California Workers' Compensation Utilization Review Plan

Medata LLC

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1. Company Introduction

Medata is the premier provider of cost management software and service solutions for insurance carriers, self-insured companies, third-party administrators, state funds and public entities in the workers' compensation and auto liability industries. At the heart of Medata is technology and relationships – our vision is to deliver innovative cost management products and build strong relationships with our employees, clients and partners. Medata's solution combines document management, utilization review, bill review, fee negotiation, payment processing, state reporting and more, all in one platform.

Our Story

Medata incorporated in 1975 as a company specializing in the field of medical cost management for the workers' compensation community. Founder, Constantine Callas, M.D., a physician and computer product visionary, developed software that automated medical bill review and made possible a product that remains at the heart of cost management strategies today.

After more than 50 years as the leader in the industry, Medata continues to represent the principles the company was founded on by delivering innovative products and building strong relationships with our employees, clients and partners.

Medata prides itself on its experience and leadership in the workers' compensation and auto liability industries and is dedicated to offering solutions to meet today's needs and tomorrow's demands.

2. Standard Definitions – 8 CCR §9792.6.1

Medata utilizes standard definitions as described in Chapter 4.5. Division of Workers' Compensation, Subchapter 1. Administrative Director--Administrative Rules, Article 5.5.1. Utilization Review Standards - §9792.6.1

a. "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed "Request for Authorization," as defined in this section, 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, sections 9792.9.1 through 9792.12.

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

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

d. "Course of treatment" means the course of medical treatment set forth in the treatment plan contained on the "Doctor's First Report of Occupational Injury or Illness," Form DIR 5021, found at California Code of Regulations, title 8, section 14006.1, or on the applicable physician reporting forms authorized by section 9785.

e. Reserved.

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

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

h. "Disputed medical treatment" means medical treatment that has been modified, or denied by a utilization review decision.

i. “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.

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

k. “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, whose consultation for a specialized review has been requested by the claims administrator or utilization review organization, necessitating an extension of time, under section 9792.9.6, prior to the determination of medical necessity.

l. “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.

m. “Immediately” means within one business day.

n. “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 or changes its medical director, address, company name or corporate structure.

o. “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.

p. “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.

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

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

s. "MTUS Drug Formulary" means the drug formulary adopted by the Administrative Director under Labor Code section 5307.27 and defined in section 9792.27.1(m). The MTUS Drug Formulary contains the MTUS Drug List, which is set forth in section 9792.27.15.

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

u. “Request for authorization” means a written request for a specific course of proposed medical treatment that meets all of the following criteria:

   i. Unless accepted by a claims administrator under section 9792.9.1(b), a request for authorization must be set forth on a “Request for Authorization (DWC Form RFA),” as contained in California Code of Regulations (CCR), title 8, section 9785.5, completed by a treating physician and as further outlined in the subdivision and in section 9785(h).

   ii. “Completed,” for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization identifies both the employee and the requesting provider, identifies with specificity all the recommended treatments in the designated section for requests of authorization if a form is used, or, on the first page if a narrative report is used; and is accompanied by documentation, issued or created no earlier than 30 days before the date of submission of the request for authorization, that substantiates the need for the requested treatment. A request for authorization shall be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.6,

   iii. The request for authorization must be signed by the treating physician and may be mailed, faxed or, if available, sent electronically through the use of an encrypted email system or via electronic data interchange (EDI) to the address, fax number, e-mail address, or clearinghouse designated by the claims administrator under section 9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

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

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

   i. “Non-physician reviewer” means an individual designated by the claims administrator or utilization review organization to assist in determining the medical necessity of the requested treatment. A non-physician reviewer may not modify or deny a treatment request.

x. "URAC" is the non-profit organization, located at 1220 L Street, NW, Suite 900, Washington, D.C., 20005, or as indicated online at www.urac.org, that provides accreditation for workers' compensation utilization review programs.

y. "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).

z. "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.

aa. "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 a completed request for authorization, or a request for authorization accepted as complete under section 9792.9.1(b), 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.

bb. "Written" includes a communication transmitted by facsimile or in paper form. Electronic mail or electronic data interchange (EDI) may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail or by EDI, unless sent through the use of an encrypted electronic mail or EDI system.

cc. "Normal business day" or "business day" does not include Saturday, Sunday, or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website.

dd. "Working day" as used in this article is the same as "business day" or "normal business day."

3. Program Overview – 8 CCR §9792.7(a) (5)

Medata performs Utilization Review (UR) in the state of California as a service to our managed care clients. The services performed are based upon client-specific account protocols and the delegation of specific claims and services. Our clients and their Third-Party Administrators may establish a prior authorization program for certain treatment requests based on the client's established criteria. Once client-specific requirements are established, Medata shall submit these as addendums to our CA UR Plan preserving documented CA protocols.

Medata UR program abides by the UR process governed by CA Labor Code section 4610 and regulations written by the CA Division of Workers' Compensation (DWC), which lay out timeframes and other rules for conducting UR. The rules, contained in Title 8, California Code of Regulations, sections 9792.6 et seq, also require approved UR plans to be filed with the DWC administrative director, which also identifies the claims administrator client(s) on whose behalf it performs any utilization review functions. Medata's Utilization Review Processes ensure compliance with the DWC Rules and Regulations.

Medata maintains proof of accreditation through the Workers' Compensation Utilization Management Accreditation program administered by URAC.[1]

Medata shall submit with our plan a completed DWC Form UR-01, "Utilization Review Plan Application or Modification," set forth in section 9792.7.1, with an original signature by the medical director. The utilization review plan shall be submitted in compact discs or flash drives, or other electronic format agreed to by the Administrative Director and the applicant, in word-searchable PDF format. The hard copy of the completed, signed original shall be maintained by the applicant and made available for review by the Administrative Director upon request.[2]

Medata releases URAC from any obligation it may have, contractual or other, regarding nondisclosure of any of its files relating to the utilization review plan's accreditation or audits with URAC. Accordingly, the Division of Workers' Compensation may obtain such documents from URAC for the purpose of ensuring or enforcing compliance with the rules governing utilization review at sections 9792.6.1 through 9792.12.[3]

Program Policy

The entirety of the Medata UR policies and procedures and resultant UR processes are designed and implemented to be in full compliance with the entirety of the California UR rules and regulations.

UR is a collaborative process to promote quality outcomes, which enhance the physical, psychosocial, and vocational health of individuals. The process follows mandates per SB1160 and the California Labor Code section 4610. Medata's UR Program applies and provides technical knowledge and experience to the field of utilization review to assess the medical necessity of provider requests for services. Criteria used in the utilization review process shall be consistent with MTUS/ACOEM Practice Guidelines

[1] 8 CCR §9792.7(a)(6)
[2] 8 CCR §9792.7(c)(2)
[3] 8 CCR §9792.7(c)(3)

presumed correct on the issue of extent and scope of medical treatment per California statute and is referenced for decisions of medical necessity. For all conditions not addressed by the MTUS/ACOEM Practice Guidelines, Medata UR employs the use of and authorizes treatment in accordance with other evidence-based medical treatment guidelines that are generally recognized by the medical community and are scientifically based including, but not limited to, Official Disability Guidelines (ODG.)

Medata will make available the complete UR plan, consisting of the policies and procedures and a description of the UR process, through electronic means. If a member of the public requests a hard copy of the UR plan, we may charge reasonable copying and postage expenses related to disclosing the complete UR plan. Such charge will not exceed $0.25 per page plus actual postage costs.[4]

Files and other records, whether electronic or paper, that pertain to the utilization review process shall be retained for at least three (3) years following either: (1) the most recent utilization review decision for each injured employee, or (2) the date on which any appeal from the assessment of penalties for violations of Labor Code section 4610 or sections 9792.6 through 9792.12 is final, whichever date is later.[5]

Hours of Operation

Medata will maintain telephone access and have a representative personally available by telephone at (855) 445-0306 from 9:00 AM to 5:30 PM Pacific Time on business days for health care providers to request authorization for medical services. Medata will have a facsimile number, (877) 201-5336 and email address, MedataUR@medata.com available for physicians to request authorization for medical services. Medata maintains a process to receive communications from health care providers requesting authorization for medical services after business hours. This requirement is satisfied by maintaining a voice mail system or a facsimile number, or a designated email address for after business hours requests.[6]

Medical Director – 8 CCR § 9792.7 (a) (1)

Medata's Medical Director is Dr. Dorian Kenleigh, M.D., Board Certified in Occupational Medicine.

Dr. Kenleigh is responsible for decisions made in our CA utilization review process.

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American Board of Preventive Medicine, Occupational and Environmental Medicine

[4] 8 CCR §9792.7(m)
[5] 8 CCR §9792.7(n)
[6] 8 CCR §9792.9.1(a)(3)

Executive Oversight

Medata's Executive Oversight consists of delegates from medicine, technology, jurisdictional experts, operations, and human resources. All committee members report directly to the Chief Executive Officer. These delegates ensure the highest standards are applied throughout all of Medata's products and processes.

Utilization Review Staff – 8 CCR §9792.7

Medata's Utilization Review Plan was developed, and is maintained and updated, by the Medical Director in conjunction with the Executive Oversight Committee.

Sr. Director of Clinical Services - Qualification and Functions

Medata's Sr. Director of Clinical Services is a Registered Nurse (RN) and supervises the Initial Clinical Reviewers (Non-physician reviewers).

Initial Clinical Reviewers (Non-physican reviewers) - Qualification and Functions

Medata's Initial Clinical Reviewers qualifications include: a health profession degree, current license or certification to practice a health profession.

Review clinical documentation and apply clinical review criteria, approved by the Medical Director and Executive Oversight Committee, to the request for authorization. Reviewers may issue certifications if the request for authorization matches the clinical review criteria and is medically necessary. Initial Clinical Reviewers that are Registered Nurses may not process non-certifications but forward all reviews for which they are not recommending certification, to a Clinical Peer Reviewer (physician reviewer). Initial Clinical Reviewers may request additional clinical information, which they deem reasonable and necessary to complete UR, from the provider via fax, phone, mail or email.

Clinical Peer (Expert Reviewer) - Qualification and Functions

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

Clinical Peer Reviewers perform second review on requests for authorization, reconsiderations, or appeals consideration. They review the clinical documentation and apply clinical review criteria, approved by the Medical Director, to the request for authorization. Clinical Peer Reviewers issue determinations of medical necessity that comply with all CA regulations. Clinical Peer Reviewers may request additional clinical information, which they deem reasonable and necessary to complete UR, from the provider via fax, phone, mail or email.

Non-Clinical Administrative Staff - Qualification and Functions

The general qualifications of the Non-Clinical Administrative Staff include experience in administrative or customer service, or an equivalent combination of education and experience. The Non-Clinical

Administrative Staff are responsible for providing administrative support for processes within UR and for performing customer service for the various stakeholders in the UR process.

Quality Management

Medata's Quality Management Program consists of a committee of delegates from medicine, compliance, and operations. All committee members report directly to the Medical Director. These delegates ensure the highest standards are applied to Medata's UR program. On a monthly basis, a sample of medical treatment requests is audited to ensure regulatory compliance, proper application of medical treatment guidelines and determination, as well as adherence to company procedures.

The Committee will monitor quality improvement initiatives and evaluate the UR program annually.

4. Treatment Guidelines/ Clinical Review Criteria – 8 CCR §9792.7(a)(3)

The Medical Treatment Utilization Schedule (MTUS) provides medical treatment guidelines for UR and an analytical framework for the evaluation and treatment of injured workers.

The MTUS is promulgated by the DWC administrative director under Labor Code sections 5307.27 and 4604.5, and can be found in sections 9792.20 et seq. of Title 8, California Code of Regulations. The recommended guidelines set forth in the MTUS are presumptively correct on the issue of extent and scope of medical treatment. MTUS constitutes the standard for the provision of medical are in accordance with LC §4600 for all injured worker's diagnosis with industrial conditions because it previews a framework for the most effective treatment of work-related illness or injury to achieve functional improvement, return-to-work, and disability prevention. MTUS is the primary source of guidance for physician reviewers for the evaluation of treatment of injured workers.[7]

Medata will not deny treatment on the sole basis that the treatment is not addressed by MTUS.

Medata's reviewing physicians follow the medical evidence search sequence required by in 8 CCR §9792.21.1 for the evaluation and treatment of injured workers. The search sequence includes:[8]

- Search the recommended guidelines set forth in the current MTUS to find a recommendation applicable to the injured workers' medical condition or injury. In situations where a medical condition or injury is not addressed by the MTUS or if MTUS' presumption of correctness is being challenged, then:
- Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury and choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1. If no applicable recommendation is found, or if the treating or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then;
- Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury and choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1. If no applicable recommendation is found within guidelines that are recognized by the national medical community, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then;
- Search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury and choose the recommendation that is supported

[7] 8 CCR §9792.21(c)
[8] 8 CCR §9792.21.1(a)

with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1.

Guidelines used in the UR process to determine whether to approve, modify, or deny medical treatment services are developed with involvement from actively practicing physicians. These guidelines must be consistent with the MTUS, including the drug formulary adopted pursuant to Cal. Lab. Code § 5307.27, and including the methodology for evaluating medical evidence under section 9792.25.1. These guidelines are evaluated annually and updated, if necessary. [9]

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

The current clinical review criteria utilized are:

- The State of California 8 CCR 9792.21 Medical Treatment Utilization Schedule (MTUS). https://www.dir.ca.gov/t8/ch4_5sb1a5_5_2.html
- American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, current edition, available through the Reed Group's MDGuidelines http://mdguidelines.com.
- The Official Disability Guidelines published by MCGHealth. https://www.mcg.com/odg (current edition).
- Any current treatment guideline issued by the American Academy of Orthopedic Surgeons (AAOS) http://www.orthoguidelines.org/
- Any current guideline issued by the American Academy of Neurology (AAN) https://www.aan.com/policy-and-guidelines/guidelines/ Any current guideline issued by the American Academy of Pain Medicine: https://painmed.org/clinical-guidelines/
- Current edition of the American Geriatrics Society Beers Criteria for potentially inappropriate medication use in older adults https://geriatricscareonline.org/ProductAbstract/american-geriatrics-society-updated-beers-criteria-for-potentially-inappropriate-medication-use-in-older-adults/CL001
- Current edition of the Appropriateness Criteria published by the American College of Radiology (ACR) https://www.acr.org/Clinical-Resources/ACR-Appropriateness-Criteria
- Any current guideline issued by the North American Spine Society https://www.spine.org/shop?category=11
- Any current guideline issued by the American Psychiatric Association https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines
- Any current guideline issued by the American Association of Physical Medicine and Rehabilitation https://www.aapmr.org/quality-practice/clinical-practice-guidelines
- Any current guideline issued by the American Physical Therapy Association http://www.apta.org/evidenceresearch/ebptools/cpgs/
- Opioid Treatments for Chronic Pain https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/protocol

[9] 8 CCR §9792.8(a)(1)

- Non-opioid Pharmacologic Treatments for Chronic Pain https://effectivehealthcare.ahrq.gov/products/nonopioid-chronic-pain/protocol
- Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review Update https://effectivehealthcare.ahrq.gov/products/nonpharma-treatment-pain/research-2018
- US Department of Health and Human Services: Pain Management Best Practices: https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf
- AAFP/ACP joint Guideline: Nonpharmacologic and Pharmacologic Management of Acute Pain From Non–Low Back, Musculoskeletal Injuries in Adults: https://www.acpjournals.org/doi/10.7326/M19-3602

Where published guidelines do not exist or do not address the procedure or treatments requested, reviewers will rely on the best available published scientific evidence, and are expected to consult current medical literature available from the National Library of Medicine (PubMed) https://www.ncbi.nlm.nih.gov/pubmed/, current authoritative specialty textbooks and the Cochrane Library https://www.cochranelibrary.com/

If the request for authorization is being modified or denied, then the Medata reviewing physician will provide a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury. The citation provided will be the primary source relied upon and if the reviewing physician provides more than one citation, then a narrative will be included in the UR decision explaining how each guideline or study cited provides additional information that is not addressed by the primary source.[10] The format of the citations provided by the UR reviewing physician include the following elements:[11]

When citing the MTUS, the citation shall include:

- Term "MTUS" or "Medical Treatment Utilization Schedule";
- Effective year of the guideline;
- Title of the chapter referenced (e.g., Low Back Complaints);
- Section referenced within the chapter (e.g., Surgical Considerations).

When citing other medical treatment guidelines, the citation shall include:

- Name or abbreviated name of the guidelines being cited (e.g., Official Disability Guidelines; ODG);
- Name of the organization publishing the guidelines (e.g., Work Loss Data Institute);
- Year of publication;
- Title of the chapter
- Section referenced within the chapter (if applicable)

When citing a peer-reviewed study, the citation shall include:

- Last name and first initial of the first author listed in the study;
- Published article's title

[10] 8 CCR §9792.21.1(b)(2)(a)
[11] 8 CCR §9792.21.1(d)

- Journal title (standard abbreviations may be used)
- Volume number
- Year published
- Page numbers
- OR an electronic web link (url) to the full text of the article.

MTUS Drug Formulary – 8 CCR §9792.27.1-9792.27.23 & 8 CCR §9792.9.8

Drugs prescribed or dispensed to treat a work related injury or illness fall within LC §4600's definition of "medical treatment" and are subject to the relevant provisions of MTUS, including the MTUS Treatment Guidelines, provisions relating to presumption of correctness and methods for challenging the presumption and for substantiating medical necessity where the MTUS Treatment Guidelines do not address the condition or injury.[12]

Except for continuing drug treatment related to injuries that occurred prior to January 1, 2018 (Formulary Transition), a drug dispensed on or after January 1, 2018 for outpatient use is subject to the MTUS Drug Formulary regardless of date of injury.[13]

- A drug is for "outpatient use" if it is dispensed to be taken, applied, or self-administered by the patient at home or outside of a clinical setting, including "take home" drugs dispensed at the time of discharge from a facility. "Home" includes an institutional setting in which the injured worker resides, including but not limited to, an assisted living facility.[14]
- The MTUS Drug Formulary does not apply to drugs administered to the patient by a physician. However, the physician administered drug treatment is subject to relevant provisions of MTUS, including the MTUS Treatment Guidelines.[15]

Formulary Transition[16]

For continuing drug treatment related to injuries that occurred prior to January 1, 2018, the MTUS Drug Formulary should be phased in to ensure that injured workers who are receiving ongoing drug treatment are not harmed by an abrupt change in the course of treatment. The physician is responsible for requesting a medically appropriate and safe course of treatment for the injured worker in accordance with MTUS, which may include use of a Non-Exempt drug or unlisted drug where that is necessary for the injured worker's condition or necessary for safe weaning, tapering, or transition to a different drug.

If the injured worker with a date of injury prior to January 1, 2018 is receiving a course of treatment that includes a Non-Exempt drug, an unlisted drug, or a compounded drug, the physician shall submit Primary Treating Physician's Progress Report" form (Form PR-2) and a Request for Authorization that shall address the injured worker's ongoing drug treatment plan. The report shall either:

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

[12] 8 CCR §9792.27.2(a)
[13] 8 CCR §9792.27.2(b)
[14] 8 CCR §9792.27.2(b)(1)
[15] 8 CCR §9792.27.2(b)(2)
[16] 8 CCR §9792.27.3

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

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

Previously approved drug treatment shall not be terminated or denied except as may be allowed by the MTUS and in accordance with applicable utilization review and independent medical review regulations. The claims administrator shall process the progress report, treatment plan and Request for Authorization in accordance with the standard procedures and timeframes set forth in section 9792.6.1 et seq.

Pharmacy Networks and PBM Contracts[17]

Where an employer or insurer contracts pursuant to Labor Code §4600.2 with a pharmacy, a pharmacy benefit manager, or pharmacy network for the provision of drugs for the treatment of injured workers, the drugs available to the injured worker must be consistent with the MTUS Treatment Guidelines and MTUS Drug Formulary for the condition or injury being treated, and may not be restricted pursuant to the contract.

Off-Label Drug Use[18]

Off-label use of a drug must be consistent with MTUS Treatment Guidelines, rules and the MTUS Drug Formulary. Authorization through prospective review is not required to dispense an Exempt drug for an off-label use if the MTUS Treatment Guidelines recommends off-label use of the drug to treat the condition. Authorization through prospective review is required prior to dispensing the following drugs for an off-label use:

- Non-Exempt drug; or
- Unlisted drug; or
- Exempt drug lacking recommendation in MTUS Treatment Guidelines for the intended off-label use.

When a physician believes it is medically necessary to prescribe a drug for an off-label use not recommended by the MTUS Treatment Guidelines or not addressed by the MTUS Treatment Guidelines, the permissibility of the treatment outside of the guidelines is governed by 8 CCR §9792.21(d) (condition not addressed by MTUS or seeking to rebut the MTUS), §9792.21.1 (medical evidence search sequence), §9792.25 (quality and strength of evidence definitions) and §9792.25.1 (MTUS methodology for Evaluating Medical Evidence).

Access to Drugs Not Listed as an Exempt Drug in the MTUS Drug List[19]

Drug treatment that is in conformity with the MTUS Treatment Guidelines is presumed correct on the issue of extent and scope of medical treatment pursuant to section 8 CCR §9792.21(c), and LC §4604.5.

[17] 8 CCR §9792.27.4
[18] 8 CCR §9792.27.5
[19] 8 CCR §9792.27.6

Although the MTUS Drug List identifies Exempt drugs that do not require prospective review when dispensed in accordance with the MTUS Treatment Guidelines, other medically necessary drugs are available to the injured worker when authorized through prospective review. Any medically necessary FDA-approved drug, or nonprescription drug that is marketed pursuant to an FDA OTC Monograph, may be authorized through prospective review and dispensed to an injured worker if it is shown in accordance with the MTUS regulations that the drug is required to cure or relieve the injured worker from the effects of the injury. Determination of the medical necessity of treatment based on recommendations found outside of the MTUS Treatment Guidelines is governed by 8 CCR §9792.21(d) (condition not addressed by MTUS or seeking to rebut the MTUS), §9792.21.1 (medical evidence search sequence), §9792.25 (quality and strength of evidence definitions) and §9792.25.1 (MTUS methodology for Evaluating Medical Evidence).

Brand Name and Generic Drugs[20]

If a physician prescribes a brand name drug when a less costly therapeutically equivalent generic drug exists, and writes "Do Not Substitute" or "Dispense as Written" on the prescription in conformity with Business and Professions Code §4073, the physician must document the medical necessity for prescribing the brand name drug in the patient's medical chart and in the Doctor's First Report of Occupational Injury or Illness (Form 5021) or Primary Treating Physician's Progress Report (Form PR-2.) The documentation must include the patient-specific factors that support the physician's determination that the brand name drug is medically necessary. The physician must submit a Request for Authorization and obtain authorization through prospective review before the brand name drug is dispensed.

Physician-Dispensed Drugs[21]

Physician-dispensed drugs must be authorized through prospective review prior to being dispensed, except as provided in 8 CCR §9792.27.12(b) ("Special Fill"), and §9792.27.13 ("Perioperative Fill"). A physician may dispense up to a seven-day supply of one or more drugs that are designated as "Exempt" in the MTUS Drug List without obtaining authorization through prospective review, if the drug treatment is in accordance with the MTUS Treatment Guidelines and the up-to-seven-day supply is dispensed at the time of an initial visit that occurs within 7 days of the date of injury. This does not invalidate a provision in a Medical Provider Network agreement which restricts physician dispensing by medical providers within the network, nor does it permit physician dispensing where otherwise prohibited by a pharmacy benefit contract per LC §4600.2(a).

Compounded Drugs[22]

Compounded drugs must be authorized through prospective review prior to being dispensed. When it is necessary for medical reasons to prescribe or dispense a compounded drug instead of an FDA-approved drug or over-the-counter drug that complies with an OTC Monograph, the physician must document the medical necessity in the patient's medical chart, and in the Doctor's First Report of Injury (Form 5021) or Progress Report (PR-2) and must submit a Request for Authorization. The documentation must include the patient-specific factors that support the physician's determination that a compounded drug is

[20] 8 CCR §9792.27.7
[21] 8 CCR §9792.27.8
[22] 8 CCR §9792.27.9

medically necessary. This does not invalidate a provision in a Medical Provider Network agreement which restricts physician dispensing of compounded drugs by medical providers within the network, nor does it permit physician dispensing of compounded drugs where otherwise prohibited by a pharmacy benefit contract per LC §4600.2(a).

MTUS List – Exempt, Non-Exempt, Unlisted Drugs and Prospective Review[23]

The MTUS Drug List is outlined by active drug ingredient(s).

A drug that is listed as Exempt may be dispensed to the injured worker without obtaining authorization through prospective review if the drug treatment is in accordance with the MTUS Treatment Guidelines, except:

- Brand name drugs per §9792.27.7;
- Physician-dispensed drugs per §9792.27.8.
- Compounded drugs per §9792.27.9 even if one or more of the ingredients is listed as "Exempt" on the MTUS Drug List.

Drugs identified as "Non-Exempt" require authorization through prospective review prior to the time the drug is dispensed. Expedited review should be conducted where it is warranted by the injured worker's condition.

For a drug that is identified as eligible for "Special Fill" or "Perioperative Fill", the usual requirement to obtain authorization through prospective review prior to dispensing the drug is altered for the specified circumstances set forth in §9792.27.12 and §9792.27.13. If the requirements set forth in §9792.27.12 or §9792.27.13 are not met, then the drug is considered "Non-Exempt" and is subject to authorization through prospective review.

Unlisted drugs require authorization through prospective review prior to the time the drug is dispensed. A combination drug that is not on the MTUS Drug List is an unlisted drug even if the individual active ingredients are on the MTUS Drug List.

Waiver of Prospective Review[24]

Nothing in the MTUS Drug Formulary prohibits waiver of the prospective review requirement for a Non-Exempt or unlisted drug if the drug falls within a utilization review plan's provision of prior authorization without necessity of a request for authorization, where that provision is adopted pursuant to section 8 CCR §9792.7(a)(5).

Special Fill[25]

The MTUS Drug List identifies drugs that are subject to the Special Fill policy. Under this policy, a drug that usually requires prospective review because it is "Non-Exempt" will be allowed without prospective review as specified below:

- The drug identified as a Special Fill drug may be dispensed to the injured worker without seeking prospective review if all of the following conditions are met:

[23] 8 CCR §9792.27.10
[24] 8 CCR §9792.27.11
[25] 8 CCR §9792.27.12

- The drug is prescribed at the single initial treatment visit following a workplace injury, provided that the initial visit is within 7 days of the date of injury; and
- The prescription is for a supply of the drug not to exceed the limit set forth in the MTUS Drug List; and
- The prescription for the Special Fill-eligible drug is for:
  - An FDA-approved generic drug or single source brand name drug, or,
  - A brand name drug where the physician documents and substantiates the medical need for the brand name drug rather than the FDA-approved generic drug, and
- The drug is prescribed in accordance with the MTUS Treatment Guidelines.

When calculating the 7-day period, the day after the date of injury is "day one."

An employer or insurer that has a contract with a pharmacy, pharmacy network, pharmacy benefit manager, or a medical provider network (MPN) that includes a pharmacy or pharmacies within the MPN, may provide for a longer Special Fill period or may cover additional drugs under the Special Fill policy pursuant to a pharmacy benefit contract or MPN contract.

Perioperative Fill[26]

The MTUS Drug List identifies drugs that are subject to the Perioperative Fill policy. Under this policy, the Non-Exempt drug identified as a Perioperative Fill drug may be dispensed to the injured worker without seeking prospective review if all of the following conditions are met:

- The drug is prescribed during the perioperative period; and
- The prescription is for a supply of the drug not to exceed the limit set forth in the MTUS Drug List; and
- The prescription for the Perioperative Fill - eligible drug is for:
  - An FDA-approved generic drug or single source brand name drug, or,
  - A brand name drug where the physician documents and substantiates the medical need for the brand name drug rather than the FDA-approved generic drug, and
- The drug is prescribed in accordance with the MTUS Treatment Guidelines.

For purposes of this section, the perioperative period is defined as the period from 4 days prior to surgery to 4 days after surgery, with the day of surgery as "day zero".

An employer or insurer that has a contract with a pharmacy, pharmacy network, pharmacy benefit manager, or a medical provider network that includes a pharmacy or pharmacies within the MPN, may provide for a longer Perioperative Fill period or may cover additional drugs under the Perioperative Fill policy pursuant to a pharmacy benefit contract or MPN contract.

Health and Safety Regulations[27]

The MTUS Drug Formulary and associated regulations do not relieve an employer of any responsibilities pursuant to applicable health and safety regulations such as the requirements of the California occupational Bloodborne Pathogens standard at 8 CCR §5193, including the responsibility to provide urgent post-exposure prophylaxis as needed to protect the health of the employee.

[26] 8 CCR §9792.27.13
[27] 8 CCR §9792.27.14

Formulary Dispute Resolution [28]

Disputes over the medical necessity of pharmaceutical treatment covered by the MTUS Drug Formulary are governed by the utilization review and independent medical review provisions of LC §4610, §4610.5, and 8 CR §9792.6.1 et seq, and §9792.10.1 et seq. A request for independent medical review of a formulary request must be submitted to the Division within ten (10) days of the service of the utilization review decision to the employee.[29]

Disputes over failure to follow formulary rules, other than medical necessity disputes, shall be resolved through the procedure for expedited hearings set forth in WCAB rules, 8 CCR 10782.

Utilization Review – Medical Treatment – Within the First 30 Days of the DOI[30]

A treating physician specified in Labor Code §4610(b) (medical provider network physician, health care organization physician, a physician predesignated per LC §4600(d), or an employer-selected physician) may render medically necessary treatment or services to an injured worker without prospective utilization review for the first thirty (30) days after the date of injury, provided that:

- The treatment or service is for a body part or condition that has been accepted as compensable.
- The treatment or service is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director under Section 5307.27.
- The initial treating physician timely submits the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, as required by section 9785, subdivision (e), setting forth in detail the anticipated treatment plan for the injured worker.
- All treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, are set forth in a request for authorization provided to the claims administrator in accordance with section 9785(h). The form shall be submitted to the claims administrator concurrent with the Doctor's First Report of Occupational Injury or Illness. Subsequent treating physicians during the 30-day period shall submit a request for authorization following their first visit with the injured worker indicating all treatment being rendered.
- The treating physician's medical treatment bill for the non-emergency treatment rendered or services provided under this section is submitted within thirty (30) days of the date the service was provided. Medical treatment bills for emergency treatment services shall be submitted within 180 days of the date that the treatment was provided.

The following medical treatment services, unless previously authorized by the claims administrator or rendered as emergency medical treatment, cannot be provided under subdivision (a) and are subject to authorization by prospective utilization review under 8 CCR §9792.9.1 or §9792.9.3.[31]

- Pharmaceuticals, to the extent they are not expressly exempt from prospective review under the MTUS Drug Formulary

[28] 8 CCR §9792.27.17
[29] 8 CCR §9792.10.1 & CA Labor Code §4610.5(h)(1)(A)
[30] 8 CCR §9792.9.7 & CA Labor Code §4610(b) and (c)
[31] 8 CCR §9792.9.7(b)

- Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician's office. This includes all necessary and routine pre-operative, intra-operative, and post-operative services performed for the purpose of surgery including, but not limited to, related diagnostic tests or procedures, rehabilitation services, durable medical equipment or supplies, and routine post-surgical pain management treatment or services. For the purpose of this section, "surgery" means: 1) any procedure set forth in the Surgery section of the American Medical Association's Current Procedural Terminology (CPT®) which is incorporated by reference at section 9789.31(h), and any updates pursuant to section 9789.36; or 2) any procedure code defined as "surgery" in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule found in the Healthcare Common Procedure Coding System (HCPCS), which is incorporated by reference at section 9789.31(i), and any updates pursuant to section 9789.36.
- Psychological or psychiatric treatment services, which includes diagnostic services, psychotherapy, and other services or procedures to an individual or group in all care settings provided by a physician or other qualified health care provider, and including psychiatric pharmaceuticals, to the extent they are not expressly exempt from prospective utilization review under the MTUS Drug Formulary.
- Home health care services, including health care and other medically necessary services provided to the injured worker in the residential setting.
- Imaging and radiology services, excluding X-rays
- All durable medical equipment, prosthetics, orthotics, and supplies where the purchase or rental cost of the item with necessary supplies, if any, for the expected course of treatment is greater than $250.00 as determined by the DWC Official Medical Fee Schedule (OMFS), or, for an unlisted item, where the billed amount will be greater than $250.00.
- Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies. For the purpose of the subdivision, electrodiagnostic medicine is a medical specialty where the physician uses neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic, neuromuscular, and/or muscular systems. This includes, but is not limited to, procedures set forth in the American Medical Association's Current Procedural Terminology (CPT®) Medicine section, under the subheading "Neurology and Neuromuscular Procedures," and any test that measures the speed and degree of electrical activity in the muscles and nerves in order to make a diagnosis.
- Spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections.
- Any other service designated and defined through rules adopted by the administrative director

If a physician renders treatment under this section without timely submitting the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, to the claims administrator as required by section 9785(e), or without timely submitting a complete request for authorization as required by section 9792.6.1(u), the claims administrator may remove the physician's ability to provide further medical treatment that is exempt from prospective review to the employee for the remainder of the thirty-day time period referenced at subdivision (a) by issuing written notice to the physician. The written notice must identify that the physician either failed to timely submit the DIR Form 5021 or failed to timely submit a complete request for authorization, advise that the physician can no longer render exempt treatment to the

injured worker for the remainder of the thirty days, and advise that any such treatment is subject to prospective utilization review.[32]

Retrospective utilization review may be performed for any treatment provided per LC §4610(b) solely for the purpose of determining if the physician is prescribing treatment consistent with the schedule for medical treatment utilization, including, but not limited to, the drug formulary. If retrospective review identifies a pattern and practice of the physician or provider failing to render treatment consistent with the medical treatment utilization schedule, including the MTUS Drug Formulary, the claims administrator may:

- Remove the ability of the physician to render treatment exempt from prospective review to any injured worker whose claim is adjusted or administered by the claims administrator. The claims administrator must provide written notice to the physician that:
    1. documents, based on retrospective review, the physician's pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary;
    2. advises that based on the documented failure the physician can no longer render exempt treatment to any injured worker whose claims are adjusted or administered by the claims administrator; and
    3. advises of the requirement of prospective utilization review for all subsequent medical treatment.
- Remove the physician as the injured worker's primary treating physician by filing a petition for change of primary treating physician under section 9786.
- Terminate the physician from the claims administrator's or employer's medical provider network or health care organization.

For the purpose of this section, "pattern and practice" means when treatment has been rendered inconsistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, for twenty (20) separate and unrelated recommended medical services or goods with ten (10) or more injured workers over the course of three (3) months; or for eight (8) separate and unrelated medical services or goods with two (2) or less injured workers within a month.

Any dispute between the treating physician and the claims administrator regarding application of the provisions as allowed in this section shall be resolved by the Workers' Compensation Appeals Board.

[32] 8 CCR §9792.9.7(d)

5. Utilization Review Process – 8 CCR §9792.7 (a)(1)(2)

Initiation of Review Process

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

A request for authorization transmitted by facsimile, electronic mail, or electronic data interchange after 5:30 P.M. Pacific Time shall be deemed to have been received by the claim's administrator on the following business day, except in the case of an expedited or concurrent review.[33]

Where the request for authorization is received by mail absent documentation of receipt, the request shall be deemed to have been received five business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service or Proof of Service. Where the request is delivered via certified mail, with return receipt mail, absent documentation of receipt, the request for authorization shall be deemed to have been received on the receipt date entered on the return receipt. In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the request for authorization shall be deemed to have been received by the claim's administrator five days after the latest date the sender wrote on the document.[34]

Prior Authorization Plans 8 CCR §9792.7 (a) (5)

Medata performs UR in the state of California as a service to our managed care clients. The services performed are based upon client-specific account protocols and the delegation of specific claims and services. Our clients and their Third-Party Administrators may establish a prior authorization program for certain treatment requests based on the client's established criteria. (Provided in Section 14).

Initial Screening

Medata's initial screening process is automated through our client's existing claims interface into our bill review engine. The data accessed at the initiation of the review process includes the following information, claim case, adjuster, claimant, provider, attorney, date of service, date of injury, body part, bill history, etc.

If necessary, non-clinical administrative staff will perform the following functions:

- Performance of review of service request for completeness of information;
- Collection and transfer of non-clinical data;
- Acquisition of structured clinical data; and
- Activities that do not require evaluation or interpretation of clinical information.
- Asking scripted clinical questions
- Accepting responses to scripted clinical questions

[33] 8 CCR §9792.9.1(a)(1)
[34] 8 CCR §9792.9.1(a)(2)

Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a claims administrator, non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it "not complete" and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt. A request for authorization accepted as complete shall be subject to investigation under section 9792.11 and the assessment of administrative penalties under section 9792.12.[35]

Initial Clinical Review

Initial Clinical Reviewers perform first level review on requests for authorization. They review the clinical documentation and apply clinical review criteria, to the request for authorization. Initial clinical reviewers are non-physician reviewers (i.e. nurses).

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

Initial Clinical Reviewers may not issue a determination to deny or modify and will refer all reviews for which they are not recommending certification to a Clinical Peer Reviewer.

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

Initial clinical reviewers may make a determination that no review is required when a decision to modify or deny a request for authorization has been made in the last 12-months for a request received for the same treatment and by the same physician (or another physician within the requesting physician's practice group) when the further recommendation is not supported by a documented change in the facts material to the basis of the utilization review decision, consistent with 8 CCR §9792.9.5(g) and LC §4610(k).

Peer Clinical Review

Clinical Peer Reviewers perform second level reviews and internal appeals on requests for authorization, reconsiderations or appeals consideration. They review the clinical documentation and apply clinical review criteria to the request for authorization.

Clinical Peer Reviewers issue determinations of medical necessity. Only Clinical Peer Reviewers may issue modifications or denials. Clinical peer reviewers may make a determination that no review is required, consistent with 8 CCR 9792.9.5(g).

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

[35] 8 CCR §9792.9.1(b)

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.[36]

Expedited Review – 8 CCR §9792.7(a) (2) and §9792.9.3(c)

The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. Consistent with 8 CCR §9792.9.3(c), request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the standard timeframe for utilization review would be detrimental to the injured worker's condition, shall be reviewed by under the timeframe set forth in subdivision (b). A finding that a request for expedited review is not reasonably supported by such evidence must be made and documented by a licensed health care provider.

For Prospective and Concurrent Expedited Reviews – if the employee's condition is one in which the employee 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 employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

In emergency situations posing an immediate threat to the health and safety of patients, Medata shall advise requesting party that failure to obtain prior authorization for emergency health care services is not an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker, and that emergency health care services may be subject to retrospective UR. If the party requires that prospective UR be performed in situations where the health or safety of a patient is under immediate threat, the call shall be transferred directly to the Medical Director or Sr. Director of Clinical Services, in his/her absence, to the Director, Core Operations or Sr. Director of Operations & Processes.

The Sr. Director of Clinical Services will assign the initial clinical reviewer, clinical peer reviewer, and QA reviewer that are immediately available for reviews. The availability of each reviewer will be confirmed by either the Medical Director or Sr. Director of Clinical Services, by telephone. Until the review is completed, the Medical Director or Sr. Director of Clinical Services, will evaluate the progress of the review by checking its status at intervals not to exceed 30 minutes. Immediately upon reaching a determination, the system shall generate a determination letter that shall be immediately faxed to the provider. The Medical Director or Sr. Director of Clinical Services will further contact the requesting provider via telephone to verify the receipt of the determination to ensure its arrival.

Requests for Additional Information – 8 CCR §9792.9.6

During the UR process, non-clinical administrative staff, initial clinical review staff or clinical peer reviewers may determine that additional information must be requested from the provider in order to

[36] 8 CCR §9792.9.5(f)

make a determination of medical necessity. In this case, the request for additional information must be made within 5 business days of the receipt of request for authorization per 8 CCR §9792.9.6.

When additional information is required and requested, the decision shall be made within 14 calendar days of receipt of the initial request for authorization for prospective or concurrent review or within thirty (30) days of the request for retrospective review, consistent with 8 CCR §9792.9.6(c)(1).

Clinical peer reviewers may also determine that additional tests, exams, or specialty consultation must be requested from the provider in order to make a determination of medical necessity. In this case, the request for additional tests, exams, or specialty consultation must be made within 5 business days of the receipt of request for authorization per 8 CCR §9792.9.6(b)(2) by notifying 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 indicate that a consultation by an expert reviewer is needed, in which case, the specialty of the expert reviewer to be consulted must be identified.

If the results of the additional examination or test required under subdivision (a) (f)(1)(B), or the specialized consultation under subdivision (a) (f)(1)(C), that is requested by the physician reviewer under this subdivision is not received within thirty (30) days from the date of the request for authorization, the reviewer shall deny the treating physician’s request in accordance with the applicable requirements under section 9792.9.5(e)

When additional tests, exams, or specialty consultation results is required and requested, the decision shall be made within five (5) business days of receipt of the information requested, consistent with 8 CCR §9792.9.6(d)(1).

When a conditional non-certification is made due to lack of information or due to lack of additional tests, exams, or specialty consultation results, the denial shall state that the decision will be reconsidered once the requested information or requests results are received, consistent with 8 CCR §9792.9.6.

The system shall generate the appropriate correspondences which shall be delivered to the required stakeholders in a manner and a timeframe consistent with the requirements in 8 CCR §9792.9.3. Medata will document all attempts to obtain additional information.

6. Notification of Determination

Requirements

Upon conclusion of the review, the system shall generate the determination letters. Determination correspondence shall contain the following elements:

Certification letters:[37]

a) The date on which the complete, or accepted as complete, request for authorization was first received

b) The date on which a decision is made

c) Medical treatment service requested

d) Specific medical treatment service approved

e) If applicable, the written decision shall also include the date the request for information, exam, or consultation under section 9792.9.6, subdivision (a)(1)(A), (B), or (C) was requested, and the date the information was received.

f) If applicable, for approvals of a request for authorization of a drug

1. where the request for authorization did not indicate "Do Not Substitute" or "Dispense as Written," the written decision approving the request in generic form shall indicate, "generic substitute authorized" or words to that effect and meaning.

2. that is exempt on the Drug Formulary, the written decision approving the request shall indicate, "Exempt per MTUS Drug Formulary" or words to that effect and meaning.

g) If applicable, for approvals of a request for authorization of non-drug treatment that are exempt under section 9792.9.7 (i.e., the 30-day exemption), the written decision approving the request shall identify the exempt treatment as, "30-day exemption" or words to that effect and meaning.

Non-Certification/Modification letters:[38]

a) The date on which the completed, or accepted as complete, request for authorization was first received;

b) Date on which the decision is made;

c) The date of receipt of additional information was received, if applicable;[13]

d) A list of all medical records reviewed;

e) Description of the specific course of medical treatment set forth on the request for authorization;

f) Specific description of the medical treatment service approved, if any;

g) A clinical rationale which shall include:

[37] 8 CCR §9792.9.4(a)(1)
[38] 8 CCR §9792.9.5(e)

- A clear, concise, and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity or if applicable, that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation. Where the requesting physician has expressly opined that 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.

h) For decisions based on medical necessity, a citation to and a description of the relevant medical criteria or guidelines used to reach the decision

i) Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.

j) Details about the claims administrator's internal utilization review appeals process available to the requesting physician, if any, including with respect to disputes over the necessity of or availability of the requested information, and a clear statement that the internal appeals process is on a voluntary/optional basis that neither triggers no bars use of the dispute process under LC §4610.5 and §4610.6

k) Name and specialty of the reviewer or expert reviewer and the following statement: "In the event that you would like to discuss this decision with the reviewer, please call 855-445-0306 so that a convenient time may be arranged for this discussion. All reviewers or expert reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. PST per regulations 9792.9.5(e)(14)." In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

l) The Application for Independent Medical Review, DWC Form IMR, with all fields, except for the signature of the employee, completed; with an addressed envelope, for mailing to the Administrative Director or his or her designee

m) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

n) The following mandatory language: "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."

o) The following mandatory language "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."

p) The signature of either the claims administrator or the physician reviewer.

On all correspondences to non-physician providers of goods or services, the clinical rationales and guidelines shall be removed consistent with CA Labor Code and Regulations.

The system shall generate the appropriate correspondences on Medata letterhead which shall be delivered to the required stakeholders in a manner and a timeframe consistent with 8 CCR §9792.9.3.

Copies of Medata's determination letter templates are included in this plan. Please note that each client may require customization to the overall content and format of the letters; however, Medata ensures that all customized letters are compliant with the Labor Code and regulations.

Determination of need for new review following denial – 8 CCR §9792.9.5

Consistent with 8 CCR §9792.9.5(g) and LC §4610(k), a utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical necessity shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.[39]

Medata will notify the requesting provider if a request for authorization will not be reviewed according to 8 CCR §9792.9.5(g) and LC §4610(k).

Timeframes – 8 CCR §9792.9.3

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

The first day in counting any timeframe requirement is the first normal business or working day after receipt of the completed or accepted as complete request for authorization, except when the timeline is measured in hours. When the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the request for authorization.[40]

The Sr. Director, Operations and Processes and QA reviewers monitor the timeframes of all reviews to ensure that they are completed timely.

[39] 8 CCR §9792.9.5(g)
[40] 8 CCR §9792.9.3(a)

In California, timeframes are monitored for compliance with 8 CCR§ 9792.9.3 and review due dates are set to ensure completion in a timely fashion.

1) Prospective or concurrent decisions to approve, modify or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured workers' condition, not to exceed five business days from the date of receipt of the completed request for authorization.[41]

    a) If appropriate information, which is necessary to render a decision, is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five business days from the date of receipt of the written request for authorization by notifying 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 indicate that a consultation by an expert reviewer is needed, in which case, the specialty of the expert reviewer to be consulted must be identified.

    b) If the reasonable information is received prior to the 14th calendar day following the date of receipt of the written request for authorization, the reviewer shall make a decision within five business days of the receipt of the information, but never longer than the 14th calendar following the date of receipt.

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

    d) Efforts to obtain information from the requesting provider shall be documented by telephone, facsimile, or if agreed to by the parties, encrypted electronic mail prior to issuing a denial due to lack of reasonable and necessary information.

    e) Consistent with LC §4610, in no event shall the determination be made more than 14 calendar days from the date of receipt of the original request for authorization from the health care provider.

    f) Consistent with LC §4610(i)(1), if the request for authorization is for a formulary drug only, in no event will the determination be made more than five working days from the date of receipt of the request.

    g) Prospective or concurrent and expedited approvals shall be communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or if agreed to by the parties, encrypted electronic mail. If the initial communication is by telephone, written communication shall issue to the requesting physician within 24 hours of the decision for concurrent review and within two business days for prospective review[42]

    h) Prospective or concurrent decisions to modify or deny shall be initially communicated to the requesting provider by telephone, facsimile, or if agreed to by the parties, encrypted electronic

[41] 8 CCR §9792.9.3(b)
[42] 8 CCR §9792.9.4(b)

mail within 24 hours of the decision. Written communication of the decision shall issue to the injured worker, and if applicable, the injured workers representative within 24 hours of the decision for concurrent review and within two business days for prospective review. Written communication in shall also issue to the requesting physician where the initial communication of the decision to the physician was by telephone.

i) If the review is expedited, the decision shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination.[43]

2) 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 information regarding rendered medical treatment that is sufficient for a reviewer to make a determination as to whether the treatment was medically necessary.[44]

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

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

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

3) Consistent with 8 CCR §9792.10.1(d); any appeal review must be completed within 30 calendar days of the date of the receipt of request for appeal.

4) The calculation of time as outlined in this section applies to all utilization review decisions insofar as they do not contravene the timeframes relating to MTUS formulary disputes, which are subject to the requirements of section 9792.9.8[45]

[43] 8 CCR §9792.9.3(c)
[44] 8 CCR §9792.9.3(d)
[45] 8 CCR §9792.9.3(e)

7. Reconsideration/Appeals Process

Internal Appeals

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

Within 10 calendar days of receipt of the non-certification, the prescribing physician may submit a written appeal and include any documentation the physician would like Medata to consider. A board-certified peer reviewer of an appropriate clinical specialty will be assigned to review the request and all submitted documentation. This peer reviewer will not have been involved in the previous non-certification determination pertaining to this particular request. Medata will complete the appeal and notify the prescribing physician of the results within 30 calendar days.

Reconsiderations Following Denial for Lack of Information

If a non-certification is rendered due to insufficient or lack of information, and previously requested information is subsequently provided, Medata will reconsider the decision within five working days of receipt of the requested information. The peer reviewer may be the reviewer originally assigned to the review. The UR decision shall be communicated per the notification requirements.

8. Disputed Liability and UR Deferral – 8 CCR §9792.9.2

Consistent with 8 CCR §9792.9.2, Utilization review of a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

A claims administrator who determines that Labor Code section 4610(k) precludes the need for utilization review must comply with the requirements under this section.

A request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change. Such a request must be reviewed by a physician reviewer and any modification or denial of the request must comply with applicable requirements as set forth at section 9792.9.5.

If the claims administrator disputes liability as allowed under this subdivision, it may, no later than five business days from receipt of the request for authorization, issue a written decision deferring utilization review of the requested treatment. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall only contain the following information specific to the request:

- The date on which the request for authorization was first received.
- A description of the specific course of proposed medical treatment for which authorization was requested.
- A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.
- A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.
- The following mandatory language advising the injured employee: "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me. And
- "For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

If utilization review is deferred, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, the time for the claims administrator to conduct retrospective UR in accordance with this section shall begin on the date the determination of the

claims administrator's liability becomes final. The time for the claims administrator to conduct prospective UR shall commence from the date of our receipt of a request for authorization after the final determination of liability.

9. Independent Medical Review – 8 CCR §9792.10.3 and §9792.10.4 (b) (4) and (5)

A request for independent medical review of a utilization review decision that denies or modifies a medical treatment request must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days of service of the written utilization review determination issued by the claims administrator under section 9792.9.5(e).[46]

If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the request for independent medical review must be filed by the eligible party within 10 days of service of the written utilization review decision.[47]

A request for independent medical review must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision denying or modifying the request for authorization of medical treatment.

The physician whose request for authorization of medical treatment was denied or modified may join with or otherwise assist the employee in seeking an independent medical review. The physician may submit documents on the employee's behalf to the independent medical review organization and may respond to any inquiry by the independent review organization.

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

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

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

Consistent with 8 CCR §9792.10.3(c), Medata will respond to any request for additional information from the Administrative Director regarding IMR eligibility within five business days of receipt of request for information.

[46] 8 CCR §9792.10.1(a)(1)
[47] 8 CCR §9792.10.1(a)(2)

Consistent with 8 CCR §9792.10.5(a)(1), documentation required for IMR as described in 8 CCR §9792.10.5(a)(1)(A-F) must be delivered to the independent review organization within:

- 24 hours of receipt of notification of IMR, for expedited review; otherwise;
    - 15 calendar days of the date designated on notification if transmitted via mail; or
    - 12 calendar days of the date designated on notification if transmitted electronically.
    - 10 calendar days for disputes regarding only a drug or drugs listed on the MTUS Drug Formulary

Such documentation shall include, at minimum:

- A copy and list of all reports of the physician relevant to the employee's current medical condition produced within six months prior to the date of the request for authorization, including those that are specifically identified in the request for authorization or in the utilization review determination. If the requesting physician has treated the employee for less than six months prior to the date of the RFA, provide a copy and list of all reports relevant to the employee's current medical condition produced within the described six month period by any prior treating physician or referring physician.
- A copy of the written Application for Independent Medical Review, DWC Form IMR, that was included with the written determination.
- A copy of all information, including correspondence, provided to the employee concerning the utilization review decision regarding the disputed treatment.
- A copy of any materials the employee or the employee's provider submitted in support of the request for the disputed medical treatment.
- A copy of any other relevant documents or information used in determining whether the disputed treatment should have been provided, and any statements by the claim's administrator explaining the reasons for the decision to deny or modify the recommended treatment on the basis of medical necessity.
- Response, if any, to any additional issues raised in the employee's application for independent medical review.

If the claims administrator or Medata becomes aware of any newly developed or discovered relevant medical records in its possession, they shall forward such materials to the Independent Medical Review Organization (IMRO) immediately. At the same time that documentation is provided to the IMRO, a notification that lists all documents sent to the IMRO shall be sent to the patient or the patient's representative. Such notice shall also be accompanied by a copy of all documents not previously provided to the patient or the patients' representative, excluding mental health records pursuant to Health and Safety Code section 123115(b) unless the offer of medical records is declined or otherwise prohibited by law.

Following submission of documentation to the IMRO, the IMRO may request additional information related to medical necessity. Should such request be received by Medata, we shall provide any available

information requested within one calendar day for expedited review; and within five business days for all other reviews. Such information will be sent to both the IMRO and all other parties within the timeframes indicated.

10. Financial Incentive Policy – LC §4610(g)(3)(B)(i)

Medata does not offer or provide any financial incentive or consideration to physicians based on the number of modifications or denials made by the physician in performing UR, nor to any of its internal clinical personnel or Medical Directors.

11. Confidentiality and Information Security

In the course of administering the program, staff may have access to highly sensitive personal and confidential information on individuals. Confidential information is defined as data that provides enough specifics to allow identification or recognition of an individual patient or provider. This information is safeguarded by staff and maintained in accordance with state, federal and external accreditation agency regulations and standards. Staff must sign and abide by the company confidentiality policy annually as a condition of employment.

Medata's policies ensure the security and confidentiality of all data records. Medata ensures compliance with all state and industry regulations as we maximize effectiveness through our technology solutions. Medata is SOC I and SOC II certified and abides by all audit procedures required for this designation.

Protected Health Information (PHI) must be encrypted during transmission over networks not owned and/or operated by Medata, LLC Personally Identifiable Information (PII) must be encrypted during transmission over networks not owned and/or operated by Medata, LLC.

It is the nature of Medata's application that all customer data contains PII/PHI and is in use at any time, and therefore at least one recent backup of this data will be kept at all times to ensure readily available replacement data. In the event of client or customer separation from Medata, LLC, the copy of all application data will be stored for seven years in a physically secured and non-volatile format. Any customer data which is to be retained outside of applications in use by the customer will be reviewed for removal of PHI/PII by IT Department personnel prior to long term storage. Data generated by servers including but not limited to logs or messages must be retained on backup server to preserve their integrity for research, or forensic use.

Medata accounts pertaining to all Medata systems are to be established by the IT System Administrator or above upon receipt of a work order or ticket from a member of management. All access from employees to any Medata system must be done in a way that complies with the IT policies, and all accounts must be set up with passwords compliant to password policies. Accounts and all data stored therein are the property of Medata, LLC, and will be added or erased at the sole discretion of Medata or its authorized representatives. Accounts may be disconnected without notice, provided there is justifiable cause for such action, including but not limited to abuse, security breach, or illegal/inappropriate activity. Account information will not be written down or stored in publicly viewable media except to communicate this information for the first login, and the user must change their password immediately after receipt. This policy must be technically enforced by the application if possible. Client accounts must use all the same policies and procedures for security, least privileged access, and strong password settings.

Customer Data classified as Type 3 Data in the Data Classification policy; workstations will have whole disk encryption with pre-boot authorization configured. Employee workstations will not have access to any unsecured shared drive, web-based (cloud) storage services and file transmission services (including without limitation Instant Messaging services with external access and web-based external email services). All access to the Internet from workstation will be logged, and logs will be retained for a minimum of 18 months. Employee may not communicate, store or process Confidential Information on any email, storage or processing repository that is outside the direct ownership and control of Medata. As an example, the use of personal web email accounts, web-based backup services, Internet-based document

editing or public cloud-based computing, storage or transmission services are prohibited without the express written permission from the customers IT Security Officer.

Any employee found to be in violation of our IT Policies may be subject to disciplinary action up to and including termination.

12. URAC Certification of Award

urac

CERTIFICATE OF AWARD

in recognition of

Medata, LLC
300 Barr Harbor Drive, Suite 600
West Conshohocken, Pennsylvania 19428

for compliance with

Workers' Compensation Utilization Management 8.1
Accreditation Program

is awarded

Full Accreditation

Effective from 02/01/2025 through 01/01/2028

Shawn Griffin, MD
President & Chief Executive Officer

Certificate Number: WUM010031

urac
ACCREDITED

URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation. URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.

13.Decision/Determination Letters - Labor Code sections 4600

The following letter templates are enclosed.

1. Template – Certify
2. Template – City of LA Certify
3. Template – Non-Certify
4. Template – City of LA Non-Certify
5. Template – Modify
6. Template – City of LA Modify
7. Template – Request for Additional Information
8. Template – Appeal Certify
9. Template – Appeal Non-Certify
10. Template – Appeal Modified

medata

[DATE LETTER GENERATED]

[REQUESTING PROVIDER NAME]
[REQUESTING PROVIDER LOCATION/FACILITY NAME]
[REQUESTING PROVIDER STREET ADDRESS]
[REQUESTING PROVIDER CITY, ST, ZIP]

INJURED WORKER: [INJURED WORKER NAME]
CLAIM NUMBER: [CLAIM NUMBER]
DATE OF INJURY: [DATE OF INJURY VALUE]

INSURANCE TYPE: WC
JURISDICTION: CA
NETWORK STATUS: [HCN/MPN VALUE Y/N]

REQUEST ID: [REQUEST ID #]
DATE COMPLETE RFA FIRST RECEIVED: [CLIENT RECD DATE]
DATE ADDITIONAL INFORMATION REQUESTED: [DATE or N/A]
DATE ADDITIONAL INFORMATION RECEIVED: [DATE or N/A]

DETERMINATION: [DETERMINATION DESCRIPTION]
DETERMINATION DATE: [DETERMINATION DATE]
CERTIFICATION NUMBER: [Insert MCN]

NOTICE OF UTILIZATION REVIEW DETERMINATION: CERTIFY

Dear [Requesting Provider Name],

Medata has been requested by [Client Name] to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the requested health care services are **Certified** as medically necessary.

Type of Review
[Insert Initial Doc Type]
[Insert Review Type]

Treatment/Service Requested
[Insert 'Provider Request Detail' text box content from 'Review Data' page – 'UR Provider Detail' note]

UR Determination
[Insert 'Determination Note' text content]

Guideline/Criteria Applied
[Name of Guideline Selected]

Clinical Rationale
[Insert 'Clinical History' text box content]

[Insert 'Rationale' text box content]

Please feel free to contact us at PO Box 62289, Irvine, CA 92602-6076, (855) 445-0306 (p), or (877) 201-5336 (fax) should you have any additional questions regarding this claim or if medical necessity substantiates further treatment.

Respectfully,

Medata Utilization Review
Phone: (855) 455-0306
Fax: (877) 201-5336

cc:
- [Claimant] [injured worker first name last name, address]
- [Ancillary Provider] [ancillary provider name]
- [Attorney] [applicant attorney name, address]
- [Attorney] [defense attorney name, address]
- [Client] [adjuster name, email address]

Disclaimer
Utilization Review strictly analyzes the medical necessity of treatment requests. Medata Utilization Review does not affirm the acceptance of this workers' compensation claim. Nothing within this notice guarantees payment for services or compensability of the claim. Reimbursement authorization for any approved procedures/services, if applicable, is given based only upon medical necessity rationale explicitly provided in this letter. Actual reimbursement amounts are subject to applicable fees, coding, documentation, site of service, licensure scope, and policy requirements as set forth by jurisdictional rules, regulations, and standards of practice.

[DATE LETTER GENERATED]

[REQUESTING PROVIDER NAME]
[REQUESTING PROVIDER LOCATION/FACILITY NAME]
[REQUESTING PROVIDER STREET ADDRESS]
[REQUESTING PROVIDER CITY, ST, ZIP]

INJURED WORKER: [INJURED WORKER NAME]
CLAIM NUMBER: [CLAIM NUMBER]
DATE OF INJURY: [DATE OF INJURY VALUE]

INSURANCE TYPE: WC
JURISDICTION: CA
NETWORK STATUS: [HCN/MPN VALUE Y/N]

REQUEST ID: [REQUEST ID #]
DATE COMPLETE RFA FIRST RECEIVED: [CLIENT RECD DATE]
DATE ADDITIONAL INFORMATION REQUESTED: [DATE or N/A]
DATE ADDITIONAL INFORMATION RECEIVED: [DATE or N/A]

DETERMINATION: [DETERMINATION DESCRIPTION]
DETERMINATION DATE: [DETERMINATION DATE]
CERTIFICATION NUMBER: [Insert MCN]

NOTICE OF UTILIZATION REVIEW DETERMINATION: CERTIFY

Dear [Requesting Provider Name],

Medata has been requested by City of Los Angeles to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the requested health care services are **Certified** as medically necessary.

Type of Review
[Insert Initial Doc Type]
[Insert Review Type]

Treatment/Service Requested
[Insert 'Provider Request Detail' text box content from 'Review Data' page – 'UR Provider Detail' note]

UR Determination
[Insert 'Determination Note' text content]

Guideline/Criteria Applied
[Name of Guideline Selected]

Clinical Rationale
[Insert 'Clinical History' text box content]

[Insert 'Rationale' text box content]

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

The above certified and/or modified treatment plan services are to be performed by the indicated network provider(s) and within facilities in the City of Los Angeles Medical Provider Networks (MPN) and Anthem Preferred Provider Organization (PPO).

http://www.cityoflampn.com/

Any treatment or services performed outside of network providers, MPN facilities or PPO are not certified.

Please feel free to contact us at PO Box 62289, Irvine, CA 92602-6076, (855) 445-0306 (p), or (877) 201-5336 (fax) should you have any additional questions regarding this claim or if medical necessity substantiates further treatment.

Respectfully,

Medata Utilization Review
Phone: (855) 455-0306
Fax: (877) 201-5336

cc:

- [Claimant] [injured worker first name last name, address]
- [Ancillary Provider] [ancillary provider name]
- [Attorney] [applicant attorney name, address]
- [Attorney] [defense attorney name, address]
- [Client] [adjuster name, email address]

Disclaimer

Utilization Review strictly analyzes the medical necessity of treatment requests. Medata Utilization Review does not affirm the acceptance of this workers' compensation claim. Nothing within this notice guarantees payment for services or compensability of the claim. Reimbursement authorization for any approved procedures/services, if applicable, is given based only upon medical necessity rationale explicitly provided in this letter. Actual reimbursement amounts are subject to applicable fees, coding, documentation, site of service, licensure scope, and policy requirements as set forth by jurisdictional rules, regulations, and standards of practice.

[DATE LETTER GENERATED]

[REQUESTING PROVIDER NAME]
[REQUESTING PROVIDER LOCATION/FACILITY NAME]
[REQUESTING PROVIDER STREET ADDRESS]
[REQUESTING PROVIDER CITY, ST, ZIP]

INJURED WORKER: [INJURED WORKER NAME]
CLAIM NUMBER: [CLAIM NUMBER]
DATE OF INJURY: [DATE OF INJURY VALUE]

INSURANCE TYPE: WC
JURISDICTION: CA
NETWORK STATUS: [HCN/MPN VALUE Y/N]

REQUEST ID: [REQUEST ID #]
DATE COMPLETE RFA FIRST RECEIVED: [CLIENT RECD DATE]
DETERMINATION: [DETERMINATION DESCRIPTION]
DETERMINATION DATE: [DETERMINATION DATE]
DATE ADDITIONAL INFORMATION REQUESTED: [INSERT DATE ADDTL INFO REQUESTED, OR IF NULL, INSERT N/A]
DATE ADDITIONAL INFORMATION RECEIVED: [INSERT DATE ADDTL INFO RECEIVED, OR IF NULL, INSERT N/A]

NOTICE OF UTILIZATION REVIEW DETERMINATION: NON-CERTIFY

Dear [Requesting Provider Name],

Medata has been requested by [Client Name] to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the requested health care services are **Non-Certified**.

Type of Review
[Insert Initial Doc Type]
[Insert Review Type]

Treatment/Service Requested
[Insert 'Provider Request Detail' text box content from 'Review Data' page – 'UR Provider Detail' note]

UR Determination
[Insert 'Determination Note' text content]

Medical Records Reviewed
See enclosed peer review report.

Clinical Rationale
See enclosed peer review report.

Guideline/Criteria Applied
[Name of Guideline Selected]

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact Medata at (855) 445-0306 so that a convenient time may be arranged for this discussion. Reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. Pacific Time.

Reviewed By
[Insert Reviewer Name and Credentials]
[Insert Reviewer Board Specialties]
License(s): [Insert Reviewer State Licenses]

Example:
John Doctor, MD
Pain Medicine, Orthopedic Surgery
License(s): CA – G123456, TN – 455451, TX – N07893, MS - 123456]

Please feel free to contact us at PO Box 62289, Irvine, CA 92602-6076, (855) 445-0306 (p), or (877) 201-5336 (fax) should you have any additional questions regarding this claim or if medical necessity substantiates further treatment.

Respectfully,

Medata Utilization Review
Phone: (855) 455-0306
Fax: (877) 201-5336

cc:

- [Claimant] [injured worker first name last name, address]
- [Ancillary Provider] [ancillary provider name]
- [Attorney] [applicant attorney name, address]
- [Attorney] [defense attorney name, address]
- [Client] [adjuster name, email address]

Disclaimer
Utilization Review strictly analyzes the medical necessity of treatment requests. Medata Utilization Review does not affirm the acceptance of this workers' compensation claim. Nothing within this notice guarantees payment for services or compensability of the claim. Reimbursement authorization for any approved procedures/services, if applicable, is given based only upon medical necessity rationale explicitly provided in this letter. Actual reimbursement amounts are subject to applicable fees, coding, documentation, site of service, licensure scope, and policy requirements as set forth by jurisdictional rules, regulations, and standards of practice.

Medata Optional Internal UR Appeals Process

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

1. Be submitted in writing; and

2. Be received by Medata within ten (10) calendar days of the date of the original determination; and

3. Contain either:
   a. Additional information supporting the request; or
   b. The basis or rationale for disagreement with the denial.

Voluntary internal appeal requests which do not match the above requirements will not be considered.

Appeals and information may be faxed to (877) 201-5336 or may be submitted via mail to Medata, PO Box 62289, Irvine, CA 92602-6076.

California Labor Code and Regulation Mandatory Language and Independent Medical Review Dispute Resolution

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 Name] at [Claims Adjuster Phone]. However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the modified or denied utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured workers' attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Division of Workers' Compensation
Department of Industrial Relations
State of California

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- **Sign and date this application and consent to obtain medical records.**
- **Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:**
  Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 606-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular ☐ Expedited ☐ Modification after Appeal ☐

Medication Only – MTUS Formulary Drug List ☐ Retrospective for Exempt Treatment (Non-Drug) ☐ Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

***** Mailing Date of the Utilization Review Determination Letter:

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☐No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

1.
2.
3.

4.

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☐30 days from the mailing date of the written determination letter.

☐10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETNG THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" determination letter) that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review ("IMR") of the medical treatment request by a physician who is not connected to your Claims Administrator. If the IMR is decided in your favor, your Claims Administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your Claims Administrator.

- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.

- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.

- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.

- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

  DWC-IMR, c/o Maximus Federal Services, Inc.
  PO Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days

from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)			
Address:			
City:	State:		Zip Code:
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:			Date:

medata

[DATE LETTER GENERATED]

[REQUESTING PROVIDER NAME]
[REQUESTING PROVIDER LOCATION/FACILITY NAME]
[REQUESTING PROVIDER STREET ADDRESS]
[REQUESTING PROVIDER CITY, ST, ZIP]

INJURED WORKER: [INJURED WORKER NAME]
CLAIM NUMBER: [CLAIM NUMBER]
DATE OF INJURY: [DATE OF INJURY VALUE]

INSURANCE TYPE: WC
JURISDICTION: CA
NETWORK STATUS: [HCN/MPN VALUE Y/N]

REQUEST ID: [REQUEST ID #]
DATE COMPLETE RFA FIRST RECEIVED: [CLIENT RECD DATE]
DETERMINATION: [DETERMINATION DESCRIPTION]
DETERMINATION DATE: [DETERMINATION DATE]
DATE ADDITIONAL INFORMATION REQUESTED: [INSERT DATE ADDTL INFO REQUESTED, OR IF NULL, INSERT N/A]
DATE ADDITIONAL INFORMATION RECEIVED: [INSERT DATE ADDTL INFO RECEIVED, OR IF NULL, INSERT N/A]

NOTICE OF UTILIZATION REVIEW DETERMINATION: NON-CERTIFY

Dear [Requesting Provider Name],

Medata has been requested by City of Los Angeles to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the requested health care services are **Non-Certified**.

Type of Review
[Insert Initial Doc Type]
[Insert Review Type]

Treatment/Service Requested
[Insert 'Provider Request Detail' text box content from 'Review Data' page – 'UR Provider Detail' note]

UR Determination
[Insert 'Determination Note' text content]

Medical Records Reviewed
See enclosed peer review report.

Clinical Rationale
See enclosed peer review report.

Guideline/Criteria Applied
[Name of Guideline Selected]

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact Medata at (855) 445-0306 so that a convenient time may be arranged for this discussion. Reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. Pacific Time.

Reviewed By
[Insert Reviewer Name and Credentials]
[Insert Reviewer Board Specialties]
License(s): [Insert Reviewer State Licenses]

Example:
John Doctor, MD
Pain Medicine, Orthopedic Surgery
License(s): CA – G123456, TN – 455451, TX – N07893, MS - 123456]

Please feel free to contact us at PO Box 62289, Irvine, CA 92602-6076, (855) 445-0306 (p), or (877) 201-5336 (fax) should you have any additional questions regarding this claim or if medical necessity substantiates further treatment.

Respectfully,

Medata Utilization Review
Phone: (855) 455-0306
Fax: (877) 201-5336

cc:

- [Claimant] [injured worker first name last name, address]
- [Ancillary Provider] [ancillary provider name]
- [Attorney] [applicant attorney name, address]
- [Attorney] [defense attorney name, address]
- [Client] [adjuster name, email address]

Disclaimer
Utilization Review strictly analyzes the medical necessity of treatment requests. Medata Utilization Review does not affirm the acceptance of this workers' compensation claim. Nothing within this notice guarantees payment for services or compensability of the claim. Reimbursement authorization for any approved procedures/services, if applicable, is given based only upon medical necessity rationale explicitly provided in this letter. Actual reimbursement amounts are subject to applicable fees, coding, documentation, site of service, licensure scope, and policy requirements as set forth by jurisdictional rules, regulations, and standards of practice.

Medata Optional Internal UR Appeals Process

Medata does not offer an internal appeal on a voluntary basis for City of Los Angeles claims.

California Labor Code and Regulation Mandatory Language and Independent Medical Review Dispute Resolution

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 Name] at [Claims Adjuster Phone]. However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the modified or denied utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured workers' attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Division of Workers' Compensation
Department of Industrial Relations
State of California

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- **Sign and date this application and consent to obtain medical records.**
- **Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:**
  Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 606-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular ☐ Expedited ☐ Modification after Appeal ☐

Medication Only – MTUS Formulary Drug List ☐ Retrospective for Exempt Treatment (Non-Drug) ☐ Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

***** Mailing Date of the Utilization Review Determination Letter:

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☐No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

1.
2.
3.

4.

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☐30 days from the mailing date of the written determination letter.

☐10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETNG THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" determination letter) that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review ("IMR") of the medical treatment request by a physician who is not connected to your Claims Administrator. If the IMR is decided in your favor, your Claims Administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your Claims Administrator.

- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.

- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.

- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.

- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

  DWC-IMR, c/o Maximus Federal Services, Inc.
  PO Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days

from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)			
Address:			
City:	State:		Zip Code:
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:			Date:

[DATE LETTER GENERATED]

[REQUESTING PROVIDER NAME]
[REQUESTING PROVIDER LOCATION/FACILITY NAME]
[REQUESTING PROVIDER STREET ADDRESS]
[REQUESTING PROVIDER CITY, ST, ZIP]

INJURED WORKER: [INJURED WORKER NAME]
CLAIM NUMBER: [CLAIM NUMBER]
DATE OF INJURY: [DATE OF INJURY VALUE]

INSURANCE TYPE: WC
JURISDICTION: CA
NETWORK STATUS: [HCN/MPN VALUE Y/N]

REQUEST ID: [REQUEST ID #]
DATE COMPLETE RFA FIRST RECEIVED: [CLIENT RECD DATE]
DATE ADDITIONAL INFORMATION REQUESTED: [DATE or N/A]
DATE ADDITIONAL INFORMATION RECEIVED: [DATE or N/A]

DETERMINATION: [DETERMINATION DESCRIPTION]
DETERMINATION DATE: [DETERMINATION DATE]
CERTIFICATION NUMBER: [Insert MCN]

NOTICE OF UTILIZATION REVIEW DETERMINATION: MODIFIED

Dear [Requesting Provider Name],

Medata has been requested by [Client Name] to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the requested health care services partially meet the established criteria for medical necessity and are being partially certified.

Type of Review
[Insert Initial Doc Type]
[Insert Review Type]

Treatment/Service Requested
[Insert 'Provider Request Detail' text box content from 'Review Data' page – 'UR Provider Detail' note]

UR Determination
[Insert 'Determination Note' text content]

Medical Records Reviewed
See enclosed peer review report.

Clinical Rationale
See enclosed peer review report.

Guideline/Criteria Applied
[Name of Guideline Selected]

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact Medata at (855) 445-0306 so that a convenient time may be arranged for this discussion. Reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. Pacific Time.

Reviewed By
[Insert Reviewer Name and Credentials]
[Insert Reviewer Board Specialties]
License(s): [Insert Reviewer State Licenses]

Example:
John Doctor, MD
Pain Medicine, Orthopedic Surgery
License(s): CA – G123456, TN – 455451, TX – N07893, MS - 123456]

Please feel free to contact us at PO Box 62289, Irvine, CA 92602-6076, (855) 445-0306 (p), or (877) 201-5336 (fax) should you have any additional questions regarding this claim or if medical necessity substantiates further treatment.

Respectfully,

Medata Utilization Review
Phone: (855) 455-0306
Fax: (877) 201-5336

cc:

- [Claimant] [injured worker first name last name, address]
- [Ancillary Provider] [ancillary provider name]
- [Attorney] [applicant attorney name, address]
- [Attorney] [defense attorney name, address]
- [Client] [adjuster name, email address]

Disclaimer
Utilization Review strictly analyzes the medical necessity of treatment requests. Medata Utilization Review does not affirm the acceptance of this workers' compensation claim. Nothing within this notice guarantees payment for services or compensability of the claim. Reimbursement authorization for any approved procedures/services, if applicable, is given based only upon medical necessity rationale explicitly provided in this letter. Actual reimbursement amounts are subject to applicable fees, coding, documentation, site of service, licensure scope, and policy requirements as set forth by jurisdictional rules, regulations, and standards of practice.

Medata Optional Internal UR Appeals Process

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

1. Be submitted in writing; and

2. Be received by Medata within ten (10) calendar days of the date of the original determination; and

3. Contain either:
   a. Additional information supporting the request; or
   b. The basis or rationale for disagreement with the denial.

Voluntary internal appeal requests which do not match the above requirements will not be considered.

Appeals and information may be faxed to (877) 201-5336 or may be submitted via mail to Medata, PO Box 62289, Irvine, CA 92602-6076.

California Labor Code and Regulation Mandatory Language and Independent Medical Review Dispute Resolution

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 Name] at [Claims Adjuster Phone]. However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the modified or denied utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured workers' attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Division of Workers' Compensation
Department of Industrial Relations
State of California

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- **Sign and date this application and consent to obtain medical records.**
- **Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:**
  Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 606-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular ☐ Expedited ☐ Modification after Appeal ☐

Medication Only – MTUS Formulary Drug List ☐ Retrospective for Exempt Treatment (Non-Drug) ☐ Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

***** Mailing Date of the Utilization Review Determination Letter:

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☐No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

1.
2.
3.

4.

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☐30 days from the mailing date of the written determination letter.

☐10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETNG THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

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IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your Claims Administrator.

- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.

- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.

- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.

- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

  DWC-IMR, c/o Maximus Federal Services, Inc.
  PO Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days

from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)			
Address:			
City:	State:		Zip Code:
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:			Date:

[DATE LETTER GENERATED]

[REQUESTING PROVIDER NAME]
[REQUESTING PROVIDER LOCATION/FACILITY NAME]
[REQUESTING PROVIDER STREET ADDRESS]
[REQUESTING PROVIDER CITY, ST, ZIP]

INJURED WORKER: [INJURED WORKER NAME]
CLAIM NUMBER: [CLAIM NUMBER]
DATE OF INJURY: [DATE OF INJURY VALUE]

INSURANCE TYPE: WC
JURISDICTION: CA
NETWORK STATUS: [HCN/MPN VALUE Y/N]

REQUEST ID: [REQUEST ID #]
DATE COMPLETE RFA FIRST RECEIVED: [CLIENT RECD DATE]
DATE ADDITIONAL INFORMATION REQUESTED: [DATE or N/A]
DATE ADDITIONAL INFORMATION RECEIVED: [DATE or N/A]

DETERMINATION: [DETERMINATION DESCRIPTION]
DETERMINATION DATE: [DETERMINATION DATE]
CERTIFICATION NUMBER: [Insert MCN]

NOTICE OF UTILIZATION REVIEW DETERMINATION: MODIFIED

Dear [Requesting Provider Name],

Medata has been requested by City of Los Angeles to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the requested health care services partially meet the established criteria for medical necessity and are being partially certified.

Type of Review
[Insert Initial Doc Type]
[Insert Review Type]

Treatment/Service Requested
[Insert 'Provider Request Detail' text box content from 'Review Data' page – 'UR Provider Detail' note]

UR Determination
[Insert 'Determination Note' text content]

Medical Records Reviewed
See enclosed peer review report.

Clinical Rationale
See enclosed peer review report.

Guideline/Criteria Applied
[Name of Guideline Selected]

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

The above certified and/or modified treatment plan services are to be performed by the indicated network provider(s) and within facilities in the City of Los Angeles Medical Provider Networks (MPN) and Anthem Preferred Provider Organization (PPO).

http://www.cityoflampn.com/

Any treatment or services performed outside of network providers, MPN facilities or PPO are not certified.

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact Medata at (855) 445-0306 so that a convenient time may be arranged for this discussion. Reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. Pacific Time.

Reviewed By
[Insert Reviewer Name and Credentials]
[Insert Reviewer Board Specialties]
License(s): [Insert Reviewer State Licenses]

Example:
John Doctor, MD
Pain Medicine, Orthopedic Surgery
License(s): CA – G123456, TN – 455451, TX – N07893, MS - 123456]

Please feel free to contact us at PO Box 62289, Irvine, CA 92602-6076, (855) 445-0306 (p), or (877) 201-5336 (fax) should you have any additional questions regarding this claim or if medical necessity substantiates further treatment.

Respectfully,

Medata Utilization Review
Phone: (855) 455-0306
Fax: (877) 201-5336

cc:

- [Claimant] [injured worker first name last name, address]
- [Ancillary Provider] [ancillary provider name]
- [Attorney] [applicant attorney name, address]
- [Attorney] [defense attorney name, address]
- [Client] [adjuster name, email address]

Disclaimer
Utilization Review strictly analyzes the medical necessity of treatment requests. Medata Utilization Review does not affirm the acceptance of this workers' compensation claim. Nothing within this notice guarantees payment for services or compensability of the claim. Reimbursement authorization for any approved procedures/services, if applicable, is given based only upon medical necessity rationale explicitly provided in this letter. Actual reimbursement amounts are subject to applicable fees, coding, documentation, site of service, licensure scope, and policy requirements as set forth by jurisdictional rules, regulations, and standards of practice.

Medata Optional Internal UR Appeals Process

Medata does not offer an internal appeal on a voluntary basis for City of Los Angeles claims.

California Labor Code and Regulation Mandatory Language and Independent Medical Review Dispute Resolution

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 Name] at [Claims Adjuster Phone]. However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the modified or denied utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured workers' attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Division of Workers' Compensation
Department of Industrial Relations
State of California

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- **Sign and date this application and consent to obtain medical records.**
- **Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:**
  Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 606-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular ☐ Expedited ☐ Modification after Appeal ☐

Medication Only – MTUS Formulary Drug List ☐ Retrospective for Exempt Treatment (Non-Drug) ☐ Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

***** Mailing Date of the Utilization Review Determination Letter:

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☐No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

1.
2.
3.

4.

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☐30 days from the mailing date of the written determination letter.

☐10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETNG THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" determination letter) that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review ("IMR") of the medical treatment request by a physician who is not connected to your Claims Administrator. If the IMR is decided in your favor, your Claims Administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your Claims Administrator.

- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.

- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.

- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.

- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

  DWC-IMR, c/o Maximus Federal Services, Inc.
  PO Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days

from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)			
Address:			
City:	State:		Zip Code:
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:			Date:

[DATE LETTER GENERATED]

[REQUESTING PROVIDER NAME]
[REQUESTING PROVIDER LOCATION/FACILITY NAME]
[REQUESTING PROVIDER STREET ADDRESS]
[REQUESTING PROVIDER CITY, ST, ZIP]

INJURED WORKER: [INJURED WORKER NAME]
CLAIM NUMBER: [CLAIM NUMBER]
DATE OF INJURY: [DATE OF INJURY VALUE]

INSURANCE TYPE: WC
JURISDICTION: CA
NETWORK STATUS: [HCN/MPN VALUE Y/N]

REQUEST ID: [REQUEST ID #]
DATE COMPLETE RFA FIRST RECEIVED: [CLIENT RECD DATE]

UR REQUEST FOR ADDITIONAL INFORMATION

Dear [Requesting Provider Name],

Medata has been requested by [Client Name] to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the non-physician reviewer or physician reviewer has determined that additional information is required to make a determination of medical necessity. We are requesting that the requesting provider submit the following information in order to allow us to complete this review:

Type of Review
[Insert Initial Doc Type]
[Insert Review Type]

Physician Requesting Authorization
[Insert Requesting Provider Name]

Treatment/Service Requested
[Insert 'Provider Request Detail' text box content from 'Review Data' page – 'UR Provider Detail' note]

Information Being Requested
[Insert Information Requested]

Please provide this information no later than 14 calendar days of the date when the RFA was first received listed above in the case of a prospective or concurrent review, or within 30 calendar days of the date when the RFA was first received listed above in the case of a retrospective review. Pursuant to 8 CCR 9792.9.6(c), if the requested information is not provided within that timeframe, the reviewer shall deny the request. The request will be reconsidered within 5 working days upon receipt of the information.

If this request results in a need for an additional examination or test to be performed upon an injured worker or a specialized consult and review of medical information, then the information may be submitted within 30 days from the date of the RFA. If the requested information is not received, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

This information may be faxed to Medata at (877) 201-5336 or mailed to PO Box 62289, Irvine, CA 92602-6076. Please feel free to contact us with any questions.

Respectfully,

Medata Utilization Review
Phone: (855) 455-0306
Fax: (877) 201-5336

cc:

- [Injured Worker] [Injured Worker name, Address]
- [Attorney] [Applicant Attorney name, Address]
- [Attorney] [Defense Attorney name, Address]
- [Client] [Adjuster name, email address]

Disclaimer
Utilization Review strictly analyzes the medical necessity of treatment requests. Medata Utilization Review does not affirm the acceptance of this workers' compensation claim. Nothing within this notice guarantees payment for services or compensability of the claim. Reimbursement authorization for any approved procedures/services, if applicable, is given based only upon medical necessity rationale explicitly provided in this letter. Actual reimbursement amounts are subject to applicable fees, coding, documentation, site of service, licensure scope, and policy requirements as set forth by jurisdictional rules, regulations, and standards of practice.

[DATE LETTER GENERATED]

[REQUESTING PROVIDER NAME]
[REQUESTING PROVIDER LOCATION/FACILITY NAME]
[REQUESTING PROVIDER STREET ADDRESS]
[REQUESTING PROVIDER CITY, ST, ZIP]

INJURED WORKER: [INJURED WORKER NAME]
CLAIM NUMBER: [CLAIM NUMBER]
DATE OF INJURY: [DATE OF INJURY VALUE]

INSURANCE TYPE: WC
JURISDICTION: CA
NETWORK STATUS: [HCN/MPN VALUE Y/N]

REQUEST ID: [REQUEST ID #]
DATE COMPLETE RFA FIRST RECEIVED: [CLIENT RECD DATE]
DATE ADDITIONAL INFORMATION REQUESTED: [DATE or N/A]
DATE ADDITIONAL INFORMATION RECEIVED: [DATE or N/A]

DETERMINATION: [DETERMINATION DESCRIPTION]
DETERMINATION DATE: [DETERMINATION DATE]
CERTIFICATION NUMBER: [Insert MCN]

NOTICE OF UTILIZATION REVIEW APPEAL DETERMINATION: CERTIFY

Dear [Requesting Provider Name],

Medata has been requested by [Client Name] to perform utilization review to determine if the requested health care services are medically necessary and appropriate for this claim. On [Date of Initial Review Determination], we completed Review [Initial Review Request ID #] at which time a physician reviewer determined that the requested care did not fully meet the criteria for medical necessity.

Following that decision, we received a voluntary appeal request on [Appeal Client Received Date] and therefore asked a different physician to re-review the treatment request. This letter is to notify you of our determination regarding medical necessity.

Type of Review
[Insert Initial Doc Type]
[Insert Review Type]

Treatment/Service Requested
[Insert 'Provider Request Detail' text box content from 'Review Data' page – 'UR Provider Detail' note]

UR Determination
[Insert 'Determination Note' text content]

Medical Records Reviewed
See enclosed peer review report.

Clinical Rationale
See enclosed peer review report.

Guideline/Criteria Applied
[Name of Guideline Selected]

Please feel free to contact us at PO Box 62289, Irvine, CA 92602-6076, (855) 445-0306 (p), or (877) 201-5336 (fax) should you have any additional questions regarding this claim or if medical necessity substantiates further treatment.

Respectfully,

Medata Utilization Review
Phone: (855) 455-0306
Fax: (877) 201-5336

cc:

- [Claimant] [injured worker first name last name, address]
- [Ancillary Provider] [ancillary provider name]
- [Attorney] [applicant attorney name, address]
- [Attorney] [defense attorney name, address]
- [Client] [adjuster name, email address]

Disclaimer
Utilization Review strictly analyzes the medical necessity of treatment requests. Medata Utilization Review does not affirm the acceptance of this workers' compensation claim. Nothing within this notice guarantees payment for services or compensability of the claim. Reimbursement authorization for any approved procedures/services, if applicable, is given based only upon medical necessity rationale explicitly provided in this letter. Actual reimbursement amounts are subject to applicable fees, coding, documentation, site of service, licensure scope, and policy requirements as set forth by jurisdictional rules, regulations, and standards of practice.

[DATE LETTER GENERATED]

[REQUESTING PROVIDER NAME]
[REQUESTING PROVIDER LOCATION/FACILITY NAME]
[REQUESTING PROVIDER STREET ADDRESS]
[REQUESTING PROVIDER CITY, ST, ZIP]

INJURED WORKER: [INJURED WORKER NAME]
CLAIM NUMBER: [CLAIM NUMBER]
DATE OF INJURY: [DATE OF INJURY VALUE]

INSURANCE TYPE: WC
JURISDICTION: CA
NETWORK STATUS: [HCN/MPN VALUE Y/N]

REQUEST ID: [REQUEST ID #]
DATE COMPLETE RFA FIRST RECEIVED: [CLIENT RECD DATE]
DATE ADDITIONAL INFORMATION REQUESTED: [DATE or N/A]
DATE ADDITIONAL INFORMATION RECEIVED: [DATE or N/A]

DETERMINATION: [DETERMINATION DESCRIPTION]
DETERMINATION DATE: [DETERMINATION DATE]

NOTICE OF UTILIZATION REVIEW APPEAL DETERMINATION: NON-CERTIFY

Dear [Requesting Provider Name],

Medata has been requested by [Client Name] to perform utilization review to determine if the requested health care services are medically necessary and appropriate for this claim. On [Date of Initial Review Determination], we completed Review [Initial Review Request ID #] at which time a physician reviewer determined that the requested care did not fully meet the criteria for medical necessity.

Following that decision, we received a voluntary appeal request on [Appeal Client Received Date] and therefore asked a different physician to re-review the treatment request. This letter is to notify you of our determination regarding medical necessity.

Type of Review
[Insert Initial Doc Type]
[Insert Review Type]

Treatment/Service Requested
[Insert 'Provider Request Detail' text box content from 'Review Data' page – 'UR Provider Detail' note]

UR Determination
[Insert 'Determination Note' text content]

Medical Records Reviewed
See enclosed peer review report.

Clinical Rationale
See enclosed peer review report.

Guideline/Criteria Applied
[Name of Guideline Selected]

Reviewed By
[Insert Reviewer Name and Credentials]
[Insert Reviewer Board Specialties]
License(s): [Insert Reviewer State Licenses]

Example:
John Doctor, MD
Pain Medicine, Orthopedic Surgery
License(s): CA – G123456, TN – 455451, TX – N07893, MS - 123456]

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact Medata at (855) 445-0306 so that a convenient time may be arranged for this discussion. All reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. Pacific Time. Please feel free to contact us should you have any additional questions regarding this claim.

Respectfully,

Medata Utilization Review
Phone: (855) 455-0306
Fax: (877) 201-5336

cc:

- [Claimant] [injured worker first name last name, address]
- [Ancillary Provider] [ancillary provider name]
- [Attorney] [applicant attorney name, address]
- [Attorney] [defense attorney name, address]
- [Client] [adjuster name, email address]

Disclaimer
Utilization Review strictly analyzes the medical necessity of treatment requests. Medata Utilization Review does not affirm the acceptance of this workers' compensation claim. Nothing within this notice guarantees payment for services or compensability of the claim. Reimbursement authorization for any approved procedures/services, if applicable, is given based only upon medical necessity rationale explicitly provided in this letter. Actual reimbursement amounts are subject to applicable fees, coding, documentation, site of service, licensure scope, and policy requirements as set forth by jurisdictional rules, regulations, and standards of practice.

Medata Optional Internal UR Appeals Process

For any treatment request which was ***modified*** or ***denied*** after an appeal, this completes the internal appeals process. Please contact the claims administrator with any questions. Participation in this optional internal appeals process neither triggers nor bars the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6 (i.e., Independent Medical Review).

California Labor Code and Regulation Mandatory Language and Independent Medical Review Dispute Resolution

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 Name] at [Claims Adjuster Phone]. However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the modified or denied utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured workers' attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Division of Workers' Compensation
Department of Industrial Relations
State of California

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- **Sign and date this application and consent to obtain medical records.**
- **Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:**
  Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 606-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular ☐ Expedited ☐ Modification after Appeal ☐

Medication Only – MTUS Formulary Drug List ☐ Retrospective for Exempt Treatment (Non-Drug) ☐ Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

***** Mailing Date of the Utilization Review Determination Letter:

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☐No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

1.
2.
3.

4.

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☐30 days from the mailing date of the written determination letter.

☐10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETNG THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" determination letter) that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review ("IMR") of the medical treatment request by a physician who is not connected to your Claims Administrator. If the IMR is decided in your favor, your Claims Administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your Claims Administrator.

- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.

- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.

- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.

- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

  DWC-IMR, c/o Maximus Federal Services, Inc.
  PO Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days

from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)			
Address:			
City:	State:		Zip Code:
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:			Date:

[DATE LETTER GENERATED]

[REQUESTING PROVIDER NAME]
[REQUESTING PROVIDER LOCATION/FACILITY NAME]
[REQUESTING PROVIDER STREET ADDRESS]
[REQUESTING PROVIDER CITY, ST, ZIP]

INJURED WORKER: [INJURED WORKER NAME]
CLAIM NUMBER: [CLAIM NUMBER]
DATE OF INJURY: [DATE OF INJURY VALUE]

INSURANCE TYPE: WC
JURISDICTION: CA
NETWORK STATUS: [HCN/MPN VALUE Y/N]

REQUEST ID: [REQUEST ID #]
DATE COMPLETE RFA FIRST RECEIVED: [CLIENT RECD DATE]
DATE ADDITIONAL INFORMATION REQUESTED: [DATE or N/A]
DATE ADDITIONAL INFORMATION RECEIVED: [DATE or N/A]

DETERMINATION: [DETERMINATION DESCRIPTION]
DETERMINATION DATE: [DETERMINATION DATE]
CERTIFICATION NUMBER: [Insert MCN]

NOTICE OF UTILIZATION REVIEW APPEAL DETERMINATION: MODIFIED

Dear [Requesting Provider Name],

Medata has been requested by [Client Name] to perform utilization review to determine if the requested health care services are medically necessary and appropriate for this claim. On [Date of Initial Review Determination], we completed Review [Initial Review Request ID #] at which time a physician reviewer determined that the requested care did not fully meet the criteria for medical necessity.

Following that decision, we received a voluntary appeal request on [Appeal Client Received Date] and therefore asked a different physician to re-review the treatment request. This letter is to notify you of our determination regarding medical necessity.

Type of Review
[Insert Initial Doc Type]
[Insert Review Type]

Treatment/Service Requested
[Insert 'Provider Request Detail' text box content from 'Review Data' page – 'UR Provider Detail' note]

UR Determination
[Insert 'Determination Note' text content]

Medical Records Reviewed
See enclosed peer review report.

Clinical Rationale
See enclosed peer review report.

Guideline/Criteria Applied
[Name of Guideline Selected]

Reviewed By
[Insert Reviewer Name and Credentials]
[Insert Reviewer Board Specialties]
License(s): [Insert Reviewer State Licenses]

Example:
John Doctor, MD
Pain Medicine, Orthopedic Surgery
License(s): CA – G123456, TN – 455451, TX – N07893, MS - 123456]

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact Medata at (855) 445-0306 so that a convenient time may be arranged for this discussion. All reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. Pacific Time. Please feel free to contact us should you have any additional questions regarding this claim.

Respectfully,

Medata Utilization Review
Phone: (855) 455-0306
Fax: (877) 201-5336

cc:

- [Claimant] [injured worker first name last name, address]
- [Ancillary Provider] [ancillary provider name]
- [Attorney] [applicant attorney name, address]
- [Attorney] [defense attorney name, address]
- [Client] [adjuster name, email address]

Disclaimer
Utilization Review strictly analyzes the medical necessity of treatment requests. Medata Utilization Review does not affirm the acceptance of this workers' compensation claim. Nothing within this notice guarantees payment for services or compensability of the claim. Reimbursement authorization for any approved procedures/services, if applicable, is given based only upon medical necessity rationale explicitly provided in this letter. Actual reimbursement amounts are subject to applicable fees, coding, documentation, site of service, licensure scope, and policy requirements as set forth by jurisdictional rules, regulations, and standards of practice.

Medata Optional Internal UR Appeals Process

For any treatment request which was ***modified*** or ***denied*** after an appeal, this completes the internal appeals process. Please contact the claims administrator with any questions. Participation in this optional internal appeals process neither triggers nor bars the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6 (i.e., Independent Medical Review).

California Labor Code and Regulation Mandatory Language and Independent Medical Review Dispute Resolution

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 Name] at [Claims Adjuster Phone]. However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the modified or denied utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured workers' attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Division of Workers' Compensation
Department of Industrial Relations
State of California

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- **Sign and date this application and consent to obtain medical records.**
- **Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:**
  Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 606-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular ☐ Expedited ☐ Modification after Appeal ☐

Medication Only – MTUS Formulary Drug List ☐ Retrospective for Exempt Treatment (Non-Drug) ☐ Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

***** Mailing Date of the Utilization Review Determination Letter:

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☐No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

1.
2.
3.

4.

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Employee Signature Date

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☐30 days from the mailing date of the written determination letter.

☐10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

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- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.

- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.

- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.

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  DWC-IMR, c/o Maximus Federal Services, Inc.
  PO Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days

from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

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- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)			
Address:			
City:	State:		Zip Code:
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:			Date:

14. Client Prior Authorization Plans

The following clients have enclosed plans:

1. County of Los Angeles

County of Los Angeles Workers' Compensation Program
Utilization Review Approvals and Referrals

The County of Los Angeles Workers' Compensation Program (Program) goal is to provide unencumbered evidence-based medical treatment for employees that have sustained industrial injuries. To accomplish this goal, claims examiners can authorize a wide range of medical treatment for accepted body parts without the need to send request for authority (RFA) to utilization review. The Program expects claims examiners to use sound professional judgement in applying the utilization review triggers (example: 36 physical therapy visits may be reasonable for post-surgery functional recovery, but 24 physical therapy visits for a sprained finger may not be reasonable). Questions regarding medical treatment authorization can be elevated to Third-Party Administration management, the medical management cost containment contractor, and On-Site County Representatives as needed.

Claims examiners are the frontline in identifying medical provider fraud, waste, or abuse. Please report any unusual treatment or billing patterns to your management so it can be investigated.

Claims examiners can approve the following medical services without submitting to the utilization review organization.

Diagnostic Testing – Initial Requests or Surgeon Requesting Additional Study

- X-rays
- MRI
- EMG Nerve Conduction Study
- CT Scan/ Bone Scan / Ultrasound/ Doppler
- EKG, EEG with no surgical request

Physical Therapy, Occupational Therapy, Chiropractic Care, Functional Restoration

- PT/OT: 24 visits or 36 visits post-surgery (major surgeries)
- Chiropractic Care: 24 visits
- Acupuncture: 24 visits
- Aqua Therapy up to 6 visits
- Gym membership up to $500 per year (one-year limit)
- Exercise programs up to $500

Evaluation and Management

- Office visit and follow-up office visits
- In office corticosteroid injection
- Trigger point injections (up to four)
- Mohs micrographic surgery (skin cancer)
- Referral to a specialist/ transfer of care/ consultations
- LAB studies and pre-op clearance (CBC, CMP, EKG, Chest X-ray) specific to surgery performed and accepted body part(s). (Authorized post UR cert of the

surgery)

Durable Medical Goods (less than $350)

• Cane and crutches
• Braces for lumbar, cervical, knee, wrist, elbow (stock not customized)
• Walker
• Transcutaneous Electrical Nerve Stimulation (TENS) Trial x 30 days
• TENS supplies if TENS unit has been approved
• Commode □ Shower Bench □ Wheelchair rental

Greater than $350.00 but still ok to approve at adjuster level

• Home health evaluation only
• Discharge from hospital or facility
• Hearing aids/ audiograms/audio testing

Prescription Medication

• Heart - cardiac, hypertension, diabetic medications
• Cancer related medications (high cost experimental medications need UR)
• Neuropathic pain medications (Lyrica, Gabapentin, etc.)
• NSAID: Naproxen, Ibuprofen, Aspirin, etc.
• Gastrointestinal/Gerds drugs: Prilosec, Zantac, Omeprazole, Zantac
• Antidepressants if psychiatric injury is accepted
• Naloxone (Narcan)nasal spray to reverse/blocks effects of the opioid (do not approve Evzio)
• Muscle relaxants and Corticosteroids (Flexeril, Cortisone, etc.) – Special Fill
• Hydrocodone/acetaminophen (Norco, Vicodin, etc.) – Special Fill, Peri-OP, low Morphine Equivalent Dose
• Analgesics-Opioids (Tramadol, Oxycodone, etc.) - Special Fill, Peri-OP, low Morphine Equivalent Dose

Claims examiners must refer the following medical services to the utilization review organization unless otherwise directed by CEO-RMB staff.

Utilization review (UR) is the process used by employers or claims administrators to review treatment to determine if it is medically necessary. All employers or their workers' compensation claims administrators are required by law to have a UR program. This program is used to decide whether or not to approve medical treatment recommended by a physician which must be based on the medical treatment guidelines.

The UR process is governed by Labor Code section 4610 and regulations written by the CA Division of Workers' Compensation (DWC), which lay out timeframes and other rules for conducting UR. The rules, contained in Title 8, California Code of Regulations, sections 9792.6 et seq, also require UR plans to be filed with the DWC administrative director.

Please be timely when submitting RFAs to the Utilization Review Organization. Utilization

Review Organizations serving the Program provide a voluntary internal utilization review appeal process that allow communication between the treating physician and peer utilization review physician intended to resolve treatment disputes.
Generally, a utilization review decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Invasive, Experimental, or Repeat Diagnostic Testing

- Myelogram, Discogram, Arthrogram, and Video Fluoroscopy
- Questionable or unwarranted requests for repeat tests
- Experimental diagnostic tests

Physical Therapy, Occupational Therapy, Chiropractic Care, Functional Restoration

- PT/OT: exceeding 24 visits or exceeding 36 visits post-surgery
- Chiropractic Care: exceeding 24 visits
- Acupuncture: exceeding 24 visits
- Gym membership exceeding $500 per year (one-year limit)
- Exercise programs exceeding $500

Pain Management

- Epidurals, Facet Nerve Blocks, Selective Nerve Root Blocks
- Morphine Pumps, Implant Pumps, Pain Pumps, Spinal Cord Stimulators
- Botox Injections, Viscosupplementation Injections
- Intradiscal Electrothermal Therapy (IDET)
- Detox Programs
- Chronic Pain Management – Interdisciplinary Program
- Radiofrequency Lesioning

Surgeries and Hospitalizations

- All
- Referrals to skilled nursing home, rehabilitation facility, or transitional facility

Prescription Medications

- Compound Medications
- Home Administered IVs
- Enorvarx-Ibuprofen 10% Kits (Kits in general)
- Pennsaid 2%
- Cannabinoids
- Duexis
- Fentanyl
- Questionable high cost medications

Miscellaneous

- Home Healthcare, Gardening, Transportation
- Dental Services
- Weight Loss Programs
- Home Modifications, Furniture, Gym Equipment
- TENS (or like type electrical stimulators) exceeding 30-day trial
- Shockwave Therapy
- Platelet-rich plasma injections

Reviewed and approved

DocuSigned by:
Avrom Gart
9B745EFF046545B...
1/30/2020

Avrom Gart, MD

California Medical Director, Medata

Medical Director, P&S Network

DocuSigned by:
EADDFD4EC930421...
1/29/2020

David Deitz, MD, PhD

National Medical Director, Medata

Revision and Review History

Month/Year	Policy Action Type	Summary
4/2019	Creation/Effective Date	Created policy for CA DWC Filing
4/2020	Annual Review	No changes
4/2021	Annual Review	No change
8/2021	Regulatory Agency Requested Updates	Non-Substantive Changes per DWC Audit
4/2022	Annual Review	No changes
4/2023	Annual Review	No changes
11/2023	Regulatory Agency Requested Updates and Medical Director change	New medical director Dr. Zenia Cortes and slight language change to the non-certify / deny letters in the IMR appeal rights section requested by the state. Criteria list.
1/2024	Regulatory Agency Requested Update	Updated “Medata, Inc.” to “Medata, LLC” in correlation with change in Organizational designation related to MedRisk’s acquisition of Medata.
4/2025	Annual Review	No changes
3/2026	Annual Review / New Regulatory Updates / Medical Director Change	New medical director Dr. Dorian Kenleigh / Updates due to DWC UR regulations revisions effective April 1, 2026 / Branding