California Worker's Compensation Utilization Review Plan

Revised: February 2022

Table of Contents

Utilization Review Standards - Definitions

(a) “Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on either a completed “Request for Authorization,” DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2), that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the “Request for Authorization,” DWC Form RFA if that form was initially submitted by the treating physician.

(b) “Claims Administrator” is a self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). “Claims Administrator” includes any utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.

(c) “Concurrent review” means utilization review conducted during an inpatient stay.

(d) “Course of treatment” means the course of medical treatment set forth in the treatment plan contained on the “Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021, found at California Code of Regulations, title 8, section 14006, or on the “Primary Treating Physician's Progress Report,” DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(s) “Request for authorization” means a written request for a specific course of proposed medical treatment.

> (1) Unless accepted by a claims administrator under section 9792.9.1(c)(2), a request for authorization must be set forth on a “Request for Authorization (DWC Form RFA),” completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5. Prior to March 1, 2014, any version of the DWC Form RFA adopted by the Administrative Director under section 9785.5 may be used by the treating physician to request medical treatment.
>
> (2) “Completed,” for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization must identify both the employee and the provider, identify with specificity a recommended treatment or treatments, and be accompanied by documentation substantiating the need for the requested treatment.
>
> (3) The request for authorization must be signed by the treating physician and may be mailed, faxed or e-mailed to, if designated, the address, fax number, or e-mail address designated by the claims administrator for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

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

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

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

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

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

(y) “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.

Source: 8 CCR § 9792.6.1

Utilization Review Program Structure

Program Objectives

Utilization review (UR) is the process used by employers or claims administrators to review treatment to determine if it is medically necessary and appropriate for an accepted injury. All employers or their workers' compensation claims administrators are required by law to have a UR program.

At Genex, we strive to ensure our clients' employees receive best-practice clinical care through our utilization review program. Our utilization management solution is a web-based program that allows our clinical peer reviewers to effectively and efficiently review submitted requests for authorization while focusing on quality of care. The program also allows the integration of utilization review procedures into claims management. Consequently, the UR information is immediately available to the claims personnel.

The Genex UR program follows the HIPAA Privacy Rules, URAC WCUM Standards as well as all California labor code and regulations. Genex Services has been accredited by URAC in Workers' Compensation Utilization Management since 1996.

Upon request, Genex shall make available this complete utilization review plan, including a complete copy of Genex policies and procedures and description of the utilization review process, at no cost.

Quality Assurance/Quality Control (QAQC) Committee

Reporting directly to the Executive Vice President, the Quality Assurance/Quality Control (QAQC) Committee meets quarterly to identify problems and trends and discuss solutions for identified program deficiencies and compliance with regulatory and URAC requirements.

Objective: Genex's QAQC Committee is tasked with identifying deficiencies within the Utilization Review program and implementing solutions that address quality, service or safety issues.

Composition: The QAQC Committee is composed of the following individuals:

- Medical Director
- Director of Operations
- Production Manager
- Clinical Staff Member
- Non-Genex representative

Procedures:

1. The QAQC Committee reports directly to the Executive Vice President.
2. The QAQC Committee will meet quarterly and maintain minutes of the scheduled meeting for review and approval at subsequent meetings.
3. The Committee will:
    - Evaluate the effectiveness of the quality management program annually
    - Approve quality improvement projects
    - Monitor quality improvement initiatives
    - Provide staff guidance on quality management projects and priorities

Medical Director

Genex's Medical Director is Helga Daftarian, DO

American Board of Preventive Medicine
California Osteopathic License: #15850 (valid through 1/31/2023)
Address: P.O. Box 4379, Westlake Village, CA 91359
Telephone: 800.844.4235 Option 2

Qualifications: Dr. Daftarian is a physician licensed by the Osteopathic Medical Board of California and holds an unrestricted license to practice medicine in the State of California. Dr. Daftarian is also board certified in occupational medicine, with 15 years of experience in medical practice, and nearly 21 years of experience serving as medical director within utilization management and case management operations.

Dr. Daftarian is a graduate of Kirksville College of Osteopathic Medicine. Board certified in occupational medicine, Dr. Daftarian completed her residency at University of Utah Hospitals and Clinics and has served as a staff physician for the United States Navy. She served as an epidemic intelligence service officer drafting public health related documents for publication for the CDC/NIOSH. Since 2000, Dr. Daftarian has also been involved as a medical director for case management, utilization management, and quality management programs as well as engaged in both clinical and operational aspects of each program.

Functions: The Medical Director is responsible for credentialing of the clinical staff, clinical oversight and quality management of Genex's utilization management program. Consistent with 8CCR 9792.6, the Medical Director is responsible for all decisions made in the utilization review process. Genex's Medical Director fulfills this responsibility by monitoring the clinical staff as well as by ensuring that the policies and procedures utilized within the utilization management process are compliant with the CA Labor Code and Regulations. Through administration and oversight of the Quality Assurance

program and all Genex utilization management committees, the Genex Medical Director ensures that all Genex staff and contractors adhere to the utilization management plan through all clinical and non-clinical facets.

Utilization Review Staff

Senior Clinical Staff

Qualifications: The general qualifications of Senior Clinical Staff include: a health profession degree such as, but not limited to, MD, DO, DC, DPM, LAc, PhD, RN; a current license or certification to practice a health profession; and two years professional experience preferred. Senior Clinical Staff must be licensed by a State or by the District of Columbia.

Functions: The Senior Clinical Staff facilitate the day-to-day operations and the general administration of the Utilization Management program. Senior Clinical Staff assists in supervising all staff and contractors and serve on all committees.

Initial Clinical Reviewer

Qualifications: The general qualifications of Initial Clinical Reviewers include: a health profession degree such as, but not limited to, MD, DO, DC, DPM, LAc, PhD, RN; a current license or certification to practice a health profession; and two years professional experience preferred. Initial Clinical Reviewers must be licensed by a State or by the District of Columbia.

Functions: Initial Clinical Reviewers perform first level review on requests for authorization. They review the clinical documentation and apply clinical review criteria, approved by the Medical Director and Clinical Review Committee, to the request for authorization.

Initial Clinical Reviewers may issue certifications if the request for authorization matches the clinical review criteria and is medically necessary.

Initial Clinical Reviewers may not process modifications or non-certifications but shall forward all reviews for which they are not recommending certification to a Clinical Peer Reviewer.

Initial Clinical Reviewers may request additional clinical information, which they deem reasonable and necessary to complete utilization management, from the provider via fax, phone, mail or email.

Clinical Peer Reviewer

Qualifications: The general qualifications of Clinical Peer Reviewers include: a health profession degree such as, but not limited to, MD, DO, DC, DPM, LAc, PhD; a current license or certification to practice a health profession; five years professional experience preferred; board certification, preferred where applicable, for appeals consideration. Clinical Peer Reviewers must be licensed by a State or by the District of Columbia.

Functions: Clinical Peer Reviewers perform second or third level review on requests for authorization, reconsiderations or appeals consideration. They review the clinical documentation and apply clinical review criteria, approved by the Medical Director and Clinical Review Committee, to the request for authorization.

Clinical Peer Reviewers issue determinations of medical necessity.

Clinical Peer Reviewers may request additional clinical information, which they deem reasonable and necessary to complete utilization management, from the provider via fax, phone, mail, or email.

Quality Assurance/Quality Control Reviewers
Qualifications: The general qualifications of QAQC Reviewers include: a health profession degree such as, but not limited to, MD, DO, DC, DPM, LAc, PhD, RN; a current license or certification to practice a health profession; and two years professional experience preferred.

Functions: QAQC Reviewers perform a quality assurance check on reviews before the determination is released to all stakeholders and the electronic file closed. If the QAQC Reviewer identifies a review with quality assurance issues, they shall return the review to the Initial Clinical Reviewer or Clinical Peer Reviewer for revision. QAQC Reviewers do not perform any utilization review decision making. QAQC Reviewers are required to notify the Senior Clinical Staff of emerging quality assurance/quality control trends.

Director of Operations
Roland Kratzer

Qualifications: Mr. Kratzer has over 20 years' experience in operations management of manufacturing, distribution, and service companies. Mr. Kratzer holds an MBA from The Wharton School.

Functions: The Director of Operations directs the Utilization Management business and administrative operations to fulfill the Genex mission statement. The Director of Operations oversees the security and day-to-day operations in the Utilization

Management facilities; and the general administration and financial management of the Utilization Management program.

Production Manager
Qualifications: The general qualifications of the Production Manager include: a bachelor's degree, one year of experience in administrative or customer service, or an equivalent combination of education and experience.

Functions: The Production Manager is responsible for providing administrative support services and supervision of non-clinical staff. They oversee the Utilization Management administrative department including: management of all aspects of non-clinical staff personnel including hiring, training, supervision and performance evaluation; performance of quality control on administrative utilization management procedures including timeframe adherence; oversight of customer satisfaction and customer relations; and communication and consultation with the Medical Director and Senior Clinical Staff in regard to performance of daily tasks.

Non-Clinical Administrative Staff
Qualifications: The general qualifications of the Non-Clinical Administrative Staff include a bachelor's degree, one year of experience in administrative or customer service, or an equivalent combination of education and experience.

Functions: The Non-Clinical Administrative Staff are responsible for providing administrative support for processes within utilization management and for performing customer service for the various stakeholders in the utilization management process.

Utilization Review Process

Telephone and Facsimile Access

Genex shall maintain toll-free telephone and toll-free fax access from 9:00 AM to 5:30 PM Pacific Time Monday through Friday on normal business days for providers to request authorization for medical services and appeals considerations.

Genex shall maintain toll free telephone with voice mail, and toll-free fax access, during all non-business hours for providers to request authorization for medical services and appeals considerations.

Genex employees and contractors shall return all mail inquiries, voice mail messages, email messages, or fax messages within 1 business day of receipt and record all

communication responses in the Genex utilization management electronic review file. Genex shall maintain the highest level of professionalism in all communications associated with utilization management and inquiries shall be transferred to appropriate personnel per Genex policies and procedures.

Utilization Review Requests

Requests for authorization for a course of medical treatment must be submitted on completed "Request for Authorization," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2)(A-B), that has been transmitted by the treating physician to the claims administrator.

Failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services may be subject to retrospective review.

Date of Receipt

Written requests for authorization shall be deemed to have been received by facsimile on the date the request was received if the receiving facsimile electronically date stamps the transmission. If there is no electronically stamped date recorded, then the date of receipt shall be deemed to be the date the request was transmitted.

A request for authorization transmitted by facsimile after 5:30 P.M. Pacific Time shall be deemed to have been received by the claims' administrator on the following business day as defined in Labor Code section 4600.4 and in section 9 of the Civil Code.

Where the request for authorization is received by mail and a proof of service by mail exists, the request shall be deemed to have been received five (5) days after the deposit in the mail at a facility regularly maintained by the United States Postal Service. Where the request is delivered via certified mail, return receipt mail, the request shall be deemed to have been received on the receipt date entered on the return receipt. In the absence of a proof of service by mail or a dated return receipt, the request shall be deemed to have been received on the date stamped on the document by the recipient. In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the request for authorization shall be deemed to have been received by the claims' administrator five (5) days after the latest date the sender wrote on the document.

Pre-Review Screening

Should any necessary elements be missing from the review as it is being created, Genex non-clinical administrative staff may perform pre-review screening. If so, they shall ensure that pre-review screening occurs within 2 business days of receiving the request for authorization or appeals consideration. The Genex staff shall record all information gathered in pre-review screening in the Genex utilization management electronic review file.

Genex defines pre-review screening as including any of the following:

- Collection of structured clinical data defined as clinical information that is precise and permits exact matching against explicit medical terms, diagnoses or procedure codes, or other explicit choices, without the need for interpretation;
- Asking scripted clinical questions;
- Accepting responses to scripted clinical questions;
- Taking specific action, including amendment of items contained in the electronic review file as explicitly linked to each of the possible responses.

Pre-review screening shall not include any of the following:

- Applying clinical judgment or interpretation;
- Accepting unstructured clinical information;
- Deviating from script;
- Engaging in unscripted clinical dialogue;
- Asking clinical follow up questions;
- Issuing determinations of any kind.

For all requests for authorization; if Genex non-clinical staff determine that the DWC Form RFA is not complete as defined in section 9792.6.1(t)(2), they may either treat the form as complete and initiate review for compliance with the timeframes for decision set forth in 8CCR9792.9.1(c)(2)(A); or return it to the requesting physician marked "not complete" no later than five (5) business days from receipt.

Determination of Need for Expedited Review

Consistent with 8CCR9792.9.1(c)(4), 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 standard timeframe for utilization review would be detrimental to the injured worker's condition, shall be reviewed by under the timeframe set forth in subdivision (c)(3). A finding that a request for expedited review is not reasonably supported by such evidence must be made and documented by a licensed health care provider.

Determination of Need for New Review Following Denial

Consistent with 8CCR9792.9.1(h), review of a request for authorization is not required if there has been a denial of the same request from the same provider within 12 months from the date of the denial; unless the new request "is supported by a documented change in the facts material to the basis of the utilization review decision."

Genex may elect to take no action on a request for authorization if:

- The same treatment was denied within 12 months from the date of the denial; and
- The denial arose from a request for authorization from the same physician; and
- There is no documented change in the facts material to the basis of the original denial.

Regarding the question of whether there has been a change in the facts material to the basis of the original denial, there shall be an operating assumption that such change exists, and a new review is required; unless there is a finding by a licensed health care provider that there has been no such change. Such finding requires that there be consideration of whether there has been:

- Relevant supportive change in patient presentation; and/or
- Relevant supportive findings from new diagnostic studies or imaging; and/or
- Relevant support change in interval clinical history.

Disputes of Liability

Consistent with 8CCR9792.9.1(b)(1), utilization review of a treatment request 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 Genex disputes liability under this subdivision, it may, no later than five (5) business days from receipt of the DWC Form RFA, issue a written decision deferring utilization review of the requested treatment. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall only contain the following information specific to the request:

A. The date on which the request for authorization was first received.
B. A description of the specific course of proposed medical treatment for which authorization was requested.
C. A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.

D. A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.
E. The following mandatory language advising the injured employee:
"You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.
and
"For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

If utilization review is deferred, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, the time for the claims administrator to conduct retrospective utilization review in accordance with this section shall begin on the date the determination of the claims administrator's liability becomes final. The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a request for authorization after the final determination of liability.

Administrative Authorization

Workers' compensation insurance carriers and self-insured employers may choose to administratively approve requests for authorization without submitting the request to Genex for review.

Additionally, per Cal. Lab. Code § 4610(b), for all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Cal. Lab. Code § 4600, within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (c) of Cal. Lab. Code § 4610. The services rendered under Cal. Lab. Code § 4610(b), shall be consistent with the medical treatment utilization schedule.

Initial Clinical Review

Initial Clinical Reviewers perform first level review on requests for authorization. They review the clinical documentation and apply clinical review criteria, approved by the Medical Director and Clinical Review Committee, to the request for authorization.

Initial Clinical Reviewers may issue certifications if the request for authorization matches the clinical review criteria and is medically necessary.

Initial Clinical Reviewers may not issue modifications or non-certifications, but rather shall forward all reviews for which they are recommending modification or non-certification to a Clinical Peer Reviewer.

Initial Clinical Reviewers may request additional clinical information, which they deem reasonable and necessary to complete utilization management, from the provider via fax, phone, mail or email.

Initial clinical reviewers may determine that no review is required, consistent with 8CCR9792.9.1(h), as described above.

Initial clinical reviewers may issue a dispute of liability notice, consistent with 8CCR9792.9.1(b), as described above.

Clinical Peer Review

Clinical Peer Reviewers perform second or third level review on requests for authorization, reconsiderations or appeals consideration. They review the clinical documentation and apply clinical review criteria, approved by the Medical Director and Clinical Review Committee, to the request for authorization.

Clinical Peer Reviewers issue determinations of medical necessity. Only Clinical Peer Reviewers may issue modifications or denials.

Clinical Peer Reviewers may request additional clinical information, which they deem reasonable and necessary to complete utilization management, from the provider via fax, phone, mail or email.

In the case of concurrent review, 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.

Clinical peer reviewers may determine that no review is required, consistent with 8CCR9792.9.1(h), as described above.

Clinical peer reviewers may issue a dispute of liability notice, consistent with 8CCR9792.9.1(b), as described above.

Quality Assurance/Quality Control Reviewers

Prior to releasing the UR determination to stakeholders, reviews completed by Genex initial clinical reviewers and clinical peer reviewers shall be reviewed by QAQC reviewers. QAQC reviewers shall perform day-to-day quality assurance and quality control monitoring of:

- Reviewing internal consistency within the review to ensure that the review does not contradict itself.
- Reviewing completeness of the review to ensure that it addresses all elements of care requested by the requesting physician.
- Reviewing guidelines applied for relevance to the requested care.
- Reviewing guidelines for appropriate referencing.
- Reviewing the determination for grammar, punctuation, and spelling.

If the QAQC Reviewer notes non-material changes, such as spelling, grammar, or punctuation, they shall make the non-material changes to the review and shall release the review to stakeholders. However, if the QAQC reviewer notes material changes, such as incomplete reviews or incorrect guidelines, they shall re-assign the review to the initial clinical reviewer or clinical peer reviewer for correction.

The QAQC reviewers shall note any common errors of specific initial clinical reviewers or clinical peer reviewers and shall communicate this to the Senior Clinical Staff.

Retrospective Review

Retrospective review may be performed solely for the purpose of determining if the physician is prescribing treatment consistent with the schedule for medical treatment utilization, including, but not limited to, the drug formulary adopted pursuant to Cal. Lab. Code § 5307.27.

Treatment Guidelines

The Medical Treatment Utilization Schedule (MTUS) provides medical treatment guidelines for utilization review and an analytical framework for the evaluation and treatment of injured workers. The MTUS is promulgated by the DWC administrative

director under Labor Code sections 5307.27 and 4604.5, and can be found in sections 9792.20 et seq. of Title 8, California Code of Regulations.

The MTUS lays out treatments scientifically proven to cure or relieve work-related injuries and illnesses. It also deals with how often the treatment is given (frequency), extent of treatment (intensity), and for how long (duration), among other things.

Genex reviewing physicians follow the medical evidence search sequence required by in 8 CCR § 9792.21.1. Genex utilizes the Medical Treatment Utilization Schedule for the review of treatment requests. If the MTUS is not applicable, the reviewer shall search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1. If no applicable recommendation is found, or if the reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then the reviewing physician shall search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1 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 the reviewing physician shall search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1.

Guidelines used in the utilization review process to determine whether to approve, modify, or deny medical treatment services are developed with involvement from actively practicing physicians. These guidelines must be consistent with the MTUS, including the drug formulary adopted pursuant to Cal. Lab. Code § 5307.27. These guidelines are evaluated annually and updated, if necessary.

Additionally, these guidelines are disclosed to the physician and to the employee within the utilization review determination if they are used as the basis of a decision to modify or deny services in a specified case under review. GENEX’s guidelines are available to the

public upon request. A charge shall not be required for an employee whose physician's request for medical treatment services is under review.

Genex has procedures in place for reviewing/updating treatment guidelines which include the annual evaluation of existing evidence-based medical treatment guidelines to determine Genex's primary and secondary medical treatment guidelines for use in the evaluation of workers compensation medical care. Updates for commercial criteria are obtained as they become available, to ensure that Genex is utilizing the most current version of commercial criteria.

Citation of Guidelines and Other Authority

Citations provided by the Genex reviewers include the following elements.

- When citing the MTUS, the citation shall include:
  - the term "MTUS" or "Medical Treatment Utilization Schedule";
  - the effective year of the guideline;
  - the title of the chapter referenced (e.g., Low Back Complaints);
  - the section referenced within the chapter (e.g., Surgical Considerations).
- When citing other medical treatment guidelines, the citation shall include:
  - the name or abbreviated name of the guidelines being cited (e.g., Official Disability Guidelines; ODG);
  - the name of the organization publishing the guidelines (e.g., Work Loss Data Institute);
  - the year of publication;
  - the title of the chapter
  - the section referenced within the chapter (if applicable)
- When citing a peer-reviewed study, the citation shall include:
  - the last name and first initial of the first author listed in the study; or the published article's title
  - journal title (standard abbreviations may be used)
  - volume number
  - year published
  - page numbers

Requests for Additional Information

During the utilization management process, non-clinical administrative staff, Initial Clinical Reviewers, or Clinical Peer Reviewers may determine that additional information must be requested from the provider in order to make a determination of medical necessity. In this case, the request for additional information shall be sent within 2 business days of receiving the request for authorization from either the claims

administrator or the provider, or sooner if required to comply with the requirement in 8CCR9792.9.1(f)(2)(A) that such request for information must be made within 5 business days of the receipt of request for authorization.

When additional information is required and requested, the decision shall be made within 14 calendar days of receipt of the initial request for authorization, consistent with 9792.9.1(f)(3)(A).

The Clinical Peer Reviewer may also determine that additional tests, exams, or specialty consultation must be requested from the provider in order to make a determination of medical necessity. In this case, the request for additional tests, exams, or specialty consultation shall be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, within 2 business days of receiving the request for authorization from either the claims administrator or the provider, or sooner if required to comply with the requirement in 8CCR9792.9.1(f)(2)(B-C) that such request for information must be made within 5 business days of the receipt of request for authorization.

When additional tests, exams, or specialty consultation results is required and requested, the decision shall be made within 30 calendar days of receipt of the initial request for authorization, consistent with 9792.9.1(f)(3)(B).

When a denial is made due to lack of information or due to lack of additional tests, exams, or specialty consultation results, the denial shall state that the decision will be reconsidered once the requested information or requests results are received, consistent with 9792.9.1(f)(3)(A-B).

The Genex System shall generate the appropriate correspondences which shall be delivered to the required stakeholders in a manner and a timeframe consistent with the requirements in 8CCR9792.9.1. Genex will document all attempts to obtain additional information.

Utilization Review Process for Expedited Reviews

Genex shall complete prospective or concurrent utilization management of expedited reviews, either request for authorization or appeals considerations, in a timely fashion appropriate to the injured worker’s condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination.

For the purposes of this section, decisions related to expedited review refer to the following situations:

- When the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or;
- The normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

Please note that the provider must certify, in writing, and document the need for an expedited review upon submission of the request. A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under 9792.9.1(c)(3) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in 9792.9.1(c)(3).

In emergency situations posing an immediate threat to the health and safety of patients, Genex shall inform the party that failure to obtain prior authorization for emergency health care services is not an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker, and that emergency health care services may be subject to retrospective utilization review. If the party requires that prospective utilization review be performed in situations where the health or safety of a patient is under immediate threat, the call shall be transferred directly to the Senior Clinical Staff, in their absence, to the Director of Production/Senior Utilization Management Supervisor.

The Senior Clinical Staff, Director of Operations, or a Senior Utilization Management Supervisor, shall assign the Initial Clinical Reviewer, Clinical Peer Reviewer, and QAQC Reviewer (who only reviews for accuracy and completeness) that are immediately available for the review. The availability of each reviewer shall be confirmed by the Senior Clinical Staff, Director or Production, or Senior Utilization Management Supervisor by telephone.

Until the review is completed, the Senior Clinical Staff, Director of Operations, or a Senior Utilization Management Supervisor, shall evaluate the progress of the review by checking its status at intervals not to exceed 30 minutes. Immediately upon reaching a determination, the Genex system shall generate a determination letter that shall be immediately faxed to the provider. The Senior Clinical Staff, Director of Operations, or Senior Utilization Management Supervisor shall further contact the requesting provider via telephone to verify the receipt of the determination to ensure its arrival.

Decision Timeframes

The Genex RITE software is designed to ensure that reviews are completed within the regulatory timeframes. The system automatically calculates the due date based on type of review (prospective, concurrent, retrospective), date of receipt of request, presence or absence of notification of extension of due date, and the date of receipt of all necessary information reasonably required to make the determination.

The Production Manager, Review Management staff and QAQC reviewers monitor the timeframes of all reviews to ensure that they are completed timely.

In California, timeframes are monitored for compliance with 8CCR 9792.9.1 and review due dates are set to ensure completion in a timely fashion.

Prospective review

Prospective decisions shall be made in a timely fashion that is appropriate for the nature of the injured workers' condition, not to exceed five (5) business days from the date of receipt of the written request for authorization.

If appropriate information, which is necessary to render a decision, is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) business days from the date of receipt of the written request for authorization.

If the reasonable information is received prior to the fourteenth (14^{th}) day following the date of receipt of the written request for authorization, the reviewer shall make a decision within five (5) business days of the receipt of the information.

If the reasonable information requested is not received within 14 days of the date of the original request for authorization, a Clinical Peer Reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.

Efforts to obtain information from the requesting provider shall be documented prior to issuing a denial due to lack of reasonable and necessary information.

Consistent with LC4610, in no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization from the health care provider.

Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five (5) working days from the date of receipt of the medical treatment request.

Prospective decisions to modify or deny are communicated to the requesting provider initially by telephone, fax, or electronic mail within 24 hours of the decision. The communication by telephone shall be followed by written notice within 2 business days of the decision.

If the review is expedited, the decision shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination.

Concurrent review

Concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the injured workers' condition, not to exceed five (5) business days from the date of receipt of the written request for authorization.

If appropriate information, which is necessary to render a decision, is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) business days from the date of receipt of the written request for authorization.

If the reasonable information is received prior to the fourteenth (14^{th}) day following the date of receipt of the written request for authorization, the reviewer shall make a decision within five (5) business days of the receipt of the information.

If the reasonable information requested is not received within 14 days from the receipt of the completed request for authorization, a Clinical Peer Reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.

Consistent with LC4610, in no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization from the health care provider.

Prior to issuing any denial or modification on a concurrent review, the Clinical Peer Reviewer shall attempt to contact the requesting physician by telephone. The requesting physician will be notified of the pending decision; and prior to issuance a care plan will be agreed upon by the requesting physician that is appropriate for the medical needs of the employee.

Concurrent decisions to modify or deny are communicated to the requesting provider initially by telephone, fax, or electronic mail within 24 hours of the decision. The communication by telephone shall be followed by written notice within 24 hours of the decision.

If the review is expedited, the decision shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination.

Retrospective review

For retrospective reviews, decisions shall be communicated to the requesting physician within 30 days of receipt of the medical information that is reasonably necessary to make this determination.

If appropriate information, which is necessary to render a decision, is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) business days from the date of receipt of the written request for authorization.

If the reasonable information is received prior to the thirtieth (30^{th}) calendar day following the date of receipt of the written request for authorization, the reviewer shall make a decision within thirty (30) calendar days of the receipt of the information.

If the reasonable information requested is not received within 30 calendar days of the date of the original request for authorization, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.

Appeal review

Consistent with 8 CCR 9792.10.1(d)(2); any appeal review must be completed within 30 days of the date after receipt of the request under subdivision 9792.10.1(d)(1).

Notification Requirements

The policy of Genex is to provide correspondences at each step of the utilization management process to inform all parties of the status of the review. Utilization management correspondences shall meet the requirements outlined in 8CCR 9792.9.1 per Genex policies and procedures.

Decisions to Approve a Request for Authorization

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

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

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

    - Payment, or partial payment consistent with the provisions of California Code Regulations, title 8, section 9792.5, of a medical bill for services requested on the DWC For RFA, within the 30-day timeframe set forth in subdivision (c)(4), shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete.

    - A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured employee who received the medical services, and his or her attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

Decision to Modify or Deny a Request for Authorization

- For prospective, concurrent, or expedited review, a decision to modify or deny shall be communicated to the requesting physician within 24 hours of the

decision and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail.

- The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request.

- In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee. The non- physician provider of goods or services identified in the request for authorization, and for who contact information has been included, shall be notified in writing of the decision modifying or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

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

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

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

  B. The date on which the decision is made.

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

  D. A list of all medical records reviewed.

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

F. A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision.

   - If a utilization review decision to modify or deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

G. The Application for Independent Medical Review, DWC Form IMR, with all fields, except for the signature of the employee, to be completed by the claims administrator.

   - The application, set forth at section 9792.10.1, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.

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

I. Include the following mandatory language advising the injured employee:

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

   And

   "For information about the workers' compensation claims process and your

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

J. Details about the claims administrator's internal utilization review appeals process for the requesting physician, and a clear statement that the internal appeals process is 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.

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

Reconsideration/Appeal Process

Voluntary Internal Appeal Process

A prescribing physician may appeal a utilization review decision through Genex's voluntary internal appeal process. Participation in Genex's internal appeal program is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of the Labor Code section 4610.5 and 4610.6 but may be pursued on an optional basis.

Within 10 calendar days of receipt of the adverse determination, the prescribing physician may submit a written appeal to Genex. The appeal should include any documentation the prescribing physician would like the appellate reviewer to consider. A board-certified specialty matched reviewer will be assigned to review the request, and all submitted documentation. This Genex peer reviewer must not have been involved in any previous non-certification or modification determination pertaining to this particular episode of care, nor can the appellate reviewer report to the clinician who performed the original review. Genex will complete the appeal and communicate the results to the

requesting physician, the injured worker, and his or her representative, if any, within thirty (30) calendar days.

Reconsideration Process

A claimant or prescribing physician may request a reconsideration if an adverse determination was rendered due to insufficient information. Such denials only occur after the parties have received a written request for information and have failed to respond within 45 calendar days of the determination date. A reconsideration of such denial will be initiated upon receipt of any medical information above and beyond that which was available at the time the original request for authorization was received. Genex will reconsider the adverse determination within the timeframe applicable to the original review. The Genex reviewer may be the Reviewer originally assigned to the review. The Utilization Review decision shall be communicated as per the notification requirements.

A claims administrator may request a reconsideration if a determination, including a certification, was rendered due to the reviewer not having access to crucial information; failed to consider substantive information; made significant errors in interpreting the medical documentation; and/or misapplied treatment guidelines. A reconsideration at the request of the claims administrator will be initiated upon written request from the claims administrator along with receipt of any medical information above and beyond that which was available at the time the original request for authorization was received. The written request from the claims administrator must be received within 14 calendar days of the original determination. Genex will reconsider the determination within the timeframe applicable to the original review. The Genex reviewer may be the Reviewer originally assigned to the review. The Utilization Review decision shall be communicated as per the notification requirements. In the event of reversal or alteration of a certification, there shall be made available the opportunity for a standard appeal. Such reconsideration is not available in cases where the claims administrator is requesting reconsideration of an appeal nor in the case of an initial certification if the service has already been rendered.

A clinical peer reviewer may request a reconsideration if an adverse determination was rendered and new or additional information has persuaded the reviewer to overturn, in part or in full, the prior adverse determination. A reconsideration at the request of the clinical peer reviewer will be initiated upon written request from the clinical peer reviewer, to include a description of the basis for overturn of the original decision, along with receipt of any medical information above and beyond that which was available at the time the original request for authorization was received. The written request from the clinical peer reviewer must be received within 30 calendar days of the original

determination. Genex will reconsider the adverse determination within the timeframe applicable to the original review. The Genex reviewer may be the Reviewer originally assigned to the review. The Utilization Review decision shall be communicated as per the notification requirements. Such reconsideration will not be considered as a substitute for the appeals process afforded to the injured worker/provider.

Disputes

If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6.

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

A request for independent medical review must be communicated by the employee, the employee's representative, or the employee's attorney by mail, facsimile, or electronic transmission to the Administrative Director, or the Administrative Director's designee, within 30 days of service of the utilization review decision and ten (10) days for formulary disputes. The request must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision modifying or denying the request for authorization of medical treatment.

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. The physician may submit documents on the employee's behalf to the independent medical review organization and may respond to any inquiry by the independent review organization.

A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit an application for independent medical review on its own behalf within 30 days of receipt of the utilization review decision that either modifies or denies the provider's retrospective request for authorization of the emergency medical treatment.

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

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

Financial Incentive Policy

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

Independent Medical Review

Following receipt of the Application for Independent Medical Review, DWC Form IMR, the Administrative Director shall determine whether the disputed medical treatment identified in the application is eligible for independent medical review. The Administrative Director may reasonably request additional appropriate information from the parties in order to make a determination that a disputed medical treatment is eligible for independent medical review. The Administrative Director shall advise the claims administrator, the employee, and the employee's provider, as appropriate, by the most efficient means available. The parties shall respond to any reasonable request made within fifteen (15) days following receipt of the request. Following receipt of all information necessary to make a determination, the Administrative Director shall either immediately inform the parties in writing that a disputed medical treatment is not eligible for independent medical review or assign the request to independent medical review.

A request for independent medical review shall be deferred if at the time of a utilization review decision, the claims administrator is also disputing liability for the treatment for any reason besides medical necessity.

The parties may appeal an eligibility determination by the Administrative Director that a disputed medical treatment is not eligible for independent medical review by filing a petition with the Workers' Compensation Appeals Board.

Within one business day following a finding that the disputed medical treatment is eligible for independent medical review, the independent review organization delegated the responsibility by the Administrative Director to conduct independent medical review.

Within fifteen (15) days following receipt of the mailed notification from the independent review organization that the disputed medical treatment has been assigned for independent medical review, or within twelve (12) days if the notification was sent electronically, or for expedited review within twenty-four (24) hours following receipt of the notification, the claims administrator shall provide to the independent medical review organization all of the following documents:

A. A copy of all reports of the employee's treating physician relevant to the employee's current medical condition produced within one year prior to the date of the request for authorization, including those that are specifically identified in the request for authorization or in the utilization review determination.

B. A copy of the adverse determination by the claims' administrator notifying the employee and the employee's treating physician that the disputed medical treatment was modified or denied.

C. A copy of all information, including correspondence, provided to the employee by the claims' administrator concerning the utilization review decision regarding the disputed treatment.

D. A copy of any materials the employee or the employee's provider submitted to the claims' administrator in support of the request for the disputed medical treatment.

E. A copy of any other relevant documents or information used by the claims administrator in determining whether the disputed treatment should have been provided, and any statements by the claims' administrator explaining the reasons for the decision to modify or deny the recommended treatment on the basis of

medical necessity.

F. The claims administrator's response to any additional issues raised in the employee's application for independent medical review.

The claims' administrator shall send the employee or the employee's representative a notification that lists all of the documents submitted to the independent review organization and provide a copy of all documents that were not previously provided to the employee or the employee's representative. Any newly developed or discovered relevant medical records forwarded to the independent review organization the claims administrator shall also be sent to the employee or the employee's representative, or the employee's treating physician unless declined or prohibited by law.

The independent review organization may reasonably request appropriate additional documentation or information necessary to make a determination that the disputed medical treatment is medically necessary. Additional documentation or other information requested shall be sent by the party to whom the request was made, with service on all other parties, within five (5) business days after the request is received in routine cases or one (1) calendar day after the request is received in expedited cases.

The independent medical review process may be terminated at any time upon the claims administrator's written authorization of all disputed medical treatment.

The independent review organization shall provide the Administrative Director (AD), the claims administrator, the employee, and the employee's provider with a final determination regarding the medical necessity of the disputed medical treatment.

For regular review, the independent review organization shall complete its review and make its final determination within thirty (30) days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information. For expedited review where the disputed medical treatment has not been provided, the independent review organization shall complete its review and make its final determination within three (3) days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information provided.

The final determination issued by the independent review organization shall be deemed to be the determination of the Administrative Director and shall be binding on all parties.

The parties may appeal an eligibility determination by the Administrative Director by filing a petition with the Workers' Compensation Appeals Board if there is clear and convincing evidence that:

- The AD acted without or in excess of her powers
- The final determination was procured by fraud
- The medical reviewer was subject to a material conflict of interest
- The final determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color or disability
- The final determination was the result of a plainly erroneous mistake of fact

If the final determination of the Administrative Director is reversed by the Workers' Compensation Appeals Board, the dispute shall be remanded to the Administrative Director. The Administrative Director shall:

1. Submit the dispute to independent medical review by a different independent review organization, if available;
2. If a different independent medical review organization is not available after remand, the Administrative Director shall submit the dispute to the original independent review organization for review by a different reviewer in the organization.

The costs of independent medical review and the administration of the independent medical review system shall be borne by claims administrators.

Confidentiality and Information Security Policy

This policy affects all Genex employees and contractors who perform utilization management operations, and all others who serve on committees or boards.

The policy of GENEX is to handle all information in a manner that that ensures the privacy and security of the records. All information that identifies a specific individual shall be kept confidential and shall not be disclosed to any individual or organization outside of disclosures permitted or required by law. The release or re-release of confidential information to unauthorized persons is strictly prohibited.

All GENEX employees and contractors, who perform utilization management operations, as well as all committee members and board members, shall sign a confidentiality agreement to ensure protection of patients' health information.

All GENEX employees and contractors, who respond to communications, shall undergo training regarding this policy, these procedures and their implementation.

All information that identifies a specific individual shall be kept confidential and shall not be disclosed to any individual or organization outside of disclosures permitted or required by law.

To the extent permitted by state and federal law, the release of information on a specific review is restricted to the following people:

- GENEX employee's or contractors who require the information to perform utilization management operations;
- The patient whose information is at issue;
- The patient's legal counsel;
- The claims administrator for the claim at issue;
- Client appointed personnel specified by the client as being involved in the claim and/or review (e.g. nurse case manager);
- The defense attorney;
- The requesting physician, or their office staff;
- The attending physician, or their office staff;
- The secondary physicians, or their office staff;
- The non-physician provider of goods and/or services at issue.

If a GENEX employee or contractor receives a request for information regarding a specific claim or review, they shall verify that the requestor is one of the parties listed above. If it cannot be established that the requestor is such a party, the requestor shall be referred to the claims administrator for further help.

The release of patient information, such as social security number, date of birth, contact information that does not specifically bear upon the utilization management determination shall be prohibited. If any person requests this information, the requestor shall be referred to the claim administrator for further help.

The release of provider information, such as federal tax I.D. number or contact information, which does not specifically bear upon the utilization management determination, shall only be accessible to the client for purposes of billing and bill review. Any other release of this information shall be prohibited. If any person requests this information, the requestor shall be referred to the claim administrator for further help.

In the event that GENEX publishes data, such as quality review studies or performance tracking, in every instance where such publication includes data which identifies a

particular physician or health care provider, the physician or health care provider shall be provided written notice of the publication.

Description of Claims Administrator's Process

A percentage of Genex clients choose to outsource their entire Utilization Management process to Genex, whereas others choose to perform initial utilization management functions, such as certifying some requests for authorization, in house.

For those clients who outsource their entire Utilization Management process to Genex, the claims administrators are responsible for notifying all parties how to contact Genex for utilization management functions. For inquiries outside of business hours, the claims administrators shall record a message on their voice mail providing Genex's contact information including phone and fax numbers. Further, the client shall maintain a 24-hour voice mail system and incoming fax line to receive requests for authorization during and after business hours. For these clients, as soon as the claims administrator receives a request for authorization, they shall immediately forward it to Genex for completion.

For those clients who choose to perform initial utilization management functions in-house, said clients must determine if they require Genex's Medical Director, or a Medical Director of their own, to oversee their in-house utilization management process.

If the client wishes to have Genex's Medical Director oversee their in-house utilization management process, they must comply with Genex policies and procedures which outlines the procedures clients must follow in the utilization management process.

If the client wishes to have a non-Genex Medical Director oversee their in-house utilization management process, the client must separately file a letter with the Administrative Director which shall include a copy of the policies and procedures they will follow in the performance of utilization management. These policies and procedures must be developed and approved by their own Medical Director. This letter shall further identify Genex as their Utilization Review Organization for all requests that are forwarded for peer review. For these clients, Genex's Medical Director shall only be responsible for requests forwarded to Genex for review. Genex's Medical Director shall not be responsible for any portion of the utilization management process performed prior to the review being submitted to Genex and shall not be responsible for any determinations rendered by the client.

Genex Utilization Review Clients for California

Client – City of Glendale

Prior authorization process
The City of Glendale utilizes a prior authorization process as follows:

The following services and/or procedures shall be considered pre-authorized by the City of Glendale. The provider shall not be required to submit requests through utilization review for these services. For all services and/or procedures not addressed on this list, please submit requests for authorization directly to the claim's administrator.

Physical Therapy and Occupational Therapy
- *Up to 12 physical therapy visits per claim*
- *Up to 12 occupational therapy sessions per claim*

Post-Op Physical Therapy and Occupational Therapy
- *Up to 12 physical therapy visits post-operatively*
- *Up to 12 occupational therapy sessions post-operatively*

Chiropractic Therapy
- *Up to 8 chiropractic therapy sessions per claim*

Medications
- *Over the counter medications*
- *Ibuprofen and NSAIDs*
- *Up to one-month prescription of non-narcotic and narcotic pain medication administered in first month of injury. Only Vicodin, Darvocet, Tramadol (Ultram).*
- *Up to one-month prescription of muscle relaxants administered in first month of injury where the patient has acute muscle spasm on clinical exam.*
- *Continued prescription refills for patients when the claims administrator has given pre-approval for longer term medication use. For a duration of 6 months of refills.*

Diagnostic Testing
- *Initial x-ray study of a body part if any red-flags listed below are present.*
  Red Flags:
  ** Recent history of significant trauma to body part*
  ** Suspected fracture or dislocation*
- *EKG*
- *MRI*

- *CT scans*

Durable Medical Equipment
(DME supplies must be provided by the City of Glendale's designated vendors)
- *DME under $500.00*

Corticosteroid injections
- *Shoulder: Rotator cuff: For rotator cuff*

Surgeries
- *Hernia repair*
- *Initial arthroscopic meniscectomy or meniscoplasty of the knee (excludes repeat or revision procedure)*
- *Arthroscopic carpal tunnel release (excludes open carpal tunnel release)*
- *Trigger finger release*
- *DeQuervain's release*

All Specialty Consultations (except Psych)
- *For accepted body parts*

Claims Administrator Approvals
The City of Glendale claims administrators may issue approvals on requests for authorization that are not addressed by the prior authorization process. The steps that they follow to issue these approvals are outlined in Genex's policies and procedures.

The approvals issued by the claims administrators, in compliance with Genex policies and procedures, are supervised by Genex's medical director.

Upon request of the treating physician the claims examiners, with the approval of the HR Director, will be allowed to approve EKGs, CT Scans, MRIs, and EMG/NCS, (excluding surface EMGs (SEMGs)). When said diagnostic examinations can reasonably reduce lost time and overtime expenditures, approval will be granted expeditiously.

Utilization Review Organization
All requests received by the City of Glendale which the adjustors feel may require physician review are forwarded to Preferred Management. Preferred Management reviews the requests following steps outlined in Preferred Management's and Genex's filings with the AD.

The approvals issued by Preferred Management, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

All requests received by Preferred Management which are determined to require physician review are forwarded to Genex.

Client – City of Los Angeles

Prior authorization process

The City of Los Angeles uses a prior authorization process as follows:

On July 1, 2010 the City of Los Angeles implemented a Prior Authorization Program (PAP). This program allows physicians in the City of LA's contracted First Care Panel, USHW and Kaiser, to provide medical treatments and diagnostic tests on accepted and delayed claims without going through the process of utilization review based on their adherence to the MTUS and evidence-based medicine. All treatment requests must follow the Title 8 CCR § 9792.20-9792.24.3 MTUS criteria.

The City of Los Angeles' First Care Panel consists of USHW and Kaiser. This Prior Authorization Program is pertaining to these providers only.

General Instructions

A. No Request for Authorization (RFA) for the services or treatments provided to the patient under the PAP program be submitted.
B. A PR-2 or 5021 must be submitted and indicate clearly that the services and procedures rendered supports the medical necessity of the treatment provided.
   Fax the documents to:
   City of Los Angeles UR designated Fax at 213-473-3377
   Tristar Risk Management UR designated Fax at 626-407-0415
   AIMS UR designated Fax at 909-348-0919
   Elite Claims Management, Inc. UR designated FAX at 951-676-7258
C. No RFA's should be sent to the City of LA Contracted Managed Care Providers. A prescription, doctor's medical report or notification form should only be used to inform the providers of the treatment or tests needed.
D. No Certification Letter will be sent by the City of Los Angeles claims administrators for those procedures which fall under this program.

The Prior Authorization Program will include the following procedures or ancillary services:

PLEASE NOTE: Initial diagnostic tests or procedures can be done to all or any accepted body part(s) and must be provided by the City of Los Angeles' Contracted Managed Care Providers listed below. Repeated tests are not included in the PAP.

1. **Diagnostic Tests: One Call Medical (866) 557-8670**
    a. MRI
    b. CT Scan
    c. X-rays
    d. EMG/NCS

2. **Physical Medicine: Med Risk (855) 806-9754**
    a. Physical Therapy – 12 sessions
    b. Occupational Therapy – 12 sessions
    c. Acupuncture – 12 sessions
    d. Chiropractic – 12 sessions
    e. Aquatic Therapy – 6 sessions

    This treatment must be provided within the first 3 months of injury or within 3 months post-surgery.

3. **Medications: Express Script (800) 945-5951**
    a. 90 Days of prescription drug per Pharmacy Benefit Management (PBM) Formulary: Express Script
    b. First Care may dispense first fill per City of Los Angeles Formulary. This fill is for the first 30 days.

4. Durable Medical Equipment: Optum (800) 419-9191
    a. Non-surgical basic equipment such as (First Care Panel can dispense:
        i. Splints
        ii. Crutches
        iii. Braces
        iv. Canes
        v. Walkers
        vi. Standard wheelchair rental
        vii. Off the shelf braces or splints
        viii. Walking boots
        ix. Slings
        x. Hot and cold packs
    b. Post-Surgical Discharge DME such as:
        i. Cold packs or cold therapy unit

ii. Cold Packs
iii. Ankle Foot Orthotics
iv. Walking cane
v. Crutches
vi. Braces
vii. Walker
viii. Wheelchair rental
ix. Tub/Shower Chair
x. 3-1 commode

5. **Office Visits & Specialty Referrals**
    a. Routine Office Visits and Follow Ups
    b. Specialty Referral
    c. When diagnosis of hernia is made on initial visit, refer to General Surgeon immediately.

6. **Psychology**
    a. 6 initial Psychological Visits for an accepted psych claim

7. **Corticosteroid Injections (Non-diabetic patients)**
    a. Elbow: Up to 3 injections in cases of severe pain from epicondylitis. Improvement must be shown after initial injection.
    b. Knee: Up to 3 injections if the patient has osteoarthritis. Improvement must be shown after initial injection.
    c. Shoulder: Up to 3 injections if the patient has rotator cuff disease. Improvement must be shown after initial injection.
    d. Fingers: Up to 3 injections for Trigger Finger. Improvement must be shown after initial injection.

8. **Other Services**
    a. Tetanus Shot if over 10 years from the last injection
    b. Pre-Op Medical Clearance when surgery is certified
    c. Blood Tests: CBC, BMP, UA, CXR, EKG (only if heart claim) with City of Los Angeles' Network Provider, MedHealth Medical Toxicology; www.medhealth-medical.com

<u>Claims Administrator Approvals</u>

The City of Los Angeles in-house claims administrators, and the claims administrators working on the City of Los Angeles account at the designated third-party administrator,

may issue approvals on requests for authorization. The steps that they follow to issue these approvals are outlined in Genex's policies and procedures.

The approvals issued by the claims administrators, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

Utilization Review Organization
All requests received by the City of Los Angeles which they determine to require physician review are forwarded to Genex.

Client – City of Santa Monica

Prior authorization process
The City of Santa Monica does not utilize a prior authorization process.

Claims Administrator Approvals
The City of Santa Monica has not made known to Genex the processes they follow in issuing claims administrator approvals, nor the name of the medical director they are utilizing to supervise the approvals*. Please contact the City of Santa Monica if this information is required.

** The administrative approvals issued by the City of Santa Monica staff are not supervised by the Genex Medical Director. Consequently, we are not a party to any administrative approvals issued.*

Utilization Review Organization
All requests received by the City of Santa Monica which they determine to require physician review are forwarded to Genex.

Client – Contra Costa County

Prior authorization process
Contra Costa utilizes a prior authorization process as follows:

Prior Authorization
The following services and/or procedures shall be considered pre-authorized. The provider shall not be required to submit requests through utilization review for these services. For all services and/or procedures not addressed on this list, please submit requests for authorization directly to the claim's administrator.

Physical Therapy / Chiropractic Care / Acupuncture
• Up to 12 physical therapy visits per claim
• Up to 12 post-operative physical therapy visits per claim, if applicable
• Up to 12 chiropractic visits per claim
• Up to 12 acupuncture visits per claim

Medications
• Over the counter medications including Ibuprofen and NSAIDs.
• Up to two-week prescription of non-narcotic pain medication administered in first month of injury.
• Up to two weeks prescription of muscle relaxants administered in first month of injury where the patient has acute muscle spasm on clinical exam.
• Continued prescription refills for patients when the claims administrator has given pre-approval for longer term medication use

Diagnostic Testing
(Diagnostic testing must be performed by Contra Costa County designated vendors.)
• Initial x-ray study of a body part if any red-flags listed below are present.
• Initial MRI of a body part if any red-flags listed below are present.
• Initial CT study of a body part if any red-flags listed below are present.
• Initial EMG/NCV study for diagnostic confirmation of Carpal Tunnel Syndrome where clinical signs exist supporting diagnosis of median nerve entrapment.
• Initial EMG/NCV study for diagnostic confirmation of nerve root compression where clinical signs of myotome, dermatome, or reflex changes exist.

Red Flags:
** Recent history of significant trauma to body part*
** Suspected fracture or dislocation*
** Suspected infection*
** Suspected tumor*
** Rapidly progressive neurologic deficit*
** Vascular compromise*

Durable Medical Equipment
(DME supplies must be provided by Contra Costa County designated vendors.)
• DME items, costing $500 or less, when prescribed by Contra Costa County designated occupational medicine providers.
• DME items, costing $200 or less, if prescribed by non-Contra Costa County designated providers.

Miscellaneous

- *Care consistent with stipulated award*
- *Care consistent with AME/PQME report recommendations*
- *Care consistent with second opinion consultations approved and authorized by Contra Costa County*

Claims Administrator Approvals

Contra Costa County claims administrators may issue approvals on requests for authorization that are not addressed by the prior authorization process. The steps that they follow to issue these approvals are outlined in Genex's policies and procedures.

The approvals issued by the claims administrators, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

Utilization Review Organization

All requests received by Contra Costa County which require physician review are forwarded to Genex.

Client – Fontana Unified School District

Prior authorization process

Fontana Unified School District (FUSD) utilizes a prior authorization process as follows:

Prior Authorization

Per CA Department of Industrial Relations, Title 8, Section 5.5.1, Utilization Review Standards, Section 9792.7(a)(5). The following services and/or procedures shall be considered authorized. The provider shall not be required to submit requests through utilization review for these services. For all services and/or procedures not addressed on this list, please submit requests for authorization directly to the claim's administrator.

Physical Therapy/Occupational Therapy

- *First 8 physical therapy visits for the neck and spine*
- *First 6 physical therapy visits for all other body parts to include the knees, ankle, etc. Any request in excess of 8 visits for the spine and neck, or 6 visits for all other body parts, should be forwarded to Fontana Unified School District.*
- *First 8 Occupational Therapy visits for the hand and foot only.*

Post-Operative Physical Therapy/Occupational Therapy

- *First 10 physical therapy/occupational therapy sessions post-operatively*

Medications

- *Over the counter medications including Ibuprofen and NSAIDs.*
- *Up to two-week prescription of non-narcotic pain mediation administered in the first two months of injury*

Diagnostic Testing
(Diagnostic testing must be performed by FUSD designated vendors.)
• X-ray study of a body part if any red-flags listed below are present.
• Initial MRI of a body part if any red-flags listed below are present.
• Initial CT study of a body part if any red-flags listed below are present.
• Initial EMG/NCV study for diagnostic confirmation of Carpal Tunnel Syndrome where clinical signs exist supporting diagnosis of median nerve entrapment.
• Initial EMG/NCV study for diagnostic confirmation of nerve root compression where clinical signs of myotome, dermatome, or reflex changes exist.

Red Flags:
** Recent history of significant trauma to body part*
** Suspected fracture or dislocation*
** Suspected infection*
** Suspected tumor*
** Rapidly progressive neurologic deficit*
** Vascular compromise*

Durable Medical Equipment
(DME supplies must be provided by FUSD designated vendors)

- *DME items costing $100 or less.*

As a reminder, FUSD has its own durable medical equipment provider. Please send us your prescription in writing and we will process the request for you.

All Specialty Consultations:
For accepted body parts/conditions immediately following injury, for the following:
** Request for orthopaedics, neurology, surgical intervention, and PM&R*

AME/QME: Requests for med-legal evaluations/diagnostics

Claims Administrator Approvals

FUSD claims administrators may issue approvals on requests for authorization that are not addressed by the prior authorization process. The steps that they follow to issue these approvals are outlined in Genex's policies and procedures.

The approvals issued by the claims administrators, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

Utilization Review Organization
All requests received by FUSD which the adjustors feel may require physician review are forwarded to peer review.

The approvals issued by Preferred Management, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

All requests received by Preferred Management which are determined to require physician review are forwarded to Genex.

Client – Great West Casualty Company

Prior authorization process
Great West Casualty Company utilizes a prior authorization process as follows:

Prior Authorization

The following services and/or procedures shall be considered pre-authorized by Great West Casualty Company. The provider shall not be required to submit requests through utilization review for these services. For all services and/or procedures not addressed on this list, please submit requests for authorization directly to the claim's administrator.

Physical Therapy

- *Up to 6 physical therapy visits per claim*

Medications

- *Over the counter medications including Ibuprofen and NSAIDs.*
- *Up to two-week prescription of non-narcotic pain medication administered in first month of injury.*
- *Up to two weeks prescription of muscle relaxants administered in first month of injury where the patient has acute muscle spasm on clinical exam.*
- *Continued prescription refills for patients when the claims administrator has given pre-approval for longer term medication use*

Diagnostic Testing

- *Initial x-ray study of a body part if any red-flags listed below are present.*
  Red Flags:
  ** Recent history of significant trauma to body part*
  ** Suspected fracture or dislocation*

Claims Administrator Approvals

Great West Casualty Company claims administrators may issue approvals on requests for authorization that are not addressed by the prior authorization process. The steps that they follow to issue these approvals have been defined by Great West Casualty Company.

The approvals issued by the claims administrators, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

Utilization Review Organization

All requests received by Great West Casualty Company which the adjustors feel may require physician review are forwarded to Preferred Management Corporation. Preferred Management reviews the requests following steps outlined in Preferred Management's and Genex's filings with the AD.

The approvals issued by Preferred Management, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

All requests received by Preferred Management which are determined to require physician review are forwarded to Genex.

Client – WCF Insurance

Prior authorization process

WCF Insurance utilizes a prior authorization process as follows:

Prior Authorization

The following services and/or procedures shall be considered pre-authorized by WCF Insurance. The provider shall not be required to submit requests through utilization review for these services. For all services and/or procedures not addressed on this list, please submit requests for authorization directly to the claim's administrator.

Physical Therapy/Chiropractic Care/Acupuncture
• Up to 12 physical therapy visits and/or occupational therapy visits per claim.

• Up to 18 post-operative physical therapy and/or occupational therapy visits per claim, if applicable.
• Up to 12 chiropractic visits per claim.
• Up to 12 post-operative chiropractic visits per claim, if applicable.
• Up to 12 acupuncture visits per claim.
• Up to 12 post-operative acupuncture visits per claim, If applicable.
• Up to 6 sessions of physical therapy or occupational therapy or chiropractic or acupuncture for reported flare-up; provided the duration of care is to be no more than 4 weeks, and the frequency of flare-ups is no more than 2 per year.

Follow Up Visits/Referrals
• Consultants, referrals, and follow up visits deemed appropriate by the claims administrator.

Psychological Visits
• Up to 10 visits per claim.

Medications
• Over the counter medications.
• Up to two-week prescription of non-narcotic pain medication administered in first month of injury or following acute flare up.
• Up to two weeks prescription of muscle relaxants administered in first month of injury, or following acute flare up, where patient has acute muscle spasm on clinical exam.
• Continued prescription refills for patients when the claims administrator has given pre-approval for longer term medication use.
• Medications and/or supplies for the management or monitoring of diabetes, asthma, or COPD.
• Opiates/opioids for end-of-life care for patients with terminal cancer.

Surgery
• Rotator cuff repair, with positive MRI findings of rotator cuff tear.
• Capral Tunnel with moderate to severe EMG/NCV findings and clinical signs of median nerve compression.
• Meniscus repairs with MRI signs of menisci tear and clinical signs of meniscal injury.
• Hernia repair.
• Removal and/or biopsy of suspected skin cancers.

Injections (Note: All cervical epidural injections must be sent to peer review)

• Up to three lumbar epidural injections. Patient must have referral of pain to the lower extremity. For second and third injections, patient must have demonstrated a significant improvement in symptoms for a period of at least 4 weeks following injection.
• Any request for injection, if less than 2 injections per body part.
• Up to 3 maximum injections, excluding viscosupplementation.
• Series of 3 injections of hylan (Synvisc) or a series of 3-5 injections of hyaluronic acid (Supartz).

Diagnostic Testing (Note: Myelograms, surface EMGs, and discograms must be sent to peer review)
• Initial x-ray study of a body part if any red flags listed below are present.
• Initial MRI of a body part if any red flags listed below are present.
• Initial CT study of a body part if any red flags listed below are present.
• Follow up x-ray, CT, or MRI if the patient has proven unresponsive to at least 3 months conservative care or has experienced a significant change in their condition.
• Initial EMG/NCV study for diagnostic confirmation of carpal tunnel syndrome where clinical signs exist supporting diagnosis of median nerve entrapment.
• Initial EMG/NCV study for diagnostic confirmation of nerve root compression where clinical signs of myotome, dermatome, or reflex changes exist.
• Follow up EMG/NCV if the patient has proven unresponsive to at least 6 months of conservative care or has experienced a significant change in their condition.
• Per-op medical clearance: CBC, EKG, UA, etc.
• Polysomnogram.

Red Flags:
• Recent history of significant trauma to body part.
• Suspected fracture or dislocation.
• Suspected infection.
• Suspected tumor.
• Rapidly progressive neurologic deficit.
• Vascular compromise.

Durable Medical Equipment
• DME items, costing $500 or less.
• Prosthetic devices (limbs, hearing aids, glass eyes, etc.).
• CPAP or BiPAP and supplies in cases of diagnosed sleep apnea.

Miscellaneous
• Care consistent with stipulated award.
• Care consistent with AME/PQME report recommendations.

• Care consistent with second opinion consults formally approved by the client.
• Up to 1 week of Home Health Care/transfer to Skilled Nursing Facility/Convalescent/Residential Facility.
• Non-invasive/remote checks of function of implanted devices (pacemakers, pumps, etc.).

Claims Administrator Approvals
WCF Insurance claims administrators may issue approvals on requests for authorization that are not addressed by the prior authorization process. The steps that they follow to issue these approvals are outlined in Genex's policies and procedures.

The approvals issued by the claims administrators, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

Utilization Review Organization
All requests received by WCF Insurance which are determined to require physician review are forwarded to Genex.

Client – State Compensation Insurance Fund

Prior authorization process
State Fund uses a prior authorization process as follows:

Effective 1/1/19

State Fund's UR Passport Program provides some MPN physicians the authority to perform routine medical procedures without utilization review for claims wherein liability has been accepted, or liability is on delay but meets the requirement for provision of medical treatment of up to $10,000 per LC5402(c). Passport physicians shall provide treatment consistent with MTUS. This document serves as a guide to assist Passport Providers in determining which procedures are pre-authorized under this program and which ones require submission of DWC Form RFA to be processed for utilization review. The goal is to provide timely and quality medical care supported by evidence-based medicine guidelines and best practice.

Pre-Authorized under Passport
MEDICATION / PHARMACY - NON-OPIOID

- All CA exempt medications on MTUS Drug Formulary
    - Please note: DWC will periodically make updates to the MTUS Drug Formulary
- Acid reducers and intestinal acidifiers

- Antibiotics (some may require referral)
- Anticonvulsants
- Antidepressants (some may require referral)
- Antidiarrheals
- Antiemetics (some may require referral)
- Antihistamines and beta agonists
- Anti-inflammatory medications (except rheumatology medications such as Arava, Enbrel, and Humira)
- Anti-ulcer (misc. – Carafate, Cytotec)
- Corticosteroids (non-topical) – up to initial 30-day supply
- HIV prophylaxis medications
- Hypnotics – up to initial 7-day supply
- Laxatives
- Muscle relaxers (except Soma, Soma Compound, and Amrix) – up to initial 30-day supply
- Non-narcotic analgesics
- NSAIDs (except most topical and combo NSAIDs)
- Topical analgesics (OTC brands only such as Aspercreme, Ben-Gay, Bioflex, Salonpas, Bioefreeze, etc.)
- Topical: antibiotics, antipruritics, burn products, anti-infectives, corticosteroids, skin cleansers, emollients, scabicides and wound care products
- Cancer medications – chemotherapy, radiation therapy, hydration supplies (on accepted cancer claims)
- Cardiac/heart medication – (on accepted cardiac/heart claims)
- Diabetes medications – (on accepted diabetes claims)
- Ophthalmic – all types (on accepted eye injury claims)
- Otics – all types (on accepted ear injury claims)
- Skin medications – Carac cream, Efudex cream, Imiquimod (on accepted skin cancer/condition claims)

MEDICATION / PHARMACY - OPIOID

- Short-acting opioids/narcotic analgesics – authorized up to 4 days
    - (Excludes Buprenex, Subutex, Suboxone, Opana, Methadone, Actiq, Fentora, Fentanyl powder, Talwin NX, and Stadol)
- Narcotic combinations – authorized up to 4 days
    - (Example: Percocet, Lortab, Vicodin, Norco)

DIAGNOSTIC TESTING

- X-rays

- Routine pre-op testing (CBC, chemistry panel, PT/PTT, urinalysis, chest x-ray, EKG/ECG)
- Urine drug screening – (at baseline; up to 4 times a year)
- MRI/CT after 4-6 weeks of conservative treatment for routine injuries
- MRI/CT before 4 weeks of conservative treatment after major trauma, with documentation of neurological deficit, or red flags
- Repeat MRI within 6 months or longer after previous MRI, if surgery is being considered and/or there is significant change in medical condition
- EMG/NCV
    - with documented neurological deficit (CTS/cubital tunnel syndrome, cervical/lumbar radiculopathy)
    - after 3 weeks of conservative treatment without documented neurological deficit
- Stress treadmill, nuclear stress test, echocardiogram (EKG/ECG), ultrasound (once a year on accepted heart/cardiac claims)

DURABLE MEDICAL EQUIPMENT

- Standard wheelchair, braces, crutches, commodes, etc. (i.e., non-powered DME)
- Standard prefabricated orthotics
- Replacement prosthetic (if current prosthesis' structural integrity is compromised)
- Prosthetics maintenance
- TENS unit (2 or 4 leads) - 1 month rental
- E-stimulator unit, interferential unit - 1 month rental
- Pulse oximeter
- CPM (continuous passive motion) rental – for post-op, 21-day rental only
- Ice pack/cold pack
- Other DME rentals for a period of 3 months or less
- Supplies for approved DME such as electrodes, batteries, etc. up to six months
- Standard hearing aids/replacement every 5 years, if necessary (as long as acoustic neuroma is not mentioned in the report) and repairs up to 4 times in a 5-year period
- Diabetes testing supplies and needles - (on accepted diabetes claim)
- Medical devices/supplies for wound care and first aid

SURGERY and INJECTION

- Initial carpal tunnel or ulnar release within 2 years of date of injury with positive symptoms and exam findings and moderate/severe NCS/EMG
- Initial arthroscopic surgery of the knee within 2 years of date of injury with positive symptoms and exam findings and positive MRI

- Initial arthroscopic surgery of the shoulder within 2 years of date of injury with positive symptoms and exam findings and positive MRI
- Foreign body removal, and incision and drainage (I&Ds)
- Hernia repair – initial only
- Initial hardware removal – non-spine
- Steroid injections - up to 3 injections per year to a region
- Trigger point injections (soft tissue)
  - up to 4 injections per visit
  - repeat injection after 6 weeks, if there is documented evidence of functional improvement/greater than 50% pain relief
  - repeat injection over 2 months
- Reprogramming of implantable pain pump (if State Fund authorized the initial surgery)
- Tune-up, reprogramming, and lead replacements of pacemaker (if State Fund authorized the original pacemaker surgery, on accepted heart/cardiac claims)
- Destruction of skin areas by cryo-surgery, liquid nitrogen, Mohs surgery (on accepted skin cancer/condition claims)
- Biopsy and pathology (on accepted skin cancer/condition claims)

PHYSICAL MEDICINE and REHABILITATION

- Physical therapy/occupational therapy/chiropractic treatment
  - up to 24 visits each (PT, OT, and chiro)
  - over 24 visits (no surgery) with CM approval
  - up to an additional 24 visits (combined total PT, OT, or chiro) *post-surgery*, within 6 months of date of surgery, and prescribed/approved by the surgeon
- Acupuncture up to 24 Visits
- Pool therapy up to 24 Visits
- Gym membership up to 3 months
- Biofeedback up to 10 sessions
- Massage up to 6 sessions

MISCELLANEOUS

- Office visits, follow up office visits
- Specialist consults (use discretion for new body part AOE/COE situations)
- Chronic pain programs and treatment plans with approved vendors by referral to the CPP
- Initial ergonomic evaluation
- Psychiatric, psychology, or cognitive behavioral therapy – up to 10 visits

<u>Claims Administrator Approvals</u>

The State Fund in-house staff may issue approvals on requests for authorization. The approvals issued by the State Fund staff are supervised by State Fund's medical director.

Utilization Review Organization
Requests received by State Fund which they determine to require physician review are forwarded to Genex, or to another URO contracted with State Fund.

Client – The Reny Company

Prior authorization process
The Reny Company does not utilize a prior authorization process.

Claims Administrator Approvals
The Reny Company performs bill review and other cost containment services on behalf of their contracted clients. One component of these cost containment solutions is the performance of utilization review.

The Reny Company staff do not issue approvals on requests for authorization received from providers, but rather forward all requests to Preferred Management for review.

Utilization Review Organization
All requests received by The Reny Company are forwarded to Preferred Management Corporation. Preferred Management reviews the requests following steps outlined in Preferred Management's and Genex's filings with the AD.

The approvals issued by Preferred Management, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

All requests received by Preferred Management which are determined to require physician review are forwarded to Genex.

Client – City of Simi Valley

Prior authorization process
The City of Simi Valley utilizes a prior authorization process as follows:

Prior Authorization

The following services and/or procedures shall be considered pre-authorized by the City of Simi Valley. The provider shall not be required to submit requests through utilization

review for these services. For all services and/or procedures not addressed on this list, please submit requests for authorization directly to the claim's administrator.

Physical Therapy/Occupational Therapy
• Up to 6 physical/occupational therapy visits per claim

Post-Operative Physical Therapy/Occupational Therapy
• Up to 12 physical/occupational therapy visits per claim

Chiropractic Care
• Up to 12 chiropractic sessions

Medications
• Over the counter medications including Ibuprofen and NSAIDs.
• Up to two-week prescription of non-narcotic pain medication administered in first month of injury.
• Up to two weeks prescription of muscle relaxants administered in first month of injury
• Continued prescription refills up to 90 days for patients when the claims administrator has given pre-approval for longer term medication use

Diagnostic Testing (Diagnostic tests must be performed by a City of Simi Valley designated vendor)
• Initial x-ray study of a body part if any red-flags exist

Specialist Appointments
• Orthopedic Consultations shall be approved as long as it is to examine an injury or illness accepted in the Workers' Compensation claim

Durable Medical Equipment (DME supplies must be provide by the City of Simi Valley's designated vendors)
• Post-surgical DME

Corticosteroid injections (in non-diabetic patients):
• Elbow: single injection in cases of severe pain from epicondylitis
• Knee: three injections or less if the patient has osteoarthritis
• Shoulder: three injections or less if the patient has rotator cuff disease

Claims Administrator Approvals

The City of Simi Valley claims administrators may issue approvals on requests for authorization that are not addressed by the prior authorization process. The steps that they follow to issue these approvals are outlined in Genex's policies and procedures.

The approvals issued by the claims administrators, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

Utilization Review Organization
All requests received by the City of Simi Valley which the adjustors feel may require physician review are forwarded to reviewer level. For those reviews forwarded to Preferred Management Corporation and Genex, the requests will be processed following steps outlined in Preferred Management's and Genex's filings with the AD.

The approvals issued by Preferred Management, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

All requests received by Preferred Management which are determined to require physician review are forwarded to Genex.

Client – Paradigm Corp

Prior authorization process
Paradigm Corp does not utilize a prior authorization process.

Claims Administrator Approvals
Paradigm Corp claims administrators may issue approvals on requests for authorization that are not addressed by the prior authorization process. The steps that they follow to issue these approvals are outlined in Genex's policies and procedures.

The approvals issued by the claims administrators, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

Utilization Review Organization
All requests received by Paradigm Corp which are determined to require physician review are forwarded to Genex.

Client – School Insurance Authority

Prior authorization process

School Insurance Authority (SIA) has not made known to Genex their prior authorization process. Please contact SIA if this information is required.

Claims Administrator Approvals
SIA staff may issue approvals on requests for authorization. The approvals issued by SIA staff are supervised by SIA's Medical Director.

** The administrative approvals issued by SIA staff are not supervised by the Genex Medical Director. Consequently, we are not a party to any administrative approvals issued.*

Utilization Review Organization
SIA reviews requests following steps outlined in SIA's filings with the AD. The approvals issued by SIA are supervised by SIA's Medical Director.

All requests received by SIA which are determined to require physician review are forwarded to Genex.

Client – Aramark

Prior authorization process
Kaiser/KOJ and Yosemite Medical Clinics do not require pre-authorization except for surgery and pain management services.

Claims Administrator Approvals
Aramark claims administrators may issue approvals on requests for authorization that are not addressed by the prior authorization process. The steps that they follow to issue these approvals are outlined in Genex's policies and procedures.

The approvals issued by the claims administrators, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

Utilization Review Organization
All requests received by Aramark which require physician review are forwarded to Genex.

Additional Clients

For all clients listed below, the policies and procedures for utilization review are those included in this UR Plan filing.

Prior Authorization Process

None of these clients utilize a prior authorization process.

Claims Administrator Approvals

These clients may issue approvals on requests for authorization. The steps that they follow to issue these approvals are outlined in Genex's policies and procedures.

The approvals issued by the claims administrators, in compliance with Genex policies and procedures, are supervised by Genex's Medical Director.

Utilization Review Organization

All requests received by these clients which they determine to require physician review are forwarded to Genex.

Accident Fund Holdings
Accident Fund Ins Co of America
Ace Beverage
Ace Hardware Corporation
ACWA JPIA
Adminsure
Advanced Auto Parts
Advocate Healthcare
Allianz (AGCS)
Allianz Resolution Management
Allied Waste
AMFO Members Insurance Company (AMIC)
Applied Underwriters
Argo Insurance (C00685)
Argonaut Insurance Company (C02056)
Armour Risk Management
Arrowpoint Capital
ASC-Davies
Athens Administrators
Athens Administrators (CATHEN)
BC Rentals
BCI Technologies Inc
Berkley Environmental (f.k.a. Berkley Entertainment)
Berkley Industrial Comp
Beta Healthcare Group
Betty Ford Center
Bivar Inc
Blue Star Claims Management (C00736)
Brotherhood Mutual Insurance Company
Bridgestone America Inc
Budweiser
C & K Market
C & S Wholesale Grocers
CCMSI
California Insurance Guarantee Association (CIGA)
California Private Schools WC SIG
CBCS Integrated Claims Solutions
CEMEX USA, Inc.
Central Valley Meat Company
Cherokee
Church Mutual Insurance Co
CIGNA Corporation
City of Brea
City of Burbank
Clarendon National Insurance Co.
CNA Commercial Insurance
Community Health Systems
Continental Tire, The Americas, LLC
Copper Point/Pacific Comp

Cornerstone Comp
CSD-Custodian
CSD-Dept Not Mentioned
CSD-Environmental Service
CSD-Fire/Life Safety Service
CSD-Fire/Life Safety Service/No Division
CSD-Police
CSD-Police/Field Operations
CSD-Water Utilities
Dish Network Corporation
E. J. Gallo
ESIS/ACE USA (C02257)
Farmers Insurance
Federal Express Corporation
FirstGroup America
Fresno Unified School District
Gallagher Bassett
GDBD
Georgia Pacific
Golden State Foods
Good Technology
Grass Valley Ford
Great American Insurance Group
GreenGate Fresh LLP
Greenpath Recovery
Guardian Comp Inc
Hanover Insurance Company (C02225)
Hanover Insurance Group (C92430)
HCA – Sedgwick
HCA - Broadspire
Holiday Inn
Horizon Hobby
Hyde Park Convalescent Hospital
ICW Group
IMT Insurance Group
Innovative Claims Solutions (Excel Managed Care)
Insperity
Intact Insurance (f.k.a. One Beacon Insurance Group)
Intercare
Intercare/Employers
Intercare Insurance Services
IPMG (Insurance Program Mgrs Group)
Keenan
Kentucky Fried Chicken – KFC
LWP Claims Solutions (Excel Managed Care)
Leggett & Platt
Liberty RCS
Liberty Safeco
Little Caesars Pizza
Lockheed Martin
Loma Linda University
Los Angeles County Office of Education
Los Angeles Municipal Transportation Authority
Marriott
McKee Foods Corporation
Mission Beverage Co
Monument LLC
Municipal Pooling Authority
Murphy & Beane
Murphy & Beane (CMURPH)
NASSCO (C95469)
Nationwide Agribusiness Ins Co (C96772)
Nationwide Insurance
Next Level Administrators
Office Depot
Old Republic Insurance
PMA Group
PRISM (Public Risk Innovation, Solutions and Management)
QBE WC
Quality Comp - Part of Monument, LLC
Ray's Food Place
Red Robin Gourmet Burgers, Inc
Retirement/San Diego, County of
Reyes Holdings

Risk Enterprise Mgmt
SeaBright
Schifrin, Gagnon & Dickey (C95874)
Sedgwick CMS, Inc (C93941)
Sedgwick/Coca Cola
Sedgwick/Coca Cola2
Selective Insurance Company
Seneca Family of Agencies - Part of Monument, LLC
Shell Oil
Sheriffs Dept-San Diego, County Of
Southern California Pizza Company - Part of Monument, LLC
Sierra Nevada Administrators
Sodexo
Sompo
Sprint
Starbucks Casualty Program
StarStone
Starwood Hotels & Resorts
Summit Holdings
Sutter Health Workers' Comp
The Cities Group
Tokio Marine Insurance (C92213)
TOPA Risk Services (C02749)
Trinet SOI
Tristar Risk Management (C93098)
Tyson Foods, Inc
UC Berkeley
UC Davis
UC Davis Medical Center
UC Irvine
UC Irvine Medical Center
UC Lawrence Berkeley National Lab
UC Los Angeles
UC Los Angeles Medical Center
UC Merced
UC Office of The President
UC Riverside
UC San Diego
UC San Diego Medical Center
UC San Francisco
UC San Francisco Medical Center
UC Santa Barbara
UC Santa Cruz
UC Santa Monica - UCLA Medical Center
United Airlines, Inc (sCO)
United Airlines, Inc (sUA)
Utica Mutual/Utica National (C00946)
Utica National Insurance
Vanliners Ins Company LWP
Veritas Claims
Warner Brothers Workers' Comp
Water Pollution Control-City of San Francisco
WBS, Inc
WC Staffing Inc dba West Coast
Zurich North America

Genex Notification Letters

Enclosed are samples of all notifications issued by Genex in the course of our California Utilization Management program.

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

In Progress Notification

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>

Dear <Name>,

We have received a request for authorization for the above referenced claim.

Physician requesting authorization:
<Physician Name>

Specific Treatment Plan Requested
<Requested treatment plan>

Listed below is the applicant attorney we have on file. If this information is correct, no further action is necessary. If this information is incorrect, please notify us immediately so we can update our records. Please note if the fields below are listed as N/A then we have no attorney on file.

Applicant Attorney: <Name>
Address: <Street Address> <City>, <State> <Postal code>
Phone: <Telephone>
Fax: <Fax>

Please feel free to contact us should you have any additional questions regarding this review. Our Utilization Review staff is available during normal business days from 9:00AM to 5:30PM.

Respectfully,
Genex Services

<cc>

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

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Request for Additional Information

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>

Dear <Name>,

We have been requested by <Client>, to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the reviewer has determined that additional information is required to make a determination of medical necessity. We ask that the following information be submitted as soon as possible in order to allow us to complete this review without delay:

Physician requesting authorization:
<Physician Name>

Specific Treatment Plan Requested:
<Requested treatment plan>

Information Being Requested:
<Specific information requested>

This information may be faxed to Genex at <fax> or mailed to <Address> <City>, <State> <Zip>.

Please feel free to contact us with any questions. Our Utilization Review staff is available during normal business days from 9:00 AM to 5:30 PM. Your prompt response is appreciated.

Respectfully,
Genex Services

<cc>

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

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Referral to Expert Review

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>

Dear <Name>,

We have been requested by <Client>, to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that we require a specialized consultation and review of the medical information by an expert reviewer.

Physician requesting authorization:
<Physician Name>

Specific Treatment Plan Requested:
<Requested treatment plan>

Expert Reviewer:
The expert reviewer will be specialized in <Expert reviewer specialty> and the date of the expected UR decision is: <Date>.

Please feel free to contact us with any questions. Our Utilization Review staff is available during normal business days from 9:00 AM to 5:30 PM.

Respectfully,
Genex Services

<cc>

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

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Request for Additional Tests

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>

Dear <Name>,

We have been requested by <Client>, to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the reviewer has determined that additional information is required to make a determination of medical necessity. We are requesting that the requesting provider complete the following tests and/or procedures and forward the clinical results to us:

Physician requesting authorization:
<Physician Name>

Specific Treatment Plan Requested
<Requested treatment plan>

Specific Tests/Procedures Requested By Reviewer:
<Specific tests/procedure requested by reviewer>

This information may be faxed to CID at <Fax> or mailed to <Address> <City>, <State> <Zip>.

Please feel free to contact us with any questions. Our Utilization Review staff is available during normal business days from 9:00 AM to 5:30 PM.

Respectfully,
Genex Services

<cc>

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

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Received Additional Information

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>
Date additional information received: <Date>

Dear <Name>,

We have been requested by <Client>, to perform utilization review to determine if the requested health care services are medically necessary and appropriate.

Physician requesting authorization:
<Physician Name>

Specific Treatment Plan Requested
<Requested treatment plan>

In response to a request for information, we have received additional documentation for this review. The new documentation has been forwarded to the clinical staff and they are now analyzing the request for authorization.

Please feel free to contact us should you have any additional questions regarding this claim or if medical necessity substantiates further treatment. Our Utilization Review staff is available during normal business days from 9:00 AM to 5:30 PM.

Respectfully,
Genex Services

<cc>

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

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Recommendation: CERTIFY

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>
Date additional information received, if applicable: <Date>
Decision date: <Date>

Dear <Name>,

We have been requested by <Client>, to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the following health care services are certified as medically necessary:

Specific Treatment Plan Requested
<Requested treatment plan>

UR Determination
<Authorized treatment plan>

While the medical necessity of the requested treatment/service may have been established, certification does not prevent generic substitution when clinically indicated, jurisdictionally required, and/or network negotiated.

Clinical Rationale
<Utilization review determination>

Criteria/Guidelines Applied
<Evidence-based guidelines>

Please feel free to contact us should you have any additional questions regarding this claim or if medical necessity substantiates further treatment. Our Utilization Review staff is available during normal business days from 9:00 AM to 5:30 PM.

Respectfully,

<Reviewer Signature>

<Reviewer Name>
<License>
<Board Certification>

<cc>

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

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

Genex Grievance Process

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

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Recommendation: CONDITIONALLY NON-CERTIFY

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>
Date additional information received, if applicable: <Date>
Decision date: <Date>

Dear <Name>,

We have been requested by <Client>, to perform utilization review to determine if requested health care services are medically necessary and appropriate for this claim. This letter is to notify you that the reviewer has determined that additional information is necessary prior to making a determination of medical necessity. The requesting physician has been contacted for the necessary information; however as of this date we have not received it.

At this time, we are conditionally denying this review due to lack of information. If the requesting provider does submit the requested information in the future, we will reconsider the request.

Specific Treatment Plan Requested
<Requested treatment plan>

UR Determination
<Authorized treatment plan>

Clinical Rationale
<Utilization review determination, including:
- reason for decision;
- specific description of information needed;
- date(s) and time(s) attempts made to contact physician to obtain necessary information; and
- description of manner in which request was communication>

Criteria/Guidelines Applied
<Evidence-based guidelines>

Information regarding our optional reconsiderations process is attached to this determination letter.

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

Respectfully,

<Reviewer Signature>

<Reviewer Name>
<License>
<Board Certification>

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

<cc>

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

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

Genex Grievance Process

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

Genex Reconsiderations Process

For any treatment request which was ***conditionally denied***, the treatment request will be reconsidered upon receipt of the requested information. The information may be faxed to Genex at <Fax> or may be submitted via mail to <Address> <City>, <State> <Zip>.

Additional Language required by California Labor Code and Regulations:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me <Claims Administrator Name> at <Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision and ten (10) days for formulary disputes. Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Medical Records Reviewed

The following is a list of documents reviewed:
<All documents reviewed>

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Recommendation: MODIFIED

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>
Date additional information received, if applicable: <Date>
Decision date: <Date>

Dear <Name>,

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

Specific Treatment Plan Requested
<Requested treatment plan>

UR Determination
<Authorized treatment plan>

While the medical necessity of the requested treatment/service may have been established, certification does not prevent generic substitution when clinically indicated, jurisdictionally required, and/or network negotiated.

Clinical Rationale
<Utilization review determination>

Criteria/Guidelines Applied
<Evidence-based guidelines>

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

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

Respectfully,

<Reviewer Signature>

<Reviewer Name>
<License>
<Board Certification>»

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

<cc>

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

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

Genex Grievance Process

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

Genex Reconsiderations Process

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

Genex Optional Internal UR Appeals Process

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

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

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

Appeals and/or Reconsiderations may be faxed to <Fax> or may be submitted via mail to <Address>, <City>, <State> <Zip>.

** Expedited appeals shall only be granted if:*

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

Additional Language required by California Labor Code and Regulations:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me <Claim Administrator Name> at <Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision and ten (10) days for formulary disputes. Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Medical Records Reviewed

The following is a list of documents reviewed:
<All documents reviewed>

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Recommendation: NON-CERTIFY

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>
Date additional information received, if applicable: <Date>
Decision date: <Date>

Dear <Name>,

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

Specific Treatment Plan Requested
<Requested treatment plan>

UR Determination
<Treatment plan denied>

Clinical Rationale
<Utilization review determination>

Criteria/Guidelines Applied
<Evidence-based guidelines>

Information regarding our optional internal appeals process is attached to this determination letter.

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

Respectfully,

<Reviewer Signature>

<Reviewer Name>
<License>
<Board Certification>

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

<cc>

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

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

urac®
ACCREDITED
Workers' Compensation Utilization Management
Expires 04/01/2024

Genex Grievance Process

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

Genex Optional Internal UR Appeals Process

For any treatment request which was ***modified*** or ***denied***, the claimant or requesting provider has the option of submitting a request for an internal appeal on a voluntary basis. Participation in this optional appeals process neither triggers nor bars the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6. The request for the optional internal appeal must:

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

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

Appeals and information may be faxed to <Fax> or may be submitted via mail to <Address>, <City>, <State> <Zip>.

** Expedited appeals shall only be granted if:*

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

Additional Language required by California Labor Code and Regulations:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me <Claim Administrator Name> at <Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision and ten (10) days for formulary disputes. Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Medical Records Reviewed

The following is a list of documents reviewed:
<All documents reviewed>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Appeal Review
Recommendation: MODIFIED

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>
Date additional information received, if applicable: <Date>
Decision date: <Date>

Dear <Name>,

We have been requested by <Client>, to perform utilization review to determine if the requested health care services are medically necessary and appropriate for this claim. On <Date>, we completed Review <Number> at which time a physician reviewer determined that the requested care did not fully meet the criteria for medical necessity.

Following that decision, we received an appeals request and therefore asked a different physician to re-review the treatment request. All available records submitted with the original request, as well as any additional information submitted with this request for appeal, were taken into account. This letter is to notify you of our determination regarding medical necessity:

Specific Treatment Plan Requested
<Requested treatment plan>

UR Determination
<Authorized treatment plan upheld and/or overturned>

While the medical necessity of the requested treatment/service may have been established, certification does not prevent generic substitution when clinically indicated, jurisdictionally required, and/or network negotiated.

Clinical Rationale
<Utilization review determination>

Criteria/Guidelines Applied
<Evidence-based guidelines>

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

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

Respectfully,

<Reviewer Signature>

<Reviewer Name>
<License>
<Board Certification>

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

<cc>

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

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

Genex Grievance Process

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

Genex Reconsiderations Process

For any treatment request which was ***conditionally denied***, the treatment request will be reconsidered upon receipt of the requested information. The information may be faxed to Genex at <Fax> or may be submitted via mail to <Address> <City>, <State> <Zip>.

Genex Optional Internal UR Appeals Process

For any treatment request which was ***modified*** or ***denied***, this completes the internal appeals process. Please contact the claims administrator with any questions.

Additional Language required by California Labor Code and Regulations:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me <Claim Administrator Name> at <Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the Application for Independent Medical Review, DWC Form IMR-1 which was enclosed with the original decision letter. This form must be submitted within 30 calendar days of receipt of the original decision and ten (10) days for formulary disputes. Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Medical Records Reviewed

The following is a list of documents reviewed:
< All documents reviewed>

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Review Placed on Administrative Hold

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>

Dear <Name>,

We have been requested by <Client>, to perform utilization review to determine if the requested health care services are medically necessary and appropriate.

Physician requesting authorization:
<Physician Name>

Specific Treatment Plan Requested
<Requested treatment plan>

After reviewing the submitted documents, we have determined that we are not in receipt of all necessary administrative information required to continue the UR process. We are in contact with the claims administrator to gather the additional information, and will continue the review once the information is received.

Please feel free to contact us with any questions. Our Utilization Review staff is available during normal business days from 9:00 AM to 5:30 PM.

Respectfully,
Genex Services

<cc>

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

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Review Placed on Hold at Client's Request

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>

Dear <Name>,

We have been requested by <Client>, to perform utilization review to determine if the requested health care services are medically necessary and appropriate.

Physician requesting authorization:
<Physician Name>

Specific Treatment Plan Requested
<Requested treatment plan>

We are hereby notifying you that we have been asked to place this review on hold by the client. To comply with their request, we are ceasing all activity on this review. Once we received further direction on to proceed, e.g. place the review back in progress or withdraw it complete, we will notify you of our actions.

Please feel free to contact us with any questions. Our Utilization Review staff is available during normal business days from 9:00 AM to 5:30 PM.

Respectfully,
Genex Services

<cc>

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

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Review Taken Off Hold

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>

Dear <Name>,

We have been requested by <Client>, to perform utilization review to determine if the requested health care services are medically necessary and appropriate.

Physician requesting authorization:
<Physician Name>

Specific Treatment Plan Requested
<Requested treatment plan>

This review was previously placed on hold. At this time, the review is being taken off-hold and is being re-placed into the review process.

Please feel free to contact us with any questions. Our Utilization Review staff is available during normal business days from 9:00 AM to 5:30 PM.

Respectfully,
Genex Services

<cc>

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

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Review Withdrawn by Genex

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>

Dear <Name>,

We have been requested by <Client>, to perform utilization review to determine if the requested health care services are medically necessary and appropriate.

Physician requesting authorization:
<Physician Name>

Specific Treatment Plan Requested
<Requested treatment plan>

We are hereby notifying you that we are canceling this review:

Person requesting the review be cancelled:
<Genex staff person requesting withdrawal>, <Genex staff person title>

Reason for the cancellation:
<Explanation for withdrawal>

Please feel free to contact us with any questions. Our Utilization Review staff is available during normal business days from 9:00 AM to 5:30 PM.

Respectfully,
Genex Services

<cc>

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

Review # <Number>

<Date>

<Name>
<Street Address>
<City> <State> <Postal Code>

Review Withdrawn by Client

RE: Claimant: <Name>
Claim: <Number>
Date request was first received by <Client>: <Date>
Date request received by Genex: <Date>

Dear <Name>,

We have been requested by <Client>, to perform utilization review to determine if the requested health care services are medically necessary and appropriate.

Physician requesting authorization:
<Physician Name>

Specific Treatment Plan Requested
<Requested treatment plan>

We are hereby notifying you that we are canceling this review:

Person requesting the review be cancelled:
<Client staff person requesting withdrawal>, <Client staff person title>

Reason for the cancellation:
<Explanation for withdrawal>

Please feel free to contact us with any questions. Our Utilization Review staff is available during normal business days from 9:00 AM to 5:30 PM.

Respectfully,
Genex Services

<cc>

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