physician first level reviewer who is licensed as either a licensed vocational nurse (LVN), registered nurse (RN), licensed acupuncturist (Lac), or physical therapist (PT).

Health Care Provider: 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.

Immediately: means within one business day.

Independent Medical Review (IMR): California's worker's compensation system uses a process called independent medical review (IMR) to resolve disputes about the medical treatment of injured employees. A request for medical treatment in the workers' compensations system must go through a "utilization review" process to confirm that it is medically necessary before it is approved. If utilization review denies or modifies a treating physician's request for medical treatment because the treatment is not medically necessary, the injured employee can ask for a review of that decision through IMR.

Medical Director: 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.

Medical Services: The 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.

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

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

Prior authorization: means "the claims administrator's practice of any prior authorization process, including but not limited to where authorization is provided without the submission of the RFA or DWC Form RFA." To qualify as prior authorization, the process must be clearly described in the UR plan filed with the DWC, because by definition "authorization" means "assurance that appropriate reimbursement will be made to the treating physician for an approved specific course of proposed medical treatment. See exhibit for Prior Authorization list.

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

Reconsideration: A reconsideration results when additional information requested by the Utilization Review Organization is received after a Utilization Review decision has already been determined and denied based on lack of information. The newly received information will now be reconsidered to determine if medical necessity has been established based on medical treatment guidelines, and will have the same time frame as a prospective Request For Authorization (5 business days).

Receipt Date: The receipt date refers to when the request for authorization is first received whether by the claims administrator or the utilization review organization (URO).

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

(4) Per regulation 9792.1(c)(2)(A) incomplete RFAs are addressed within the 5 business days for Prospective requests and indicate the reason why the UR process is halted. Reasons to mark an RFA as incomplete may be; denied claim, denied body part, missing physician's signature, missing medical report to substantiate the DWC form RFA request.

8 CCR 9792.9.1(c)(2)(A) Upon receipt of a request for authorization as described in subdivision (c)(2)(B), 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.
(B) The claims administrator may accept a request for authorization for medical treatment that does not utilize the DWC Form RFA, provided that: (1) "Request for Authorization" is clearly written at the top of the first page of the document; (2) all requested medical services, goods, or items are listed on the first page; and (3) the request is accompanied by documentation substantiating the medical necessity for the requested treatment.

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

Utilization review decision: A decision pursuant to Section 4610 to modify or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with, the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402. "Utilization review decision" may also mean a determination, occurring on or after January 1, 2018, by a physician regarding the medical necessity of medication prescribed pursuant to the drug formulary adopted pursuant to Section 5307.27.

Utilization Review Plan: 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.

Utilization Review Process: Utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code 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 prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

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

PROSPECTIVE REVIEW:

1.1 Definition: A prospective review relates to utilization review conducted prior to the delivery of the requested medical services, except for review conducted during an inpatient hospital stay, which is termed a concurrent review.

1.2 Time Frame: The utilization review decision for a prospective RFA must be rendered *within five (5) business days from initial receipt of the request*, whether by the employer, the claims administrator or the URO. If additional reasonable medical information is required to make the decision, 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. The date of initial receipt is counted as day zero (0), and the next business day is counted as day one (1). Business days do not consider Saturday, Sunday or holidays.

1.3 Expedited Reviews: *Expedited reviews are counted in hours regardless of whether the due date falls on a calendar or business day, and is due within 72 hours of initial receipt.* Per 9792.9.1(e)(2) emergency care contained within a prospective, concurrent or retrospective review will be addressed as an expedited request with a determination within 72 hours if receipt.

8 CCR 9792.9.1 (e)(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

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

Emergency care may be given without Utilization Review. The 72-hour statement is incorrect with regards to emergency care.

1.4 Notifications: For prospective, concurrent and expedited reviews, the decision must be communicated first to the requesting physician by telephone or fax within 24 hours

of the decision. A phone call must be followed by written notice to the requesting physician, the injured worker and the injured worker's attorney (if any): *within two business days of the decision for prospective reviews and within 24 hours for concurrent review.* If the initial decision is announced within 24 hours of the decision by a fax and all mandated language is included in the fax, the written notification to the treating physician is satisfied.

1.5 Request for Additional Information: See section below entitled, "REQUESTS FOR ADDITIONAL INFORMATION (RFI)"

1.6 UR Decisions to Approve Required Language: A written decision approving a request for authorization must specify the medical treatment service requested and approved. The written approval must also specify the specific the date the complete request for authorization was received, and the date of the decision.
(Title 8 CCR §9792.9.1(d))

1.7 UR Decisions to Modify or Deny Required Language: The timeliness of the review is documented by including the date of the decision and the date the RFA was received on the first page of the letter.

The decision must be in writing and it must contain:

1. The date the decision was made
2. A line item description of the specific course of proposed medical treatment for which authorization was requested
3. A specific description of the medical treatment service approved, if any
4. A clear and concise explanation of the reasons for the URO's decision
5. A description of the medical criteria or guidelines used
6. The clinical reasons explaining why any of the treatment may not have been medically necessary
7. The completed Application for Independent Medical Review, DWC Form IMR (except the injured worker's signature). The addressed envelope is to be included with the decision letter sent to the injured worker
8. A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days after service of the decision, and ten (10) days for formulary disputes.
9. The following mandatory language: "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.
and

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

10. Details about the claims administrator's internal utilization review appeals process for the requesting physician, 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.

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

CONCURRENT REVIEW:

1.1 Definition: A concurrent review is UR conducted on an RFA submitted for treatment during an inpatient (hospital) stay.

1.2 Time Frame: The utilization review decision for a concurrent RFA must be rendered *within five (5) business days from initial receipt of the request*, whether by the employer, the claims administrator or the URO; If additional reasonable medical information is required to make the decision, 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. The date of initial receipt is counted as day zero (0), and the next business day is counted as day one (1). Business days do not consider Saturday, Sunday or holidays. *The written decision must be sent within 24 hours for concurrent reviews instead of the two business days allotted for prospective reviews. (CCR, Title 8 §§9792.9.1(d)(2) and 9792.9.1(e)(3).)*

1.3 Notifications: For prospective, concurrent and expedited reviews, the decision must be communicated first to the requesting physician by telephone or fax within 24 hours of the decision. A phone call must be followed by written notice to the requesting physician, the injured worker and the injured worker's attorney (if any): *within 24 hours of the decision for concurrent reviews*

If the initial decision is announced within 24 hours of the decision by a fax and all mandated language is included in the fax, the written notification to the treating physician is satisfied.

1.4 Request for Additional Information: See section below entitled, "REQUESTS FOR ADDITIONAL INFORMATION (RFI)"

1.5 UR Decisions to Approve Required Language: A written decision approving a request for authorization must specify the medical treatment service requested and approved. (CCR, Title 8 §9792.9.1(d))

1.6 UR Decisions to Modify or Deny Required Language: The timeliness of the review is documented by including the date of the decision and the date the RFA was received on the first page of the letter.

The decision must be in writing and it must contain:

1. The date the decision was made
2. A line item description of the specific course of proposed medical treatment for which authorization was requested
3. A specific description of the medical treatment service approved, if any
4. A clear and concise explanation of the reasons for the URO's decision
5. A description of the medical criteria or guidelines used
6. The clinical reasons explaining why any of the treatment may not have been medically necessary
7. The completed Application for Independent Medical Review, DWC Form IMR (except the injured worker's signature). The addressed envelope is to be included with the decision letter sent to the injured worker
8. A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days after service of the decision.
9. The following mandatory language:
   "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.
   and

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

10. Details about the claims administrator's internal utilization review appeals process for the requesting physician, 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.

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

By definition, a concurrent review occurs only during an in-patient stay. For concurrent reviews, medical care must not be discontinued until the requesting physician has been notified of the UR decision and, if not approved, a care plan which is appropriate for the medical needs of the injured worker must be agreed upon with the requesting physician.

9792.9.1(e)(6)(A) "The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment: Medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee." EK Health will send a request for additional information (RFI) if needed to render an appropriate medical necessity determination.

RETROSPECTIVE REVIEW:

1.1 Definition: A retrospective review is UR conducted after medical services have been provided and for which authorization has not already been given.

1.2 Time Frame: Retrospective reviews must be completed within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination.

1.3 Notifications: When the review is retrospective, approval must be communicated to the physician, the injured worker and his or her attorney (if applicable) within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination.

1.4 Request for Additional Information: See section below entitled, "REQUESTS FOR ADDITIONAL INFORMATION (RFI)"

1.5 UR Decisions to Approve Required Language: A written decision approving a request for authorization must specify the medical treatment service requested and approved. The written approval must also specify the specific the date the complete request for authorization was received, and the date of the decision.

1.6 UR Decisions to Modify or Deny Required Language: The timeliness of the review is documented by including the date of the decision letter and the date the RFA was received on the first page of the letter.

The decision must be in writing and it must contain:

12. The date the decision was made
13. A line item description of the specific course of proposed medical treatment for which authorization was requested
14. A specific description of the medical treatment service approved, if any
15. A clear and concise explanation of the reasons for the URO's decision
16. A description of the medical criteria or guidelines used
17. The clinical reasons explaining why any of the treatment may not have been medically necessary
18. The completed Application for Independent Medical Review, DWC Form IMR (except the injured worker's signature). The addressed envelope is to be included with the decision letter sent to the injured worker
19. A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days after service of the decision, and ten (10) days for formulary disputes.
20. The following mandatory language:
    "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.
    and

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

21. Details about the claims administrator's internal utilization review appeals process for the requesting physician, 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.

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

EVIDENCE BASED TREATMENT GUIDELINES FOR DETERMINING MEDICAL NECESSITY:

The MTUS is promulgated by the DWC administrative director under Labor Code sections 5307.27 and 4604.5, and can be found in sections 9792.20 et seq. of Title 8, California Code of Regulations. Per regulation 9792.8(a)(2) areas of treatment not covered by the MTUS: When treatments are not covered by the MTUS, the medical reviewers shall conduct the medical evidence search sequence for the evaluation and treatment of injured workers as detailed in 8 CCR 9792.21.1.

EK Health reviewers will apply Labor Code §4610.5(c)(2) to determine the medical necessity and appropriateness of any Request for Authorization.

(2) "Medically necessary" and "medical necessity" mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:

(A) The guidelines adopted by the administrative director pursuant to Section 5307.27. Guidelines are reviewed by our Medical Director, and guidelines are updated automatically within online access to the MTUS via MDGuidelines.

(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

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

REQUESTS FOR ADDITIONAL INFORMATION (RFI):

9792.9.1(f)
(1) The timeframe for decisions specified in subdivision (c) may only be extended under one or more of the following circumstances:

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

(B) The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.

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

(2) (A) If the circumstance under subdivision (f)(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.
(B) If any of the circumstances set forth in subdivisions (f)(1)(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.

(3) (A) If the information reasonably necessary to make a determination under subdivision (f)(1)(A) 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.

(B) If the results of the additional examination or test required under subdivision (f)(1)(B), or the specialized consultation under subdivision (f)(1)(C), 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.

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

(5) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent decisions related to an expedited review, shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information. 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 (d)(2) or (e)(3), whichever is applicable.

(6) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or reviewer, for retrospective review, shall make the decision to approve, modify or deny the request for authorization within thirty (30) calendar days of receipt of the information requested. The decision shall include the date it was made and be communicated pursuant to subdivisions (d)(3) or (e)(4), whichever is applicable.

RFI Letter template will include the following language:

9792.9.1(f)(3)(A) *"If the information reasonably necessary to make a determination under subdivision (f)(1)(A) 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."*

OR

9792.9.1(f)(3 (B) If the results of the additional examination or test required under subdivision (f)(1)(B), or the specialized consultation under subdivision (f)(1)(C), 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.

SB 1160 RFI Updates:

Decisions denying treatment due to lack of sufficient information to make a medical necessity determination must include:

A specific description of the information needed from the treating physician

The details regarding the attempt(s) to obtain the information should be clearly documented:

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

A description of the manner in which the request was communicated.

If an RFA is denied because of the lack of information reasonably necessary to make a Utilization Review determination pursuant to 8 CCR 9792.9.1(f), the Administrative Director shall determine that IMR Application is ineligible for an IMR review.

Conditional denials: if the treater subsequently provides the specific information that was requested, utilization review will be completed at that time.

Duplicate RFA:

A UR decision to modify or deny treatment remains in effect for 12 months

No action needed on similar request by the same physician or another physician within the requesting physician's practice group, unless there is a documented change in material facts. It is documented in the UR letter in this situation when a duplicate treatment request is made and will not be addressed again by UR.

Examples of "material change":
change in job function status, diagnosis, hospital admission, new co-morbidity, changes in other parts of treatment plan

INDEPENDENT MEDICAL REVIEW (IMR):

EK Health will generate the IMR Application form with all UR denials and modifications for post 01/01/2013 dates of injuries (DOIs), and then with all DOIs after 07/01/2013; and attach it to the UR Determination (URD) letter. IMR Application forms are also generated with all voluntary appeal modifications. EK Health will also include a self-addressed envelope to the DWC's contracted vendor for handling Independent Medical Reviews.

The Application for Independent Medical Review, DWC Form IMR will have all fields on the form, except for the signature of the employee, completed by EK Health. "Not Available" will be entered if required information cannot be obtained. The written decision provided to the injured worker shall include an addressed envelope, which may be postage-paid, for mailing the DWC Form IMR to the Administrative Director or his or her designee.

A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days of receipt of the decision, and ten (10) days for formulary disputesw will be included.

The following mandatory language advising the injured employee will be included:

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

and

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

Details about the claims administrator's internal utilization review appeals process for the requesting physician 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. (See Attached Template)

The written decision modifying or denying treatment authorization provided to the requesting physician shall also contain the:

1. The name of the UR physician
2. The specialty of the UR physician
3. The telephone number in the U.S. to reach the UR physician
4. Disclose the hours of availability of the UR physician, or medical director for the treating physician to discuss the decision which shall be at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM, Pacific time or an agreed upon scheduled time to discuss the decision.
5. In the event the UR physician 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 requested.

1. CONFIDENTIALITY POLICY 8 CCR Section

Manual:	**Subject:**	**Program:**	**Publication Date:**
CM P&P Manual **UR P&P Manual**	**Confidentiality & HIPAA**	**Case Management (CM)** **Utilization Review (UM)**	**09/01/2011**
			Revision Date: 12/18/2017
			Version: URAC UM 7.3 / CM 5.1
			Activation Date: 09/01/2011
			Review Date:

Core 16 - Confidentiality of Individually-Identifiable Health Information

All health related information pertaining to the Injured Workers of clients of EK Health Services Inc. will be held privately and confidentially in accordance with HIPAA (Health Insurance Portability and Accountability Act). Although Workers' Compensation is not held to HIPPA rules, all EK Health employees are trained during initial orientation on patient confidentiality and the use and disclosure of individually identifiable health information.

The initial orientation includes instructions on the use of personal or work issued cell phones regarding patient confidentiality. Texting between the NCM and IW is only allowed by using the Care++ application, which facilitates efficient and secure messages through Ahshay.

Core (a-f)

1. During orientation all EK employees will receive a briefing from Human Resources on the importance of confidentiality of individually identifiable health information.
2. Only employees, who have a need to know, handle medical information on the Injured Worker (IW). These employees include the following: Indexers, Intake Coordinators, Care Coordinators, Case Managers, Health Care Professionals, Physician Reviewers, department supervisors and managers, account executives, and clinical staff.
3. At the time of employment with EK Health, all employees will sign the Confidentiality statement which is maintained in their personnel folder kept in the HR department that states they understand it is their responsibility to protect this information.
4. During initial orientation and ongoing by department managers, all employees and contractors are reminded that all individually identifiable health information will not be discussed (orally, written, or electronic) other than when necessary to conduct business of EK Health Services, Inc.
5. Annually, the HR department will remind all employees of the responsibilities regarding confidentiality of individually identifiable health information.
6. Individual identified health information is used to determine the medical necessity of a procedure or treatment.
7. The clinical staff uses the medical records to gleam information on the health status of the IW.
8. Only employees of EK Health, who have a need to know, will have access to health information. The staff in the following departments has access to health information: Operations, Case Management, Utilization Review, Marketing Department (Account Executives).
9. All records are submitted electronically and stored in the Ahshay system.
10. Committee members, employees and board members are required to preserve all confidential information. HR staff requires a signed confidentiality statement to protect individually identifiable health information and their signatures confirm they understand their responsibility to preserve confidentiality.
11. Annually, HR and Operations review access for all employees and any changes necessary to ensure confidentiality of the individually identifiable health information and will annually report findings to the QM (Quality Management) committee.

Related Standards

- CORE 4 - Regulatory Compliance
- CORE 13 - Information Management
- CORE 15 - Information Confidentiality and Security
- CORE 35 - Consumer Complaint Process

Assurance that only physicians may make modify/denial decisions (8 CCR Section 9792.7(b)(2):

Only a physician reviewer can deny or modify a request for medical treatment. The physician reviewer shall be competent to evaluate the specific clinical issues involved in the medical treatment services and where the requested services are within the scope of the individual's practice.

UR Client List

AutoZone	Murphy & Beane, Inc.
Beacon Mutual	MV Transportation, Inc.
Big Lots Stores, Inc.	Santa Clara County
Cast & Crew Payroll LLC	Santa Clara VTA
Charles Taylor/SISF	Sedgwick CMS
Charles Taylor/TPA	Self Insured Security Fund
City of Simi Valley	Sentry
CorVel	SISF Metro
County of San Diego	Southern California Edison
Dollar General Corporation	State Fund
ESIS	The Cities Group
Gallagher Bassett	Travelers
Great American Insurance Group	Tristar SCVTA
Hortica/Florist Mutual	Williams Sonoma
Johnston & Associates	Work First Casualty
Metro Risk Management	York Insurance Services Group
MLB	TakeOne Network Corp dba Wrapbook

SECTION II

STAFF QUALIFICATIONS AND CREDENTIALS

All claims administrators must have a UR program and all UR programs must have a medical director. The medical director is responsible for all decisions made in the UR process and must ensure that all UR decisions (approvals, modifications and denials) comply with the law. As long as the medical director of this UR plan is able to ensure that the claims adjusters (whether in-house for a self-insured employer or external through a TPA or WC insurer) are applying the standards of the UR plan, the claims adjusters can approve medical treatment authorization requests. EK Health Services' UR Plan is compliant with the rules and regulations per the CA DWC.

Under the guidance of a medical director (internal or EK Health Services), EK Health recommends that the claims administrator clients establish "UR best practices" that allow claims administrators to approve appropriate levels of care for injured workers at the lowest possible levels within the claims organization, without having to send those requests through formal utilization review. The established "UR best practices" must be compliant with the EK Health's UR Plan filed with the CA DWC. A copy of the claims administrator's "UR best practices" shall be retained by EK Health Services.

1. **Medical Director**
   - 1.1 CA DWC: "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; and has a background in managed care, utilization review and workers' compensation.
   - 1.2 CA DWC: Responsibility to ensure that the medical utilization program of the employer meets the requirements and there is a specialty physician for each "specialty" body part addressed, i.e., hand surgeon, psychiatry, etc. The Medical Director is responsible for all decisions made in the utilization review process.
   - 1.3 Douglas Benner, MD will serve as Medical Director. He will follow up with specialists as needed.

CHIEF MEDICAL OFFICER

Douglas Allan Benner, M.D., F.A.C.O.E.M.
Occupational Medicine, Board Certified
License #: C35266
(877) 861-1595
992 S. De Anza Blvd., Suite 101
San Jose, CA 95129

Job description and responsibility:

- Responsible for providing leadership, strategic direction and overall operational management of physician services and medical staff administration for EKHS.
- Works with the Administrator to develop strategic directions, policies, goals and objectives of various services for clinical areas and address operational issues that build effective relationships between EKHS, its medical staffs and regional physicians who might use the EKHS facilities for patient care services. This includes establishing relationships with new physicians and developing rapport with other non-referring physicians.
- Represents EKHS ideals, values, principles and mission to the medical staff and community physicians.
- Responsible for strategic medical affair issues including: identifying clinical issues critical to EKHS' performance and mission.
- Developing a positive impact on quality and safety, developing physician networks, joint ventures, physician relationships, physician recruitment and physician development for the system.
- Additional responsibilities include establishing and implementing evidence-based standards and policies to ensure the quality medical care.
- Serves as a community resource and provides advice and counsel to corporate administrators on medical and administrative matters related to the medical practice and current affairs.

MINIMUM EXPERIENCE REQUIRED: Licensed Physician with strong clinical background (board certified), Credentialed with the American Society of Physician Executives (preferred). 10 plus years clinical practice with experience in health plan, hospital, or peer review administrative or committee structure. Medical staff relations, quality measurement credentialing and previous medical management experience highly desirable. Knowledge of JCAHO, managed care and health policy to effectively integrate medical management.

2. **Program Director**

2.1 Overseeing the Quality Assurance Program for the Utilization Management Program.

2.2 Ensures that Program policies and procedures are carried out in an efficient and effective manner according to the guidelines and principles established by the Committee and the President.

2.3 Maintain regulatory compliance program; stay current of relevant laws via the CA Department of Worker's Compensation (http://www.dir.ca.gov/) and other statutory rules and regulations as applicable; performs analysis against organization's program and incorporate as relevant.

2.4 Presides over Utilization Management and Quality Assurance program meetings.

2.5 Responsible for the staffing of programs to meet the annual goals.

2.6 Ensures that timely reports are accurate and complete.

2.7 Is liaison between staff, medical director, and President to communicate information necessary for the viability and growth of the programs.

2.8 Identifies potential and real barriers to the strength and vitality of the programs, and independently resolves these barriers within the parameters outlined by the Committee and President.

2.9 Establishes, grooms, and maintains a cohesiveness and sense of teamwork between Program and Committee team players.

2.10 Demonstrates a strong ethical duty towards the care of clients, business relationships with customers, and the professional partnership with medical treaters.

2.11 Partners the responsibility of long-term financial stability and growth of the Programs with the President and Committee members.

2.12 Collects, compiles, interprets information specific to the goals established by the Committee in a format that is easily understandable and useful to those who utilize this information to structure their own work.

2.13 Leads the Committee in determining obtainable goals and objectives within the resources available.

3. **UR Health Care Professionals (HCP)**

3.1 Utilization Review Health Care Professionals (UR HCP) may consist of LVN, RN, LAc, PT, DC, or other licensed health care professional as a first level reviewer. Duties of a first level reviewer include review of the treatment request for potential certification, initial guideline application based on diagnosis and medical record summary. Live QA and proofing is completed by the HCP.

3.2 Required to have at least 3 years of acute care clinical experience or a background in managed care, utilization review, and workers' compensation.

3.3 Must maintain a current valid registered license.

5. Physician Reviewers:

5.1. Consulting physicians representing every major medical specialty.

5.2. Will function in a consultant capacity for unusual or medically complex cases requiring a specific specialty.

5.3. Will possess a valid California license in that specialty; unless specified per statutory rules and regulations in other states.

5.4. CA: Will be knowledgeable in the managed care process and California Workers' Compensation system.

5.5. CA: A "reviewer" is 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 that are the subject of the request for authorization, where these services are within the scope of the reviewer's practice (8CCR §9792.6.1(v))

5.6. Scope of practice is determined by the physician's licensing board and defines the procedures, actions and processes permitted for the licensed individual.

Scope of practice is also determined by the physician's experience and clinical experience, and not by his/her specialty.

5.7. The physician reviewer does not have to hold the same license as the requesting physician, as long as the reviewer's scope of practice and clinical competence cover the treatment in question.

5.8. The physician reviewer does not have to be in the same specialty as the requesting physician, as long as the reviewer's experience, scope of practice and clinical competence cover the treatment in question.

5.9. CA: To know if a physician reviewer is qualified to review an authorization request, there is a two-part test for reviewer qualifications:

1.9.1 "Competent to evaluate the specific clinical issues involved in the medical treatment services"

1.9.2 "These services are within the reviewer's scope of practice … "

1.9.3 For example, a podiatrist could review a request for authorization for surgery on the foot and ankle, but not for low back. A chiropractor may request authorization for an injured worker to be treated by an acupuncturist, but a chiropractor cannot review that request for authorization because acupuncture is not within a chiropractor's scope of practice.

5.10 CA: If the reviewer is licensed out of state and the scope of practice for that license is different than the scope of practice for the same license in California, the California UR regulations and California scope of practice will be the deciding factors. The out of state licensed physician may make the decision, but he/she must follow California laws and requirements.

6. Appeals considerations are conducted by health professionals who:

6.1. Are *clinical peers*; board certified consulting physicians representing every major medical specialty.

6.2. Hold an active, unrestricted *license* to practice medicine or a health profession;

6.3. Are *board-certified* (if applicable) by:

6.3.1. A specialty board approved by the *American Board of Medical Specialties*(doctors of medicine); **or**

6.3.2. The *Advisory Board of Osteopathic Specialists* from the major areas of clinical services (doctors of osteopathic medicine);

6.4. Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; **and**

Are neither the individual who made the original *non-certification*, nor the subordinate of such an individual.

SECTION III

UTILIZATION REVIEW OPERATIONS PROCESS:

Request for a utilization management determination services is received by the Intake Coordinator at EK Health Services. This is received from the requesting physician, other provider or the claims examiner (CE). Requests may be received in writing, by fax, mail or phone (which is answered by the third ring and contact is initiated by live person). As EKHS clients are insurance carriers and self-insured entities, EKHS does not accept request for a utilization management determination services from the injured worker unless authorized by the claims examiner. The Intake Coordinator will identify themselves as an employee of EK Health Services and give their title; they will request that all phone requests be followed by a written request.

EK Health Services has normal business hours, 9:00 AM to 5:30 PM., Pacific Time. EK Health Services has a proprietary UR process with a dedicated UR Fax number 408-725-1135 for receiving requests 24 hours a day. Telephone inquiries may be directed to 408-973-0888.

Any comments about the ability of consumers to assess services shall be reported to the Program Director, UM (Utilization Management) Supervisor or Office Manager and will be documented and tracked as per the policies: QA Evaluation of UM Healthcare Services and QA (Quality Assurance) Evaluation of Administrative Staff. This information will be reported to the QA Committee for discussion and resolution to improve or correct any problem.

UR PLAN AVAILABLE TO THE PUBLIC:

EK Health Services' UR Plan is available to the public upon request. (8 CCR §9792.7(d))

The claims administrator or representative (EKHS) may make available the complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process, through electronic means. If a member of the public requests a hard copy of the utilization review plan, the claims administrator or representative (EKHS) 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.

SECTION IV

INTERNAL VOLUNTARY APPEALS PROCESS:

EK Health Services maintains a formal process to consider voluntary *appeals* of *non-certifications and partial certifications (UR Denials or Modifications)* that includes:

1. The availability of *standard appeal* for non-urgent cases and *expedited appeal* for *cases involving urgent care*; **and**
2. Written appeals policies and procedures that:
   2.1 Clearly describe the *appeal* process, including the right to *appeal* of the *worker*, *provider,* or *facility rendering service*;
   2.2 Provide for explicit time frames for each stage of the *appeal* resolution process; **and**
   2.3 Are available, upon request, to any *worker, provider, or facility rendering service.*
   2.4 Details about the claims administrator's internal utilization review appeals process for the requesting physician 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.

Any request by the injured worker or treating physician for an internal utilization review appeal process conducted under this section must be submitted to the claims administrator within ten (10) days after the receipt of the utilization review decision. A request for an internal utilization review appeal must be completed by the physician reviewer within thirty (30) days after receipt of the request. An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination that determines the medical necessity of the disputed treatment.

Any determination by the claims administrator following an internal utilization review appeal that results in a modification of the requested medical treatment shall be communicated to the requesting physician and the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney according to the requirements set forth in section 9792.9.1(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.

Appeal considerations are reviewed by Physician Reviewer health professionals who are: *clinical peers*;

1. Hold an active, unrestricted *license* to practice medicine or a health profession;
2. Are *board-certified* (if applicable) by:
   2.1 A specialty board approved by the *American Board of Medical Specialties* (doctors of medicine); **or**

2.2 The *Advisory Board of Osteopathic Specialists* from the major areas of clinical services (doctors of osteopathic medicine);

3. Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; **and**
4. Are neither the individual who made the original *non-certification*, nor the subordinate of such an individual.

The second review Physician Reviewer will make his/her recommendations determining whether the non-certification is upheld or overturned. The Physician Reviewer has three working days (72 hours for Urgent; 30 calendar days for Standard) to make his/her decision. Once the decision is made, a determination letter will be sent to the injured worker, physician and/or provider, the claims examiner, and the injured worker's attorney/representative if applicable. There are two types of internal voluntary appeal:

A. **Urgent** - This requires prompt action and is used in cases requiring ongoing treatment such as continued hospitalization or other services. These requests are reviewed and completed as soon as possible, and no later than 72 hours after the initiation of the appeals process.
B. **Standard** – These are reviewed and completed within 30 calendar days after receipt of the request.

Details regarding the internal utilization review appeals process, and a clear statement that the appeals process is on a voluntary basis, will be given with each adverse UR determination including the following mandatory statement:

TO THE INJURED WORKER, the INJURED WORKER'S REPRESENTATIVE, OR the INJURED WORKER'S ATTORNEY (Labor Code 4610.5 AND 4610.6 Process):

If you disagree with the utilization review decision, 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 you on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision, and ten (10) days for formulary disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster at the number provided at the top of this letter. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

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 closest to you. For recorded information and a list of offices, call toll-free 1-800-736-7401.

TO THE REQUESTING PHYSICIAN:

Our reviewers at EK Health Services are available from 9:00 AM to 5:30 PM Pacific Time. If you have any questions or need clarification please call (408) 973-0888 where we also offer a 24 hour voice mail available. Our facsimile number is 408-725-1135. You may also reach us through email at info@ekhealth.com

INTERNAL VOLUNTARY APPEALS PROCESS

EK Health Services, Inc. has a voluntary internal utilization review appeals process or first level reviews only. This internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis. If a request for authorization is modified or non-certified, all parties including the injured worker, treating physician/provider, or the facility rendering service has the right and opportunity to initiate an internal voluntary appeal of the determination by telephone or written notification. Written notification from the requesting party for Internal Voluntary Appeals must be received within 10 calendar days from the date of the receipt of the non-certification. Participation in the Internal Voluntary Appeals Process DOES NOT extend the deadlines of the Labor Code 4610.5 or 4610.6 Process.

SECTION V

SB 1160 Exempt Treatment

Effective 1/1/2018
ONLY for NEW injuries that occur ON or AFTER 1/1/18
Prospective UR not required within initial 30 days of the date of injury for ALL treatments except those which do not meet one of the criteria on this page or are specifically listed as Non-exempt treatments.
https://leginfo.legislature.ca.gov/bill_id=2015200160SB1160

Specific Exempt Service Types include:
Emergency services
Medications as designated under the MTUS Rx drug formulary
Services provided by a predesignated physician, MPN or HCO providers, or employer-selected physicians or facilities

Services must:
Relate to an accepted body part or condition that is addressed by the MTUS
Treatment plan must be outlined in the physician's report and accompanying request for authorization (RFA) and provided to the claims administrator or employer

All treatment rendered must be consistent with the MTUS, and NOT indicated as a Non-Exempt treatment.

Retrospective UR may be conducted for any treatment provided solely for the purpose of determining if the provider is prescribing treatment consistent with the MTUS.

Specific exclusions requiring Prospective UR:
Home Health Care services
Advanced imaging outside of x-rays (i.e. MRIs, CTs)
Electrodiagnostic studies (i.e. NCV/EMG)
DME exceeding $250.00
Psychological treatment
Non-emergency surgery (including pre & post op services)
Certain medications not covered by the formulary

MTUS Formulary Exempt Medications

Assembly Bill 1124 required the adoption of an evidence-based workers' compensation drug formulary

January 1st, 2018 Effective Date
Applies to drugs dispensed on or after 1/1/18 – regardless of date of injury
https://www.dir.ca.gov/dwc/mtus/MTUS-Formulary.html

Goal of Formulary
Expedite use and access to medically appropriate drugs for therapeutic and analgesic purposes

Accessible through MDGuidelines website, or PDF and Excel copies can be obtained at the following address:

http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/MTUS-Formulary.htm

Formulary to be consistent with the adoption of new MTUS based on current ACOEM Guidelines.

Only applies to outpatient drugs: dispensed to be taken, applied, or self-administered by the patient at home or outside of a clinical setting (does not apply to injections)

"Exempt" Drugs – No Prospective Review if in accord with MTUS

"Non-Exempt" (& Unlisted Drugs) – Prospective Review required

"Special Fill" & "Perioperative Fill" of specified Non-Preferred drugs – No Prospective Review if in accord with MTUS

Can be subject to Retrospective UR to determine if the specific drug's use was in accordance with the MTUS

Indications for discontinuation:
Resolution of pain
Lack of Efficacy
Adverse Effects that necessitate discontinuation

For patients with a date of injury prior to January 1, 2018 receiving treatment that includes a Non-Exempt drug, an unlisted drug, or a compounded drug, the physician shall submit a progress report and a Request for Authorization that shall address the injured worker's ongoing drug treatment plan. The report shall either:

Include a treatment plan setting forth a medically appropriate weaning, tapering, or transitioning of the worker to a drug pursuant to the MTUS; or

Provide supporting documentation, as appropriate, to substantiate the medical necessity of, and to obtain prior authorization for the Non-Exempt drug, unlisted drug, or compounded drug

The progress report, including the treatment plan and Request for Authorization must be submitted at the time the next progress report is due

Select Non-Exempt Drugs can be 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 the prescription is for a supply of the drug not to exceed the limit set forth in the MTUS Drug List

Generic only unless medication is only Single Source Brand or when physician substantiates medical necessity for brand medications

Can be subject to Retrospective UR to determine if the specific drug’s use was in accordance with the MTUS

Non-Exempt drug may be prescribed/dispensed without Prospective Review:

Prescription may be provided 4 days prior through 4 days after surgery; and is not exceed the limit set forth in the MTUS Drug List, not to exceed 4 days dosing

Generic only unless medication is only Single Source Brand or when physician substantiates medical necessity for brand medications

Can be subject to Retrospective UR to determine if the specific drug’s use was in accordance with the MTUS

MTUS Treatment Guideline Updates

MTUS 2017:
(adopted ACOEM disorder chapters)

Initial Approaches to Treatment (ACOEM June 30, 2017)
Cervical and Thoracic Spine Disorders (ACOEM May 27, 2016)
Shoulder Disorders (ACOEM August 1, 2016)
Elbow Disorders (ACOEM April 15, 2013)
Hand, Wrist, and Forearm Disorders (ACOEM June 30, 2016)
Low Back Disorders (ACOEM February 24, 2016)
Knee Disorders (ACOEM October 28, 2015)
Ankle and Foot Disorders (ACOEM September 1, 2015)
Eye Disorders (ACOEM April 1, 2017)
Hip and Groin Disorders (ACOEM May 1, 2011)
Occupational/Work-Related Asthma (ACOEM January 4, 2016)
Interstitial Lung Disease (ACOEM January 4, 2016)
Chronic Pain (ACOEM May 15, 2017)
Opioids (ACOEM April 20, 2017)

Also included:
-Prevention
-General Approach to Initial Assessment and Documentation
-Cornerstones of Disability Prevention and Management

-Acupuncture Medical Treatment Guidelines and Post-Surgical Treatment Guidelines from previous MTUS deleted - these treatments are addressed within individual ACOEM chapters

-Previous MTUS guideline for Stress Related Conditions has not been replaced - ODG Mental Illness and Stress is the appropriate guideline for these psychological disorders

-Traumatic Brain Injury (ACOEM November 15, 2017)
TBI will be added by July 18.

URAC:

UROs that address modification or denial of treatment requests be approved by the DWC and accredited by an independent nonprofit organization (URAC).

Requirement note: the availability of peer-to-peer communication in the event of a UR modification or denial is required.

All UROs will need to submit new written UR Plans no later than 7/1/18

EK Health Services, Inc. has been URAC accredited since 2005, and is currently accredited through 07/2026

UROs are prohibited from offering financial incentives to physicians based on the number of UR denial or modification decisions they issue.

EK Health Services has never had this type of program and will continue that policy.

Claims administrators cannot refer matters to a UR entity in which the claims administrator has a financial interest unless there is a prior written disclosure to the employer and DWC Administrative Director of the name of the UR entity and the financial interest in the UR entity.

The DWC Administrative Director has authority to review contracts between the UR physician and the claims administrator or employer for purposes of enforcing these provisions.

SECTION VI

Employers, Self-insureds, Insurance Carriers and other entities may designate EK Health Services, Inc. as their Utilization Review Organization and utilize the EK Health Services Utilization Review Plan. The Administrative Director shall be notified by letter of that designation within thirty (30) days from the commencement of EK Health as the URO.

In addition, at their option, Employers, Self-insureds, Insurance Carriers and other entities may add Prior Authorization Plans or other modifications to the EK Health UR Plan. If such an option is exercised by any Employer, Self-insureds, Insurance Carrier and other entity, the Administrative Director shall be notified by letter of that designation within thirty (30) days from the commencement of EK Health as the URO along with a complete copy of any Prior-Authorization Plans or Modifications.

The Administrative Director shall be notified by letter within thirty (30) days from the commencement of any material modifications to the EK Health UR Plan or to any of Prior Authorization Plans.

Exhibits – Letter Templates attached

A. UR Approval Letter Template
B. UR Adverse (Denial/Modification) Letter Template
C. UR Appeal Approval Letter Template
D. UR Appeal Denial/Modification Letter Template
E. RFI Letter Template
F. Conditional Denial Letter Template (after no RFI response)

A. UR Approval Letter Template:

EK Health
Transforming Managed Care™

June 09, 2023

Dr. Test Provider:
Test Provider
1234 Test Lane
Lancaster, CA 93535

Re:	Claim Test	ID#:	ctest5035-9
Cl#:	2906123456 / TRK# XXX	Er:	
Ref#:	dddddd	Adjuster:	Ernest Alzar
DOI:	03/21/2008	Adj Phn:	
Carrier:	Test, Carrier	Tracking #:	

Date RFA was first received by carrier: 08/20/2018
Date request received by URO: 05/08/2017
Decision Date: 07/03/2017 02:35 PM

Utilization Review Determination

Dear Dr. Test Provider:

You have made a workers' compensation request for authorization. This letter notifies the decision based on medical necessity and appropriateness for the treatment requested. This letter does not give a decision on issues about the causes of the affected body part or claim. The claims examiner may object to those issues and offer ways to resolve those issues.

The claims administrator may select the specific provider or program. Questions about the financial aspects of the claim can be answered by the claims examiner.
Utilization Review determines if the requested medical treatment is medically necessary and appropriate. This letter does not give a decision on issues about the causes of the affected body part or claim. The claims examiner may object to those issues and may offer ways to resolve those issues.

The claims administrator may select the specific provider or program and can answer financial questions about the claim.

ITEMS REQUESTED:
ITEM 1. PROSPECTIVE: Follow-up Office Visit (RFA: 00/00/00, DOS: 00/00/00) QTY: 1.00
ITEM 2. PROSPECTIVE: Chiropratic Treatment for the Lumbar Spine (RFA: 00/00/00, DOS: 00/00/00) QTY: 6.00

APPROVED:
ITEM 1: PROSPECTIVE: Follow-up Office Visit (RFA: 00/00/00, DOS: 00/00/00) QTY: 1.00
ITEM 2: PROSPECTIVE: Chiropratic Treatment for the Lumbar Spine (RFA: 00/00/00, DOS: 00/00/00) QTY: 6.00

ADDITIONAL TREATMENT REQUESTS

MEDICAL RECORDS REVIEW PREPARED BY LICENSED HEALTHCARE PROFESSIONAL (HCP)

First level reviewer's section. Summarization of treatments requested and medical documents.

1512 S. DE ANZA BLVD. #316- SAN JOSE, CA95129- PHONE: (877) 861-1595- FAX: (408) 725-1135
WWW.EKHEALTH.COM

Other:

Notes section for this review.

PHYSICIAN REVIEWER'S RATIONALE

Second level (Physician) reviewer's section. Contain's determination for treatments reviewed along with a rationale for the determination, guidelines to support the rationale, and documentation of call to the treating physician's office if applicable.

DETAILED ICD-10/CPT INFORMATION

This request is APPROVED as follows:
ICD: M48.06, Spinal stenosis, lumbar region
Treatment: 99215, PROSPECTIVE: Follow-up Office Visit (RFA: 00/00/00, DOS: 00/00/00)
Quantity requested: 1.00 APPROVED: 1.00
To start: 06/09/2023 To end: 07/24/2023
ICD: M48.06, Spinal stenosis, lumbar region
Treatment: 98940, PROSPECTIVE: Chiropratic Treatment for the Lumbar Spine (RFA: 00/00/00, DOS: 00/00/00)
Quantity requested: 6.00 APPROVED: 6.00
To start: 06/09/2023 To end: 07/24/2023

In addition to the records listed in the report, the following records were reviewed:

Document Date - Description

Sincerely,

Jacqueline Hu,

Distribution:

- (Carrier Contact) Ernest Alzar via (via fax) to (209) 275-9012
- (Attorney) Test & Test via (via email) to jhu@datacare.com
- (Referrer) Leticia Nelson via (via email) to letician@artinsuranceservices.com
- (Provider) Test Provider via (via mail) to Test Provider 1234 Test Lane, Lancaster, CA 93535
- (Patient) Claim Test via (via mail) to 101 ABC STREET, Lathrop, CA 94044

Medical Criteria or Guidelines Used

Reference to the applicable guidelines for the treatments being reviewed.

B.UR Adverse (Denial/Modification) Letter Template:

June 09, 2023

Dr. Test Provider:
Test Provider
1234 Test Lane
Lancaster, CA 93535

Re:	Claim Test	ID#:	ctest5035-9
Cl#:	2906123456 / TRK# XXX	Er:	
Ref#:	dddddd	Adjuster:	Ernest Alzar
DOI:	03/21/2008	Adj Phn:	
Carrier:	Test, Carrier	Tracking #:	

Date RFA was first received by carrier: 08/20/2018
Date request received by URO: 05/08/2017
Decision Date: 07/03/2017 02:35 PM

Utilization Review Determination

Dear Dr. Test Provider:

You have made a workers' compensation request for authorization. This letter notifies the decision based on medical necessity and appropriateness for the treatment requested. This letter does not give a decision on issues about the causes of the affected body part or claim. The claims examiner may object to those issues and offer ways to resolve those issues.

Utilization Review determines if the requested medical treatment is medically necessary and appropriate. The claims administrator may select the specific provider or program. Questions about the financial aspects of the claim can be answered by the claims examiner.

ITEMS REQUESTED:
ITEM 1. PROSPECTIVE: Follow-up Office Visit (RFA: 00/00/00, DOS: 00/00/00) QTY: 1.00
ITEM 2. PROSPECTIVE: Chiropratic Treatment for the Lumbar Spine (RFA: 00/00/00, DOS: 00/00/00) QTY: 6.00

MODIFIED:
ITEM 2: PROSPECTIVE: Chiropratic Treatment for the Lumbar Spine (RFA: 00/00/00, DOS: 00/00/00) QTY: 3.00

DENIED:
ITEM 1: PROSPECTIVE: Follow-up Office Visit (RFA: 00/00/00, DOS: 00/00/00) (Lack of medical necessity)

ADDITIONAL TREATMENT REQUESTS

MEDICAL RECORDS REVIEW PREPARED BY LICENSED HEALTHCARE PROFESSIONAL

First level reviewer's section. Summarization of treatments requested and medical documents.

1512 S. DE ANZA BLVD. #316- SAN JOSE, CA95129- PHONE: (877) 861-1595- FAX: (408) 725-1135

WWW.EKHEALTH.COM

Other:

Notes section for this review.

PHYSICIAN REVIEWER'S RATIONALE

Second level (Physician) reviewer's section. Contain's determination for treatments reviewed along with a rationale for the determination, guidelines to support the rationale, and documentation of call to the treating physician's office if applicable.

DETAILED ICD-10/CPT INFORMATION

This request is MODIFIED as follows:
ICD: M48.06, Spinal stenosis, lumbar region
Treatment: 99215, PROSPECTIVE: Follow-up Office Visit (RFA: 00/00/00, DOS: 00/00/00)
Quantity requested: 1.00 DENIED
ICD: M48.06, Spinal stenosis, lumbar region
Treatment: 98940, PROSPECTIVE: Chiropratic Treatment for the Lumbar Spine (RFA: 00/00/00, DOS: 00/00/00)
Quantity requested: 6.00 MODIFIED: 3.00
To start: 06/09/2023 To end: 07/24/2023

In addition to the records listed in the report, the following records were reviewed:

Document Date - Description

I hereby attest that I am competent to and have the requisite license to evaluate the specific clinical issues involved in medical treatment services; and that I know of no reason for me to have recused myself from the review herein.

Sincerely,

Jacqueline Hu,

Distribution:

- (Carrier Contact) Ernest Alzar via (via fax) to (209) 275-9012
- (Attorney) Test & Test via (via email) to jhu@datacare.com
- (Referrer) Leticia Nelson via (via email) to letician@artinsuranceservices.com
- (Provider) Test Provider via (via mail) to Test Provider 1234 Test Lane, Lancaster, CA 93535
- (Patient) Claim Test via (via mail) to 101 ABC STREET, Lathrop, CA 94044

Medical Criteria or Guidelines Used

Reference to the applicable guidelines for the treatments being reviewed.

APPEAL PROCESS

TO THE INJURED WORKER, the INJURED WORKER'S REPRESENTATIVE, OR the INJURED WORKER'S ATTORNEY:
If you disagree with the utilization review decision, 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 you on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision and ten (10) days for formulary disputes. You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster at the number provided at the top of this letter. However, if you are represented by an attorney, please contact your attorney instead of your adjuster. 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.

TO THE REQUESTING PHYSICIAN:

The Undersigned Reviewer at EK Health Services is available from 9:00 AM to 5:30 PM pacific time. If you have any questions or need clarification, please call (408) 973-0888 and you can leave a message on our 24 hour voicemail at extension 100. We can also be reached by fax at 408-725-1135 or e-mail at info@ekhealth.com.

INTERNAL VOLUNTARY APPEALS PROCESS

EK Health Services, Inc. uses an internal voluntary utilization review (IVA) process for first level reviews only. The IVA process does not cause or prevent you from initiating a dispute resolution process of Labor Code sections 4610.5 and 4610.6. The injured worker, treating physician/provider, or facility can request IVA when EK Health Services, Inc. changes or denies a request for authorization. The IVA process does not extend deadlines for initiating a dispute resolution process. All parties, including the injured worker, treating physician/provider, or the facility rendering service has the right to request an IVA by telephone or in writing. Written notice must be received within 10 calendar days from the date of the receipts of the denied decision.

For information about the workers' compensation claims process and your rights and obligations, please go to www.dwc.ca.gov. Or please contact an Information and Assistance (I&A) Officer at the state Division of Workers' Compensation. The phone number is 1-800-736-7401.

C. UR Appeal Approval Letter Template:

June 09, 2023

Dr. Test Provider:
Test Provider
1234 Test Lane
Lancaster, CA 93535

Re:	Claim Test	ID#:	ctest5035-9
Cl#:	2906123456 / TRK# XXX	Er:	
Ref#:	dddddd	Adjuster:	Ernest Alzar
DOI:	03/21/2008	Adj Phn:	
Carrier:	Test, Carrier	Tracking #:	

Date RFA was first received by carrier: 08/20/2018
Date request received by URO: 05/08/2017
Decision Date: 07/03/2017 02:35 PM

Utilization Review Determination

Dear Dr. Test Provider:

You have made a workers' compensation request for authorization. This letter notifies the decision based on medical necessity and appropriateness for the treatment requested. This letter does not give a decision on issues about the causes of the affected body part or claim. The claims examiner may object to those issues and offer ways to resolve those issues.

The claims administrator may select the specific provider or program. Questions about the financial aspects of the claim can be answered by the claims examiner.
EK Health Services, Inc. has an internal voluntary utilization review (IVA) process for first level reviews only. The IVA process does not cause or prevent you from initiating an Independent Review process based on Labor Code sections 4610.5 and 4610.6. The injured worker, treating physician/provider, or facility can request IVA when EK Health Services, Inc. changes or denies a request for authorization. You can request an IVA by calling or sending a written request to EK Health Services, Inc. EK Health Services, Inc. needs to receive a written request for IVA within ten (10) calendar days from the date of receipt of the decision notice. The IVA process does not extend deadlines for initiating a dispute.

ITEMS REQUESTED:
ITEM 1. APPEAL: Follow-up Office Visit (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00) QTY: 1.00
ITEM 2. APPEAL: Chiropractic Treatment for the Lumbar Spine (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00) QTY: 6.00

APPROVED:
ITEM 1: APPEAL: Follow-up Office Visit (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00) QTY: 1.00
ITEM 2: APPEAL: Chiropractic Treatment for the Lumbar Spine (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00) QTY: 6.00

ADDITIONAL TREATMENT REQUESTS

1512 S. DE ANZA BLVD. #316- SAN JOSE, CA95129- PHONE: (877) 861-1595- FAX: (408) 725-1135
WWW.EKHEALTH.COM

MEDICAL RECORDS REVIEW PREPARED BY LICENSED HEALTHCARE PROFESSIONAL (HCP)

First level reviewer's section. Summarization of treatments requested and medical documents.

Other:

Notes section for this review.

PHYSICIAN REVIEWER'S RATIONALE

Second level (Physician) reviewer's section. Contain's determination for treatments reviewed along with a rationale for the determination, guidelines to support the rationale, and documentation of call to the treating physician's office if applicable.

DETAILED ICD-10/CPT INFORMATION

This request is APPROVED as follows:
ICD: M48.06, Spinal stenosis, lumbar region
Treatment: 99215, APPEAL: Follow-up Office Visit (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00)
Quantity requested: 1.00 APPROVED: 1.00
To start: 06/09/2023 To end: 07/24/2023
ICD: M48.06, Spinal stenosis, lumbar region
Treatment: 98940, APPEAL: Chiropratic Treatment for the Lumbar Spine (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00)
Quantity requested: 6.00 APPROVED: 6.00
To start: 06/09/2023 To end: 07/24/2023

In addition to the records listed in the report, the following records were reviewed:

Document Date - Description

Through my signature below, I hereby attest that (a) I have the requisite license or certification that typically manages the medical condition, procedure, treatment or issue under review herein; (b) I have the current, relevant experience and/or knowledge to render a determination for case under review herein; and (c) that I know of no reason for me to have recused myself from the review herein.

Sincerely,

Jacqueline Hu,

Distribution:

- (Carrier Contact) Ernest Alzar via (via fax) to (209) 275-9012
- (Attorney) Test & Test via (via email) to jhu@datacare.com
- (Referrer) Leticia Nelson via (via email) to letician@artinsuranceservices.com
- (Provider) Test Provider via (via mail) to Test Provider 1234 Test Lane, Lancaster, CA 93535
- (Patient) Claim Test via (via mail) to 101 ABC STREET, Lathrop, CA 94044

Medical Criteria or Guidelines Used

Reference to the applicable guidelines for the treatments being reviewed.

D. UR Appeal Denial/Modification Letter Template:

June 09, 2023

Dr. Test Provider:
Test Provider
1234 Test Lane
Lancaster, CA 93535

Re:	Claim Test	ID#:	ctest5035-9
Cl#:	2906123456 / TRK# XXX	Er:	
Ref#:	dddddd	Adjuster:	Ernest Alzar
DOI:	03/21/2008	Adj Phn:	
Carrier:	Test, Carrier	Tracking #:	

Date RFA was first received by carrier: 08/20/2018
Date request received by URO: 05/08/2017
Decision Date: 07/03/2017 02:35 PM

Utilization Review Determination

Dear Dr. Test Provider:

You have made a workers' compensation request for authorization. This letter notifies the decision based on medical necessity and appropriateness for the treatment requested. This letter does not give a decision on issues about the causes of the affected body part or claim. The claims examiner may object to those issues and offer ways to resolve those issues.

EK Health Services, Inc. has an internal voluntary utilization review (IVA) process for first level reviews only. The IVA process does not cause or prevent you from initiating a dispute based on Labor Code sections 4610.5 and 4610.6. The injured worker, treating physician/provider, or facility can request IVA when EK Health Services, Inc. changes or denies a request for authorization. You can call or send a written request to EK Health Services, Inc. EK Health Services, Inc. must receive a written request for IVA within ten (10) calendar days from the date of receipt of the decision notice. Participation in the IVA Process DOES NOT extend the deadlines of the Labor Code 4610.5 or 4610.6 dispute resolution procedures.

ITEMS REQUESTED:
ITEM 1. APPEAL: Follow-up Office Visit (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00) QTY: 1.00
ITEM 2. APPEAL: Chiropratic Treatment for the Lumbar Spine (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00) QTY: 6.00

MODIFIED:
ITEM 2: APPEAL: Chiropratic Treatment for the Lumbar Spine (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00) QTY: 3.00

DENIED:
ITEM 1: APPEAL: Follow-up Office Visit (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00) (Lack of medical necessity)

1512 S. DE ANZA BLVD. #316- SAN JOSE, CA95129- PHONE: (877) 861-1595- FAX: (408) 725-1135

WWW.EKHEALTH.COM

ADDITIONAL TREATMENT REQUESTS

MEDICAL RECORDS REVIEW PREPARED BY LICENSED HEALTHCARE PROFESSIONAL

First level reviewer's section. Summarization of treatments requested and medical documents.

Other:

Notes section for this review.

PHYSICIAN REVIEWER'S RATIONALE

Second level (Physician) reviewer's section. Contain's determination for treatments reviewed along with a rationale for the determination, guidelines to support the rationale, and documentation of call to the treating physician's office if applicable.

DETAILED ICD-10/CPT INFORMATION

This request is MODIFIED as follows:
ICD: M48.06, Spinal stenosis, lumbar region
Treatment: 99215, APPEAL: Follow-up Office Visit (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00)
Quantity requested: 1.00 DENIED
ICD: M48.06, Spinal stenosis, lumbar region
Treatment: 98940, APPEAL: Chiropratic Treatment for the Lumbar Spine (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00)
Quantity requested: 6.00 MODIFIED: 3.00
To start: 06/09/2023 To end: 07/24/2023

In addition to the records listed in the report, the following records were reviewed:

Document Date - Description

Through my signature below, I hereby attest that (a) I have the requisite license or certification that typically manages the medical condition, procedure, treatment or issue under review herein; (b) I have the current, relevant experience and/or knowledge to render a determination for case under review herein; and (c) that I know of no reason for me to have recused myself from the review herein.

Sincerely,

Jacqueline Hu,

Distribution:

- (Carrier Contact) Ernest Alzar via (via fax) to (209) 275-9012
- (Attorney) Test & Test via (via email) to jhu@datacare.com
- (Referrer) Leticia Nelson via (via email) to letician@artinsuranceservices.com
- (Provider) Test Provider via (via mail) to Test Provider 1234 Test Lane, Lancaster, CA 93535
- (Patient) Claim Test via (via mail) to 101 ABC STREET, Lathrop, CA 94044

Medical Criteria or Guidelines Used

Reference to the applicable guidelines for the treatments being reviewed.

E. UR Request for Additional Information (RFI) Letter Template:

EK Health
Transforming Managed Care™

June 09, 2023

Dr. Test Provider
Test Provider
1234 Test Lane
Lancaster, CA 93535

Re:	Claim Test
Cl#:	2906123456 / TRK# XXX
Ref#:	dddddd
Er:	
DOI:	03/21/2008
ID#:	ctest5035-9
Carrier:	
Advanced Risk Technologies	
Test, Carrier	
Tracking#:	

REQUEST FOR ADDITIONAL INFORMATION

Dear Dr. Test Provider:

Utilization Review is to provide a review of requested medical treatment to determine medical necessity and appropriateness. On 05/08/2017 (carrier receipt date) we received your request for:

PROSPECTIVE: Chiropratic Treatment for the Lumbar Spine (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00)
QTY: 6.00

We do not have all the information necessary for utilization review. We have delayed the medical necessity determination for the all the treatment(s) requested because information pertaining to the request(s) is lacking and necessary to evaluate the request(s).

Please provide the following information as soon as possible so that UR decisions on non-CA MTUS formulary requests can be made prior to the 14th calendar day from the carrier receipt date of the RFA in order to comply with the statutory time lines.

If the request is for medication listed on the current MTUS formulary, please provide the following information as soon as possible and in no case later than 4 days from the carrier receipt date of the RFA in order to comply with statutory time lines:

1. Chiropractic Therapy notes.
2. Total number of sessions completed to date: _____
3. Start date: _____Last date of service: _____
4. Functional and objective improvement:

Please send your response to: Fax (408) 725-1135 or email me at knjohnson@ekhealth.com. If this information is not provided timely, the request(s) will have to be denied due to lack of information.

1512 S. DE ANZA BLVD. #316 • SAN JOSE, CA 95129 • PHONE: (877) 861-1595 • FAX: (408) 725-1135
WWW.EKHEALTH.COM

Upon receipt of the required information, EK Health Services will proceed with the Utilization Review. Payment for services that are not Certified by Utilization Review may be denied by the Carrier/Employer. Questions about the financial aspects of this claim should be addressed with the claims examiner.

For approved requests, provider selection is subject to claims administrator approval.

Sincerely,

Keshia J.

Keshia Johnson, , LVN
Utilization Review Nurse
Signature date: 06/09/2023

Distribution:
- (Carrier Contact) Ernest Alzar via (via fax) to (209) 275-9012
- (Attorney) Test & Test via (via email) to jhu@datacare.com
- (Provider) Test Provider via (via mail) to Test Provider 1234 Test Lane, Lancaster, CA 93535
- (Patient) Claim Test via (via mail) to 101 ABC STREET, Lathrop, CA 94044

F. UR Conditional Denial Letter Template:

June 09, 2023

Dr. Test Provider:
Test Provider
1234 Test Lane
Lancaster, CA 93535

Re:	Claim Test	ID#:	ctest5035-9
Cl#:	2906123456 / TRK# XXX	Er:	
Ref#:	dddddd	Adjuster:	Ernest Alzar
DOI:	03/21/2008	Adj Phn:	
Carrier:	Test, Carrier	Tracking #:	

Date RFA was first received by carrier: 08/20/2018
Date request received by URO: 05/08/2017
Decision Date: 07/03/2017 02:35 PM

Utilization Review Determination

Dear Dr. Test Provider:

You have made a workers' compensation request for authorization. This letter notifies the decision based on medical necessity and appropriateness for the treatment requested. This letter does not give a decision on issues about the causes of the affected body part or claim. The claims examiner may object to those issues and offer ways to resolve those issues.

Utilization Review determines if the requested medical treatment is medically necessary and appropriate. The claims administrator may select the specific provider or program. Questions about the financial aspects of the claim can be answered by the claims examiner.

ITEMS REQUESTED:
ITEM 1. PROSPECTIVE: Chiropratic Treatment for the Lumbar Spine (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00) QTY: 6.00

DENIED:
ITEM 1: PROSPECTIVE: Chiropratic Treatment for the Lumbar Spine (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00) (Lack of Information)

ADDITIONAL TREATMENT REQUESTS

MEDICAL RECORDS REVIEW PREPARED BY LICENSED HEALTHCARE PROFESSIONAL

First level reviewer's section. Summarization of treatments requested and medical documents.

The following information is reasonably necessary to make a determination concerning the above treatment requests:

1512 S. DE ANZA BLVD. #316- SAN JOSE, CA95129- PHONE: (877) 861-1595- FAX: (408) 725-1135

WWW.EKHEALTH.COM

1.
2.
3.

The following are the attempts made to the Requesting Physician in order to obtain the necessary medical information:

-date at time: RFI was sent to; Dr. _____ by fax to _____. IW Name by mail to _____. Applicant Attorney by fax to _____.

-__/__/__ at _:__ AM/PM PST. A follow-up call for additional information was made to Dr. Treater at (xxx) xxx-xxxx. HCP was transferred to ____ voicemail. A message was left with requesting_____.

__/__/__ as of __:__AM/PM PST No response received. Due to time constraints, this review will be sent for peer to peer review.

Other:

Notes section for this review.

PHYSICIAN REVIEWER'S RATIONALE

Second level (Physician) reviewer's section. Contain's determination for treatments reviewed along with a rationale for the determination, guidelines to support the rationale, and documentation of call to the treating physician's office if applicable.

i. The treatment request is denied based on Lack of Information. We did not receive a response to our Request for Information. If the requested information is received, we will reconsider your request at that time.

b. Guidelines/References:

DETAILED ICD-10/CPT INFORMATION

This request is DENIED as follows:
ICD: M48.06, Spinal stenosis, lumbar region
Treatment: 98940, PROSPECTIVE: Chiropratic Treatment for the Lumbar Spine (DOD: 00/00/00, RFA: 00/00/00, DOS: 00/00/00)
Quantity requested: 6.00 DENIED

In addition to the records listed in the report, the following records were reviewed:

Document Date - Description

I hereby attest that I am competent to and have the requisite license to evaluate the specific clinical issues involved in medical treatment services; and that I know of no reason for me to have recused myself from the review herein.

Sincerely,

Jacqueline Hu,

Distribution:

- (Carrier Contact) Ernest Alzar via (via fax) to (209) 275-9012

- (Attorney) Test & Test via (via email) to jhu@datacare.com
- (Referrer) Leticia Nelson via (via email) to letician@artinsuranceservices.com
- (Provider) Test Provider via (via mail) to Test Provider 1234 Test Lane, Lancaster, CA 93535
- (Patient) Claim Test via (via mail) to 101 ABC STREET, Lathrop, CA 94044

Medical Criteria or Guidelines Used

Reference to the applicable guidelines for the treatments being reviewed.

APPEAL PROCESS

TO THE INJURED WORKER, the INJURED WORKER'S REPRESENTATIVE, OR the INJURED WORKER'S ATTORNEY:
If you disagree with the utilization review decision, 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 you on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision and ten (10) days for formulary disputes. You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster at the number provided at the top of this letter. However, if you are represented by an attorney, please contact your attorney instead of your adjuster. 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.

TO THE REQUESTING PHYSICIAN:

The Undersigned Reviewer at EK Health Services is available from 9:00 AM to 5:30 PM pacific time. If you have any questions or need clarification, please call (408) 973-0888 and you can leave a message on our 24 hour voicemail at extension 100. We can also be reached by fax at 408-725-1135 or e-mail at info@ekhealth.com.

INTERNAL VOLUNTARY APPEALS PROCESS

EK Health Services, Inc. uses an internal voluntary utilization review (IVA) process for first level reviews only. The IVA process does not cause or prevent you from initiating a dispute resolution process of Labor Code sections 4610.5 and 4610.6. The injured worker, treating physician/provider, or facility can request IVA when EK Health Services, Inc. changes or denies a request for authorization. The IVA process does not extend deadlines for initiating a dispute resolution process. All parties, including the injured worker, treating physician/provider, or the facility rendering service has the right to request an IVA by telephone or in writing. Written notice must be received within 10 calendar days from the date of the receipts of the denied decision.

For information about the workers' compensation claims process and your rights and obligations, please go to www.dwc.ca.gov. Or please contact an Information and Assistance (I&A) Officer at the state Division of Workers' Compensation. The phone number is 1-800-736-7401.

Prior Authorization (General) Plan:

EK HEALTH

UTILIZATION REVIEW

HCP & Express Approval™ Best Practice List - California Specific

Code	DIAGNOSTICS	Qty.	Notes
76938 76934 75956 75957	X-Rays	1	Initial X-Ray or >6 months since last X-Ray; 1 per body region
72149	MRIs w/ contrast	1	Recommended for infection or spinal tumors
70540 - Cervical Spine 70552 - Brain 72141 - Lumbar Spine 72195 - Pelvis 73218 - Upper Extremity 73718 - Lower Extremity 74181 - Abdomen	MRI/CT w/o contrast	1	A) after major trauma B) with documentation of neurological deficit C) for pre-operative study for imminent surgery D) >6 weeks of failed conservative treatment for routine injuries
73202 70488 71270	CT	1	Displaced fractures
NCV 95907-95913 EMG 95860-95887	EMG/NCV	1	Initial EMG/NCV: A) Documented neurological deficit (CTS/cubital tunnel syndrome, cervical/lumbar radiculopathy) B) After 6 weeks of conservative treatment with documented neurological deficit.

Code	PHYSICAL MEDICINE	Qty.	Notes
98940	Chiropractic	12	Initial 12 visits; Additional 12 visits w/documented functional improvement.
97110	Physical therapy	12	Initial 12 visits; Additional 12 visits w/documented functional improvement.
97110	Occupational Therapy	12	Initial 12 visits; Additional 12 visits w/documented functional improvement.
97001971129700397010971 40	Physical therapy (Post-Op) / Occupational Therapy	24	Initial 24 visits
97810978119781397814	Acupuncture	12	Initial 12 visits

Code	MEDICATIONS	Qty.	Notes
1) Ibuprofen 63739013710 800mg tab 2) Celecoxib (Celebrex) 3) Aspirin 49483000110 325mg tab 4) Diclofenac 61442010260 50mg tab 5) 53746019405(Naproxen)	**Anti-inflammatory meds (NSAIDs): Examples** 1) Ibuprofen 2) Celecoxib (Celebrex) 3) Aspirin 4) Diclofenac 5) Naproxen	60	Initial 60 day supply
1) Amoxicillin 57237003001 250mg tab 2) Erythromycin 68308025010 250mg cap 3) Bactrim 49708014501 400-80mg tab	**Antibiotics: Examples** 1) Amoxicillin 2) Erythromycin 3) Bactrim	30	Initial 30 day supply
1) Cyclobenzaprine (Flexeril) 51079064417 10mg tab 2) Baclofen 63739047910 10mg tab 3) Zanaflex 10144059415 4mg tab 4) Skelaxin 60793013605 800mg tab	**Muscle relaxers: Examples** 1) Cyclobenzaprine (Flexeril) 2) Baclofen 3) Zanaflex 4) Skelaxin	3	Up to 3 weeks; Except compounded meds & creams
1) Mirtazapine (Remeron) 00052010730 30mg tab 2) Escitalopram (Lexapro) 00456201011 10mg tab 3) Venlafaxine (Effexor) 68382001801 25mg tab 4) Sertraline (Zoloft) 00049491094 100 mg tab 5) Citalopram (Celexa) 00456401001 10mg tab 6) Buproprion (Wellbutrin) 00173017755 75mg tab 7) Paroxetine (Paxil) 60505366403 20mg tab 8) Milnacipran (Savella) 00456155060 50mg tab 9) Fluoxetine (Prozac) 00002400630 10mg tab 10) Duloxetine (Cymbalta) 00002323704 60mg tab 11) Fluvoxamine (Luvox) 62559015801 25mg tab 12) Reboxetine (Vestra) Not found in Medical or Redbook	**Antidepressants: Examples** 1) Mirtazapine (Remeron) 2) Escitalopram (Lexapro) 3) Venlafaxine (Effexor) 4) Sertraline (Zoloft) 5) Citalopram (Celexa) 6) Buproprion (Wellbutrin) 7) Paroxetine (Paxil) 8) Milnacipran (Savella) 9) Fluoxetine (Prozac) 10) Duloxetine (Cymbalta) 11) Fluvoxamine (Luvox) 12) Reboxetine (Vestra)	30	Initial 30 day supply
1) Lyrica (pregabalin) 00071101568 100mg tab 2) Neurontin (Gabapentin) 00185009110 100mg tab 3) Dilantin (Phenytoin) 62756040201 100mg cap 4) Valium (diazepam) 51079028401 2mg tab 5) Ativan (lorazepam) 00591024110 1mg tab	**Anticonvulsants: Examples** 1) Lyrica (pregabalin) 2) Neurontin (Gabapentin) 3) Dilantin (Phenytoin) 4) Valium (diazepam) 5) Ativan (lorazepam)	30	Initial 30 day supply
1) Prilosec (Omeprazol) 00186060628 10mg 2) Tagamet (Cimetidine) 60505001806 200mg tab 3) Zantac (Ranitidine) 53746025360 150mg tab 4) Pepcid (Famotidine) 63739048410 20mg tab 5) Axid (Nizatidine) 68462042560 150mg cap	**GI Medications: Examples** 1) Prilosec (Omeprazol) 2) Tagamet (Cimetidine) 3) Zantac (Ranitidine) 4) Pepcid (Famotidine) 5) Axid (Nizatidine)	60	Initial 60 day supply If patient is taking anti-inflammatory drugs, such as NSAIDs or Steroids
	>3 Medications	0	No more than 3 prescriptions on a single visit
52544091 03 Norco 5-325 52544016105 Norco 10-325	**Opioids**	30	Initial 30 day fill or less for acute injuries or immediate post-op period; short acting opiates like **Norco** or **Vicodin.**

	Soma (Carisoprodol)	0	Not recommended at any time.
	Long Acting Opiates for acute injuries or immediately post-op: Examples A) Morphine Sulfate Extended Release (ER) B) Methadone Hydrochloride C) Duragesic - Fentanyl D) MS Contin E) Nucynta ER F) OxyContin G) Opana ER	0	Not recommended at any time.

Code	DME	Qty.	Notes
99070 - Generic	Standard braces	1	
A4570	Splint	1	
E0100	Cane	1	
A4565	Slings	1	
E0114	Standard crutches	1	
E0143	Walker	1	
E0238	Heat Pad	1	
A4630	Batteries	1	
E0163 E0164	Standard commodes	1	
	Non-powered DME < $500.00	1	

E0730 Tens Four Lead E0720 Tens Two Lead	TENS unit - 2 or 4 leads	30	30 day trial after failure to respond to 4 weeks of conservative care
E0936	Continuous passive motion (CPM)	21	21 day use with total knee replacement (TKR), ACL repair/cartilage restoration
E0217 E0218	Cryotherapy (Cold therapy unit)/compression devices	1	1 week post operative use

Code	CONSULTS	Qty.	Notes
99214	Surgical consult	1	Pre-operative evaluation prior to surgery
99201 99202 99203 99204 99205 99211 99212 99213 99214 99215 99241 99242 99243 99244 99245	Specialty consults	1	Initial consult (except Pain Management consult must go to physician reviewer)

Code	INJECTIONS	Qty.	Notes
20526 20550 20553	Cortisone/steroid injections	2	Up to 2 injections to one location or anatomical area per year (non-spinal)
20552	Non-spinal injections	2	Up to 2 injections per year for: A) Trigger points B) Tendon sheaths C) Bursa
	Epidural Steroid Injections (ESI) - Diagnostic (Blocks)	2	A) Radiculopathy corroborated by imaging and/or EDS B) Unresponsive to conservative treatment C) Performed w/ fluoroscopy for guidance D) No more than 2 DIFFERENT nerve root levels - transforaminal E) No more than 1 nerve root level - interlaminar F) Never at the same level G) 2nd block MUST be at least 1 week after 1st block & at different level
62310 - Cervical/Thoracic 62311 - Lumbar Transforaminal ESI: 64479 - Cervical/Thoracic 64483 - Lumbar	Epidural Steroid Injections (ESI) - Therapeutic	2	A) Radiculopathy corroborated by imaging and/or EDS B) Unresponsive to conservative treatment C) Performed w/ fluoroscopy for guidance D) No more than 2 DIFFERENT nerve root levels - transforaminal E) No more than 1 nerve root level - interlaminar F) Repeat ESI only if functional improvement, decreased pain of at least 50% and reduction of medication for > 6 weeks G) Repeat ESI for ACUTE exacerbation of pain -or- new onset of radicular pain

Code	SURGERY	Qty.	Notes

27750 27848 28400 28675	Displaced fracture	1	
20670 20680	Hardware removal	1	Non-spine hardware removal
49505	Initial Hernia Repair	1	

Code	LAB TESTS	Qty.	Notes
80047 80076 71010 71035 93000 93010 93042 93660	CBC	1	Routine pre-op testing
80047 80076 71010 71035 93000 93010 93042 93660	Chemistry panel	1	Routine pre-op testing
71020	Chest X-ray	1	Routine pre-op testing
80047 80076 71010 71035 93000 93010 93042 93660	EKG	1	Routine pre-op testing
G0431 G0434	UDS	4	A) Patient on opioids or other chronic pain medications B) Not more than 4 UDS/year C) Cause/Suspicious Behavior