Mitchell International, Inc.

Workers' Compensation Solutions
Medical Management Services

California Workers' Compensation Utilization Review Plan

Effective October 6, 2021

Table of Contents

I. Medical Director and Other Staff

Number:	**CA Staff 2**
Subject:	**Medical Director Qualifications**
Policy:	**The Medical Director shall ensure that the utilization review process by which Mitchell International, Inc.'s (Mitchell's) staff and any delegated entities review, approve, modify or deny requests for authorization from physicians and providers prior to, retrospectively, or concurrently with the provision of medical services, complies with Labor Code §4610 and the implementing utilization review regulations adopted by the California Division of Workers' Compensation (DWC).**

The Medical Director will serve as the senior clinical staff member for the Mitchell Workers' Compensation Utilization Review program. The Medical Director is responsible for all decisions made in the Mitchell utilization review process.

The Medical Director is a physician and surgeon who:

1. Holds a current, unrestricted license to practice medicine in the state of California issued by the Medical Board of California or the Osteopathic Board of California;
2. Has qualifications to perform clinical oversight of the utilization review services provided in Mitchell's MMS Department;
3. Has post-graduate experience in direct patient care; and
4. Has Board certification by a specialty board approved by the American Board of Medical Specialties (doctor of medicine); or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine);

Additionally, the Medical Director:

1. Has periodic consultation with practitioners in the field;
2. Is a member of the Mitchell MMS Quality Management Committee; and
3. Will be involved in judgments about the use of clinical quality measures and clinical aspects of performance for quality improvement projects that are clinical in nature.

The Medical Director for Mitchell's Utilization Review Department is:

Helga S. Daftarian, D.O., M.P.H., M.B.A.
Board certified American Board of Preventive Medicine/Occupational Medicine,
American Osteopathic Board of Preventive Medicine/Occupational Medicine
Osteopathic Medical Board of California: License #20A15850, Expires January 31, 2023
Email: Helga.Daftarian@mitchell.com
(Please do not send personally identifiable health information by email. Please use the fax number below.)
Tel. #: (866) 931-5100, Request to be transferred to the Medical Director's phone line.
Fax. #: (800) 281-5438, Request delivery to the Medical Director on the cover sheet.
1350 Lakeshore Drive, Suite 100
Coppell, TX 75019
Normal Business Hours: 9 AM to 5:30 PM EST

Number:	**CA Staff 1**
Subject:	**Staffing Qualifications and Requirements**
Policy:	**Mitchell uses non-clinical staff, licensed clinical staff (Initial Clinical Reviewers), physician Reviewers (Reviewers), and expert Reviewers (Reviewers) to perform utilization review in accordance with applicable California workers' compensation laws. Each licensed or certified staff member will immediately notify their supervisor or manager of any change in the status of their license or certification. Utilization review services will be provided in accordance with applicable California law and URAC workers' compensation utilization management standards.**

Non-clinical staff will assist Initial Clinical Reviewers by performing data entry, faxing, emailing, case file setup, etc. They will:

1. have a minimum education to include high school diploma or General Education Development (GED);
2. be supervised by a licensed, clinical staff member, or have access to a licensed, clinical staff member at all times while performing their duties;
3. will have prior medical claims handling experience either in the health or workers' compensation industry; and
4. will undergo training and extensive oversight following employment by Mitchell.

For positions requiring licensure or certification:

1. Prior to employment and no less than every three (3) years thereafter, Mitchell or its designee will verify the licensure and credentials of each staff member through a primary source**;**
2. Each staff member will immediately notify their supervisor of any adverse change(s) in their license or certification status and
3. Mitchell will implement corrective action in response to adverse changes in licensure or certification status.

Individuals who conduct initial clinical review (i.e. **Initial Clinical Reviewers**) are appropriate health professionals who:

1. Have undergone formal training in a health care field;
2. Hold an active professional relevant license in a health care field issued by a state;
3. Have professional experience in direct patient care;
4. Hold an associate or higher degree in a health care field, or hold a state license or state certificate in a health care field;
5. Continue their clinical education in order to maintain licensure;
6. Stay abreast of current changes in workers' compensation law; and
7. May only make approval of medical necessity decisions.

Individuals who conduct reviews of requests for authorization that cannot be authorized by Initial Clinical Reviewers (i.e. **Reviewers**)

1. Shall be a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner;
2. Shall be licensed by any state or the District of Columbia; and
3. Shall be competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the Reviewer's practice.

Expert Reviewers meet the same qualifications as Reviewers and shall be consulted by the Reviewer or the Medical Director to provide specialized review of medical information.

Individuals who conduct voluntary internal appeal level reviews (i.e. **Appeal Reviewers**) shall hold the same qualifications as the Reviewer and in addition shall be:

1. Board-certified (if applicable) by
   a. A specialty board approved by the *American Board of Medical Specialties* (doctors of medicine); or

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

2. Neither the individual who made the original non-certification, nor the subordinate of such an individual. For example, an associate medical director cannot conduct an appeal review of an initial non-certification (modify or deny decision) made by the medical director to whom the associate medical director reports.

Only a Reviewer, Expert Reviewer, Appeal Reviewer, or Mitchell's Medical Director may modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve or due to incomplete or insufficient information under subdivisions (i) and (j) of Labor Code §4610.

II. Description of review process for treatment requests, decisions made on such requests and process for handling expedited reviews

Number: **CA Definitions 1**

Subject: **Definitions**

Policy: **Definitions of frequently used terms are helpful in understanding Mitchell's California workers' compensation utilization review process, including provision of information on the independent medical review process. These definitions are derived from the California state laws, URAC workers' compensation standards, and Mitchell policies. This provides uniform terminology for all Mitchell staff involved in the utilization review process.**

ACOEM

The American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines published by the Reed Group containing evidence-based medical treatment guidelines for conditions commonly associated with the workplace. ACOEM guidelines may also be obtained from the American College of Occupational and Environmental Medicine, 25 Northwest Point Blvd., Suite 700, Elk Grove Village, Illinois, 60007-1030 (www.acoem.org).

Adjuster authorization

An approval response to a request for authorization that meets criteria established by the carrier/claims administrator.

Appeal Process (Voluntary Internal)

A voluntary request for an internal utilization review of an initial modify or deny decision to be conducted by an Appeal Reviewer. The internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6 but may be pursued on an optional basis. It must be requested orally or in writing within ten (10) days of receipt of the modify or deny utilization review. The appeal may be requested by the provider, the facility rendering service, the injured worker, or the injured worker's representative. The Appeal Reviewer will hold qualifications as listed below.

The appeal decision will be conducted in an expedited manner if the original review decision was an expedited review decision, i.e. an Expedited Appeal. The Appeal Reviewer will review the same medical documentation reviewed by the original Reviewer and will review any additional information submitted by the requesting party. The appeal decision must be issued within thirty (30) days after receipt of the appeal request for non-expedited modify/deny decisions. Expedited appeal requests will be completed as soon as possible with verbal notice given no more than 72 hours after receipt of the timely expedited appeal request. The appeal process will run concurrently with the independent medical review dispute resolution process. The voluntary appeal process is separate from the re-review/reconsideration and the peer-to-peer discussion processes.

Appeal Reviewer

A medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner who:

a) Is a clinical peer to the ordering provider;
b) Is competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the Reviewer's practice;
c) Is in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate;
d) Holds an active, unrestricted license by any state or the District of Columbia to practice medicine or a health profession;
e) Is board certified (if applicable) by: a specialty board approved by *the American Board of Medical Specialties* (doctor of medicine); or the *Advisory Board of Osteopathic Specialists* from the major areas of clinical services (doctors of osteopathic medicine); and

f) Is neither the individual who made the original non-certification nor the subordinate of such an individual. Subordinate means someone who reports directly to the individual who made the original modify or deny decision.

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 §4600 of the Labor Code, subject to the provisions of §5402 of the Labor Code, based on either a completed "Request for Authorization," DWC Form RFA, as contained in CCR, title 8, §9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under §9791.9.1(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 CCR, title 8, §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.

Authorization without prospective review within 30 days from the date of injury – when applicable

For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment

- rendered for a body part or condition that is accepted as compensable by the employer,
  - by a member of the medical provider network or health care organization, or
  - by a physician predesignated pursuant to subdivision (d) of Section 4600, or
  - by a physician or facility selected by the employer, and
- within the 30 days following the initial date of injury,
- that is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7 and is consistent with the medical treatment utilization schedule,
- shall be authorized without prospective utilization review, except as provided in subdivision (c). See **Mandatory Preauthorization List** below.

The report required under Labor Code Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation. (See Labor Code 4610 (b))

Brand Name Drug

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

Chronic Pain

Pain lasting three or more months from the initial onset of pain.

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 §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.

Clinical Peer

A physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e. the same licensure category as the ordering provider.

Clinical Review Criteria

Treatment guidelines used by Mitchell to evaluate the medical necessity and appropriateness of requests for authorization that conform to the California Medical Treatment Utilization Review Schedule requirements.

Combination drug	A fixed dose combination of two or more active drug ingredients into a single dosage form that is FDA-approved for marketing.
Complaint	An expression of dissatisfaction regarding Mitchell's products or services. ***Note:*** This is sometimes referred to as "grievance." This definition does not include voluntary *Appeals*.
Completed	For purposes of the definition of "request for authorization" 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.
Compounded drug	Any drug subject to: (1) Article 4.5 (commencing with §1735) or article 7 (commencing with §1751) of division 17 of title 16 of the California Code of Regulations, or (2) Other regulation adopted by the State Board of Pharmacy to govern the practice of compounding, or (3) Federal law governing compounding, including title 21, United State Code, §§353a, 353a-1, 353b.
Concurrent Review	Utilization review conducted during an inpatient stay. Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve the injured worker from the effects of the industrial injury.
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 CCR, title 8, §14006, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in §9785.2 or in narrative form containing the same information required in the DWC Form PR-2.
Deferral of utilization review of request for authorization	Utilization review of a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity. A timeframe applies as noted below in "Dispute liability."
Denial	A decision by a physician Reviewer that the requested treatment or service is not authorized.
Dispute liability	An assertion by the claims administrator that a factual, medical, or legal basis exists, other than medical necessity, that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment. If the claims administrator disputes the liability under 8 CCR §9792.9.1, it may no later than five (5) business days from receipt of the DWC Form RFA issue a written decision deferring utilization review of the requested treatment unless the requesting phyhsician has been previously notified of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment.
Disputed medical treatment	Medical treatment that has been modified or denied by a utilization review decision.
Drug Formulary	"MTUS Drug Formulary" means the MTUS Drug List set forth in §9792.27.15 and the formulary rules set forth in §§9792.27.1 through 9792.27.23.
Drug List	"MTUS Drug List" means the drug list and related information in §9792.27.15, which sets forth the Exempt or Non-Exempt status of drugs listed by active drug ingredient(s).

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. Failure to obtain prior authorization for 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, however, may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.
Evidence-Based Medicine (EBM)	A systematic approach to making clinical decisions which allows the integration of the best available research evidence with clinical expertise and patient values.
Exempt Drug	A drug on the MTUS Drug List which is designated as being a drug that does not require authorization through prospective review prior to dispensing the drug, provided that the drug is prescribed in accordance with the MTUS Treatment Guidelines. The Exempt status of a drug is designated in the column with the heading labeled "Exempt / "Exempt / Non-Exempt.
Expedited Appeal	See **Appeal Process (Voluntary Internal)** above.
Expedited Review	Utilization review or independent medical review conducted when the injured workers' 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. **The requesting physician must indicate the need for an expedited review upon submission of the request for authorization.**
Expert Reviewer	An Expert Reviewer: a) is a medical doctor, doctor of osteopathy, psychologist, acupuncturist, dentist, optometrist, podiatrist, or chiropractic practitioner; b) holds a current and valid license by any state or the District of Columbia c) is 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; d) may be consulted by the Reviewer or the Medical Director to provide specialized review of medical information.
Functional improvement	Either a clinical significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the medical evaluation and treatment and a reduction in the dependency on continued medical treatment.
Generic drug	A drug that is produced or distributed under an FDA Abbreviated New Drug Application (ANDA) approved by the FDA. A generic drug may be substituted for a therapeutic equivalent brand name drug pursuant to applicable state and federal laws and regulations.
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 §4616.
Immediately	Within one business day.
Independent Medical Review	Medical dispute resolution process whereby the modify or deny determination of the claims administrator or their utilization review agent is reviewed by a physician who is not connected

to the claims administrator or their utilization review agent. The independent medical review request must be made timely by the appropriate parties on the form specified by the California Division of Workers' Compensation agency. The initial modify or deny determination and any voluntary appeal determinations that result in a modification must contain a completed copy (except for the employee's signature) of the DWC Form IMR.

Initial Clinical Review

Clinical review conducted by appropriately licensed or certified health professionals (registered nurses, licensed vocational nurses, certified case managers, etc.). Initial clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to a Reviewer to make a medical necessity decision.

Initial Clinical Reviewer

An individual who:

a) has undergone formal training in a health care field;
b) holds an active professional relevant license in a health care field issued by a state or holds an associate or higher degree in a health care field;
c) has professional experience in direct patient care;
d) continues their clinical education in order to maintain licensure;
e) keeps abreast of current changes in workers' compensation law; and
f) only makes authorization/approval of medical necessity decisions.

Mandatory prospective review list within first thirty (30) days following the initial date of injury

As of January 1, 2018, Labor Code 4610 (c)(1) outlines non-emergency services rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility that require mandatory prospective review within the first thirty (30) days following the initial date of injury. Also see "Authorization without prospective review within 30 days from the date of injury – when applicable)" definition above.

(1) Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to §5307.27.
(2) Nonemergency inpatient and outpatient surgery, including all pre-surgical and postsurgical services.
(3) Psychological treatment services.
(4) Home health care services.
(5) Imaging and radiology services, excluding X-rays.
(6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule.
(7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
(8) Any other service designated and defined through rules adopted by the administrative director.

Material modification

When the claims administrator changes utilization review vendors or makes a change to the utilization review standards as specified in California utilization review regulations 8 CCR §9792.7.

Medical Director

The Medical Director for the MMS California utilization review plan:

(a) Has a current, unrestricted clinical license to practice medicine in the state of California issued pursuant to §2050 or §2450 of the Business and Professions Code;
(b) Has post-graduate experience in direct patient care;
(c) Holds Board certification in a relevant specialty;
(d) Has periodic consultation with practitioners in the field; and
(e) Shall be responsible for all decisions made in the utilization review process.

Medical services

Those goods and services provided pursuant to Article 2 (commencing with Labor Code §4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

Medical Treatment Guidelines	The most current version of written recommendations which are systematically developed by a multidisciplinary process through a comprehensive literature search to assist in decision-making about the appropriate medical treatment for specific clinical circumstances reviewed and updated within the last five years.
Medical Treatment Utilization Schedule (MTUS)	The standards of care adopted by the Administrative Director pursuant to Labor Code §5307.27 and set forth in CCR, Title 8, §9792.20. et seq. The MTUS is based on the principals of Evidenced-Based Medicine (EBM). EBM is a systematic approach to making clinical decisions which allows the integration of the best available evidence with clinical expertise and patient values. EBM is a method of improving the quality of care by encouraging practices that work and discouraging those that are ineffective or harmful. EBM asserts that intuition, unsystematic clinical experience, and pathophysiologic rationale are insufficient grounds for making clinical decisions. Instead, EBM requires the evaluation of medical evidence by applying an explicit systematic methodology to determine the quality and strength of evidence used to support the recommendations for a medical condition or injury. The best available evidence is then used to guide clinical decision making. The recommended guidelines set forth in the MTUS are presumptively correct on the issue of extent and scope of medical treatment. The MTUS constitutes the standard for the provision of medical care in accordance with Labor Code §4600 for all injured workers diagnosed with industrial conditions because it provides a framework for the most effective treatment of work-related illness or injury to achieve functional improvement, return-to-work, and disability prevention. The MTUS shall be the primary source of guidance for treating physicians and physician Reviewers for the evaluation and treatment of injured workers. As of January 1, 2018, the MTUS includes a drug formulary.
Medically necessary and medical necessity (for purposes of LC 4610.5 and 4610.6)	Medical treatment that is reasonably required to cure or relieve the 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 Labor Code §5307.27 (MTUS). (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.
Methodology for Evaluating Medical Evidence (MEME)	The Methodology for Evaluating Medical Evidence (MEME) in the CA MTUS is set forth in §9792.25.1 of the California regulations. Physician Reviewers shall apply the MTUS MEME to evaluate the quality and strength of evidence used to support the recommendations that are at variance with one another. The MTUS MEME provides a process to evaluate studies, not guidelines. Therefore, the physician Reviewer shall evaluate the underlying study or studies used to support a recommendation found in a guideline. Medical care shall be in accordance with the recommendation supported by the best available evidence.
Modification	A decision by a physician Reviewer that part of the requested treatment or service is not medically necessary.
MTUS Drug Formulary	The MTUS Drug List set forth in §9792.27.15 and the formulary rules set forth in §§9792.27.1 through 9792.27.23.

MTUS Drug List	The drug list and related information in §9792.27.15, which sets forth the Exempt or Non-Exempt status of drugs listed by active drug ingredient(s).
Nationally recognized	Published in a peer-reviewed medical journal; or developed, endorsed and disseminated by a national organization with affiliates based in two or more U.S. states and is the most current version.
Non-Exempt Drug	A drug on the MTUS Drug List which is designated as requiring authorization through prospective review prior to dispensing the drug. The Non-Exempt Drug status of a drug is designated in the column labeled "Exempt / Non-Exempt."
Normal business day	A "normal business day" does not include Saturday, Sunday, or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website. See Labor Code §4600.4
ODG Workers' Compensation Guidelines by MCG	The medical treatment and return-to-work guidelines plus drug formulary for workers' compensation published by MCG. ODG by MCG, 2801 Vía Fortuna, #660, Austin, TX 78746.

Peer-to-peer discussions/Peer-to-peer consultations (CA)	As of January 1, 2018, Labor Code §4610 (n) requires each employer, insurer or other entity to maintain telephone access during California business hours
	• for physicians to request authorization for health care services and
	• to conduct **peer-to-peer discussions** regarding issues, including
	  • the appropriateness of requested treatment,
	  • modification of a treatment request, or
	  • to obtain additional information needed to make a medical necessity decision.
	
	In addition, Labor Code §4610 (g)(4) effective July 1, 2018, requires utilization review procedures that modify or deny request for authorization be accredited. The accreditation standards must meet specified criteria including "peer-to-peer" consultation. Additional clarification on peer-to-peer consultation will be provided by the California Division of Workers' Compensation once rules are adopted to implement the statutory changes effective July 1, 2018. Absent further clarification at this time, peer-to-peer discussions and peer-to-peer consultations are considered to be equivalent terms.
	
	Per §9792.9.1. (e)(5)(K) the physician Reviewer, Expert Reviewer or Medical Director shall be available at a minimum of four (4) hours per week during normal business hours of 9 AM to 5:30 PM or an agreed upon scheduled time to discuss the modify or deny decision with the requesting physician. In the event the Reviewer is unavailable, the requesting physician may discuss the decision with another Reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services. There is no time limit in the California utilization review regulations within which the requesting physician must request a peer-to-peer discussion.

Perioperative Fill	The policy set forth in §9792.27.13 allowing dispensing of identified Non-Exempt drugs without prospective review where the drug is prescribed within the perioperative period and meets specified criteria.
Physician	Includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law. See Labor Code §3209.3
Physician (for purposes of the	For purposes of the MTUS Drug Formulary, "Physician" means a medical doctor, doctor of

MTUS Drug Formulary)	osteopathy, or other health care provider whose scope of practice includes the prescription of drugs. However, for purposes of membership on the Pharmacy and Therapeutics (P&T) Committee, "physician" means a medical doctor or doctor of osteopathy licensed pursuant to the California Business and Professions Code.
Physician Reviewer Organization	Organization that contracts with various physician Reviewers who are qualified in accordance with Labor Code §4610 and the California workers' compensation utilization review regulations to make utilization review decisions on requests for authorization for California workers' compensation claims.
Prospective review	Any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services. As of January 1, 2018, Labor Code §4610 (c)(1) outlines non-emergency services rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility that require mandatory prospective review within the first thirty (30) days following the initial date of injury. See **Mandatory Prospective Review List** definition above.
Re-Review (Reconsideration)	The requesting physician may, at any time following receipt of a denial based on lack of sufficient information decision, provide information not previously provided with the original request for authorization. The additional information will be reviewed by an appropriate utilization review staff member and may result in approval of the re-review/reconsideration request by an Initial Level Clinical Reviewer or approval, modify, or denial of the requested services by the (Physician) Reviewer who issued the initial modify or deny decision or another physician Reviewer if the original physician Reviewer is not available at the time the request is received. A re-review decision shall be made for non-expedited prospective or concurrent reviews within five (5) business days of receipt of the additional information, for expedited prospective or concurrent reviews within 72 hours of receipt of the additional information, and for retrospective reviews within thirty (30) calendar days of receipt of the additional information. .
Request for authorization (RFA)	A written request for a specific course of proposed medical treatment. Unless accepted by a claims administrator under §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 CCR, title 8, §9785.5. "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. The request for authorization must be signed by the treating physician and may be mailed, faxed or emailed 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.
Retrospective review	Utilization review conducted after medical services have been provided and for which approval has not already been given.
Reviewer (physician Reviewer)	A Reviewer shall: a) be a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner; b) hold a current and valid license by any state or the District of Columbia; and c) be competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the Reviewer's practice.

Scientifically based	Based on scientific literature, wherein the body of literature is identified through performance of a literature search, the identified literature is evaluated, and then used as the basis to support a recommendation.
Special Fill	The policy set forth in §9792.27.12 allowing dispensing of identified Non-Exempt drugs without prospective review where the drug is prescribed or dispensed in accordance with the criteria set forth in subdivision (b) of §9792.27.12.
Strength of Evidence	Establishes the relative weight that shall be given to scientifically based evidence.
Unlisted Drug	A drug that does not appear on the MTUS Drug List and which is one of the following: an FDA-approved or a nonprescription drug that is marketed pursuant to an FDA OTC Monograph. An "unlisted drug" does not include a compounded drug but does include a combination drug.
URAC	An independent, nonprofit accrediting organization for utilization review processes. Per Labor Code §4610 (g)(4) effective January 1, 2018, a utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, by URAC and shall retain active accreditation while providing utilization review services to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical material used in issuing a utilization review decision, peer-to-peer consultation, internal appeal procedure, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision.. The Administrative Director shall adopt rules to implement the selection of an independent, nonprofit organization for accreditation purposes. Until those rules are adopted, the administrative direction designates URAC as the accrediting organization.
Utilization review decision	A decision pursuant to CA Labor Code §4610 to approve, modify or deny a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to CA Labor Code §4600 or §5402(c).
Utilization Review Organization (URO)	Includes any person or entity with which the employer, or an insurer, or third party administrator, contracts to fulfill part or all of the employer's utilization review responsibilities under Labor Code §4610 and Title 8 of the CCR, §§9792.6.1 through 9792.15.
Utilization review plan	The written plan filed with the Administrative Director pursuant to Labor Code §4610, setting forth the policies and procedures, and a description of the utilization review process. The utilization review plan shall contain: a) the name, address, phone number, and medical license number of the employed or designated medical director who is a 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 who ensures that the process by which the claims administrator and/or utilization review organization reviews and approves, modifies or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with Labor Code §4610 and the implementing regulations; b) a description of the process whereby requests for authorization are reviewed, decisions on such requests are made, and a description of the process for handling expedited reviews; c) a description of the specific criteria used routinely in the review and throughout the decision-making process, including treatment protocols or standards used in the process. The treatment protocols or standards governing the utilization review

process shall be consistent with the Medical Treatment Utilization Schedule adopted by the Administrative Director pursuant to Labor Code §5307.27;

d) a description of the qualifications and functions of the personnel involved in decision-making and implementation of the utilization review plan; and

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

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 §3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code §4600. The utilization review process begins when the completed DWC Form RFA, or a request for authorization accepted as complete under §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.

Voluntary Internal Appeal — See definition for **Appeal Process (Voluntary Internal).**

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.

Number: **CA Policies and Procedures 1**

Subject: **California Utilization Review Plan**

Policy: **The Mitchell MMS department will maintain and comply with approved, written policies and procedures governing all aspects of operations as described in the Mitchell California Utilization Review Plan. The written policies and procedures governing the utilization review process shall be consistent with the recommended standards in the MTUS (Labor Code §5307.27), including the drug formulary. The complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process that modifies or denies requests for authorization, shall be filed with and approved by the Administrative Director of the California DWC. A modified utilization review plan shall be filed with the Administrative Director or his/her designee within 30 calendar days after a material modification is made.**

The Mitchell California utilization review plan contains the utilization review policies and procedures that describe the process whereby requests for authorization are reviewed and decisions on such requests are made and shall include a description of the process for handling expedited reviews. The plan shall contain the following minimum information:

a) the name, address, phone number, and medical license number of the medical director who is a 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 who ensures that the process by which the claims administrator and/or utilization review organization reviews and approves, modifies or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with Labor Code §4610 and the implementing regulations;

b) a description of the process whereby
   i. requests for authorization are reviewed,
   ii. decisions on such requests are made, and a
   iii. description of the process for handling expedited reviews;

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

d) a description of the qualifications and functions of the personnel involved in decision-making and implementation of the utilization review plan; and

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

Mitchell shall neither offer nor provide any financial incentive or consideration to a physician Reviewer or other health care provider based on the number of modifications or denials made by the physician Reviewer or other health care provider.

The policies and procedures will be reviewed no less than annually and revised as necessary to remain in compliance with California workers' compensation utilization review statutes, regulations, and applicable case law. The Medical Director will review and approve all new and revised policies and procedures.

Clients contracting for Mitchell's utilization review services may submit a letter to the Administrative Director identifying Mitchell as their external utilization review organization in lieu of filing a copy of Mitchell's utilization review plan with the Administrative Director of the California of DWC.

On or before July 1, 2018, a utilization review process that modifies or denies request for authorization of medical treatment shall be accredited and shall retain active accreditation while providing utilization review services. The accreditation shall be by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical material used in issuing a utilization review decision, peer-to-peer consultation, internal appeal procedure, and requiring a policy preventing financial incentives to doctors

and other providers based on the utilization review decision.

On or before July 1, 2018, each employer, either directly or through its insurer or an entity with which an employer or insurer contracts for utilization review services, shall submit a description of the utilization review process that modifies or denies requests for authorization of medical treatment and the written policies and procedures to the administrative director for approval. Approved utilization review process descriptions and the accompanying written policies and procedures shall be disclosed by the employer to employees and physicians and made available to the public by posting on the employer's, claims administrator's, or utilization review organization's Internet Web site.

Mitchell, the employer, or the claims administrator shall disclose the utilization review process descriptions for modifying or denying requests for authorization of medical treatment and accompanying policies and procedures (California UR plan) to employees and physicians. If a member of the public requests a hard copy of the utilization review plan, Mitchell 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. Mitchell, the employer, or the claims administrator shall make a complete copy of the utilization review plan available to the public by posting on the employer's, claims administrator's, or utilization review organization's Internet Web site. A copy of the Mitchell utilization review plan shall be provided upon request without charge to the injured worker, injured worker's attorney, and the physician requesting services.

Number:	**CA Phones 1**
Subject:	**Telephone, including facsimile, access**
Policy:	**Mitchell's utilization review department will provide appropriate levels of toll-free telephone and toll-free facsimile access to all callers. Mitchell shall maintain telephone access during California business hours for physicians to request authorization for health care services and to conduct peer-to-peer discussions regarding issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity decision.**

Mitchell provides access to staff via at least one toll-free phone number on normal business days from 8:00 A.M. to 5:30 P.M. Pacific Time. Mitchell also provides toll-free facsimile number(s) to receive written communications from physicians 24 hours a day, 7 days a week. Mitchell can also receive requests for authorization via email; however, an employee's health records shall not be transmitted via email. Requestors may call toll-free number 800-407-0704 or 866-931-5100 to request additional information on how to send requests for authorization to Mitchell.

All incoming toll-free telephone numbers include an announcement to alert all callers, including physicians or their designated utilization review representatives, non-physician health care providers, facilities, and injured workers, that calls may be monitored or recorded for quality purposes.

Mitchell provides a phone system for callers to leave a message at times they are unable to reach a staff member. The system will time and date stamp all messages. During non-business hours, incoming calls will be answered with a greeting which includes instructions regarding how the caller can access services.

Phone accessibility statistics will be reviewed at least quarterly by the Mitchell MMS Quality Committee**.**

Number: **CA Requests for Authorization**

Subject: **Requests for authorization and deferred utilization review of requests for authorization**

Policy: **A physician providing treatment under Labor Code §4600 shall send any request for authorization for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer, or other entity according to rules adopted by the Administrative Director. Mitchell and/or the claims administrator may receive written requests for authorization via express delivery, facsimile, mail, and/or electronic mail. Written requests for authorization must be on the current DWC Form RFA and must include supporting documentation as required by applicable regulations. A claims administrator may choose to accept a request for authorization 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.

The request for authorization for a course of treatment as defined in §9792.6.1(d) must be in written form set forth on the "Request for Authorization (DWC Form RFA)," as contained in CCR, title 8, §9785.5.

(1) For purposes of this section, the DWC Form RFA shall be deemed to have been received by the claims administrator or Mitchell by facsimile or by electronic mail on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received.

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

(2) (A) Where the DWC Form RFA is sent by mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator five (5) business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.
(B) Where the DWC Form RFA is delivered via certified mail, with return receipt mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator on the receipt date entered on the return receipt.
(C) In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the DWC Form RFA shall be deemed to have been received by the claims administrator five days after the latest date the sender wrote on the document.

The first day in counting any timeframe requirement is the day after receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA. A DWC Form RFA transmitted by facsimile after 5:30 PM PT shall be deemed to have been received by Mitchell on the following business day except in the case of an expedited review or concurrent review.

Upon receipt of a request for authorization as described in 8 CCR §9792.9.1 (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 §9792.7 or a physician Reviewer must either regard the request as a complete DWC Form RFA and comply with the timeframes for decision set forth in the applicable utilization review regulations 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.

Deferred utilization review of requests for authorization:
Utilization review of a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity. If utilization review is deferred pursuant to 8 CCR §9792.9.1 (b), and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, the time for the claims administrator to conduct:

1) Retrospective utilization review shall begin on the date the determination of the claims administrator's liability becomes final.
2) Prospective utilization review shall commence from the date of the claims administrator's receipt of a request for authorization after the final determination of liability.

Number:	**CA Treatment Requests for Dates of Injury on and after January 1, 2018**
Subject:	**CA Treatment Requests for Dates of Injury on and after January 1, 2018**
Policy:	**Changes to the utilization review statute (Labor Code §4610) became effective January 1, 2018. Changes include:** • **mandatory prospective review for certain treatments provided by specified types of treating physicians/facilities within thirty days of the date of the injury, and** • **no prospective review allowed for certain treatments with the medical treatment utilization schedule, performed by specified types of treating physicians/facilities within the first thirty days of the injury**

Within the 30 days following the initial date of injury on or after January 1, 2018:

Treatment subject to prospective review:
Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network (MPN) or health care organization (HCO), a predesignated physician, an employer-selected physician, or an employer-selected facility shall be subject to prospective utilization review:

(1) Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to §5307.27.
(2) Nonemergency inpatient and outpatient surgery, including all pre-surgical and postsurgical services.
(3) Psychological treatment services.
(4) Home health care services.
(5) Imaging and radiology services, excluding X-rays.
(6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule.
(7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
(8) Any other service designated and defined through rules adopted by the administrative director.

Treatment not subject to prospective review:
Emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule (MTUS) adopted pursuant to §5307.7, that are rendered through a member of the MPN or HCO, a predesignated physician, an employer-selected physician, or an employer-selected facility shall be authorized without prospective utilization review, except those treatments noted above. The services rendered shall be consistent with the MTUS. The report required under §6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.

Number: **CA Drug Formulary**

Subject: **CA Drug Formulary**

Policy: **Drugs prescribed or dispensed to treat a work-related injury or illness are included in the definition of "medical treatment" and are subject to the relevant provisions of the MTUS, including the MTUS Treatment Guidelines, provisions relating to the presumption of correctness, and the methods for rebutting the presumption and for substantiating medical necessity where the MTUS Treatment Guidelines do not address the condition or injury. A drug formulary for all California workers' compensation claims regardless of date of injury, with a time-limited exception for certain dates of injury prior to January 1, 2018, was implemented January 1, 2018. [See §9792.27.3, subdivision (b)].**

A drug **dispensed** on or after January 1, 2018, for outpatient use shall be subject to the MTUS Drug Formulary, regardless of the date of injury, except for continuing drug treatment subject to §9792.27.3, subdivision (b).

(1) A drug is for "outpatient use" if it is dispensed to be taken, applied, or self-administered by the patient at home or outside of a clinical setting, including "take home" drugs dispensed at the time of discharge from a facility. "Home" includes an institutional setting in which the injured worker resides, including but not limited to, an assisted living facility.

(2) The MTUS Drug Formulary does not apply to drugs administered to the patient by a physician; however, the physician administered drug treatment is subject to relevant provisions of the MTUS, including the MTUS Treatment Guidelines.

Effective January 1, 2018, for all days of injury prior to January 1, 2018, for continuing drug treatment if the injured worker is receiving a course of treatment that includes a Non-Exempt drug, an unlisted drug, or a compounded drug [i.e. subject to §9792.27.3, subdivision (b)]:

(a) The MTUS Drug Formulary should be phased in to ensure that injured workers who are receiving ongoing drug treatment are not harmed by an abrupt change to the course of treatment. The physician is responsible for requesting a medically appropriate and safe course of treatment for the injured worker in accordance with the MTUS, which may include use of a Non-Exempt drug or unlisted drug where that is necessary for the injured worker's condition or necessary for safe weaning, tapering, or transition to a different drug.

(b) The physician shall submit a progress report issued pursuant to Labor Code §9785 and a Request for Authorization that shall address the injured worker's ongoing drug treatment plan. The report shall either:

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

(2) Provide supporting documentation, as appropriate, to substantiate the medical necessity of, and to obtain authorization for, the Non-Exempt drug, unlisted drug, or compounded drug, pursuant to the MTUS (via guidelines, Medical Evidence Search Sequence, and/or Methodology for Evaluating Medical Evidence.)

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

(d) Previously approved drug treatment shall not be terminated or denied except as may be allowed by the MTUS and in accordance with applicable utilization review and independent medical review regulations.

(e) The claims administrator shall process the progress report, treatment plan and Request for Authorization in accordance with the standard procedures and timeframes set forth in §9792.6.1 et seq.

Number:	**CA Decisions 1**
Subject:	**Summarized Utilization Review Process**
Policy:	**The utilization review process will be conducted in a timely manner in accordance with applicable California Labor Code and utilization review regulatory requirements as well as applicable URAC standards. (Policy CA TAT 1)**

1. Written requests for authorization are received by Mitchell from the requesting provider or the client.
2. Mitchell non-clinical staff assigns the request for authorization to an Initial Clinical Reviewer to review for appropriateness and medical necessity as well as the need for additional information **(Policy CA Decisions 2)** or to a non-clinical staff member to issue a written authorization decision if the treatment meets the standard for adjuster authorization**.**
3. If clinical review criteria are met, the request for authorization will be approved by the Initial Clinical Reviewer **(Policy CA Decisions 2)**. Verbal notification (when appropriate) or facsimile notice will be sent to the requesting provider. Written notification will be provided to all appropriate parties. **(Policy CA Notifications 1)**.
4. If the requested services do not meet the MTUS guidelines or other approved clinical review criteria where the MTUS guidelines are not applicable, the Initial Clinical Reviewer will forward the request for authorization and all supporting documentation, if any, to a qualified physician Reviewer **(Policy CA Decisions 4)**. Note: Only a physician Reviewer may modify or deny a request for authorization or deny a medical service due to incomplete or insufficient information.
5. The physician Reviewer will review the available information. If the physician Reviewer cannot make an approval decision, he/she may conduct a peer-to-peer discussion with the requesting physician or ordering provider prior to making a utilization review decision. (**Policy CA Decisions 4)** The physician Reviewer will make an approval, modify or denial decision.
6. Verbal notification (when appropriate) or fax notice of the physician Reviewer decision will be sent to the requesting provider. Written notification will be provided to all appropriate parties. **(Policy CA Notifications 1)**.
7. The opportunity for a peer-to-peer discussion will be offered on all written notifications of initial modify or deny decisions. **(Policy CA Peer-to-Peer Discussion 1)**
8. The re-review (reconsideration) process will be offered on all initial denial decisions resulting from incomplete or insufficient documentation. **(Policy CA Re-Review 1)**
9. An voluntary internal appeal process for initial modify or deny decisions will be offered unless prohibited by client agreement **(Policy CA Appeals 1)**.

When conducting utilization review, Mitchell:

1. Accepts information from any reasonably reliable source that will assist in the utilization review process;
2. Collects only the information necessary to review the admission, procedure or treatment, length of stay, or frequency or duration of services;
3. Requires only the section(s) of the medical record necessary in that specific case to review medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; and
4. Administers a process to share all clinical and demographic information on individual workers among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from claimants or providers.

5. Establishes and implements mechanisms to promote collaboration, coordination, and communication across disciplines and departments within Mitchell, with emphasis on integrating administrative activities, quality improvement, and clinical operations.

Prospective and concurrent review determinations will be based solely on the medical information available to Mitchell at the time of the review determination. Retrospective review determinations will be based solely on the medical information which was available to the attending physician or ordering provider at the time the medical care was provided.

Failure to obtain prior authorization for 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, however, may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.

Concurrent Review (utilization review conducted during an inpatient stay):
The following requirement shall be met prior to issuing a concurrent review decision to deny authorization for medical treatment:

1. Medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision to modify or deny a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

2. Medical care provided during a concurrent review shall be medical treatment that is reasonably required to cure or relieve from the effects of the industrial injury. Mitchell ensures that the frequency of reviews for the extension of inpatient hospital stays is based on the severity or complexity of the claimant's condition or on necessary treatment and discharge planning activity (i.e., not routinely conducted on a daily basis).

Expedited Review:
Expedited reviews shall be made in a timely fashion appropriate for the injured worker's condition not to exceed within 72 hours of receipt of the request for authorization. Expedited review timeframes apply when the injured workers' 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. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health shall be reviewed by Mitchell under the non-expedited timeframes set forth in 8 CCR §9792.9.1 (c)(3).

Time Limit for Utilization Review Decision:
A utilization review decision to modify or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Number:	**CA Decisions 2**
Subject:	**Initial Clinical Reviewer Decisions**
Policy:	**Initial Clinical Reviewers review requests for authorization in a timely and professional manner in accordance with the official MTUS adopted by the Administrative Director. The MTUS is the primary source of guidance for treating physicians and physician Reviewers for the evaluation and treatment of injured workers. Injuries not covered by the MTUS are not automatically denied but are reviewed in accordance with the medical evidence search sequence specified in the MTUS. Initial Clinical Reviewers may make authorization decisions requests that meet approved clinical review criteria, but they cannot make modify or deny decisions.**

1. Requests for authorization are assigned to Initial Clinical Reviewers to review for medical necessity to cure or relieve. Expedited review requests will be immediately forwarded to an Initial Clinical Reviewer for review. A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health shall be reviewed under the non-expedited timeframes set forth in 8 CCR §9792.9.1 (c) (3).
2. If the Initial Clinical Reviewer determines the available information is insufficient to conduct a review, one or more requests will be made to obtain the needed information as described in **Policy CA Decisions 3**. All attempts to obtain medical information necessary to make a determination will be documented.
3. The Initial Clinical Reviewer will make a timely approval decision if the request meets the MTUS clinical review criteria. All appropriate parties will be notified of the decision **(Policy CA Notifications 1, Policy CA TAT 1)**.
4. If the Initial Clinical Reviewer cannot make an approval decision based on the available information, the Initial Clinical Reviewer will either:
   a) Forward the request and any supporting documentation to a physician Reviewer to make a decision, **(Policy CA Decisions 4)** or
   b) Discuss the treatment request with the requesting physician if the information received from the requesting physician appears to be inconsistent with the MTUS clinical review criteria. The requesting physician may voluntarily withdraw a portion of the request for authorization or the entire request for authorization and submit an amended request for treatment authorization that meets the MTUS clinical review criteria to be approved by the Initial Clinical Reviewer. If the requesting physician does not wish to withdraw the request, the request and any supporting information will be forwarded to a physician Reviewer. **(Policy CA Decisions 4)**

Number: **CA Decisions 3 – Extension of Timeframe for Decisions**

Subject: **Lack of information reasonably necessary**

Policy: **If information reasonably and necessary required to make a utilization review decision is not provided by the requesting physician with the request for authorization, a request for additional information will be made. A request for authorization will not be denied on the basis of lack of medical information necessary to make a decision without documentation reflecting the attempt to obtain the necessary medical information by facsimile, mail, and/or email.**

1. Additional information, if necessary, will be requested from the requesting physician within five (5) working days from the date of receipt of a written request for non-expedited concurrent review or non-expedited prospective review, within 30 days of receipt of a written request for retrospective review, and no more than 72 hours from receipt of a written request for expedited review. The written request for additional information will include the additional information needed and the due date to receive the information.

2. If an extension is necessary because the Reviewer:
   a. has asked that an additional examination or test that is reasonable and consistent with professionally recognized standards of medical practice be performed on the injured worker or
   b. needs a specialized consultation and review of medical information by an expert reviewer

   a written notice will be sent to the requesting physician, injured worker, and if the injured worker is represented by counsel, the injured workers' attorney, within five (5) business days from the date of the receipt of the request for authorization that the Reviewer cannot make the 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 written notice shall include the anticipated date on which a decision will be rendered.

3. All attempts to obtain reasonably necessary information will be documented in Mitchell's software and shall include copies of any correspondence sent to the requesting physician. Documentation shall include date, time, person contacted, and means of contact.

4. If the information reasonably necessary to make a determination is received in a timely manner, an Initial Clinical Reviewer may make an approval decision. If the Initial Clinical Reviewer is unable to approve the request, the request is forwarded to a physician Reviewer with all available information. (See **Policy CA TAT 1** and **Policy CA Decisions 1**).

5. The Initial Clinical Reviewer will forward the request for authorization and all available information to a physician Reviewer. (**Policy CA Decisions 4**) if reasonably necessary information is not received:
   a. within 14 days of receipt of the written non-expedited prospective or concurrent review request for authorization,
   b. within 30 days from receipt of a retrospective review request for authorization, or
   c. within 72 hours of receipt of the expedited prospective or expedited concurrent review request for authorization.

Number: **CA Decisions 4**

Subject: **Physician Reviewer Decisions**

Policy: **Requests for authorization that cannot be approved by the Initial Clinical Reviewer or an adjuster will be assigned to a qualified physician Reviewer who will use the California Medical Treatment Utilization Schedule (MTUS) to review the request. The MTUS is the primary source of guidance for treating physicians and physician Reviewers for the evaluation and treatment of injured workers. Injuries not covered by the MTUS shall not be automatically denied but shall be reviewed in accordance with the medical evidence search sequence specified in the MTUS. Mitchell shall neither offer nor provide any financial incentive or consideration to a physician Reviewer based on the number of modifications or denials made by the physician Reviewer.**

1) The request for authorization will be assigned to an appropriately qualified physician Reviewer. The physician Reviewer shall be competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the Reviewer's scope of practice, and shall be a currently licensed medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner who holds a current and valid license issued by any state or the District of Columbia.

2) Before accepting an assignment to conduct utilization review on a specific request for authorization, the physician Reviewer must verify there is no conflict of interest on that specific case. If the physician Reviewer determines a conflict of interest exists, he/she will not review the request for authorization, and it will be assigned to a different qualified physician Reviewer.

3) The physician Reviewer will review the request for authorization along with the available information and compare it to the current MTUS for a recommendation applicable to the injured worker's medical condition or injury. In the limited situation where a medical condition or injury is not addressed by the MTUS or if the MTUS' presumption of correctness is being challenged, then the physician Reviewer shall:
   A) Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury and choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence (MEME) set forth in §9792.25.1. If no applicable recommendation is found, or if the physician Reviewer believes there is another recommendation supported by a higher quality and strength of evidence, then
   (B) Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury and choose the recommendation that is supported with the best available evidence according to the MTUS MEME set forth in §9792.25.1. Medical treatment guidelines can be found in the National Guideline Clearinghouse that is accessible at the following website address: www.guideline.gov/. If no applicable recommendation is found, or if the physician Reviewer believes there is another recommendation supported by a higher quality and strength of evidence, then
   (C) Search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury and choose the recommendation that is supported with the best available evidence according to the MTUS MEME set forth in §9792.25.1. A search for peer-reviewed published studies may be conducted by accessing the U.S. National Library of Medicine's database of biomedical citations and abstracts that are searchable at the following website: www.ncbi.nlm.nih.gov/pubmed. Other searchable databases may also be used.

3) If the physician Reviewer cannot approve the request for authorization based on the available information, the physician Reviewer will attempt to contact the requesting physician for a peer-to-peer discussion prior to issuing a decision.

4) A recommendation supported by inapplicable studies should not be used as the source to support, deny, or modify a request

for authorization. A recommendation supported by studies determined to be of poor quality due to the presence of bias should not be used as the source to support, deny or modify a request for authorization.

5) The physician Reviewer will make a decision based upon the available information prior to the expiration of the timeframe for making the decision **(Policy CA TAT 1)**. The physician Reviewer may:
    a. Approve the request;
    b. Modify the request;
    c. Deny the request for lack of medical necessity to cure or relieve; or
    d. Deny the request for incomplete or insufficient information.

6) If the physician Reviewer denies the request due to incomplete or insufficient information, the decision shall specify:
    a. The reason for the decision.
    b. A specific description of the information needed.
    c. The date and time of attempts made to contact the physician to obtain the necessary information.
    d. A description of the manner in which the request was communicated, and
    e. The request will be reconsidered upon receipt of the reasonably necessary information.
    f. Alternatively, the physician Reviewer may extend the timeframe for the decision specified in 8 CCR §9792.9.1 (c) by requesting reasonably necessary information in a timely manner in accordance with 8 CCR §9792.9.1 (f)(1)(A).

7) Verbal notification (when appropriate) or fax notice of the physician Reviewer decision will be sent to the requesting provider. Written notification will be provided to all appropriate parties. **(Policy CA Notifications 1)**.

Number: **CA TAT 1**

Subject: **Timeframes for Making Utilization Review Decisions**

Policy: **The utilization review timeframes in the California Labor Code and California DWC Utilization Review regulations will be followed to enable the provision of timely, necessary medical care appropriate for the nature of the injured worker's condition. Utilization review timeframes are calculated from the earliest date of receipt of the requesting physician's treatment request for authorization by the employer, third party claims administrator, Mitchell, or other entity. The first day in counting any timeframe requirement is the day after receipt of the DWC Form RFA except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA. A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under 8 CCR §9792.9.1 (c) (3) would be detrimental to the injured worker's condition, shall be reviewed by Mitchell under the non-expedited timeframes set forth in 8 CCR §9792.9.1 (c) (3).**

REQUEST TYPE Initial Level	REASONABLY NECESSARY MEDICAL INFORMATION RECEIVED WITH THE REQUEST FOR AUTHORIZATION	REASONABLY NECESSARY MEDICAL INFORMATION NOT RECEIVED WITH THE REQUEST FOR AUTHORIZATION. Not applicable to requests subject to the drug formulary.	EXPEDITED REQUEST - Prospective or Concurrent Review Only.
Prospective Formulary Utilization Review	Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of first receipt of the medical treatment request.	N/A	To be completed as soon as possible based on the clinical situation, but in no case later than 72 hours of receipt of the request for authorization. Timeframe is counted in hours even for requests received after 5:30 PM PT.
Prospective and Concurrent Utilization Review	Not to exceed 5 working days from the date of first receipt of the written request for authorization and the supporting information	The information needed must be requested within five business days of receipt of the request for authorization. The decision must be issued in no more than 5 business days from the receipt of the information reasonably necessary to make the determination or within 14 days from the date of receipt of the original completed request for authorization, whichever is the shorter timeframe. If the needed information is not received within 14 days of receipt of the request, the request shall be denied by a physician Reviewer with the stated condition that the request will be reconsidered upon receipt of the information.	
Retrospective Utilization Review	**30 calendar days.**	**30 calendar days** from receipt of the request for authorization and medical information reasonably necessary.	Not Applicable

REQUEST TYPE	NON-EXPEDITED REQUESTS:	EXPEDITED REQUEST - Prospective and Concurrent Review Only.
Re-Review (Reconsideration) prospective and concurrent utilization review only for denials due to lack of information	There is no time limit in which to request a re-review/reconsideration. A decision must be made within five (5) working days from the date of receipt of the reasonably necessary information.	There is no time limit in which to request a re-review/ reconsideration. A decision to be completed as soon as possible based on the clinical situation, but in no case later than 72 hours of receipt of the additional information reasonably necessary.
Re-Review (Reconsideration) – retrospective utilization review only for denials due to lack of information	There is no time limit in which to request a re-review/reconsideration. A re-review/reconsideration decision must be made within thirty (30) days from the date of receipt of the reasonably necessary information.	N/A
Peer-to-peer discussion request after receipt of a modify/deny decision – prospective, concurrent, and retrospective utilization review	Must be requested within ten (10) days after receipt of the initial modify or deny decision to the injured employee. The same reviewer or a reviewer with equivalent qualifications or the medical director will conduct the discussion within one business day of the request or an agreed upon time. If the requestor intends to file a voluntary appeal, the peer-to-peer discussion must be requested before the deadline to request a voluntary appeal as listed below. A decision will be made within five (5) working days from the date of the peer-to-peer discussion.	Must be requested within ten (10) days after receipt of the initial modify or deny decision to the injured employee. The same reviewer or a reviewer with equivalent qualifications or the medical director will conduct the discussion within one business day of the request or an agreed upon time. If the requestor intends to file a voluntary appeal, the peer-to-peer discussion must be requested before the deadline to request a voluntary appeal as listed below. A decision will be made as soon as possible based on the clinical situation, but in no case later than 72 hours of the date of the peer-to-peer discussion.
Voluntary internal Appeal – prospective, concurrent, and retrospective utilization review	Must be requested verbally or in writing within ten (10) days after receipt of the initial modify or deny decision to the injured employee. The appeal will be conducted by an appeal Reviewer different from the original Reviewer with suitable qualifications as defined elsewhere in this plan. The appeal determination must be issued within thirty (30) calendar days from receipt of the request for voluntary internal appeal.	Must be requested verbally or in writing within ten (10) days after receipt of the initial modify or deny decision to the injured employee. The appeal will be conducted by an appeal Reviewer different from the original Reviewer with suitable qualifications as defined elsewhere in this plan. The appeal decision must be completed as soon as possible based on the clinical situation, but in no case later than 72 hours of receipt of the information reasonably necessary. Applies to expedited prospective and expedited concurrent voluntary internal appeal reviews only.

Extension of Decision Timeframes:

The timeframes for processing initial review level requests may only be extended if the adjuster, initial clinical reviewer, or physician Reviewer is not in receipt of all the information reasonably necessary to make a determination.

If insufficient information is received with the request for authorization, the physician Reviewer or non-physician reviewer shall request information from the treating physician within five (5) business days from receipt of the request for authorization. The policy for requesting information prior to issuing denial decisions based on lack of receipt of information reasonably necessary to make a determination is discussed in detail in **Policy CA Decisions 3**. If the information requested 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 receipt of the request for retrospective review, the physician Reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

Re-Review/Reconsideration and Peer-to Peer Discussion Decision Timeframes:
Following receipt of the additional information reasonably necessary to make a decision or a completed peer-to-peer discussion requested after the requesting provider receives an initial modify or deny utilization review decision, a decision must be made to approve, modify, or deny:

- the non-expedited prospective or concurrent re-review request within five (5) working days;
- the expedited re-review request (prospective or concurrent) within no more than seventy-two (72) hours; or
- the retrospective re-review request within thirty (30) days .

The written re-review/reconsideration decision shall include the date the information was received or the peer-to-peer discussion was completed/attempted, if any, and be communicated timely to the appropriate parties.

Timeframes for voluntary internal appeals:

A voluntary internal appeal request must be submitted within ten (10) days after receipt of the modify or deny utilization review decision.

Voluntary internal appeal decisions will be made within the following timeframes:

a. Expedited: ASAP, but not more than 72 hours after receipt of the request for appeal.
b. Non-Expedited: Not more than 30 calendar days from receipt of the request for appeal.

Number: **CA Notifications 1**

Subject: **Written Notifications**

Policy: **Mitchell will provide written notification of each utilization review decision to the appropriate parties as defined by California Labor Code and implementing utilization review regulations unless those responsibilities are assumed by Mitchell's client(s). If verbal notice of the decision is initially given to the requesting physician, it will be followed by a written notice to the requesting physician within 24 hours of a concurrent review decision and within two business days of the prospective review decision.**

Verbal notifications, if any, will be made during the reasonable and normal business hours of the party being called. The verbal notification, if any, will be made within 24 hours of the decision and will be documented.

Decisions to approve a physician's request for authorization prior to, or concurrent with, the provision of medical services to the injured worker shall be communicated by phone, facsimile, or electronic mail to the requesting physician within 24 hours of the decision. The initial communication, if by phone, shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two business days for prospective review.

Decisions to modify or deny a physician's request for authorization prior to, or concurrent with the provision of medical services to the injured worker shall be communicated to the requesting physician by phone, facsimile, or electronic mail within 24 hours of the decision. Verbal notice may be provided by a physician Reviewer, an Initial Clinical Reviewer or another staff member. Any telephonic communication of the decision to the requesting physician shall be followed by written notice within 24 hours of the concurrent review decision and within two business days of the prospective review decision. Written notice to the injured worker, the injured worker's attorney, if the injured worker is represented by counsel, and counsel contact information is known, and the injured worker's representative if one is established at the time of the determination, shall be delivered within 24 hours of the concurrent review decision and within two business days of the prospective review decision.

Retrospective decisions to approve, modify or deny shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney if the injured worker is represented by counsel, and counsel contact information is known, and the injured worker's representative if one is established at the time of the determination, , within 30 days of receipt of the medical information that is reasonably necessary to make the decision.

Content requirements for written notices:

a) Decisions to approve a request for authorization:
   1) The specific medical treatment service requested;
   2) The specific medical treatment service approved;
   3) The date of the decision;
   4) The date of receipt of additional information, if applicable; and
   5) The specific date the complete request for authorization was first received.

b) Decisions to modify or deny a request for authorization shall be signed by either the claims administrator or the physician Reviewer and shall only contain the information specific to the request:
   1) The decision (modify or deny);
   2) The date on which the DWC Form RFA was first received;
   3) The date of decision;
   4) The date of receipt of additional information, if applicable;
   5) A description of the specific course of proposed medical treatment for which authorization was requested;
   6) A specific description of the medical treatment service approved, if any;

7) A clear, concise and appropriate explanation of the physician Reviewer's decision, including the clinical reasons (rationale) regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to 8 CCR §9792.8. The description of the relevant medical criteria or guidelines shall include a citation to the guideline or study containing the recommendation the physician Reviewer believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury. The citation provided by the physician Reviewer shall be the primary source relied upon which he or she believes contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury. If the physician Reviewer provides more than one citation, then a narrative shall be included by the physician Reviewer in the utilization review decision explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited. The citation shall be in the format specified in 8 CCR §9792.21.1. (d) (listed below):
   a) When citing the MTUS:
      (A) Indicate the MTUS is being cited and the effective year of the guideline;
      (B) Title of chapter (e.g., Low Back Complaints); and
      (C) Section of chapter (e.g., Surgical Considerations).
   b) When citing other medical treatment guidelines:
      (A) Title of organization publishing the guideline (e.g., ACOEM or ODG);
      (B) Year of publication;
      (C) Title of chapter; and
      (D) Section of chapter.
   c) When citing a peer-reviewed study:
      (A) First author's last name and first name initial;
      (B) Published article title;
      (C) Journal title (standard abbreviations may be used);
      (D) Volume number;
      (E) Year published; and
      (F) Page numbers;
8) If the utilization review decision is due to incomplete or insufficient information necessary to make a decision, the decision shall specify:
      (A) The reason for the decision.
      (B) A specific description of the information that is needed.
      (C) The date(s) and time(s) of attempts made to contact the physician to obtain the necessary information.
      (D) A description of the manner in which the request was communicated;
9) A list of all medical records reviewed;
10) The physician or expert Reviewer's name, specialty, state(s) of licensure, and license(s) number(s), the U.S. telephone number of the physician Reviewer or Expert Reviewer, and 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;
11) 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 at the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

12) Details about Mitchell's voluntary internal utilization review appeals process for the requesting physician, if any, and a clear statement that the internal appeals process is a voluntary process that neither triggers not bars use of the dispute resolution procedures of Labor Code §4610.5 and 4610.6, but it may be pursued on an optional basis**;**
13) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code §4610.5 and 4610.6. In addition, the statement will advise 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 ten (10) calendar days after the service of the utilization review decision to the employee for formulary disputes and within thirty (30) calendar days after the service of the utilization review decision to the employee for all other medical treatment disputes;
14) The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee, must be completed by the claims administrator. The written decision provided to the injured worker shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.

Peer-to-peer discussions and re-review (reconsideration) requests that result in a modification of the original utilization review decision will include a new IMR form with the written decision. Peer-to-peer discussions and re-review (reconsideration) requests that do not result in a change to the original utilization review decision shall not include a new IMR form with the written decision. Peer-to-peer discussions and re-review requests that result in the overturning of the original modify or deny decision will be issued written authorization decisions to ensure timely, medically necessary treatment of injured workers.

Voluntary internal appeals that result in a modify decision must include a new IMR form which indicates it is a modification after appeal. Appeals that result in an upheld denial decision should not include a new IMR form.

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

Number:	**CA Re-Review 1**
Subject:	**Re-Review/reconsideration process**
Policy:	**Mitchell shall offer a re-review (reconsideration) process for initial denial decisions due to incomplete or insufficient information.**

Re-review (reconsideration) process:

The injured worker, the injured worker's representative, injured worker's attorney, if any, or the requesting physician may request a re-review/reconsideration of a denial decision based on lack of sufficient information by providing additional information that was not available during the initial utilization review process.

Re-review requests may be performed by the same physician Reviewer who made the original decision, another physician Reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, or an initial clinical reviewer if the request for authorization can now be approved based on the additional information provided.

Requests for re-review/reconsideration will be completed within the timeframes specified in **Policy CA TAT 1**.

Number:	**CA Peer-to-Peer Discussion 1**
Subject:	**Peer-to-peer discussion process**
Policy:	Mitchell shall offer a peer-to-peer discussion opportunity for all initial modify and deny decisions to facilitate the utilization review process, speed the exchange of medical information, and accelerate the provision of medical benefits to injured workers.

Peer-to-peer discussion process:

Mitchell will facilitate a peer-to-peer discussion between the requesting or treating physician and the initial physician Reviewer to discuss initial modify or deny decisions.

The opportunity for a peer-to-peer discussion described in the initial modify or deny written decision shall 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 physician Reviewer, an expert physician Reviewer or the Mitchell 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.

As an added best practice, the physician Reviewer will also attempt a peer-to-peer discussion with the requesting provider before issuing an initial modify or deny written decision. The attempted peer-to-peer discussion does not extend the turn-around time for the physician Reviewer to make a utilization review decision. Per URAC's interpretive guide to the Workers' Compensation Utilization Management (WCUM) standards, version 7.3, "the goal of the peer-to-peer discussion is to allow the treating provider a chance to discuss a utilization management determination before the initiation of the appeal process. It is hoped that some disagreements can be worked out without the need for a formal and often-adversarial appeal process."

Number: **CA Appeals 1**

Subject: **Voluntary Internal Appeals Process**

Policy: **A voluntary internal appeals process shall be offered on initial modify and deny utilization review decisions. Two turnaround times are offered depending upon the type of utilization review request processed: Standard or Expedited. The voluntary internal appeal may be requested verbally or in writing.**

Voluntary internal appeal process:
The injured worker, the injured worker's representative, the provider, or the facility rendering service may request a voluntary appeal of a modify or deny utilization review decision. The appeal will be conducted by an Appeal Reviewer different from the physician Reviewer who made the original modify or deny decision and who is qualified to conduct the appeal as described in **Policy CA Staff 1** and in **CA Definitions 1.** Recipients of voluntary appeal decisions are the same parties described in **Policy CA Notifications 1**.

Standard appeal process:
An appeal request must be received by Mitchell within 10 days after receipt of the modify or deny decision. Mitchell will complete the appeal review within 30 calendar days of receipt of the voluntary appeal request. **See Policy CA TAT 1.**

Expedited appeal process:
An appeal request must be received by Mitchell within 10 days after receipt of the modify or deny decision. Expedited appeal requests will be completed as soon as possible with verbal notice given no more than 72 hours after receipt of the timely expedited appeal request. **See Policy CA TAT 1.**

Each appeal decision will be recorded in Mitchell's software and will include:

1. The name of the injured worker, health care provider, and/or servicing facility, when available;
2. Copies of all correspondence received from those parties or issued by Mitchell regarding the voluntary internal appeal;
3. Dates of reviews, documentation of actions taken, and final resolution;
4. Minutes or transcripts of any review proceedings (if any); and
5. Name and credentials of the reviewer who made the appeal decision.

An voluntary internal appeal shall be considered complete upon the issuance of a final independent medical review determination per 8 CCR §9792.10.6 (h) that determines the medical necessity of the disputed treatment.

Any voluntary internal appeal determination that results in a modification of the original denial decision 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 8 CCR §9792.9.1(e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under §9792.9.1(e) (5) (G) must indicate that the decision is a modification after appeal.

Appeal decisions that uphold the original utilization review decision should not include a new IMR form.

Number:	**CA Independent Medical Review 1**
Subject:	**Independent Medical Review**
Policy:	**Apparent medical necessity disputes shall be resolved pursuant to the independent medical review process in Labor Code §§4610.5 and 4610.6 unless deferred for other dispute(s) of liability issues.**

Neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is modified or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review or the Workers' Compensation Appeals Board.

Medical necessity disputes of modify and deny utilization review decisions shall be resolved in accordance with the independent medical review provisions of Labor Code §4610.5 and 4610.6. 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 DWC Form IMR within 30 calendar days after service of the non-formulary decision to the employee. For formulary disputes, the IMR must be submitted within ten (10) days after the service of the utilization review decision to the employee.

A copy of the written decision denying or modifying the request for authorization of medical treatment must be sent with the DWC Form IMR when independent medical review is requested. Mitchell's voluntary internal appeal process neither triggers nor bars use of the dispute resolution procedures of Labor Code §4610.5 and 4610.6, but it may be pursued on an optional basis.

The physician whose request for authorization of medical treatment was modified or denied may join with or otherwise assist the employee in seeking an independent medical review.

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

Mitchell's clients retain responsibility for providing information to the independent medical review organization designated by the DWC Administrative Director for processing requests for independent medical review. Mitchell's clients also retain responsibility for payment of any fees associated with the independent medical review process.

III. Clinical Criteria

Number: **CA Criteria 1**

Subject: **Clinical Review Criteria**

Policy: **Mitchell will use the California Medical Treatment Utilization Schedule (MTUS) to review the medical necessity of requests for authorization, including drug requests Drugs prescribed or dispensed to treat a work-related injury or illness fall within the definition of "medical treatment" and are subject to the relevant provisions of the MTUS, including the MTUS Treatment Guidelines, provisions relating to the presumption of correctness, and the methods for rebutting the presumption and for substantiating medical necessity where the MTUS Treatment Guidelines do not address the condition or injury. All medical conditions or injuries not addressed by the MTUS shall be reviewed in accordance with the medical evidence search sequence specified in the MTUS. Mitchell does not use internally derived treatment guidelines.**

Mitchell will use the criteria described in the DWC's medical treatment guideline schedule, the MTUS. The recommended guidelines set forth in the MTUS are presumptively correct on the issue of extent and scope of medical treatment. The MTUS constitutes the standard for the provision of medical care in accordance with Labor Code §4600 for all injured workers diagnosed with industrial conditions. The MTUS shall be the primary source of guidance for treating physicians and physician Reviewers for the evaluation and treatment of injured workers.

There are two limited situations that may warrant treatment based on recommendations found outside of the MTUS.

1) First, if a medical condition or injury is not addressed by the MTUS, medical care shall be in accordance with other medical treatment guidelines or peer-reviewed studies found by applying the Medical Evidence Search Sequence set forth in §9792.21.1. Treatment shall not be denied on the sole basis that the condition or injury is not addressed by the MTUS.
2) Second, if the MTUS' presumption of correctness is successfully challenged. The recommended guidelines set forth in the MTUS are presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof; therefore, the treating physician who seeks treatment outside of the MTUS bears the burden of rebutting the MTUS' presumption of correctness by a preponderance of scientific medical evidence.

Medical Evidence Search Sequence for the evaluation and treatment of injured workers:

(1) Search the recommended guidelines set forth in the current MTUS to find a recommendation applicable to the injured worker's medical condition or injury.
(2) In the limited situation where a medical condition or injury is not addressed by the MTUS or if the MTUS' presumption of correctness is being challenged, then:
    (A) Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence (MEME) set forth in §9792.25.1. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then
    (B) Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured

worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS MEME set forth in §9792.25.1. Medical treatment guidelines can be found in the National Guideline Clearinghouse that is accessible at the following website address: www.guideline.gov/. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then

(C) Search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS MEME set forth in §9792.25.1. A search for peer-reviewed published studies may be conducted by accessing the U.S. National Library of Medicine's database of biomedical citations and abstracts that is searchable at the following website: www.ncbi.nlm.nih.gov/pubmed. Other searchable databases may also be used. When competing recommendations are cited to guide medical care, physician Reviewers shall apply the MTUS MEME to evaluate the quality and strength of evidence used to support the recommendations that are at variance with one another. The MTUS MEME provides a process to evaluate studies, not guidelines. Therefore, the reviewing physician shall evaluate the underlying study or studies used to support a recommendation found in a guideline. Medical care shall be in accordance with the recommendation supported by the best available evidence.

The relevant portion of the criteria or guidelines used shall be disclosed in written form to the requesting physician, the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney, if used as the basis of a decision to modify or deny services in a specific case under review. Mitchell will not charge an injured worker, the injured worker's representative, the injured worker's attorney, or the requesting physician for a copy of the relevant portion of the criteria or guidelines used to modify or deny the treatment request.