COMPALLIANCE UTILIZATION REVIEW PLAN

1010 E UNION ST, SUITE 203

PASADENA, CA 91106

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INTRODUCTION

CompAlliance's Mission Statement

- To assure that the injured or ill employee received the appropriate care from the appropriate provider in an expeditious fashion.
- CompAlliance strives to be a leader in medical/ disability cost containment solutions for our clients by providing flexible services to adapt to THEIR needs, not OURS.
- Our Goal is to excel in regulatory compliance, exceed best-practice standards and continue to choose the RIGHT people for the job.
- Our passion and integrity remain at the core of servicing our clients and remains the golden thread and the golden rule in our business practice.

The purpose of this utilization review plan, as noted in Labor Code Section 4610 and CCR § 9792.6.1 et seq of title 8 of the California code of regulations is to provide a UR process compliant with these laws that will ensure appropriate medical care for injured workers and consistent with evidence based medicine.

CompAlliance will amend this utilization review plan as appropriate with the changes that are adopted and incorporated in the regulations by the Administrative Director from time to time.

UTILIZATION REVIEW DEFINITIONS

"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.

"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.

"Concurrent Review" means utilization review conducted during an inpatient stay.

"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.

"Denial" means a decision by a physician reviewer that the requested treatment or service is is not authorized.

"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.

"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 workers' permanent ability to regain maximum function.

"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.

"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.

"Immediately" means within one business day.

"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.

"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.

"Medical Management" for the purposes of this UR plan means contacting treating providers to negotiate and prior-authorize appropriate treatment plans in order to expedite treatment for the injured worker and promote a safe and swift return to work.

"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.

"Medical Treatment Utilization Schedule (MTUS)" 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.

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

"Prior Authorization" means treatment provided by our Clients MPN Providers that do not need to go through Utilization Review. Clients exercising this option maintain their own lists of Prior Authorized Services.

"Prospective Review" means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the required medical services.

"Request for authorization" means a written request for a specific course of proposed medical treatment, pursuant to Labor Code section 4610(h). A request for authorization must be set forth on a "Request for Authorization for Medical Treatment (DWC Form RFA)," completed by a treating physician, as contained in

California Code of Regulations, title 8, section 9785.5. "Completed," for the purpose of this section and for purposes of investigations and penalties, means that information specific to the request has been provided by the requesting treating physician for all fields indicated on the DWC Form RFA. The form must be signed by the physician and may be mailed, faxed or e-mailed.

"Retrospective Review" means utilization review conducted after medical services have been provided, and for which approval has not already been given.

"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 reviewers' practice.

"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).

"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.

"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.

"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.

Medical Necessity:

The following describe what is considered “medically necessary or appropriate”. The procedure, test or service is:

- Necessary to cure or relieve the effects of the injury
- Safe and effective
- Consistent with the patient’s symptoms, diagnoses, condition or injury
- Likely to provide a clinically meaningful benefit
- Likely to produce the intended health result
- Likely to be more effective than more conservative or less costly services
- Provided not only as a convenience to the patient or the provider
- Represents a benefit that outweighs any risk
- Reasonably expected to diagnose, correct, cure, alleviate or prevent the worsening of illnesses or injuries
- Enables the patient to make reasonable progress in treatment
- Meets the prevailing standard for medical care as outlined in the MTUS or other accepted evidence-based guidelines [unless the treating physician has presented reasonable information to explain why the particular patient does need atypical, unexpected treatment.]

UR STANDARDS

Telephone Access:

Physicians may request authorization for health care services between the hours of 9AM and 5:30PM pacific standard time, through CompAlliance's telephone (626-585-1808) and facsimile access numbers (626-795-7150) on normal business days as defined in LC 4600.4 and civil code section 9.

After business hours, the voicemail will direct them to leave their request in a dedicated voicemail mailbox, or to fax their request to the CompAlliance fax number given in the voicemail directions – fax number 626-795-7150 may be used in the absence of a client-specific fax number.

CompAlliance's written Policy and Procedures governing the UR process are consistent with URAC and the State of California Utilization Review Regulations.

CompAlliance utilizes the recommended standards set forth in the MTUS. These guidelines shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker for the effects of his or her injury.

The UR plan is:

- Evaluated at least annually and updated when necessary.
- Includes involvement from actively practicing physicians in its development.
- May be disclosed by the employer to employees, physicians, and the public upon request. This plan is available to the general public on our web site: http://www.compalliance.com.
- Disclosed to the physician and the injured employee and their representative if used as the basis of a decision to modify deny services,

The criteria shall be consistent with the MTUS adopted on an ongoing basis.

Dependent upon our individual client directives for each client either the CompAlliance Nurse Consultant or the claims adjuster will be the first level of review on treatment requests. Any treatment request to be modified or denied will be transferred to a Reviewer or Expert Reviewer.

QUALITY ASSURANCE

Quality Management Program Overview:

Policy Statement:

CompAlliance is committed to providing quality services to its customers and consumers. As such, CompAlliance has identified key indicators of quality relevant to the scope of the organization, which will be tracked and trended to continuously assess quality products and services.

CompAlliance has dedicated specific staff members to oversee the metrics of this program. This committee is titled the Quality Management Committee. The Quality Management Committee (QMC) is responsible for approval of quality program operations.

The Director of Quality Assurance is granted authority for Quality Management by the organization's governing body at CompAlliance. The Director of Quality Assurance is responsible for the overall operation of the Quality Management Program and chairs the Quality Management Committee (QMC).

As part of the CompAlliance Quality Management Program, we provide written documentation of our objectives. CompAlliance documents performance measures relevant to access to services, complaints and satisfaction. These measures are quantifiable.

CompAlliance identifies and implements quality improvement projects (QIPs) and processes, which allow the organization to improve, maintain and ensure quality services for client organizations, providers and consumers.

Purpose and Scope:

The Quality Management program provides a framework to ensure alignment of business objectives, products and services delivery, and key performance

measures. It enables objective and systematic measurement and improvement of product, service, and process improvement.

Worker's compensation utilization reviews (UM) are the major service, and the framework includes supporting business processes and performance measures.

The program helps ensure that Utilization Management services are fair and consistent, problems are resolved in compliance with required timeframes, and there is appropriate and cost-effective use of healthcare resources.

The scope of the Quality Management program includes:

- Identifying business and quality/value objectives
- Establishing data collection, and data/process management, control, and reporting methods and systems
- Developing analysis and decision support tools, methods, and systems
- Developing annual program plans and activities that address objectives and regulatory standards/requirements, and Quality Management Committee oversight of activity status
- Establishing and maintaining a 'dashboard' of key performance measures
- Monitoring compliance with URAC and other regulatory requirements and initiating corrective actions to address deficiencies
- Analysis of results and identification of quality improvement projects (QIPs) or other actions to address gaps and initiate preventive improvements
- Deploying product, service, or process changes/improvements to applicable stakeholders

TREATMENT GUIDELINES

CompAlliance will utilize the Medical Treatment Utilization Schedule as defined in the Utilization Review Definitions.

For all conditions or injuries not covered by the MTUS, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based.

- Evaluated annually
- Disclosed to the treating physician and the injured employee
- Publicly available.

CompAlliance is utilizing other evidence based guidelines when appropriate or after the MTUS has been utilized as a first resource.

- Work Loss Data Institute Official Disability Guidelines (ODG)
- Reed Groups MD Guidelines (MDA)

PROGRAM CONFIGURATION

CompAlliance's Medical Director:

Gracia Goade, M.D. California License # G40760

Telephone: 626-585-1808

Address: 1010 E Union St. #203, Pasadena, Calif. 91106

Medical Director is responsible for the overall UR plan and ensures that the utilization review process is followed in accordance with this document. CompAlliance's medical director is a licensed physician who holds an unrestricted license to practice in California and is competent by his/her licensure and scope of practice to evaluate the specific clinical issues involved in medical treatment services.

The Medical Director oversees the Reviewers and Expert Reviewers and may be called upon for final UR decisions. He/She is ultimately responsible for the UR decisions.

He/She may also make the final decision when a request is to be transferred to a Specialty Panel Reviewer (Expert Reviewer).

CompAlliance's Reviewers and Expert Reviewers:

Reviewers and Expert Reviewers are defined in the list of definitions.

Specialty Panel (Expert Reviewers)

CompAlliance's specialty panel consists of Board Certified specialists in various disciplines. The Reviewer and/or the Medical Director will review a case before a case is referred to an Expert Reviewer for an appeal if deemed necessary or appropriate.

The Medical Director, Reviewers, Expert Reviewers are contracted health professionals that work off-site and provide UR services that are compliant with California law. Pursuant to 9792.9.1(e), and 9792.12(b0(4)(E), a reviewing

physician, expert reviewer, or the Medical Director, are available during CompAlliance's business hours, 9:00am through 5:30pm.

Nurse Consultant(s):

CompAlliance's Nurse Consultants are Registered Nurses currently licensed in the state in which they are stationed to complete reviews.

Nurse Consultants work either on-site at CompAlliance headquarters or off-site and provide first level utilization review and utilization management services dependent upon client directives.

This first level review will be completed within appropriate timeframes in the event that the case will need to be transferred to a Reviewer or Expert Reviewer. They will assess the medical information and request additional medical information as necessary within timeframes.

They may approve the request based on the clinical information given and appropriate guidelines.

Dependent upon client directives, the UR program may enhance its Utilization Review to include communication with providers of care and facilities along with specific client personnel to enhance the program for pro-active medical management (treatments monitored, agreed upon between all parties and performed without the UR process as defined) and return to work and transitional care alternatives consistent with guidelines and cost-efficiency and safety for the injured worker.

UTILIZATION REVIEW PROCESS

The CompAlliance Nurse Consultant performs the initial first level assessment for utilization unless client directives state that the claims adjuster or technician will perform the first level of review. The nurse may recommend an approval based on their assessment of the medical information received or upon further discussion with the requesting provider when appropriate and guidelines are met. The Nurse Consultant may request additional information needed to make a decision within timeframes laid out by the regulations. The nurse does not deny or modify treatment requests.

Referrals:

Referrals for UR treatment review must be in written form and are accepted electronically, by fax, or by mail. Requests for treatment must be set forth on form DWC RFA and must be accompanied by a Doctors First Report, PR-2, or Narrative Report substantiating the need the Requested Treatment.

According to the individual client directives, the claims adjuster or UR technician may authorize limited procedures for common conditions and will review the initial medical information for incomplete records. If they feel that additional information is necessary to complete a UR review, they *will notify the provider that the request is incomplete, stating why the request was incomplete and that a new RFA with the missing information must be submitted (as per L.C. 9792.9.1(c)(2)(A)),* keeping within regulatory timeframes and statutes.

Per LC 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 Section 4600, within the

30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. For treatment rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer-selected physician, the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.

(c) Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

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

Any request that cannot be authorized by Claims will be referred to CompAlliance for review and potentially to a CompAlliance Reviewer or Expert Reviewer if appropriate.

For those clients that have their own MPN, they will work within their contractual boundaries which may include that treatment requests do not have to be referred for authorization if they comply with the MTUS and/or that they may have limited authority to provide specific services without the need to submit requests for pre-authorization through utilization review.

Initial review (for UR request referred to CompAlliance):

If, upon receipt of a UR Referral from our client, the Nurse (or Physician) reviewer determines that the request is incomplete, because the request was not accompanied by documentation substantiating the medical necessity for the requested treatment, the nurse (or Physician) will return the RFA to the provider, within 5 business days, as an incomplete request using the following verbiage and indicating why the request was incomplete.

> *We are returning your Request for Authorization (RFA) of Treatment of [--- Date ---] because it is INCOMPLETE.*
>
> *In order to expedite the review of your requested treatment, please resubmit your request with the missing documentation, no later than [--- Date ---]. Please assure that your new request is accompanied by appropriate medical records, including documentation addressing the following:*
>
> > *The nurse would insert, in this space, what is missing from the incomplete RFA ---- SAMPLE LANGUAGE: "A report with the objective findings of the most recent Exams, Results of Diagnostic Tests, Radiology Reports, goals of requested treatment"*
>
> *Per Labor Code sections §9785(g) (Reporting Duties of the Primary Treating Physician.), "The DWC Form RFA must include as an attachment documentation substantiating the need for requested treatment."*
>
> *As per Labor Code §9792.9.1(c)(2)(A), we are returning your Request for Authorization to you as INCOMPLETE, and you must submit a new RFA with the missing documentation in order for your request to be considered by Utilization Review.*
>
> *When we have received a complete request with the documentation substantiating the need for the requested treatment, we will begin the Utilization Review process as per Labor Code §9792.9.1.*

The Nurse Consultant will perform the initial medical review of the information received (when attached with the treatment request); that should include an initial

evaluation, diagnosis and treatment provided along with a treatment plan. The Nurse Consultant will assess if the reasonable information necessary to make a recommendation is missing and if so, send a request for information notice to the requesting physician defining what information is missing, keeping timeframes per regulations under consideration.

Documentation of Decisions:

Any Activity and decision undertaken by Nurse Consultants and Reviewers/ Expert Reviewers are always clearly documented in CompAlliance's medical management software, the client's software program or hardcopy when the client does not possess a system.

Approvals:

Upon review of the available information the Nurse Consultant may approve the treatment request if clinically appropriate and guidelines are met. Approval notices will follow UR regulations.

Approval notification is given to the claim's payer so that the claim's payor may appropriately reimburse for the specified course of medical treatments that were approved by CompAlliance.

Modify, Denials: (only made by a CompAlliance Reviewer, Expert Reviewer or the Medical Director)

All modifications and denials will include the Reviewer's or Expert Reviewer's license number, contact information and hours of availability. Modify and Deny notices will follow UR regulations and are outlined below.

Withdraws:

At the request of the claims adjuster or the requesting provider and when deemed appropriate for the particular circumstances, a treatment request may be withdrawn from the utilization review process. Regulatory compliance will be adhered to within the scope of a UR withdraw request.

DECISION TIMEFRAMES

Decisions are made timely after a receipt of the information necessary in order to make a recommendation. Timeframes are dependent upon the type of UR being performed.

Request for Additional Information:

When a request for authorization is received that requires additional information in order to make a determination, CompAlliance will fax a "request for information letter" to the provider that will outline the additional information needed in order to complete the review. This letter will be faxed to the requesting provider within 5 days of the initial request for authorization and in no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization by the requesting physician.

If the requesting physician does not submit the requested information within 14 days of the date of the original written request, then CompAlliance shall forward the referral to a Reviewer or Expert Reviewer who may deny the request for lack of information, and will note that the request will be reconsidered upon receipt of the information requested. The reconsideration will be completed within 5 days of receipt of that information necessary to make a decision on the requested medical treatment.

Time Extension:

The claims administrator or Nurse Consultant may extend the regulatory timeframes under the following circumstance:

A) Is not in receipt of all the necessary medical information reasonably requested,

Or a Reviewer may extend the timeframe under the circumstances:

B) Needs a specialized consultation and review of medical information by an Expert Reviewer.

C) 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.

If any of the circumstances set forth in subdivisions (f)(1)(B) or (C) are deemed to apply following the receipt of a DWC Form RFA or accepted request for authorization, the reviewer shall within five (5) business days from the date of receipt of the request for authorization notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered.

The notice shall include a statement that if the injured worker believes that a bona fide dispute exists relating to his or her entitlement to medical treatment, the injured worker or the injured worker’s attorney may file and Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, in accordance with sections 10136 (b) (1), 10400, and 10408.

The non-physician provider of goods or services identified in the requested for authorization and for who contact information has been included, shall be notified in writing of the decision to extend the timeframe and the anticipated date on which the decision will be rendered in accordance with the subdivision. The written notification shall not include the rational, criteria or guidelines used for the decision.

If the information reasonably necessary to make a determination that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

If the results of the additional examination or test required, or the specialized consultation, that is requested by the reviewer is not received within thirty (30) days from the date of the request for authorization, the reviewer shall deny the treating physician's request with the stated condition that the request will be reconsidered upon receipt of the results of the additional examination or test or the specialized consultation.

Whenever a reviewer issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the claims administrator's file must document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail.

Upon receipt of the information or the report by the expert reviewer, the claims administrator shall make the decision to approve, or refer it to CompAlliance and/or the reviewer shall make a decision to modify, or deny the request within 5 working days of receipt of the information for prospective or concurrent review, unless the request is an expedited review in which case a decision will be made within 72 hours, and within 30 days of retrospective review.

Prospective and Concurrent Reviews:

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

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.

Expedited Reviews:

Prospective or concurrent decisions related to an expedited review (as noted in the definitions) shall be made in a timely fashion appropriate to the injured workers condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician should indicate the need for an expedited review upon submission of the request.

Emergency healthcare services that have not requested authorization may be subject to retrospective review, pursuant to 9792.9.1(e)(2).

Retrospective Reviews:

Retrospective decisions to approve, modify, or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination.

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 request for authorization and medical information that is reasonably necessary to make a determination.

Communication and Notification Requirements:

Approvals-

For all review types, a decision to approve the treatment request will be phoned or faxed to the requesting physician within **24 hours** of the decision. When phoned, the decision will be followed by written notice to the requesting physician within 24 hours of the decision for concurrent reviews and two (2) business days for prospective review.

Approval notification is given to the claim's payer so that they may appropriately reimburse for the specified course of medical treatments that were approved.

Negotiated Treatment-

When the Nurse Consultant has a dialogue with the requesting physician and they agree upon a revised treatment plan, the requesting provider will be asked to submit a signed amended treatment request based upon the agreed upon plan. The new treatment request will then be treated as an "approval" following approval timeframes and communication policy as noted in this plan.

Modification-

When a Reviewer or Expert Reviewer makes a modification to a treatment request, the decision shall be communicated to the requesting physician initially by phone or fax. If by phone, a letter will be sent within 24 hours for concurrent and within two (2) business days of the decision for prospective.

The letter shall include:

- The date on which the RFA was first received
- The date on which the decision was made.
- Description of the specific course of proposed medical treatment for which authorization was requested.
- A list of the medical records reviewed
- A specific description of the medical treatment service approved, if any.
- A clear and concise explanation of the reasons for the claims administrators' decision.
- Clinical reasons regarding medical necessity.
- The completed IMR application
- Will be copied to the injured worker and their attorney if applicable
- Please see "Denial" section below for all language that will be included in the letter pursuant to § 9792.9.1(e)(5)

The Non-physician provider of goods or services for whom contact information has been included, shall be notified in writing of any decision to modify the treatment request but shall not include the rational, criteria or guidelines used for the decision.

Denial-

When a Reviewer or Expert Reviewer denies a treatment request, the decision shall be communicated to the requesting physician initially by phone or fax. If by phone, a letter will be sent within 24 hours for concurrent and within two (2) business days of the decision for prospective.

The letter shall include:

- The date on which the RFA was first received
- The date on which the decision was made.
- Description of the specific course of proposed medical treatment for which authorization was requested.
- A list of the medical records reviewed
- A specific description of the medical treatment service approved, if any.
- A clear and concise explanation of the reasons for the reviewing physician's decision including:
    - Clinical reasons regarding medical necessity.
    - a description of the relevant medical criteria or guidelines used to reach the decision
    - If a utilization review decision 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.
- 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 hours of availability of either the reviewer, the expert reviewer or the medical director for the treating physician to discuss the decision.
- The completed IMR application
- The denial letter will be sent to the injured work and their attorney if applicable
- The letter will also include language as set forth in the regulations:

> "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 within 10 days after the service of the utilization review decision to the employee for formulary disputes, and within 30 days after the utilization review decision to the employee for all other medical treatment disputes.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

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.

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

- Details about the claims administrators' internal utilization review appeal process for the requesting physician, if any, and a clear statement that the appeals process is on a voluntary basis, including the following mandatory statement:

  To the Physician: If you disagree with this decision and/or have additional information that was not available at the time of this review and desire to initiate a re-consideration, contact CompAlliance Associates, Inc. at 1010 E Union St. #203, Pasadena, Calif. 91106. Any additional information will be reviewed, and if necessary sent to a Physician Reviewer for reconsideration according to CompAlliance's Utilization Review appeals process. This appeals process is optional, and must be initiated within ten (10) days of the determination. It 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 optionally be pursued before proceeding to the Independent Medical Review.

Non-physician provider of goods or services for whom contact information has been included, shall be notified in writing of any decision to modify the treatment request but shall not include the rational, criteria or guidelines used for the decision.

DISPUTE PROCESS

UR reconsiderations and Voluntary Appeals:

Reconsiderations of a treatment request are considered a "reconsideration" when additional information which had been previously requested is received for review. This information may be reviewed by the Nurse Consultant and approved if it meets guidelines. If the additional information received does not meet guidelines it will be referred to the Reviewer (which may be the same physician who denied the original treatment request due to lack of information.)

An appeal is when an original treatment request was denied on something other than lack of information. An appeal will go to a Reviewer who did not deny the first request and may be an Expert Reviewer dependent upon the case and the medical director's discretion. This voluntary internal appeal process neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, and may be pursued on an optional basis.

An appeal may be requested by an injured worker, or their attorney, the requesting physician or the facility in writing within 10 days of receipt of the UR review decision, pursuant to 9792.10.1. The 10 day time limit may be extended for good cause or by agreement of the parties.

If a previously appealed treatment request is still disputed after this voluntary internal appeal process, the dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6, which state 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 days after the utilization review decision to the employee for all other medical treatment disputes.

Utilization Review Appeal Process:

An appeal must be in writing and received within 10 days of the receipt of the utilization review decision and should be prominently displayed “UR Appeal” and include a copy of the specific UR decision that is being appealed.

There will be documentation of peer to peer contact or attempts thereof.

If an appeal is received based on a prior denial for lack of information with no new information attached, a notice will be sent stating that “A Notice has previously been sent regarding to this request for authorization, no further notices shall be sent.”

Utilization Review Dispute Resolution:

A clear statement that any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6, which state 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 days after the utilization review decision to the employee for all other medical treatment disputes.

Included will be the following mandatory language:

> “You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster’s 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.”

In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

Details about the claims administrator's internal utilization review appeals process, if any, and a clear statement that the appeals process is on a voluntary basis, including the following mandatory statement:

> "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 days after the utilization review decision to the employee for all other medical treatment disputes."

The written decision to modify or deny 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 hours per week during normal business hours, 9:00Am to 5:30 PM, 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.

If authorization is denied on the basis of lack of information, there will be documentation reflecting an attempt to obtain the necessary information from the requesting provider or from the provider of goods or services identified in the request for authorization either by facsimile or mail.

Within a client's MPN if the employee disputes the diagnosis or treatment of the treating physician, the dispute will be resolved in accordance with Labor code 4616.3 (c). These disputes are not considered UR disputes.

FINANCIAL INCENTIVES POLICY

In our Utilization Review Operations there is no bonus structure, salary increase or monetary reimbursement offered based on the results or cost effectiveness of the reviews. In addition, CompAlliance offers no incentives for the number or frequency of reviews completed by nurse and physician and specialty reviewers. Denials or approvals are to be based on clinical rationale and the consumers' best interests. Denial rates have no bearing on the remuneration of reviewer.

CONFIDENTIALITY

CompAlliance provides for data confidentiality and security of information systems by implementing written policies that address potential risks and vulnerabilities to the confidentiality, integrity and availability of our information systems, prevention of confidentiality and security breaches and detection, and containment and correction of confidentiality and security violations.

CompAlliance has written policy and procedures to protect the confidentiality of individually identifiable health information.

DISCLOSURE

CompAlliance hereby certifies that the information and material contained in this utilization management plan is true and accurate to the best of their knowledge pursuant to Labor Code section 4610 and 8 CCR § 9792.6.1 and 9792.9.1.

The utilization management plan is subject to amendments, and it will be disclosed to the public upon request to the claim's administrator. CompAlliance may charge members of the public reasonable copying and postage expenses related to disclosing the complete utilization plan.


VP of Operations

Signature of authorized CompAlliance Representative Date 5/19/2020

Signature of Medical Director (CompAlliance) Date 5/19/2020

CA Medical License Number: **G40760**