

URO #063

CareWorks

California Utilization Review Policy and Procedure | 2017

Utilization Review Plan

General

CareWorks Managed Care Services (CareWorks) shall ensure a process by which determination of whether evaluation and/or treatment (collectively "treatment") recommended by a health care provider is medically necessary. (The term "medical necessity" is described in more detail below.) Such determination shall be in the form of an approval, modification, or a denial of a health care provider's Request for Authorization (RFA) of treatment and/or payment for treatment. CareWorks will retain direct management control over requests for authorization. Utilization review may be prospective, retrospective and/or concurrent.

The following utilization review program is subject to other existing Company policies; as such policies may be amended from time to time, and to applicable law.

R 9792.7 Utilization Review Standards – Applicability

(a) Effective January 1, 2004, every claims administrator shall established and maintain a utilization review process for treatment rendered on or after January 1, 2004, regardless of date of injury, in compliance with Labor Code Section 4610. Each utilization review process shall be set forth in a utilization review plan which shall contain:

(1) The Name, address, phone number, and medical license number of the employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.

Medical Director:	<u>Dr. Joyce Ho</u> 10535 Boyer Blvd. #100
Address:	Austin, Texas, 78758
Office Phone:	800-580-2273
Peer to Peer Phone:	800-580-2273 (M-F 8:00am-5:30pm PST)
Specialty:	Physical Medicine and Rehabilitation
Licensure:	A94331
Licensing States:	California

(2) A description of the process whereby requests for authorization are reviewed, and decision on such requests are made, and a description of the process for handling expedited review.

PROCESS FOR TREATMENT AUTHORIZATIONS AND PAYMENT

Request for Authorization.

A health care provider shall submit a written DWC form RFA (Request for Authorization) to CareWorks or the claims administrator/carrier that shall contain the information reasonably required to process and consider the request and shall be in a form reasonably acceptable. The operation hours of the utilization review department are 8:30AM to 5:30PM PST, on normal business days, in compliance with Title 8 CCR § 9792.9.1 (a)(3)

Requests for authorization can be faxed or mailed to the attention of the claims administrator/carrier, or CareWorks' utilization review department in writing through our centralized 1.800.580.3123 facsimile number or 1.800.618.1439. All requests for review are entered by the CareWorks Intake specialist. Once the demographic information is entered and type of service request is entered into the utilization management software, a unique referral number is assigned. The case is then assigned to a nurse or medical coordinator. If there is insufficient information supplied in order to render a valid determination, the nurse or medical coordinator will request the information within five (5) working days from the date of receipt of the written request for authorization to make the proper determination. If the provider does not supply the information within 14 days of the date of receipt of the original request by the requesting physician, a reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested. If instead, the provided documentation meets the internal authorization criterion, the nurse will issue an "authorization" for the requested service. If the medical documentation does not meet criteria, the nurse refers the request to one of the utilization review physicians for review and a determination.

The claims administrator may accept a request for authorization for medical treatment that does not utilize the DWC Form RFA, provided that: (1) "Request for Authorization" is clearly written at the top of the first page of the document; (2) all requested medical services, goods, or items are listed on the first page; and (3) the request is accompanied by documentation substantiating the medical necessity for the requested treatment. Upon receipt of a request for authorization as described above or a DWC Form RFA that does not identify the employee or provider, does not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity for the requested treatment, or is not signed by the requesting physician, a non-physician reviewer as allowed by section 9792.7 or reviewer must either regard the request as a complete DWC Form RFA and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete," specifying the reasons for the return of the request no later than five (5) business days from receipt. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

CareWorks provides a voice mail recorder for after-hour calls. All voice mail messages are returned within one working day. CareWorks does not require precertification of urgent or emergent care.

Time Frames for Response and Decision

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

Effective January 1, 2004 all requests for treatment shall require evaluation in line with evidence based medicine and shall receive timely response of authorization, delay, denial or modification. The time frames for such response shall be:

- (1) 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. Concurrent review" means utilization review conducted during an inpatient stay.

For prospective or concurrent review, response shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed DWC Form RFA.

- a. If all information required to make a determination is not received, request for additional information shall not exceed five (5) business days from the date of the receipt of the request for authorization and in no event shall the determination be made more than 14 days from receipt of the complete request for authorization.
 - b. Telephonic, electronic mail, or facsimile notice of approval shall be communicated to the requesting physician within 24 hours of the decision, followed by written notice within 24 hours for concurrent review and within two business days for prospective review.
- (2) 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. For expedited review, response shall be made in a timely fashion not to exceed 72 hours

after the receipt of written request providing enough information required to make the determination.

- a. Where possible, requests for expedited or emergency authorization shall be taken in verbal form to further expedited response.
- b. In the case of emergency medical care*, concurrent or retrospective authorization review shall be made to avoid delay in medical treatment to the patient.
- c. Failure to obtain prior authorization for emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize the injured worker presenting for emergency health care services. Emergency health care services, however, may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.

*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".

- (3) Retrospective review means utilization review conducted after medical services have been provided and for which approval has not already been given. For retrospective review, response shall be communicated in a timely fashion not to exceed 30 days from the receipt of all necessary information required to make a determination.
 - a. Notification of determination shall be made in written or facsimile form to the requesting physician, the individual who received the services, and his or her attorney/designee if applicable. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

Deferral of Utilization Review

Deferral of utilization review of a medical treatment request made on the DWC Form RFA may be issued if the claims administrator/carrier disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity, as per Labor Code Section 9792.9.1 (b).

If the claims administrator/carrier disputes liability under Labor Code Section 9792.9.1 (b), it may, no later than five (5) business days from receipt of the DWC Form RFA, issue a written decision deferring utilization review of the requested treatment. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.

If utilization review is deferred pursuant to this subdivision, and it is finally determined that the claims administrator/carrier is liable for treatment of the condition for which treatment is recommended, the time for the claims administrator to conduct retrospective utilization review in accordance with this section shall begin on the date the determination of the claims administrator's liability becomes final. The time for the claims administrator to conduct

prospective utilization review shall commence from the date of the claims administrator's receipt of a DWC Form RFA after the final determination of liability.

Notification of Decision

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

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

If the request is denied or not approved in full, disputes shall be resolved in accordance with California Labor Code Section 4062 for dates of injury before 1/1/2013, and per California Labor Code Section 4610.5 and 4610.6 for dates of injuries on or after 1/1/2013, and for all requests for authorization received on or after 7/1/2013. In addition, the non-provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying or denying a request for authorization that shall not include the rationale, criteria or guidelines use for the decision.

Content of Communication

Communications regarding decisions to approve requests by physicians shall identify the specific medical treatment approved; the date the complete RFA was received; medical treatment requested; and the date of the decision.

For all written decisions sent after 7/1/2013, and for dates of injury on or after 1/1/2013

written responses regarding decisions to modify or deny medical treatment services requested by physicians shall include the following and shall be provided to the requesting physician, the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney:

1. The date on which the decision is made.
2. A description of the specific course of proposed medical treatment for which authorization was requested.
3. A list of all medical records reviewed.
4. A specific description of the medical treatment service approved, if any.
5. A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section 9792.8. If utilization review decision to modify or deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

6. The Application for Independent Medical Review, DWC Form IMR, with all fields of the form, except for the signature of the employee, to be completed by the claims administrator. The written decision provided to the injured worker, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.
7. 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 30 calendar days after service of the decision.
8. Include the following mandatory language advising the injured employee:
"You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your Attorney instead of me."

And the following:

"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."

(9) Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

(10) The written decision modifying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer.

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

Authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information from the physician or from the provider of goods or services identified in the request for authorization either by facsimile or mail.

A utilization review decision to modify or deny a request for authorization of medical

treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician 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.

Injured Worker's Notice of Right to Dispute Denial or Modification of Treatment – Dates of Injury on or after 1/1/2013 and for all decisions after 7/1/2013

This evaluation has been conducted entirely on the basis of the medical information/documentation provided for review. If additional information becomes available, it may alter the conclusions contained in this report. CareWorks decisions are based on the recommendation of the CA MTUS. If it is "silent" on an issue, one or more of the following evidence-based guidelines may be consulted: ACOEM Guidelines, Official Disability Guidelines, guidelines from specialty societies or other national organizations.

These findings apply only to the specific treatment proposed by the treating physician or facility. A separate review will be necessary if the treating physician proposes additional types of treatment. The treating physician or facility should contact CareWorks at 800-580-2273 if additional types of treatment are proposed.

CareWorks' utilization review findings are intended solely as clinical opinions to determine whether proposed treatment is medically reasonable and necessary, based on the information provided. CareWorks expresses no legal opinion through these findings regarding the liability of any party to pay for any treatment that may be provided to a non-compensable area. CareWorks' authorization or non-authorization of treatment or procedures is not intended in any way to relieve the treating physician's responsibility for patient care.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code Section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative or the injured workers' attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days of receipt of the decision.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me, Adjuster name at 800-994-4611. 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.

You may utilize our internal appeals process if you notify us within 10 days after the receipt of the utilization review decision. Please note that our internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but it may be pursued on an optional basis.

The ordering provider may contact our peer review department within two business days to discuss the adverse determination.

CareWorks' Voluntary Appeal Process

CareWorks offers a voluntary internal appeals process in which a medical provider, claimant, or claimant's representative is entitled to appeal CareWorks' findings. The requester is expected to send any pertinent medical records and/or any additional documentation that might be helpful for the reviewer. Any internal utilization review appeal process will be completed within 30 calendar days of the date of utilization review decision. Please submit the appeal in writing via USPO, telefax or electronic mail to the attention of the Appeals Department. The telefax number is 800-580-3123. The E-mail address is **appeals@CareWorks.com** and the physical address is:

**CareWorks Managed Care Services
Utilization Review
PO Box 81665
Austin, TX 78708
Fax: 800-580-3123
Email: appeals@CareWorks.com**

CareWorks' telephone number is 800-580-2273. In all correspondence, please refer to: CareWorks Utilization Review Number

Request for Additional Information

When a request for necessary additional information is requested and not received within the first 14 days of receipt of the DWC form RFA (Request for Authorization), the physician reviewer/medical director may issue a denial with the stated condition that the request will be reconsidered upon receipt of the information.

If CareWorks cannot make a decision within the timeframes specified in the immediately preceding section because CareWorks and or Claims Administrator/carrier has not received all of the information reasonably necessary and requested, because request requires consultation by an expert reviewer, or because CareWorks has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, CareWorks shall immediately notify the physician, employee, and the employer in writing that a decision cannot be made within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The non-physician provider of goods and services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision that shall not include the rationale, criteria or guidelines used for the decision. CareWorks shall also notify the physician, the provider of goods or services and the employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested CareWorks shall review and approve, modify, or deny the request for authorization within the timeframes specified in the preceding section. If the results of the additional examination or test, or the specialized consultation that is requested by the

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 with the stated condition that the request will be reconsidered upon receipt of the results of the additional examination or test or the specialized consultation.

Non-Approval When Review Concurrent

In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and CareWorks shall only be liable for those services determined medically necessary to cure and relieve. For all decisions rendered after 7/1/2013, and for dates of injury on or after 1/1/2013, dispute resolution procedures of Labor Code section 4610.5 and 4610.6 shall apply.

Modification

In the case of modification of a request made by the Physician Reviewer/Medical Director, written notice confirming this modification in line with the same process described for Delays, Denials and Approval shall be made. This notice shall identify the parties involved in the request as well as the details of the modification in line with content of notification. CareWorks shall immediately notify the physician, employee, and the employer in writing of the decision within the required timeframe. The non-physician provider of goods and services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision that shall not include the rationale, criteria or guidelines used for the decision.

There shall be no modification or denial if additional data supports medical necessity based on severity of illness/intensity of treatment. An authorization request may not be modified on the basis of lack of information without documentation of a bona fide attempt to obtain the necessary information.

DISPUTE RESOLUTION/APPEALS

Dispute Resolution – All Decisions rendered after 7/1/2013 and for Dates of Injury on or after 1/1/2013

In line with the regulations governing the dispute process for utilization review decisions as stated above, disputes/objections raised by the employee (represented or not) or the employer shall be resolved in accordance with California Labor Code Sections 4610.5 and 4610.6.

Language included in notice to the injured worker:

"If you disagree with the utilization review decision and wish to dispute this, any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative or your attorney on behalf of you on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days of receipt of the decision.

You must meet this deadline even if your treating physician is participating in the claims administrator's voluntary internal utilization review appeal process. The internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis."

More specifically, an objection to the utilization review decision must be communicated by the injured worker or the injured worker's attorney on behalf of the injured worker by signing the DWC form IMR and returning it to Maximus with a copy of the adverse decision within 30 days of receipt of the decision. (See UR Notices #16IMR Injured Worker Notice of Right to Dispute MD Denial and/or Modification)

CareWorks' Voluntary Appeal Process - All Decisions rendered after 7/1/2013

Nothing precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the employee and, if the employee is represented by counsel, the employee's attorney, have been notified of the 30-day time limit to file an objection to the utilization review decision in accordance with Labor Code sections 4610.5 and 4610.6. The voluntary appeal process is offered on a client by client basis.

Such appeals shall be in writing in a form acceptable to CareWorks or the claims administrator/carrier, shall be received within in ten (10) working days from receipt of disputed notification, and shall include additional information in the form of medical reporting, supporting position or reference the specific evidence based medicine criteria used to supporting the appeal. The Medical Director shall establish reasonable time frames for the various steps in this additional appeal rights process, with the goal of completing the process no later than 30 calendar days from the date of the decision.). Such time frames may vary from appeal to appeal.

Appeal Review

A qualified expert reviewer of the physician/provider's same specialty shall review the patient's medical records and any other materials and information submitted by the provider in support of the appeal authorization request. The Medical Director shall select the expert reviewer aligning by same specialty, which shall perform the review and prepare a written summary of findings and recommendations.

CareWorks ensures that the expert reviewer report complies with notification requirements as well as evidence based medical guidelines. This report will be generated for timely and appropriate service upon the physician/provider generating the request for appeal.

If the Expert Reviewer determines the requested treatment is medically necessary, determination shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision.

If the Expert Reviewer determines the requested treatment is not medically necessary,

CareWorks shall inform the treating provider in writing.

Payment for Authorized Services

For requests for medical services receiving "Authorization" in the form of verbal and written notification, this authorization is notification that appropriate reimbursement will be made for the 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, and subject to the provisions of section 5402 of the Labor Code. (8 CCR § 9792.6(b))

(3) A description of the specific criteria utilized routinely in the review and throughout the decision making-process, including treatment protocols or standards used in the process. A description of the personnel and other sources used in the development and review of the criteria, and methods for updating the criteria.

Standards for Reviewing Requests

The criteria used to determine whether to approve, modify, delay or deny medical treatment services shall be:

- Developed with involvement from actively practicing physicians;
- Consistent with the schedule for medical treatment utilization adopted on June 15, 2007 pursuant to California Labor Code Section 5307.27 ("official utilization schedule") and Title 8 9792.21 Medical Treatment Utilization Schedule (MTUS) adopted on June 15, 2007.
- The Medical Treatment Utilization Schedule (MTUS) is considered presumptively correct and take precedent over other criteria such as ACOEM, unless the requested treatment/condition is not covered by the MTUS.
- CareWork's utilization review service relies on Medical Treatment Utilization Schedule (MTUS) [8CCR 9792.7(a)(3)] in determinations of medical necessity of treatment. When the CA MTUS is "silent" on an issue, other evidence based medical resources are consulted.

These sources may include:

- ACOEM's Occupational Medicine Practice Guidelines/MD Guides
- Official Disability Guidelines-Treatment in Workers' Compensation
- American Academy of Orthopaedic Surgeons
- Guidelines for Chiropractic Quality Assurance & Practice Parameters (Mercy Guidelines)
- AHCPR Clinical Practice Guideline: Acute Low Back Problems in Adults
- HCIA Length of Stay by Diagnosis and Operation/Western Region
- Evaluated at least annually and updated if necessary.

(4) A description of the qualifications and functions of the personnel involved in decision-making and implementation of the utilization review plan.

Compensation, conditional employment and performance standards are not based on the number of adverse determinations or limitations on lengths of stay, services or charges or the number or frequency of phone call or contacts with health care providers or patients. All staff is required to participate in a two-week orientation program to become familiar with the policies and procedures of the Utilization Review Department.

Reviewers and Initial Screening

Non Physician Reviewer

CareWorks has established the role of the Non-Physician Reviewer (claims adjusters and supporting staff to facilitate the authorization process) to provide initial screening in the form of pre-established formulaic medically-based criteria (MTUS)) to requests for authorization or to billed charges for medical services. This initial review is used to identify treatment in line with evidence based medicine guidelines substantiated by medical documentation and reporting as well as collection of required medical information to ensure process of the requested treatment and or testing. This ensures a streamlined process whereby tracking, documentation, timeframes for response and notification in compliance with regulations is established and maintained throughout Utilization Review Program/Process.

The Non-Physician Reviewer acts in a support role to the claims administrator/carrier and clinical review offering expertise in the arena of medical services and authorization for treatment related to industrial injuries. CareWorks non physician reviewers are sought from the medical industry and require related experience in medical office, claims administration, bill review, rehabilitation, physical medicine, etc. Once hired, the Non-Physician Reviewer undergoes a stringent training program focused on policy and procedure as well as regulatory compliance and Labor Code governing the utilization review process.

Medical Review Nurse

CareWorks has established the role of "Medical Review Nurse" staffed with licensed nurses to provide evaluation of requests rising beyond the review by the Non-Physician Reviewer. The Medical Review Nurse acts as a resource for the Non-Physician Reviewer, Medical Director and Expert Panel Physicians through organization and review of the request for authorization, medical records present on the claim file as well as applicable MTUS Guidelines and other nationally recognized guidelines applicable. The Medical Review Nurse staff is maintained on site. The Medical Review Nurse acts as a liaison between the Medical Director, facilitating and documenting action taken for all requests requiring nurse and physician reviews.

The Non-Physician Reviewer and the Medical Review Nurse may request additional information and provide authorization of requested medical services, but no request for authorization shall be denied or modified and no request for payment shall be denied or reduced on the basis that the services provided were not reasonably required to cure or relieve the injury, except by a physician with an unrestricted license by his or her licensing board who has education, training, expertise, and experience that is pertinent for evaluating the specific clinical issues or services under review. Analogously, reviewers need not be chiropractors or acupuncturists to initially

apply chiropractic-based or acupuncture-based criteria, provided only licensed and qualified chiropractors and acupuncturists may deny or reduce requests in their fields on the bases that services were not reasonably required.

Medical Director/Physician Reviewer

Should evaluation of a request fall outside of Evidence Based Medicine Guidelines, beyond review by the Medical Review Nurse, or require review by a physician reviewer or expert reviewer, the request for authorization along with all supporting medical documentation is electronically transmitted to a physician reviewer who is licensed by a state or the District Of Columbia or the Medical Director. This supporting documentation shall include but is not limited to the RFA, the initial documentation received generating the request for authorization, all supporting medical documentation, diagnostic testing, and all relative information thought to have impact on the determination.

The Medical Director is responsible for all decisions made in the utilization review program and ensures the process. He/She has assisted in establishing the program along with the formulaic criteria used by the Non-Physician Reviewer and Medical Review Nurse to initially evaluate requests for authorization.

Upon evaluation of the request for authorization, the physician reviewer shall:

1. Apply evidence based medicine as defined under “Standard of Review”
2. Make himself available for physician contact and /or Make himself available for non-physician reviewer coordinator and nurse contact at a minimum of four hours per week
3. Initiate physician/provider contact when deemed necessary
4. Ensure compliance with all times frames for review decisions
5. Generate written report of review decisions which shall include:
 - a. Description of the medical treatment service evaluated
 - b. Clear and concise explanation of decision
 - c. Description of medical criteria or guidelines used
 - d. Clinical reasons regarding medical necessity
 - e. Identification of reviewer or expert reviewer containing the name and specialty of the reviewer, or expert reviewer and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the reviewer, the expert reviewer or the medical director for the treating physician to discuss the decision which shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time or an agreed upon scheduled time to discuss the decision with the requesting physician. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.
6. Serve report in electronic format to the nurse(process)

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

Prior Authorization Process

CareWorks has implemented a prior authorization process on behalf of a small handful of customers with select medical providers. This prior "authorization" program means "assurance that appropriate reimbursement will be made [to the treating physician] for an approved specific course of proposed medical treatment" (CCR, Title 8 §9792.6(et al.) This process is available to CareWorks clients by custom design.

Requests for Plan Service

In compliance with 8 CCR § 9792.7(d), "upon request by the public" CareWorks shall make available the complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process. Service shall be offered in electronic format and upon request in the form of hard copy print and standard mailing through the U.S. Postal system or electronic means upon request. The charge for such service shall be \$0.25 per page plus the actual cost of postage.

Quality Management -

CareWorks has processes in place to systematically monitor and evaluate the UR program and services. CareWorks has developed audit tools that assess for compliance to UR standards. The purpose of the CareWorks Quality Management (QM) Program is to provide a formal structure for monitoring, evaluation, and improving utilization review processes and services. The QM Committee has been delegated by the York Executive Committee with the responsibility to oversee the quality CareWorks utilization review program. The objectives of the QM program are to:

- ✓ Ensure CareWorks Utilization Review (UR) program provides customers with a high standard of service.
- ✓ Promote objective, systematic and unbiased monitoring of the UR program.
- ✓ Develop a Quality Management Program work plan for the current year.
- ✓ Use nationally recognized standards and guidelines in the development and use of UR criteria.
- ✓ Identify quality trends and issues that need to be addressed
- ✓ Provide management oversight and support for compliance with URAC standards
- ✓ Communicate UM action plans with UR staff through staff meetings, via e-mail, verbally or by providing copies of reports, QA evaluations, etc

1. Organizational Structure

The QM committee is composed of the following parties and meetings are held on a monthly basis:

- Mundy Hebert, Sr. Vice President of Utilization Review
- Joyce Ho, MD, Medical Director
- Nancy Spaniola, Assistant Vice President Utilization Review

- Amy Holcomb LVN, Assistant Vice President Compliance and Quality Review
- Kimberly Savell, LVN Unit Manager Utilization Review
- Jessica Keogh Unit Manager , Intake
- Danielle Mayo, LVN Unit Manager Utilization Review

2. Function

- ✓ Determine the topics to be monitored.
- ✓ Establish and monitor compliance with Quality Management standards and policies and procedures.
- ✓ Monitor and evaluate identified aspects of care and services by determined indicators that are objective and measurable.
- ✓ Determine performance goals
- ✓ Evaluate the effectiveness of actions to improve performance
- ✓ Evaluate policies and procedures no less than annually and revise as necessary
- ✓ Review complaints to identify any QA trends or patterns
- ✓ Monitor open issues/topics until resolution or other directions by the Quality Management Committee.
- ✓ Conduct the annual review of the CareWorks Managed Care Quality Management Program & Plan.
- ✓ Maintain contemporaneous meeting minutes.