



California Utilization Review Plan

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1 Program Overview

- A. The P&S Network Utilization Review Plan is established and maintained in compliance with Labor Code §4610 and 8 CCR § 9792 et seq.
- B. All terms used throughout the P&S Network (P&S) California (CA) Utilization Review (UR) plan have the definitions found in 8 CCR § 9792.6.1.
- C. P&S is fully accredited by URAC in Workers' Compensation Utilization Management (WCUM) in compliance with 8 CCR § 9792.7 (a)(6)(A) as well as in Independent Review Organization: Comprehensive Review.
- D. The purpose of the P&S UR program is to evaluate the medical necessity, appropriateness, and efficiency of any medical services and procedures and to provide medical necessity recommendations that are supported by current and applicable evidence-based medicine guidelines.
- E. P&S UR staff are available telephonically each normal business day for all UR services from 9:00am to 5:30pm Pacific Time, Monday through Friday. P&S is closed Saturdays, Sundays, and any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website in compliance with 8 CCR § 9792.9.1 (a)(3).
 1. P&S staff can be reached via:
 - a. Toll free telephone: 866-308-0668
 - b. Facsimile: 323-556-0556
 - c. Email: referrals@pandsnetwork.com
 2. Fax and email options are always available to receive RFA's.
 3. Voice messaging options are provided for after business hours callers. Messages are returned within one business day of receipt.
- F. P&S customers may include workers' compensation insurers, TPA's, and employers and select from the following CA UR Programs:
 1. Standard UR: client delegates UR to P&S and utilizes the P&S CA UR Plan
 2. Total UR: client delegates UR to P&S and utilizes the P&S CA UR Plan and P&S Medical Director
 3. UR Plus: client has their own CA UR Plan but is not URAC accredited and contracts with P&S for Medical Director services and for URAC accredited Physician Review services
 4. UR Limited: client has their own CA UR Plan, Medical Director, and URAC accreditation and delegates only Physician Review to P&S
- G. P&S will file an updated utilization review plan with the Administrative Director within 30 calendar days after any material modification to the plan or when assuming UR responsibilities for a claim's administrator/client in compliance with 8 CCR § 9792.7 (c)(4).
- H. Upon request by the public, P&S will make available the complete CA UR Plan in compliance with 8 CCR § 9792.7 (m)(1-2).

2 Staff Qualifications

A. Medical Director

1. Requirements

- a. Holds an unrestricted license to practice medicine in California as an MD or DO in compliance with 8 CCR § 9792.7 (a)(1)
- b. Is board certified in Physical Medicine & Rehab, Occupational Medicine, or Orthopedic Surgery or other appropriate medical specialty
- c. Has post-graduate experience in direct patient care
- d. Holds the necessary qualifications to perform clinical oversight for all P&S clinical service

2. Responsibilities

- a. Oversees and evaluates the processes by which P&S reviews and approves, modifies, or denies requests for authorization (RFA's) prospectively, retrospectively, or concurrently with the provision of medical services in compliance with 8 CCR § 9792.7 (b)(1).
- b. Designated senior clinical staff member
- c. Oversight and accountability of all clinicians
- d. Oversight and direction of all clinical decision-making tools, guidelines and criteria
- e. Leadership and oversight of the quality assurance program
- f. Consultative services and clinical support to Initial Clinical Reviewers

B. Physician Reviewers

1. Requirements:

- a. MD, DO, DC, DMD/DDS, DPM, PhD/psychologist, or a LaC licensed by any state or the District of Columbia in compliance with 8 CCR § 9792.6.1 (w)(1).
- b. Be competent to evaluate the specific clinical issues involved in the medical treatment services under review and where these services are within the reviewer's scope of practice in compliance with 8 CCR § 9792.9.5 (a).
- c. P&S requires Physician Reviewers to attest to the following when issuing a determination:
 - i. That the reviewer has a scope of licensure or certification that permits management of the issue under review, or the medical or behavioral health condition, disease, treatment or procedure under review
 - ii. That the reviewer has current, relevant experience and/or current, relevant knowledge to render a determination for the case under review.

2. Responsibilities

- a. Review RFA and supplied medical information to issue a determination, use specific medical information from the records to support the clinical rationale for the UR determination.
- b. Issue a professional peer review report with attestation and signature for all RFA's accepted for review.
- c. Only Physician Reviewers can issue modifications or denials in compliance with 8 CCR § 9792.7 (b)(2).

C. Initial Clinical Reviewers

1. Requirements

- a. Initial Clinical Reviewers are Non-Physician Reviewers that are licensed medical staff and may include RN, LPN/LVN, PT/OT, PA, DC, or other properly trained and licensed healthcare professionals approved by the Medical Director.
- b. Initial Clinical Reviewers are trained in the application of the MTUS and other evidence-based treatment guidelines utilized for the assessment of the medical appropriateness of the requested treatments and/or services.

2. Responsibilities

- a. Initial Clinical Reviewers review supplied medical information and use the applicable CA MTUS guideline to determine medical necessity of the requested medical services and treatments on assigned RFA's.
- b. Initial Clinical Reviewers can issue authorizations of medical treatment requests that comply with MTUS and in accordance with 8 CCR § 9792.7(b)(3) but they cannot issue modifications or denials.
- c. Initial Clinical Reviewers may not issue modifications or denials.

D. Administrative Staff

1. Requirements



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- a. Non-clinical, non-physician reviewers who are limited to conducting intake and other administrative tasks.
2. Responsibilities
 - a. Accepting RFA's, demographic information, and medical records and transferring/imaging the information into P&S's system.
 - b. Reviewing the RFA to determine if it is complete.
 - c. Corresponding with the adjuster to establish compensability of a claim upon receipt of an RFA directly from a provider.
 - d. Corresponding with the requesting physician to obtain missing information
 - e. Assign RFA's to Initial Clinical Reviewers
 - f. P&S does not use scripted clinical screening tools; non-clinical staff does not make any medical necessity recommendations.
 - g. Non-Clinical Administrative staff does not interpret medical information.
 - h. Complete administrative tasks as assigned by reviewers
- E. All P&S staff undergo new hire training upon hire and receive ongoing training no less than annually covering the following:
 1. Orientation to managed care, insurance, and workers compensation
 2. California regulatory requirements/rules/regulations and required forms
 3. P&S systems
 4. CA MTUS/Evidence based medicine guidelines and criteria
 5. Confidentiality, HIPAA, patient privacy
 6. URAC
- F. Upon hire and then at renewal, P&S clinical staff must present evidence of a current, unencumbered license to practice in the state or DC in which they conduct UR. The license is verified according to P&S's licensure policy and evidence of licensure verification is maintained in the credentialing file.
- G. All P&S UR activity is conducted telephonically.
- H. No financial incentive or consideration is provided to Physician Reviewers or any clinical staff based on issuance of adverse decisions, non-certifications, denials, or limitations of approval recommendations for medically necessary services that meet MTUS/evidence based clinical guidelines.

3 Utilization Review Types & Timeframes

- A. All UR timeframes are calculated in compliance with 8 CCR § 9792.9.3.
- B. **Prospective Review**
 - 1. UR conducted prior to the delivery of the requested medical services except for in-patient hospitalization, includes Medication/Formulary reviews
 - 2. Prospective review is used to review elective admissions and non-urgent services.
 - 3. Prospective review decisions are 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 completed RFA.
- C. **Expedited Review**
 - 1. Prospective and/or concurrent UR that is 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.
 - 2. The requesting physician must certify in writing and document the need for an expedited review when submitting an RFA.
 - 3. A request for expedited review that is not reasonably supported by the evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review would be detrimental to the injured workers' condition, shall be reviewed under the non-expedited timeframes.
 - 4. Expedited review decisions are not to exceed seventy-two (72) hours after receipt of the written information reasonably necessary to make the decision.
- D. **Retrospective Review**
 - 1. UR conducted after medical services have been provided and in cases where approval has not already been given.
 - 2. Retrospective review may be performed for any treatment provided solely for the purpose of determining if the physician is prescribing treatment consistent with the MTUS, including, but not limited to:
 - a. Exempt drugs per the MTUS drug formulary
 - b. Exempt treatment during the first 30 days of an injury
 - 3. Retrospective review decisions are made within thirty (30) calendar days after receipt of the request and medical information that is reasonably necessary to make the decision
- E. **Concurrent Review**
 - 1. UR conducted during an inpatient stay.
 - 2. Medical care is not discontinued until the requesting physician has been notified of the concurrent decision and a treatment plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker.
 - 3. Concurrent review decisions are made in a timely fashion that is appropriate to the nature of the injured worker's condition, not to exceed five (5) business days from the receipt of the RFA.
- F. **Reconsideration Review**
 - 1. P&S does not offer a formal voluntary appeal process but does offer a reconsideration process after a modification or denial has been issued.
 - 2. Reconsideration is conducted when:
 - a. A requesting provider has requested a discussion with the reviewing physician who issued the modification or denial in compliance with 8 CCR § 9792.9.5 (e)(14)
 - b. Additional medical information was received in compliance with 8 CCR § 9792.9.5 (e)(7)(A).
 - 3. Reconsideration requests should be received within 10 calendar days of receipt of the UR determination. Requests received after this time will be processed as a new request for authorization.
 - 4. For P2P reconsideration requests, the first call is returned within one business day of receipt.
 - 5. Reconsideration requests are completed within five (5) business days from the date of receipt of the request for peer-to-peer conversation or from receipt of the additional medical information.



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G. Emergency Services

1. Emergency services are 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. 8 CCR § 9792.6.1 (i)
2. Emergency services, admissions, or procedures are not subject to prospective review; they are allowed twenty-four (24) business hours following the emergency to notify for concurrent review.
3. Failure to obtain authorization prior to providing emergency health care services will not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker when presenting for emergency health care services.
4. Emergency health care services may be subjected to retrospective review.
5. Documentation for emergency health care services will be made available to the claims administrator upon request



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4 Evidence Based Guidelines/Criteria

- A. P&S utilizes the applicable Medical Treatment Utilization Schedule (MTUS) guideline to determine if the requested treatment is consistent with the MTUS and medically necessary pursuant to Labor Code § 5307.27.
- B. P&S Reviewers select and apply treatment guidelines according to this hierarchy:
 - 1. California Medical Treatment Utilization Schedule (MTUS) including the Drug Formulary which is considered presumptively correct and is required by regulation
 - 2. Official Disability Guidelines (ODG) for Workers' Compensation by MCG
 - 3. American College Occupational & Environment Medicine (ACOEM) Practice Guidelines
- C. Guidelines and criteria are selected and approved by the Quality Management Committee (QMC).
- D. The QMC conducts an annual review and evaluation of all guidelines utilized in the UR process.
- E. All guidelines used by P&S are proprietary and updates are performed by the owner/entity no less than annually.
- F. The P&S Medical Director is responsible to ensure all guidelines utilized in the UR process are current.
- G. Initial Clinical Reviewers are required to utilize only QMC approved guidelines and criteria.
- H. P&S does not utilize Artificial Intelligence (AI) when making UR determinations.
- I. If no applicable guideline is found in P&S's hierarchy of medical guidelines, or if the Physician Reviewer believes there is another recommendation supported by a higher quality and strength of evidence, then the Physician Reviewer will search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury and choose the recommendation that is supported with the best available evidence and in compliance with 8 CCR § 9792.25.1.

5 Requests for Authorization

- A. P&S accepts any request for authorization of medical treatment and services set forth on a DWC form RFA by a treating physician
 - 1. P&S may accept a request for authorization that is not set forth on a DWC form RFA if it includes all required information pursuant to 8 CCR § 9792.6.1 (u) (1-3).
- B. P&S accepts the RFA or narrative report directly from providers and health care facilities. Referrals from P&S client claims professionals who are in receipt of the RFA from the provider/facility are also accepted.
- C. P&S determines the received date of the RFA in compliance with 8 CCR § 9792.9.1 as follows:
 - 1. An RFA is deemed to have been received by facsimile, electronic mail, or electronic data interchange on the date the form was received if the receiving facsimile, electronic mail address, or clearinghouse electronically date stamps the transmission when received.
 - 2. If there is no electronically stamped date recorded, then the date the RFA was transmitted will be the date the form was received.
 - 3. An RFA transmitted by facsimile after 5:30 PM Pacific Time will be deemed to have been received on the following business day, except in the case of an expedited or concurrent review.
 - 4. The copy of the RFA or fax cover sheet, received by a facsimile transmission, electronic mail, or electronic data interchange will demonstrate a notation of the date, time, and place of transmission and the facsimile telephone number, electronic mail address, or identity of the payor's clearinghouse to which the request was transmitted, or be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax, electronic mail, or electronic data interchange transmission report. The requesting provider must indicate the need for an Expedited Review on the RFA form or narrative report.
 - 5. Where the RFA is sent by mail, absent documentation of receipt, the request will be deemed to have been received five (5) business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.
 - 6. Where the RFA is delivered via certified mail, return receipt mail, the form, absent documentation of receipt, will be deemed to have been received on the receipt date entered on the return receipt.
 - 7. In the absence of documentation of receipt, evidence of mailing, or dated return receipt, the RFA form will be deemed to have been received five (5) days after the latest date the sender wrote on the document.
 - 8. The timeframe for a decision on a returned, in complete RFA will begin anew upon receipt of a completed RFA.
- D. For P&S to deem an RFA or a narrative report complete, it must:
 - 1. Identify both the injured worker and the requesting provider
 - 2. Identify with specificity a recommended treatment or treatments
 - 3. Be accompanied by documentation substantiating the need for the requested treatment and issued or created no earlier than 30 days before the date of submission of the RFA. If the request is to continue a treatment plan or therapy, documentation indicating progress should be submitted, if applicable.
 - 4. Be signed by the requesting physician (electronic signature acceptable)
- E. Complete RFAs will be processed for UR
- F. Incomplete RFA's will be returned to the requesting physician within five (5) business days from receipt of the incomplete RFA which will be marked "Not Complete". The specific reason/s for the return of the request will also be included.

6 Disputed Liability

- A. A request received on a RFA form may be deferred for UR if the client's claims professional disputes liability for either the occupational injury and/or body part for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.
- B. 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, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, the time to conduct a retrospective utilization review in accordance with 8 CCR § 9792.9.2 (c) shall begin on the date the determination of the claims administrator's liability becomes final. The time to conduct prospective utilization review shall commence from the date of the client claims administrator's receipt of a RFA after the final determination of liability.
- C. The claims administrator, shall issue a written decision deferring UR of the requested treatment within five (5) business days from receipt of the RFA. The written decision will be sent to the requesting provider, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.
- D. The written notification deferring UR because of disputed liability as determined by the claims administrator includes:
 1. The date on which the RFA was first received
 2. A description of the specific course of proposed medical treatment for which authorization was requested.
 3. A clear, concise, and appropriate explanation of the reason for the claims professional's dispute of liability for the injury, claimed body part or parts, or the recommended treatment.
 4. A plain language statement advising the injured worker that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.
 5. The following mandatory language:
 - a. You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision (See attached application.). If you have questions about the information in this notice, please call 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.
 - b. For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.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.
- E. Nothing in this Utilization Review Plan modifies or alters a client claims administrator's ability to deny requests for treatment when the P&S client claims administrator has:
 1. Officially rejected compensability of the underlying claim for workers compensation. In these situations, all denials must be for lack of compensability and not on the basis of medical necessity or UR criteria; or
 2. Determined that certain body parts or medical conditions are not part of or related to the accepted compensable claim and therefore, requests for treatment related to those conditions or body parts should be denied; or
 3. Determined that the RFA was not submitted by an MPN provider where the MPN has been fully implemented

7 Utilization Review Determination Processes

A. Adjuster Authorization

1. P&S clients that are workers' compensation insurance carriers, third party administrators, and/or self-insured employers may choose to administratively approve requests for authorization without submitting the RFA to P&S for utilization review.
 - a. Each client's specific approval process for adjusters may differ and is included in the client section of this application.
 - b. Non-medical claims professionals may administratively approve requests for authorization under the direction of the Medical Director.
 - c. Non-medical claim professionals may not modify or deny a request for medical treatment based on medical necessity or lack of information.
 - d. If the claims professional cannot approve the RFA as requested and the medical treatment request is for a compensable injury/body part, the RFA is referred to P&S for UR.

B. Thirty (30) Day Prospective Review Exemption (8 CCR § 9792.9.7)

1. Treating physicians as specified in Labor Code section 4610(b) may render medically necessary treatment or services to an injured worker without prospective UR for the first thirty (30) days after the date of injury provided that:
 - a. The treatment or service is for a body part or condition that has been accepted as compensable
 - b. The treatment or service is consistent with the applicable MTUS guideline
 - c. The initial treating physician timely submits the DIR Form 5021
 - d. The treatment requested is set forth on an RFA and submitted with the DIR Form 5021
 - e. Billing for the non-emergency treatment or service is submitted within 30 days of the date the service was provided.
2. Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in 8 CCR § 9792.9.7 (b)(1-8), shall be subject to prospective utilization review:
 - a. Pharmaceuticals, to the extent they are not expressly exempt from prospective review under the MTUS Drug Formulary.
 - b. Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.
 - c. Psychological and psychiatric treatment services.
 - d. Home health care services.
 - e. Imaging and radiology services, excluding X-rays.
 - f. All durable medical equipment, whose combined total value exceeds two hundred fifty dollars (\$250), as determined by the official medical fee schedule.
 - g. Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
 - h. Spinal injections including medial branch blocks, facet joint injections, intradiscal injections, epidural injections, and sacroiliac joint injections.
 - i. Any other service designated and defined through rules adopted by the administrative director.
 - j. Treatment and services provided under this section and exempt from prospective review may be reviewed retrospectively to determine if a provider has a pattern and practice of failing to render treatment that is consistent with the MTUS including the MTUS Drug Formulary and if such a pattern and practice is found, the claims administrator, pursuant to 8 CCR § 9792.9.7 (c)(1)(A-C) may:
 - i. Remove the ability of the physician to render treatment exempt from prospective review to any injured workers whose claim is adjusted or administered by the claims administrator
 - ii. Remove the physician as the injured worker's primary treating physician
 - iii. Terminate the physician from the claim administrator's MPN
 - k. For a physician to meet the requirements of 'pattern and practice', P&S shall follow the requirements set forth in 8 CCR § 9792.9.7 (c)(2).

C. MTUS Exempt Formulary Drugs

1. Exempt Drugs on MTUS Formulary: "Exempt" indicates the drug may be prescribed/dispensed without seeking authorization through Prospective Review if in accordance with MTUS. The 'Exempt Drug' list can be found here: <https://www.dir.ca.gov/dwc/MTUS/MTUS-Formulary-Orders.html> and includes:
 - a. Drugs identified on the MTUS Drug List as exempt per § 9792.27.15
 - b. Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Special Fill policy under § 9792.27.12
 - c. Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Perioperative Fill policy under § 9792.27.13
2. Prospective review is conducted for exempt drugs after the first 30 days of an injury to determine if usage is consistent with the MTUS guidelines.
3. Retrospective review may be conducted for exempt drugs during the first 30 days of an injury to determine whether the use of the drug is consistent with the MTUS; payment for an exempt drug dispensed during the first 30 days of the injury shall not be denied based on a determination that the use of the drug was not consistent with the applicable MTUS.
4. Use of an exempt drug that is not consistent with the applicable MTUS guideline may be used as a basis to find that the physician has a pattern and practice of failing to render treatment that is consistent with the MTUS as noted above.

D. UR Initial Clinical Review

1. Initial Clinical Review is conducted when none of the above conditions apply (Section 6 A-C).
2. Initial Clinical Reviewers conduct the initial clinical review of the treatment request using the applicable California MTUS guideline(s) or other appropriate clinical guidelines or criteria to the requested medical services or treatments.
 - a. If the request meets the guidelines/criteria, the Initial Clinical Reviewer can issue an approval for the requested service in accordance with the regulatory timeframes stated within this plan for the type of review performed.
 - b. If the RFA does not meet guidelines, the Initial Clinical Reviewer may contact the requesting physician for an agreement to voluntarily amend the request to comply with the guidelines and to withdraw the original RFA.
 - i. If agreement is reached on an amendment of the original RFA, the Initial Clinical Reviewer may certify the treatment upon receipt of the requesting provider's signature confirming agreement to the amended treatment.
 - ii. If an agreement is not reached or the requesting provider confirmation signature to amend the request is not received, the original RFA will be processed as a prospective UR request.
 - iii. If the requesting provider verbally withdraws the entire request and the signature confirming withdrawal is not received, UR continues, and the request is forwarded for Physician Review
3. For requests where additional information was required and received, the Initial Clinical Reviewer proceeds with the review process.
4. In all cases, if the Initial Clinical Reviewer cannot certify the treatment as requested on the RFA, the request is forwarded for Physician Review.

E. UR Physician Review

1. Physician Review is performed when the Initial Clinical Reviewer cannot issue an approval and/or the requested treatment does not meet MTUS/treatment guidelines.
2. Only a Physician Reviewer who is competent to evaluate the specific clinical issues and which are within the scope of the physician's practice may modify or deny treatment requests.
3. Physician Reviewers may, at their discretion, attempt conversation with requesting/treating physician/provider to obtain necessary information to support the request prior to issuing a determination.
4. Physician Reviewer's must document the list of medical records reviewed, all attempts and/or a summary of any peer-to-peer conversation, the guideline used to make the determination, and the patient specific medical rationale to support the determination in the Peer Review Report.

5. Physician Reviewers must sign an attestation indicating they did not accept payment for the review outcome and that they have no conflicts of interest.

F. Incomplete/Need for Additional Clinical Information/Testing/Examination

1. The timeframe for making UR decisions may only be extended under one or more of the following circumstances:
 - a. The claims administrator or reviewer is not in receipt of all the information reasonably necessary to make a determination
 - b. The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice
 - c. The reviewer needs a specialized consultation and review of medical information by an expert reviewer.
2. If P&S is not in receipt of all clinical information reasonably necessary to make a decision, the Initial Clinical Reviewer:
 - a. Attempts telephonic contact to the requesting provider, making at least one call within two (2) business days of receipt of the RFA in cases where the medical documentation does not support the request or additional documentation is necessary to render a decision.
 - b. Sends a written request for additional information within five business days of first receipt of the RFA.
 - i. The written request for additional information is sent within four business days of first receipt of the RFA for formulary medications.
3. If the Initial Clinical Reviewer cannot approve the treatment under review based on the information provided, and both telephonic and written attempts to obtain additional information within the applicable timeframe have failed, the Initial Clinical Reviewer refers for Physician Review.
4. The Physician Reviewer reviews the available clinical information. If the reviewer determines that reasonably necessary clinical information is lacking, the reviewer will issue a denial based on lack of necessary information and will include the information necessary to complete the review.
 - a. If the treatment is subject to the formulary and is a standard Prospective or Concurrent Review, the denial for insufficient information will be made within five business days from receipt of the RFA.
 - b. If the treatment is not subject to the formulary and
 - i. If the information is not received within fourteen (14) days from receipt of the RFA for Prospective or Concurrent Review, the Physician Reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.
 - ii. If the treatment request is an expedited Prospective or Concurrent Review, the denial for insufficient information will be made within seventy-two (72) hours of receipt of the RFA.
 - iii. If the treatment request is a Retrospective Review and the information is not received within thirty (30) days from receipt of the RFA for Retrospective Review, the Physician Reviewer will deny the request for insufficient information within thirty (30) days of receipt of the RFA.
5. If a Physician Reviewer requests that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of care, or if a specialized consultation and review of medical information by an expert reviewer is needed, P&S issues written notification within five (5) business days from the first date of the request for authorization, to the treating provider, the injured worker and if the injured worker is represented by counsel, the injured worker's attorney, that a decision cannot be made within the required timeframe, and requests the additional examinations or tests required and/or the specialty of the expert reviewer to be consulted in addition to the anticipated date on which a decision will be rendered.
 - a. If the results of the additional examination or test or the specialized consultation requested is not received within thirty (30) days from the date of the RFA, the Physician Reviewer shall issue a denial of the treating physician's request with the stated condition that the request will be reconsidered upon receipt of the results of the additional examination or test or the specialized consultation.
6. If the required information is provided for reconsideration following a denial for insufficient information, a new decision to approve, modify, or deny the RFA is issued, and the notification of decision includes the date the additional information was received and is completed:



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- a. Within five (5) working days of receipt of the required information if standard prospective or concurrent review
 - b. Within seventy-two (72) hours of receipt of the information if expedited prospective or expedited concurrent review
 - c. Within thirty (30) days of receipt of the information if retrospective review
7. All attempts to obtain the necessary medical information from the physician by either telephone, facsimile, mail, or e-mail are documented including the date and time in the P&S electronic file and are included on the determination letter when applicable.



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8 UR Determination Notification Processes

A. Approvals/Authorizations Notification Process

1. UR approvals are authorizations which means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed "Request for Authorization," form or accepted as complete by the claim administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of 8 CCR § 9792.9.1 through 9792.12.
2. Prospective, Concurrent, or Expedited Review approvals in compliance with 8 CCR § 9792.9.4 (b):
 - a. Are communicated to the requesting provider within twenty-four (24) hours of the decision, initially by telephone, facsimile, or electronic encrypted mail.
 - b. Written notification to the requesting provider is issued within twenty-four (24) hours of the decision for Concurrent Review and within two (2) business days for Prospective review when initial notification occurs telephonically.
 - c. Determinations initially sent via facsimile or electronic mail are considered written notification.
3. Retrospective Review approvals are communicated to the requesting provider who provided the medical services and to the injured worker who received the medical services, and his or her attorney/designee, if applicable.
4. All P&S approval decision notifications include:
 - a. A unique ID number
 - b. The date of first receipt of the completed RFA
 - c. The specific medical treatment(s)/service(s) requested and approved/authorized
 - d. The date of the UR decision
5. A UR decision to approve an RFA of medical treatment shall remain effective for 90 days from the date of decision
6. For approvals of a concurrent review, the determination notification also includes:
 - a. The date of admission to the hospital
 - b. The number of days certified for the current review
 - c. The total number of days certified for the hospitalization
7. For approvals where additional medical information was requested, the determination letter will also include the date(s) and method(s) the request was made for additional medical information and the date the requested information was received if applicable.
8. For approvals of a RFA of a drug where it was not indicated "Do Not Substitute" or "Dispense as Written", a determination approving the request will include 'generic substitute authorized' or words to that effect or meaning.
9. For approvals of a RFA of a drug that is exempt per the MTUS Drug Formulary, a determination approving a request for such drug will include 'Exempt per MTUS Drug Formulary' or words to that effect and meaning.
10. For approvals of a RFA of a non-drug treatment that is exempt per § 9792.9.7, a determination approving a request will include '30-Day Exemption' or words to that effect and meaning.

B. Modifications and Denials Notification Process

1. Prospective, Concurrent, or Expedited Review decisions to modify or deny a request for medical treatment or services in compliance with 8 CCR § 9792.9.5 (c):
 - a. Are communicated to the requesting provider within twenty-four (24) hours of the decision by telephone, facsimile, or electronic encrypted mail.
 - b. If the initial determination was made telephonically, written notification to the requesting provider is issued within twenty-four (24) hours of the decision with a copy of the notification sent to the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, within twenty-four (24) hours of the decision for Concurrent Review and within two (2) business days for



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Prospective review, and for Expedited Review within seventy-two (72) hours of receipt of the request when initial notification occurs telephonically

- c. Determinations sent via facsimile or electronic mail are considered written notification.
2. Retrospective Review decisions to deny part or all of the requested medical treatment are communicated in writing to the requesting provider who provided the medical services and to the injured worker who received the medical services, and his or her attorney/designee, if applicable, within thirty (30) days of receipt of information that is reasonably necessary to make this decision.
3. The written notification of a modified or denied treatment includes the following information specific to the request:
 - a. A unique ID number
 - b. The date the completed RFA was first received
 - c. The date UR decision was made
 - d. A description of the specific course of proposed medical treatment(s)/service(s) for which authorization was requested
 - e. A list of all medical records reviewed
 - f. A specific description of the medical treatment service approved, if any.
 - g. A clear, concise, and appropriate explanation in plain language of the reasons for the Physician Reviewer's decision, including the clinical reasons regarding medical necessity
 - h. Where the requesting physician has expressly opined that the prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician shall provide an explanation for why the requesting physician's explanation is insufficient.
 - i. A citation to and a description of the relevant medical criteria or guidelines used to reach the decision if based on medical necessity. If the entire guideline is not included, a copy is provided at no charge upon request.
 - j. URAC Accredited seal.
 - k. The Application for Independent Medical Review, DWC Form IMR, with all fields completed except for the signature of the injured worker and an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee, is also included
 - l. A clear statement advising the injured worker 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 UR decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.
 - m. The following mandatory language advising the injured worker:
 - i. "You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision (See attached application.). If you have questions about the information in this notice, please call 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."
 - ii. "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."
 - n. The name and specialty of the Physician Reviewer or Expert Reviewer, the telephone number in the United States of the Physician Reviewer or Expert Reviewer, the hours of availability of either the Physician Reviewer, the Expert Reviewer, or the medical director for the requesting physician to discuss the decision. If the reviewing physician who issued the modification or denial is not available, the Medical Director or another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services is available for the discussion.



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- o. A UR decision to modify or deny a RFA of medical treatment shall remain effective for 12 months from the date of the decision without further action by the Claims Administrator with regard to any further recommendation by the same physician for the same treatment unless further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.
- p. If a UR decision to modify or deny a medical service is due to incomplete or insufficient information, the written notification of denial will include the reason for the decision, a specific description of the information necessary to conduct the review, the date and time of each attempt to contact the requesting provider, a description of the manner in which the request was communicated, and a toll-free facsimile and telephone number to provide the information. The notification will include a statement indicating that the request will be reconsidered and a complete review will be conducted upon receipt of the information.

9 Reconsiderations and Disputes

- A. P&S does not offer a formal internal appeals process.
- B. P&S does offer a reconsideration process after a modification or denial has been issued. Reconsideration is conducted when:
 - a. A requesting provider has requested a peer-to-peer discussion with the reviewing physician in compliance with 8 CCR § 9792.9.5 (e)(14)
 - b. Additional medical information specified in the determination is received in compliance with § 9792.9.5 (e)(7)(A).
- C. Reconsideration should be requested within 10 calendar days of receipt of a modified or denied UR determination; requests received after 10 calendar days will be processed as a new RFA.
- D. Reviewing physicians are available a minimum of four (4) hours per week during normal business hours, 9:00 a.m. to 5:30 p.m. Pacific Time, to discuss modified and denied decisions with requesting providers.
- E. If the reviewing physician who issued the modification or denial is not available, the Medical Director or another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services is available for the discussion.
- F. If the reconsideration determination results in an approval of the previously modified or denied treatment, an authorization letter is sent pursuant to 8 CCR § 9792.9.4.
- G. If the reconsideration determination results in a modification of the previously modified or denied treatment, a modification letter is sent pursuant to 8 CCR § 9792.9.5 and a new IMR form is generated if applicable.
- H. If the reconsideration determination results in a denial of the previously modified or denied treatment, a denial letter is sent pursuant to 8 CCR § 9792.9.5. A new IMR form is not generated since there is no change from the original determination and IMR issued at that time.
- I. Independent Medical Review (IMR) is used to resolve disputes regarding medical necessity determination issued in the UR process in accordance with the Independent Medical Review (IMR) provisions of Labor Code sections 4610.5 and 4610.6.
- J. A RFA is processed through UR to confirm if the treatment requested is medically necessary. If UR denies or modifies a requesting provider's medical treatment request, the injured worker can request a review of the decision through the IMR process within the timeframe indicated on the last page of the application. When P&S issues a modification or denial, P&S will
 - 1. Send the injured worker a copy of the UR decision letter and the supporting documentation by the Physician Reviewer.
 - 2. Include a DWC IMR form (IMR) with all fields completed (except for the injured worker signature)
 - 3. Indicate type of review on the application, either expedited (EXP) or regular (REG) and check if any of the special circumstances apply:
 - a. Medication Only – MTUS Formulary Durg
 - b. Retrospective for Exempt Treatment (Non-Drug)
 - c. Retrospective for Exempt Treatment (Drug)
 - 4. Include the WCIS number (also known as the JCN) if known
 - 5. Indicate whether liability is being disputed
 - 6. Include a self-addressed envelope with the DWC-IMR's address.
- K. P&S client claims administrators are responsible to respond to requests for medical records in response to receipt of a Notice of Assignment and Request for Medical Records.
- L. Upon receipt of an IMR determination that approves all or part of a RFA, either the client claims administrator or P&S will issue an authorization letter compliant with § 9792.9.4 (a)(1)(b)(c).

10 Operations & Quality Management

- A. P&S utilizes a customized system to house all data and medical information collected during the course of conducting review. The centralization of all data received allows access for all necessary staff. High-level assignment and log-on procedures ensure staff only see assigned cases and files. P&S does not store data on hard servers or on P&S premises.
- B. All UR data and information received during the course of conducting UR are stored in the electronic record and are not deleted for at least five years from the date of determination in compliance with 8 CCR § 9792.7 (n).
- C. Confidentiality of patient medical information and associated information collected during the review process is maintained with the highest level of rigor and integrity. All staff and affiliates are bound by the P&S confidentiality policy and are required to review and sign annually. All information is maintained in accordance with all federal, state and external accreditation agency requirements and regulations.
 - 1. Confidential information is not 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.
 - 2. Medical records and injured worker specific information is maintained in a secure area with access limited to essential personnel only. All medical records, documentation, and other written information are scanned into the system and later shredded onsite by an authorized vendor of P&S.
- D. P&S's Quality Management Program (QMP) is multi-faceted and designed to both identify potential and/or real quality concerns and issues and to implement expeditious resolution once identified and validated.
- E. The QMP program assesses work product to determine:
 - 1. Compliance with P&S policy and procedure
 - 2. Compliance with CA regulatory rules/regulations and URAC
 - 3. If timeframes for review were met
 - 4. If MTUS/proper evidence based guideline was selected and applied to the clinical picture under review
 - 5. If action/recommendation was supported in documentation
- F. Complaints are opportunities to improve P&S services and products. All P&S staff and affiliates are required to participate and cooperate with the Complaint Management Process. Complaints are reviewed and handled by a Manager and may be referred to the Medical Director as necessary. All complaints are reviewed in the quarterly Quality Management Committee (QMC)
- G. Quality Improvement Projects (QIP's) are implemented when P&S-wide recognition and change is needed to improve P&S products and services. The QMC approves and provides oversight for all QIP's.
- H. P&S's Quality Management Committee (QMC) is comprised of the Medical Director, Director, Operations, QA Analyst, Operations Manager, and the Credentialing & Compliance Coordinator.
- I. The role of QMC is to provide oversight and direction for all P&S products and services. The QMC meets at a minimum quarterly and also performs an annual assessment of P&S's programs which includes:
 - 1. Entire QM Program results and outcomes including QIP's
 - 2. Policy and procedure
 - 3. Complaints and IMR Data
 - 4. Key Performance Indicators (KPI) including pertinent statistical data
 - 5. Review of delegated entities services and outcomes if applicable
 - 6. Overall effectiveness of QM Program
 - 7. Review and approval of all evidence based medicine guidelines for use by Initial Clinical Reviewers.
- J. Delegation of any P&S products and services may be required for reasons including but not limited to geographic coverage, legal/regulatory compliance, and capacity. P&S maintains program responsibility for all delegated activities and conducts thorough due diligence prior to entering into an agreement. Ongoing oversight of delegated entities is the responsibility of the QMC.

11 Total Utilization Review Program

A. Introduction:

1. This policy establishes additional guidelines by which certain P&S client's contract with P&S to provide a Total Utilization Review (TURP) Program solution.
2. All TURP clients:
 - a. Delegate UR fully to P&S under the P&S CA UR Plan
 - b. Use the P&S Medical Director to provide oversight and supervision of the client's claim adjuster treatment request approvals (RFA responses).
3. Any exceptions to the standard P&S UR program for TURP clients will be noted within the TURP client specific program.
4. All approvals/authorizations issued under the TURP program are under the direction and oversight of the P&S Medical Director.

B. Adjuster and/or Non-Physician Reviewer Approval List

1. Each client determines their own list of services and/or procedures that can be approved by adjusters or non-physician reviewers upon receipt of RFA request for authorization.
2. Each client determines if they will participate in the Prior Authorization process where no RFA is required and will determine their own list of services or procedures that providers can treat without submission of an RFA.
3. The P&S Medical Director provides oversight and approval of any services/treatments that can be approved by adjusters with or without an RFA.

C. TURP Process

1. For P&S clients who choose the TURP program, the client claims administrator is responsible for notifying all parties how to contact P&S for TURP functions.
 - a. The client claims administrator can choose to have all RFA's go to P&S directly.
 - b. For clients that do not choose to have RFA's sent directly to P&S, the client shall maintain a twenty-four (24) hour voice mail system and incoming fax line to receive requests for authorization (RFA's) during and after normal business hours.
 - i. The claims administrators shall record a message on their voice mail providing P&S contact information including phone and fax numbers for inquiries during and after normal business hours.
 - ii. For these clients, as soon as the claims administrator receives a request for authorization, they shall immediately forward requests requiring UR to P&S for prompt processing.
2. For client claim administrators who choose to have all RFAs for request for authorization sent directly to P&S, the P&S Administrative Staff will contact the claim administrator to:
 - a. Verify compensability of the claim/body part prior to beginning the UR process.
 - b. Determine if the client claim administrator is to approve the RFA without UR.
 - c. Determine if the client claim administrator is to defer UR because of a liability issue or because the request was not submitted by an MPN provider.
3. P&S will send notifications in response to all received RFAs for request for authorization in accordance with the P&S client claim administrator direction and/or the results of the Utilization Review program
4. P&S Medical Director provides training for client claim administrators as well as oversight for all approval determinations made by the client claims administrators

D. Additional Letters

1. Additional Letters may be used at client claims administrator request



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12 UR Plus Program

A. Introduction:

1. This policy establishes additional guidelines by which certain P&S client's contract with P&S for certain components of the P&S CA UR program
2. All UR Plus clients:
 - a. Have their own CA UR Plan filed which outlines those services delegated to P&S
 - b. Are not URAC accredited
 - c. Contract with P&S to comply with the requirement that modifications and denials be issued by URAC WCUM accredited entities
 - d. Designate the P&S Medical Director as Medical Director of their CA UR Program
3. Any exceptions to the standard P&S UR program for UR Plus clients will be noted within the UR Plus client specific program.
4. All approvals/authorizations issued under a UR Plus program client are under the direction and oversight of the P&S Medical Director.

B. Adjuster and/or Non-Physician Reviewer Approval List

1. Each UR Plus client determines their own list of services and/or procedures that can be approved by adjusters or non-physician reviewers upon receipt of RFA request for authorization.
2. Each UR Plus client determines if they will participate in the Prior Authorization process where no RFA is required and will determine their own list of services or procedures that providers can treat without submission of an RFA.
3. The P&S Medical Director provides oversight and approval of any services/treatments that can be approved by adjusters with or without an RFA.

C. UR Plus Process

1. For P&S clients who choose the UR Plus program, the client claims administrator is responsible for referring RFA's for review where an approval was not issued
2. P&S will provide a Physician Review report for all referred RFA's
3. UR Plus clients issue their own UR determination letters in compliance with their filed CA UR Plans. The P&S Physician Review report is attached to the UR determination letter.
4. UR Plus clients are responsible to issue IMR's where applicable and to respond to IMR Notices of Assignment and Request for Information as well as for issuing approval letters upon receipt of an IMR overturn.
5. P&S Medical Director provides training for client claim administrators as well as oversight for all approval determinations made by the client claims administrators



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13 UR Limited Program

A. Introduction:

1. This policy establishes additional guidelines by which certain P&S client's contract with P&S for Physician Review only
2. All UR Limited clients:
 - a. Have their own CA UR Plan filed
 - b. Have their own URAC accreditation
 - c. Have their own Medical Director
 - d. Contract with P&S to provide Physician Review services only

B. UR Limited Process

1. For P&S clients who choose the UR Limited program, the client claims administrator is responsible for referring RFA's for review where an approval was not issued.
2. P&S will provide a Physician Review report for all referred RFA's.
3. UR Limited clients issue their own UR determination letters in compliance with their filed CA UR Plans.
4. UR Limited clients are responsible to issue IMR's where applicable and to respond to IMR Notices of Assignment and Request for Information as well as for issuing approval letters upon receipt of an IMR overturn.



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14 Notification & Communication Templates

- A. UR Approval/Authorization
- B. UR Modification
- C. UR Denial
- D. Reconsideration Approval
- E. Reconsideration Modification
- F. Reconsideration Upheld
- G. UR Request for Additional Information
- H. UR Denial for Lack of Medical Information
- I. UR Peer Clinical Review Report
- J. IMR