California Workers' Compensation Utilization Review Plan

UTILIZATION REVIEW PLAN

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UTILIZATION REVIEW STANDARDS - DEFINITIONS

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

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

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

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

(e) "Time Extension" means a determination, based on the need for additional evidence as set forth in section 9792.9.1(f), that the timeframe requirements for the utilization review process provided in section 9792.9.1(c) cannot be met.

(f) “Denial” means a decision by a physician reviewer that the requested treatment or service is 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, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.

(*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.

(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) "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

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

(1) Unless accepted by a claims administrator under section 9792.9.1(c)(2), a request for authorization must be set forth on a “Request for Authorization (DWC Form RFA),” completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5. Prior to March 1, 2014, any version of the DWC Form RFA adopted by the Administrative Director under section 9785.5 may be used by the treating physician to request medical treatment.

(2) “Completed,” for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization must identify both the employee and the provider, identify with specificity a recommended treatment or treatments, and be accompanied by documentation substantiating the need for the requested treatment.

(3) The request for authorization must be signed by the treating physician and may be mailed, faxed or e-mailed to, if designated, the address, fax number, or e-mail address designated by the claims administrator for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

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

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

(w) “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).

(x) "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.

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

(z) "Written" includes a communication transmitted by facsimile or in paper form. Electronic mail may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail.

Note: Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 3209.3, 4062, 4600, 4600.4, 4604.5, 4610 and 4610.5, Labor Code.

INTRODUCTION

This manual is intended to outline the policies and procedures for Arbicare's Utilization Review plan for the state of California as governed by Labor Code 4610 and the Division of Workers' Compensation (DWC).

This manual will be updated on a regular basis to reflect process and policy changes that affect utilization review. Please refer to the date at the bottom of each page to ensure that you are referencing the most current and updated edition of the manual.

MISSION STATEMENT

The mission of Arbicare's utilization review program is to use evidence-based medicine, technology, and regulatory expertise to help workers' compensation insurance payers to ensure the provision of medically necessary and appropriate treatment to injured workers.

REGULATORY COMPLIANCE – PURPOSE AND METHOD

Regulatory nuance is at the heart of Arbicare's program. As more jurisdictions adopt clinical treatment standards/guidelines, formularies, prior authorization requirements, traditional or specialized utilization review programs, and clinical dispute resolution processes, all utilization review must be conscious of the regulatory environment to ensure that the following always occur:

1) that injured workers do not suffer an inappropriate denial of treatment;
2) that clinical reviews of treatment apply the best evidence-based standards permitted in California; and
3) that the clinical review does not conflict with, frustrate, or inappropriately substitute any proper means of review available in California.

Arbicare tracks applicable laws and regulations in California where it operates and ensures that its practices both comply with and complement the regulatory framework and rules set forth by the DWC and labor code.

Regulatory changes that could impact Arbicare's operations are addressed with the Executive Team to determine what action is necessary or optimal in the wake of those changes. Such changes are communicated to the relevant department heads so that appropriate guidance may be provided to their subordinate staff members, and existing training materials and processes are revised, as necessary to ensure that training remains current in light of the changes.

QUALITY MANAGEMENT COMMITTEE (QMC)

Objective:

The Arbicare Quality Management Committee (QMC) meets at least quarterly to discuss both macro and micro level issues that may emerge through the course of the utilization review process. The basic function of this committee is to better understand how and why issues occur, whether they are individualistic or systematic, and how to create best-in-class solutions to better serve all stakeholders in the UR process. All done to improve and maintain proper compliance with DWC and URAC requirements.

Members:

The following individuals are part of the Arbicare QMC:

- Arbicare's Medical Director
- Arbicare's Chief Operating Officer
- Arbicare's VP of Operations
- Arbicare's Clinical Director

Structure:

Arbicare's Quality Management Committee is tasked with identifying deficiencies within the Utilization Review program and implementing solutions that address quality, service or safety issues.

Activities:

In order to function properly and meet the goals that the QMC strives for, a process must be created and followed. That designated process is as follows:

- The QMC reports directly to Arbicare's Chief Operating Officer to ensure that continued improvement in the UR process is an executive level priority and the appropriate changes and investment are well understood and executed.
- QMC will meet at least quarterly and it's the responsibly of the QMC members to maintain minutes of the scheduled meeting that must be reviewed and approved at subsequent meetings.
- At the most fundamental level, the primary job of the QMC is to approve, monitor, and provide direct oversight into all UR program changes that occur at Arbicare.
- The QMC will work closely with all Arbicare staff to educate and guide them on quality management priorities and projects, why they are necessary, and how to ensure they implemented quickly and without error.

- In order to ensure that the Quality Management Program is making positive and impactful recommendations and changes to Arbicare's UR program, the committee members and the Chief Operating Officer will meet annually to review the achievements and evaluate the effectiveness created by the committee.

INTER-DEPARTMENTAL COORDINATION

Arbicare ensures that all of its departments that have a role in its utilization review operations are able to collaborate in order to improve the quality and efficiency of Arbicare's services.

As part of its annual utilization review program review, leadership from all applicable departments are engaged to discuss:

(1) status of current quality improvement projects;
(2) suggestions for future or additional quality improvement projects;
(3) opportunities for integration of administrative activities;
(4) improvement of clinical operations;
(5) accuracy of existing marketing materials.

Additionally, proposed new marketing materials shall be circulated to heads/directors of all departments involved with services described in the materials in order to safeguard against misrepresentation about Arbicare's services. The Executive Team shall be responsible for final approval of all such materials.

MARKETING MATERIALS REVIEW

All marketing materials pertaining to Arbicare's utilization review program must first be approved by the Executive Team to ensure accurate communication of information pertaining to Arbicare's services (including those services which are delegated to contractors).

CONSUMER COMPLAINTS

All Arbicare communications to injured workers provide contact information indicating how the injured worker may submit a complaint to Arbicare or provide other information pertaining to the injured worker's satisfaction with Arbicare's process.

All complaints received by an injured worker are provided with an initial response within five (5) business days from receipt by Arbicare. Complaints submitted orally may be responded to orally; however, all complaints received in writing shall be responded to in writing.

Where a complaint is responded to in writing, an initial written response shall be sent within five business days to confirm that the complaint has been received and is under evaluation. The initial response may also include a final response, if Arbicare has been able to investigate the complaint fully and does not require additional time.

Where additional time is required, Arbicare shall, in the initial response, note that additional time is necessary to investigate the issue fully. Arbicare shall also request any documentation that may be in possession of the consumer that may facilitate review of the complaint.

A final response by Arbicare must include an explanation to the consumer of additional remedies available to the consumer, including (1) contacting the adjuster or payer; (2) contacting URAC, or (3) the California Division of Workers' Compensation where appropriate.

All complaints shall be reported by the appropriate Department head to the Quality Management Committee for review.

Arbicare will collaborate with appropriate external entities, such as (1) health care providers, (2) workers' compensation payers or adjusters; (3) nurse case managers; or (4) the California Division of Workers Compensation, to resolve complaints submitted by injured workers. Arbicare may also engage with such external entities to prevent unnecessary errors, or omissions that could result in a complaint by an injured worker.

REVIEW SERVICE COMMUNICATION

Arbicare maintains a phone system to receive calls from provider and patients during business hours. If a call is received after hours, the caller will be directed to an Arbicare voicemail system to leave a message.

All employees are required to check their voicemails at regular intervals throughout the day and respond to messages within one business day. Immediately upon receipt of a voicemail in the UR Department's voicemail box, Arbicare's system delivers software notifications to the list of all of Arbicare personnel responsible for responding to UR voicemails. The currently assigned will respond to the voicemail when appropriate and following the timeframes previously outlined.

Staff should be conscious of differing time zones when placing calls and should limit calls to the normal business hours of the locations that they are calling, unless an after-hours call has been scheduled and agreed to by all parties.

In responding to a communication from an outside party, Arbicare staff must identify themselves by name and title, and they must state that they are with Arbicare.

Where an injured worker, health care facility, or other health care professional contacts Arbicare with questions regarding the utilization review process generally, they should be directed to the appropriate Arbicare staff member (such as the VP of Operations). The appropriate staff member should provide a verbal response to verbal questions pertaining to the UR process generally. Arbicare staff members should not provide verbal information pertaining to individually identifiable health information or other confidential information except within the terms of Arbicare's Confidentiality/Information Security Policy.

UTILIZATION REVIEW PROGRAM STRUCTURE

UR STANDARDS

Arbicare's utilization review services are provided to workers' compensation insurance carriers, third party administrators (TPAs) and administering agencies, and self-insured employers managing claims in the California jurisdiction for workers' compensation.

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. Arbicare's Utilization Review process is designed to be in compliance with the DWC Rules and Regulations.

Arbicare's utilization review program is designed to be compliant with and to complement the workers' compensation regulatory framework in California. Arbicare will work with workers' compensation stakeholders and the DWC to ensure that, in the event of a regulatory change, Arbicare's utilization review program still provides the necessary effective means for injured workers to be able to obtain medically necessary treatment.

Arbicare maintains the highest standard in customer service, ensuring that its customer, requesting providers, and injured workers have a means to express grievances and to seek resolution of those grievances.

Arbicare carefully examines its program to ensure appropriate credentialing of reviewers, as well as ensuring efficient, timely, and high-quality determinations.

Arbicare's organizational structure is straightforward, but designed to be flexible in order to adapt to changes in regulatory requirements or in the needs of its customers.

Upon request by the public, Arbicare shall make available this complete utilization review plan, consisting of these policies and procedures, and description of the utilization review process, at no cost.

UTILIZATION REVIEW STAFF

Medical Director

Arbicare's senior clinical staff member is its Medical Director.

Arbicare's Medical Director is Dr. Stanley Katz. Credentials/curricula vitae for Arbicare's current and previous Medical Director's is maintained by Arbicare's VP of Operations.

Medical Director is Stanley Gordon Katz, MD

American Board of Orthopedic Surgery
California Medical License: # G49280 (valid through 4/30/2022)
Address: 1717 E Lincoln Ave, Anaheim, CA 92805
Telephone: 800.716.8295

The Medical Director may be an employee or contracted physician. The Medical Director oversees all clinical aspects of Arbicare's utilization review program, including decision-making aspects of the program to ensure it complies with Labor Code section 4610 and the Workers' Compensation Utilization Review regulations. The Medical Director also provides guidance to all other clinical review staff and is responsible for all decisions made in the Utilization Review process.

To be eligible to serve as Arbicare's Medical Director, an individual must:

a. Hold at least one current, unrestricted professional license as a doctor of medicine (MD) or doctor of osteopathic medicine (DO);
b. Hold 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.
c. Maintain at least one board certification in a specialty that is relevant to the treatment that is reviewed under Arbicare's utilization review program;
d. Have a minimum of five (5) years clinical experience
e. Be qualified to perform oversight for Arbicare's utilization review program
    i. Minimum of five (5) years' experience in post-graduate, direct patient care;
    ii. Be an active member of at least one state or national professional association.

The responsibilities of Arbicare's Medical Director include:

f. Providing oversight of all clinical review functions occurring under Arbicare's utilization review program;
g. Reviewing grievances pertaining to performance or qualifications of clinical review staff, and thereby ensuring the organizational objective to have qualified clinicians accountable to Arbicare for decisions affecting injured workers.

h. Periodic consultations with practitioners in the field via professional associations, peer-to-peer conversations, and individual consultations with providers.
i. Assisting in the development and maintenance of Arbicare's Policies and Procedures to ensure compliance with URAC standards and California regulatory requirements.
j. Assisting in the development and maintenance of training materials for all levels of the Utilization review staff including:
    i. Interpretation and utilization of MTUS and other evidence-based and nationally accepted treatment guidelines.
    ii. Understanding of common workplace injuries and treatment protocols.
k. Serving on the Quality Management Committee, actively participating in the review of complaints and grievances.
l. Serving as designated Medical Director for California Workers Compensation Utilization Review Plan.
m. Providing resources for the maintenance of a database of current medical literature and clinical practice parameters from professional trade associations, clinical research and public domain materials

VP of Operations

Qualifications: Arbicare's VP of Operations has 7 years of workers' compensation Utilization Review experience. He has worked closely in his past on medical treatment guidelines, safe weaning/tapering strategies, and best practice operational process. He holds an Masters in Public Health from Emory University.

Functions: The VP of Operations has complete responsibility over the day to day operations of California Utilization Review process. He works with clinical and non-clinical staff to ensure California regulations are followed and injured workers aren't harmed through the review process.

Clinical Director

Qualifications: Arbicare's Clinical Director is a PA-C by training and has 20+ years of experience setting up, reviewing, and doing Quality Assurance on prospective, retrospective, and concurrent reviews.

Functions: The Clinical Director does a quality check of all reviews before they are released to the appropriate stakeholders. The QA check is both clinical and non-clinical in nature. If clinical concerns arise, the Clinical Director escalates the concern to the Arbicare Medical Director for further review.

Initial Clinical Reviewer

Qualifications: Initial Clinical Reviewers are either a DC, Physician Assistant, or RN. A current license or certification to practice medicine is requested for each reviewer. They also must be licensed in the Unites States of America.

Functions: Perform first level review on requests for authorization from a California provider. They review the clinical documentation and MTUS guidelines to determine if the requested treatment aligns with MTUS guidelines and can be approved. Initial Clinical Reviewers may issue certifications if the request for authorization aligns with MTUS guidelines, but they may not ever issue non-certifications or modifications to the requested treatment. If the Initial Clinical Reviewer is unable to certify the requested treatment, he/she will elevate the request to a Clinical Peer Reviewer. Initial Clinical Reviewers may request additional clinical information from the provider if he/she believes the available information provided is insufficient to making a clinical decision to approve or elevate to a Clinical Peer Reviewer. Doing so much follow the process as designated by the California Labor Code and Utilization Review Standards.

Clinical Peer Reviewer (Expert Reviewer) – Arbicare

Qualifications: Clinical Peer Reviewers must be either an MD or DO and currently licensed to practice in any state or the District of Columbia. They must be Board certified and have at least 5 years of active practice experience.

Functions: Clinical Peer Reviewers perform second level reviews when an initial clinical reviewer can't authorize the requested treatment. This includes pre- authorization requests, reconsideration requests, and appeal requests. They review the clinical documentation and MTUS guidelines to determine if the requested treatment aligns with MTUS guidelines. Clinical Peer Reviewers issue determinations of medical necessity. Clinical Peer Reviewers may request additional clinical information from the provider if he/she believes the available information provided is insufficient to making a clinical decision. Doing so much follow the process as designated by the California Labor Code and Utilization Review Standards.

UTILIZATION REVIEW PROCESS

CONSUMER ACCESS TO SERVICES – TELEPHONE & FACSIMILE

In order to provide maximum availability for providers and to all parties involved in the California Utilization Review process, Arbicare maintains operating hours from 9:00 am pacific standard time to 5:30 pm pacific standard time on business days. Arbicare personnel are available via email, toll-free phone, and/or fax during these hours.

On holidays and weekends, Arbicare employees in key positions have been provided cell phones so that they can be available to customers, providers, reviewers and employees.

All consumer-facing deliverables are written in plain language except where specific language is required by Labor Code 4610 and the DWC rules. The Executive Team may review templates for customer-facing deliverables to assess ease of reading by injured workers.

UTILIZATION REVIEW REQUESTS

Arbicare has the ability to accept requests through email, fax, mail, secure web-form referral, and directly through Arbicare's utilization review software. Arbicare will work with each client individually to facilitate the best-case request delivery mechanism(s) of those described.

Requests for authorization for a course of medical treatment must be submitted on a Request for Authorization for Medical Treatment (DWC Form RFA). This form must be completed by the physician who is treating the injured worker. The RFA form must be signed by the treating physician and all mandatory fields with information specific to the request must be completed. The completed RFA form may be mailed, faxed or e-mailed to the appropriate party.

If the DWC Form RFA is not completed as defined in section 9792.6.1.(t)(2), Arbicare or the client's authorized individual may either:

- treat the form as complete and comply with the timeframes for decision. Or;
- return it to the requesting physician marked "not complete" no later than five (5) business days from receipt. The timeframe for a decision on that returned request for authorization shall begin start over upon receipt of a completed RFA form by the treating physician.

The claims administrator or Arbicare 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.

Failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services may be subject to retrospective review pursuant to 9792.9.1(e)(2).

Immediately, upon receipt of a request, Case Coordinators should enter the request into Arbicare's utilization review software so that it may be assigned to a reviewer and the utilization review process may begin. Once a request is entered into Arbicare's utilization review software, it is assigned a unique identification number to aid in its tracking and assignment.

The Case Coordinator is a non-clinical employee. The primary job function of the Case Coordinator is to enter requests into Arbicare's utilization review software. The Case Coordinator ensures that the request is on the proper RFA form and that all of the necessary information is accompanying the request.

Non-clinical administrative staff, including Case Coordinators, shall not make any determination or interpretation of the clinical information in the request. Non-clinical personnel are limited to the collection and transfer of non-clinical data, acquisition of structured clinical data, and other activities that do not require evaluation or interpretation of clinical information.

UTILIZATION REVIEW LIABILITY DISPUTES

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. If the claims administrator disputes its liability for the requested medical treatment, it may, no later than five (5) 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:

(A) The date on which the request for authorization was first received.

(B) A description of the specific course of proposed medical treatment for which authorization was requested.

(C) A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for the injury, claimed body part or parts, or the recommended treatment.

(D) A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

(E) The following mandatory language advising the injured employee:

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

and

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

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

TREATMENT NOT SUBJECT TO UTILIZATION REVIEW

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

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

REVIEWS

Once a valid request for utilization review has been received, it is assigned to a clinical reviewer. Requests for authorization for a course of medical treatment must be submitted on a Request for Authorization for Medical Treatment (DWC Form RFA). This form must be completed by the physician who is treating the injured worker. The RFA form must be signed by the treating physician and all mandatory fields with information specific to the request must be completed. The completed RFA form may be mailed, faxed or e-mailed to the appropriate party.

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.

INITIAL CLINICAL REVIEW

Arbicare employs or contracts with nurses and chiropractors to perform first level (initial clinical review) reviews. Only nurses and chiropractors that possess an active, professional license or certification, by any state or the District of Columbia of the United States and have relevant clinical experience may perform first level reviews.

Once a case has been assigned to an Initial Clinical Reviewer, they will review the case to ensure that the proper information that is necessary to make a determination is available. If it is not available, they may contact the treating provider to obtain the needed information. Once they have the information necessary to make a determination, they will perform the initial review using the Medical Treatment Utilization Schedule (MTUS) – 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

The Initial Clinical Reviewer may approve the request or request additional information that is necessary to render a decision within five (5) working days of receipt of the request.

During this process, if necessary, the Initial Clinical Reviewer may consult with the Medical Director or one of Arbicare's other peer reviewers to aid in making the determination.

The Initial Clinical Reviewer may either approve a request or they may elevate the request to the Peer Review level. The Initial Clinical Reviewer is never permitted to modify, deny, or non-certify a request. Only physicians can make modify and/or denial decisions.

Additionally, the Initial Clinical Reviewer reasonably request appropriate additional information that is necessary to render a decision but in no event shall this exceed the time limitations imposed in section 9792.9(c)(1), (c)(2)(A), or section 9792.9.1(c).

PEER REVIEW LEVEL

The Peer Review is initiated by the Initial Clinical Reviewer elevating a request (where certification was not issued), or in some cases, by a customer submitting a request directly for Peer Review.

Peer Reviews are performed by clinical peers of the requesters that:

1. hold an active, unrestricted license or certification to practice medicine or a health profession by any state or the District of Columbia;
2. are located within a state, territory, or the District of Columbia of the United States while conducting the peer review;
3. are qualified, by the Medical Director, to render a clinical opinion about the medical condition, procedures, and treatment under review;
4. and hold a current valid license:
    a. in the same licensure category as the requesting provider;
    or
    b. as a doctor of medicine or doctor of osteopathic medicine.

Arbicare maintains a broad network of licensed, contracted peer reviewers with varying specialties, board certifications and clinical backgrounds to perform peer reviews.

Questions about the qualification of an individual reviewer or the state specific requirements should be directed to the VP of Operations.

Peer reviewers will utilize Arbicare's utilization review software to manage the cases that are assigned to them. Once a case is assigned to them, they shall review the attached documentation, including medical records, office notes, the request for treatment, and any other available and relevant information that is attached to the case.

The peer reviewer shall then make at least one attempt to contact the requesting provider to discuss any relevant information that might be missing or unavailable in the records available to them.

If the peer reviewer is unable to have a peer to peer conversation with the ordering provider, the peer reviewer shall submit their determination into Arbicare's utilization review software .

The peer reviewer shall be provided with MTUS guidelines that are necessary, in addition to other nationally recognized treatment guidelines as secondary sources where necessary to make the determination. The peer reviewer may approve, deny, or modify a request. Arbicare may conduct surveys of peer reviewers as needed. Peer reviewers shall, upon Arbicare request, submit monthly reports to Arbicare regarding the peer reviewer's performance of review services. Additionally, peer reviewer's performance may be audited for compliance with URAC and DWC standards and guidelines communicated to the peer reviewer by clinical oversight personnel. Where the services performed by the peer reviewer are out of process (non-compliant with DWC or URAC standards or guidelines communicated to the peer reviewer by clinical oversight personnel), the peer reviewer may be asked to correct defects in services within a timeframe communicated by clinical oversight personnel.

All decisions to modify or deny treatment shall include the following:

- Reviewer's license number, specialty, contact information and hours of availability
- Date on which the decision was made
- Description of the specific course of proposed medical treatment for which authorization was requested
- Description of the medical treatment approved, if any
- Clear and concise explanation of the reason for the decision
- Description of the relevant portion of the criteria or guideline used pursuant to section 9792.8 (a)(3)

RECONSIDERATIONS

Peer reviewers shall be available to discuss their determinations with the ordering providers and attending physicians when there is a conditional denial or modification for lack of information.

When a determination is made to deny or modify the request because insufficient medical information was available, Arbicare provides the opportunity for the ordering provider, within 1 business day of receiving the denial or modification, to discuss the determination with the peer reviewer that made the determination; or with a different peer reviewer, if the original peer reviewer is unavailable. A reconsideration will be accepted by Arbicare from the ordering provider through a discussion or written response.

For a reconsideration 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 two (2) business days.

This reconsideration differs from a voluntary internal appeal of the determination. In the event that the reconsideration does not result in a certification, Arbicare shall issue the reconsideration determination and shall inform the provider and the claimant, and attorney of their right to appeal in accordance with Labor Code sections 4610.5 and 4610.6

VOLUNTARY APPEALS PROCESS

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

When a request for appeal is received, a Case Coordinator enters the request into Arbicare's utilization review software and the appeal to a peer reviewer. Appeal reviewers for a specific case must meet the following requirements:

1. Hold an active, unrestricted license or certification to practice medicine or a health profession in any state or the District of Columbia of the United States;
2. Be located in a state, territory, or the District of Columbia of the United States while conducting the appeal;
3. Be in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate;
4. May not be the same individual who made the original non-certification, or a subordinate of that individual; and
5. Are board certified (if applicable) by:
    a. A specialty board approved by the American Board of Medical Specialties, or
    b. The Advisory Board of Osteopathic Specialist from the major areas of clinical services.

In each appeal determination, the reviewer must attest that he or she has the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review and that they have current, relevant experience and/or knowledge to render a determination for the case under review.

Nothing in this section 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. Any request by the injured worker or treating

physician for an internal utilization review appeal process conducted under this subdivision must be submitted to the claims administrator within ten (10) days after the receipt of the utilization review decision.

A request for an internal utilization review appeal must be completed, and a determination issued, by the claims administrator within thirty (30) days after receipt of the request under subdivision (d)(1). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6(e) that determines the medical necessity of the disputed treatment.

Any determination by the claims administrator following an internal utilization review appeal that results in a modification of the requested medical treatment shall be communicated to the requesting physician and the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney according to the requirements set forth in section 9792.9.1(e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.1(e)(5)(G) must indicate that the decision is a modification after appeal.

REQUESTS FOR ADDITIONAL INFORMATION

There may be times when there is not enough information to make a determination on a request. In those instances, the request for additional information shall:

1. Be sent within 2 business days of receiving the request for authorization from either the claims administrator or the provider, or sooner if required to comply with the requirement in 8CCR9792.9.1(f)(2)(A) that such request for information must be made within 5 business days of the receipt of request for authorization.
2. When additional information is required and requested, the decision shall be made within 14 calendar days of receipt of the initial request for authorization, consistent with 9792.9.1(f)(3)(A).
3. The Clinical Peer Reviewer may also determine that additional tests, exams, or specialty consultation must be requested from the provider in order to make a determination of medical necessity. In this case, the request for additional tests,

exams, or specialty consultation shall be sent within 2 business days of receiving the request for authorization from either the claims administrator or the provider, or sooner if required to comply with the requirement in 8CCR9792.9.1(f)(2)(B-C) that such request for information must be made within 5 business days of the receipt of request for authorization.

4. When additional tests, exams, or specialty consultation results is required and requested, the decision shall be made within 30 calendar days of receipt of the initial request for authorization, consistent with 9792.9.1(f)(3)(B).
5. When a denial is made due to lack of information or due to lack of additional tests, exams, or specialty consultation results, the denial shall state that the decision will be reconsidered once the requested information or requests results are received, consistent with 9792.9.1(f)(3)(A-B).

Pursuant to 8 CCR § 9792.7(b)(3), a non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. A non-physician reviewer may approve requests for authorization of medical services. A non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization. Additionally, a non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision but in no event shall this exceed the time limitations imposed in section 9792.9(c)(1), (c)(2), or (d), or section 9792.9.1(c) and (d).

In accordance with 8CCR9792.9.1., Arbicare will document inside the case software system and in the determination letter 2 attempts to gain additional information necessary to complete the utilization review process.

If none of these options are successful in producing the information necessary to make a determination, Arbicare shall deny the request for lack of information within the applicable timeframe. This denial must contain the Labor Code sections 4610.5 and 4610.6. appeals language as well as the process for reconsideration. Denials for lack of

information must only be issued after 2 contact attempts have been exhausted or have failed to result in the production of the necessary information, and where an administrative denial is necessary to meet the California time service requirements. A denial for lack of information is submitted in the same manner as any other denial. Prior to issuing a denial for incomplete or insufficient information, the Peer Review Physician will attempt to contact the provider at least twice in order to obtain additional reasonably necessary information. The dates, times, and manner (phone, voicemail, fax) of the attempts will be documented in the determination letter.

Supervisors are provided with reference documentation produced by the VP of Operations to ensure that Arbicare staff and contracted reviewers are able to comply with California-specific timeframe requirements.

As of January 1, 2018, pursuant to Cal. Labor Code § 4610(i)(1), additional time is not available for prospective or concurrent reviews of treatment under the formulary; a determination must be issued within five normal business days from the receipt of the medical treatment request.

Where a Peer Review Physician issues a denial for insufficient information, the determination letter will include the following in addition to general UR denial requirements:

- the reason for the decision;
- a specific description of the information that is needed;
- the date(s) and times of the attempts (at least two) made to contact the physician to obtain the necessary information;
- a description of the manner in which the requests for additional information were communicated;
- and a stated condition that the request will be reconsidered upon receipt of the requested information.

If the required information is provided for reconsideration following a denial for insufficient information, a new determination is issued within five working days of receipt of the information (in the case of non-expedited prospective or concurrent reviews), within 72 hours of receipt of the information (in the case of expedited

prospective or expedited concurrent reviews), or within 30 days of receipt of the information (in the case of retrospective reviews), pursuant to 8 CCR 9792.9.1(f)(4), (5), and (6).

EXPEDITED REVIEWS

Prospective or concurrent utilization review of expedited reviews, either request for authorization or appeals considerations, in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. Decisions related to expedited review refer to the following situations:

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

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

In emergency situations posing an immediate threat to the health and safety of patients, Arbicare shall inform the party that failure to obtain prior authorization for emergency health care services is not an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker, and that emergency health care services may be subject to retrospective utilization review.

If the party requires that prospective utilization review be performed in situations where the health or safety of a patient is under immediate threat, the call shall be transferred directly to the Medical Director, in his/her absence, to the VP of Operations for immediate clinical attention and discussion with the claims adjuster and treating physician.

MEDICAL TREATMENT GUIDELINES

Arbicare uses the Medical Treatment Utilization Schedule (MTUS) adopted by the Administrative Director pursuant to Labor Code section 5307.27 as the primary source of treatment guidelines. Arbicare also utilizes scientifically valid, evidence-based medical treatment guidelines in the review of workers compensation treatment requests to determine medical necessity and appropriateness when MTUS does not cover a particular diagnosis, procedure or treatment. The most current edition of the *Official Disability Guidelines-Treatment in Workers' Comp* (ODG) published by MCG Health and the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines are utilized as a secondary source of guidelines.

Current versions of each of the relevant guidelines are uploaded into Arbicare's utilization review software for quick reference. Staff may also utilize the web-based versions of the guidelines, provided that they confirm the validity of the site and the version of the guidelines being published.

Annually, the Quality Management Committee will review existing evidence-based medical treatment guidelines to ensure that they continue to comply with California regulatory requirements.

The treatment guidelines must meet the following criteria:

1. The adopted treatment guidelines must be the most current edition of that body of guidelines, unless the Quality Management Committee identifies a reason why an earlier version should be used instead.
2. The treatment guidelines must be based on current clinical principles and processes.
3. The treatment guidelines must have been developed by (or with the guidance of) medical specialty associations, relevant professional societies, public or private organizations, government agencies at the Federal, State, or local level, or health care organizations.
4. Treatment guidelines must be evidence-based, scientifically valid and outcome-focused, and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care.

5. Treatment guidelines must be based on current clinical principles and processes and supporting documented medical evidence demonstrating that a systematic literature search and review of existing scientific evidence published in peer reviewed journals was performed during the guideline development.
6. The clinical practice guideline must contain systemically developed statements that include recommendations, strategies, or information that assists in making decisions about appropriate health care for specific clinical circumstances.
7. In addition to the review by the Quality Management Committee, treatment guidelines will be reviewed by appropriate, actively practice physicians and approved by the Medical Director at least annually.

Arbicare always complies with the California criteria and shall be consistent with the schedule for medical treatment utilization adopted by the administrative director that includes the drug formulary using evidence based medicine pursuant to Labor Code section 5307.27.

DECISION TIMEFRAMES

Arbicare maintains standard timeframe requirements in California. Those timeframes are monitored to ensure compliance with 8CCR 9792.9.1. Each Utilization Review due date is automatically set by Arbicare's Utilization Review software to ensure completion in a timely fashion.

PROSPECTIVE REVIEW

Except for treatment requests made pursuant to the formulary, prospective decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of a request for authorization for medical treatment and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

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

request. The request for authorization and supporting documentation may be submitted electronically under rules adopted by the administrative director.

1. Arbicare issues determinations as soon as possible after receiving a request for authorization/utilization review.
    a. 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, as described in paragraph (1) of Labor Code 4610, 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.
    b. Cases not involving urgent care – no longer than 5 business days after the receipt of request for utilization review determination.
2. For cases not involving urgent care, Arbicare may extend the period for issuing a determination for up to 14 calendar days if:
    a. The employer, insurer, or Arbicare cannot make a decision within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i) Labor code 4610 because Arbicare is not in receipt of, or in possession of, all of the information reasonably necessary to make a determination, the employer/Arbicare shall immediately notify the physician and the employee, in writing, that the employer/Arbicare cannot make a decision within the required timeframe, and specify the information that must be provided by the physician for a determination to be made. Upon receipt of all information reasonably necessary and requested by the employer/Arbicare, the employer/Arbicare shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i) and also listed in the above title "Prospective Reviews"(a)(b).
3. In no event shall Arbicare exceed the above-mentioned timeframes.

Final decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, secure email.

Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated in writing to the employee, and to the physician if the initial communication under subparagraph (A), the above paragraph, was by telephone, within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is modified or denied, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a 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.

CONCURRENT REVIEW

Except for treatment requests made pursuant to the formulary, concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of a request for authorization for medical treatment and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

Concurrent decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of receipt of the medical treatment request. The request for authorization and supporting documentation may be submitted electronically under rules adopted by the administrative director.

1. Arbicare issues determinations as soon as possible after receiving a request for authorization/utilization review:
    a. 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, as described in paragraph (1) of Labor Code 4610, 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.
    b. Cases not involving urgent care – no longer than 5 business days after the receipt of request for utilization review determination.
2. For cases not involving urgent care, Arbicare may extend the period for issuing a determination for up to 14 calendar days if:
    a. The employer, insurer, or Arbicare cannot make a decision within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i) Labor code 4610 because Arbicare is not in receipt of, or in possession of, all of the information reasonably necessary to make a determination, the employer/Arbicare shall immediately notify the physician and the employee, in writing, that the employer/Arbicare cannot make a decision within the required timeframe, and specify the information that must be provided by the physician for a determination to be made. Upon receipt of all information reasonably necessary and requested by the employer/Arbicare, the employer/Arbicare shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i) and also listed in the above title "Concurrent Reviews"(a)(b).
3. In no event shall Arbicare exceed the above-mentioned timeframes.

Final decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be

communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, secure email.

Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated in writing to the employee, and to the physician if the initial communication under subparagraph (A), the above paragraph, was by telephone, within 24 hours for concurrent review, or within two business days of the decision for concurrent review, as prescribed by the administrative director. If the request is modified or denied, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

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 an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. A compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in a way that minimizes reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. Fees shall not be levied upon insurers or self-insured employers making reports required by this section.

A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a 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.

RETROSPECTIVE REVIEW

1. Arbicare issues determinations as soon as possible after receiving a request for authorization/utilization review.
2. For retrospective reviews, Arbicare issues a determination within 30 calendar days of the receipt of request information necessary to complete the review.
3. In no event shall Arbicare exceed the above-mentioned timeframes.

If Arbicare cannot make a determination based upon the information provided, in addition to the telephonic requests, the Peer Review Physician will issue a written request for additional information within five working days of receipt of the request for retrospective review, pursuant to 8 CCR 9792.9.1(f)(1)(A). If the information is not received within thirty (30) days from receipt of the completed request for retrospective review, the Peer Review Physician shall deny the request for insufficient information, pursuant to 8 CCR 9792.9.1(f)(3)(A).

Whenever a reviewer issues a decision to deny based on the lack of medical information necessary to make the determination, Arbicare must document the attempts by the claims administrator or the reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail. This documented information is done in Arbicare's Utilization Review management software system.

A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a 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.

APPEALS

A request for independent medical review (IMR) 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 9792.9.1(e)(5). The request 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. At the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision denying, or modifying the request for authorization of medical treatment, to the claims administrator.

NOTIFICATION REQUIREMENTS

All determination documents contain the demographic information necessary for the requesting party to identify the original requests and the claimant. They also contain an Arbicare file number that is a unique number, assigned by Arbicare for tracking purposes.

Additionally, all Arbicare determination letters contain California specific disclaimers that are designed to inform the recipients of their rights and responsibilities affecting the utilization review process.

DECISIONS TO APPROVE A REQUEST FOR AUTHORIZATION

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

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

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

Payment, or partial payment consistent with the provisions of California Code of Regulations, title 8, section 9792.5, of a medical bill for services requested on the DWC Form RFA, within the 30-day timeframe set forth in subdivision (c)(5), shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete.

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

DECISIONS TO MODIFY OR DENY A REQUEST FOR AUTHORIZATION

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

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

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

A. The date on which the DWC Form RFA was first received.
B. The date on which the decision is made.
C. A description of the specific course of proposed medical treatment for which authorization was requested.
D. A list of all medical records reviewed.
E. A specific description of the medical treatment service approved, if any.
F. A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section 9792.8. If a utilization review decision to modify or deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.
G. The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee, must 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. Prior to March 1, 2014, any version of the DWC Form IMR adopted by the Administrative Director under section 9792.10.2 may be used by the claims administrator in a written decision modifying or denying treatment authorization.
H. A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days after service of the decision. However, an injured worker has (10) ten days from receipt of the decision to file for formulary disputes.
I. Include the following mandatory language advising the injured employee:
    - "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name in parentheses) at (insert telephone

number). However, if you are represented by an attorney, please contact your attorney instead of me."

and

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

J. Details about the claims administrator's internal utilization review appeals process for the requesting physician, 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.

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

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 an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062.

The treating provide does reserve to withdraw the request for authorization and amend it as necessary.

DISPUTES

If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6. Neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is modified or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review,

A request for independent medical review 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, or 10 days for drug formulary disputes, of service of the written utilization review determination issued by the claims administrator under section 9792.9.1(e)(5). The request 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. At the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision denying or modifying the request for authorization of medical treatment, to the claims administrator.

A party eligible to file a request for independent medical review includes:

- The employee or, if the employee is represented, the employee's attorney. If the employee's attorney files the DWC Form IMR, the form must be accompanied by a notice of representation or other document or written designation confirming representation.
    - An unrepresented employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf in filing an application for independent medical review under this subdivision. A designation of an agent executed prior to the utilization review decision shall not be valid.

- 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 pursuant to section 9792.10.5 (b) 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 under this section on its own behalf within 30 days after the service 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 utilization review 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, written certification from the employee's treating physician with documentation confirming that the employee faces an imminent and serious threat to his or her health as described in section 9792.6.1(j).

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 under subdivision (b)(1) is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

If the claims administrator provides the employee with a written utilization review determination modifying or denying a treatment request that does not contain the required elements set forth in section 9792.9(*l*) or section 9792.9.1(e) at the time of notification of its utilization review decision, the time limitations for the employee to submit an application for independent medical review under subdivision (b)(1) shall not begin to run until the claims administrator provides the written decision, with all required elements, to the employee.

Nothing in this section 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. Any request by the injured worker or treating physician for an internal utilization review appeal process conducted under this subdivision must be submitted to the claims administrator within ten (10) days after the receipt of the utilization review decision.

A request for an internal utilization review appeal must be completed, and a determination issued, by the claims administrator within thirty (30) days after receipt of the request under subdivision (d)(1). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6(e) that determines the medical necessity of the disputed treatment.

Any determination by the claims administrator following an internal utilization review appeal that results in a modification of the requested medical treatment shall be communicated to the requesting physician and the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney according to the requirements set forth in section 9792.9.1(e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.1(e)(5)(G) must indicate that the decision is a modification after appeal.

INDEPENDENT MEDICAL REVIEW

INITIAL REVIEW OF APPLICATION

Following receipt of the Application for Independent Medical Review, DWC Form IMR, pursuant to section 9792.10.1(b), the Administrative Director shall determine whether the disputed medical treatment identified in the application is eligible for independent medical review. In making this determination, the Administrative Director shall consider:

1) The timeliness and completeness of the Application;

2) Any previous application or request for independent medical review of the disputed medical treatment;
3) Any assertion, other than medical necessity, by the claims administrator that a factual, medical, or legal basis exists that precludes liability on the part of the claims administrator for an occupational injury or a claimed injury to any part or parts of the body.
4) Any assertion, other than medical necessity, by the claims administrator that a factual, medical, or legal basis exists that precludes liability on the part of the claims administrator for a specific course of treatment requested by the treating physician.
5) The employee's date of injury.
6) The failure by the requesting physician to respond to a request by the claims administrator under section 9792.9.1(f) for information reasonably necessary to make a utilization review determination, for additional required examinations or tests, or for a specialized consultation.

The Administrative Director may reasonably request additional appropriate information from the parties in order to make a determination that a disputed medical treatment is eligible for independent medical review. The Administrative Director shall advise the claims administrator, the employee, if the employee is represented by counsel, the employee's attorney, and the requesting physician, as appropriate, by the most efficient means available.

The parties shall respond to any reasonable request made pursuant to subdivision (b) within five (5) business days following receipt of the request. Following receipt of all information necessary to make a determination, the Administrative Director shall either immediately inform the parties in writing that a disputed medical treatment is not eligible for independent medical review and the reasons therefor, or assign the request to independent medical review under section 9792.10.4.

If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the claims administrator agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred if at the time of a utilization review decision the claims administrator is also disputing liability for the treatment for any reason besides medical necessity.

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

The Administrative Director shall retain the right to determine the eligibility of a request for independent medical review under this section until an appeal of the final independent medical review determination issued under section 9792.10.6(e) that determines the medical necessity of the disputed medical treatment has been filed with the Workers' Compensation Appeals Board, or the time in which to file such an appeal has expired.

ASSIGNMENT AND NOTIFICATION

Within one business day following receipt of the Administrative Director's finding that the disputed medical treatment is eligible for independent medical review, the independent review organization delegated the responsibility by the Administrative Director to conduct independent medical review pursuant to Labor Code section 139.5 shall notify the employer, employee, if the employee is represented the employee's attorney, and the requesting physician in writing that the dispute has been assigned to that organization for review. The notification shall contain:

1) The name and address of the independent review organization;
2) Identification of the disputed medical treatment, including the date of the request for authorization (if available), the name of the requesting physician, and the date of the claims administrator's utilization review decision.
3) The date the Application for Independent Medical Review, DWC Form IMR, was received by the Independent Review Organization.
4) A statement whether the independent medical review will be conducted on a regular or expedited basis.
5) For regular review, a statement that within fifteen (15) calendar days of the date designated on the notification, if the notification was provided by mail, or within twelve (12) calendar days of the date designated on the notification if the notification was provided electronically, the independent review organization must receive the documents indicated in section 9792.10.5. For the notification provided to the claims administrator, the statement shall provide that, pursuant

to Labor Code section 4610.5(i), in addition to any other fines, penalties, and other remedies available to the Administrative Director, the failure to comply with section 9792.10.5 could result in the assessment of administrative penalties up to $5,000.00.

6) For expedited review, a statement that within twenty-four (24) hours following receipt of the notification the independent review organization must receive the documents indicated in section 9792.10.5. For the notification provided to the claims administrator, the statement shall provide that, pursuant to Labor Code section 4610.5(i), in addition to any other fines, penalties, and other remedies available to the Administrative Director, the failure to comply with section 9792.10.5 could result in the assessment of administrative penalties up to $5,000.00.

Review conducted on a regular basis shall be converted into an expedited review if, subsequent to the receipt of the Application for Independent Medical Review, DWC Form IMR, the independent review organization receives from the employee's treating physician written certification with supporting documentation verifying that the employee faces an imminent and serious threat to his or her health as described in section 9792.6.1(j). The independent review organization shall immediately notify the parties by the most efficient means available that the review has been converted from a regular review to an expedited review

MEDICAL RECORDS

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

A. A copy 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 request for authorization, the claims administrator shall provide a copy 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.

B. A copy of the written Application for Independent Medical Review, DWC Form IMR, that was included with the written determination, issued under section 9792.9.1(e)(5), which notified the employee that the disputed medical treatment was denied or modified. Neither the written determination nor the application's instructions should be included.
C. Other than the written determination by the claims administrator issued under section 9792.9.1(e)(5), a copy of all information, including correspondence, provided to the employee by the claims administrator concerning the utilization review decision regarding the disputed treatment.
D. A copy of any materials the employee or the employee's provider submitted to the claims administrator in support of the request for the disputed medical treatment.
E. A copy of any other relevant documents or information used by the claims administrator in determining whether the disputed treatment should have been provided, and any statements by the claims administrator explaining the reasons for the decision to deny or modify the recommended treatment on the basis of medical necessity.
F. The claims administrator's response to any additional issues raised in the employee's application for independent medical review.

The claims administrator shall, concurrent with the provision of documents under subdivision (a), forward to the employee or the employee's representative a notification that lists all of the documents submitted to the independent review organization under subdivision (a). The claims administrator shall provide with the notification a copy of all documents that were not previously provided to the employee or the employee's representative excluding mental health records withheld from the employee pursuant to Health and Safety Code section 123115(b).

Any newly developed or discovered relevant medical records in the possession of the claims administrator after the documents identified in subdivision (a) are provided to the independent review organization shall be forwarded immediately to the independent review organization. The claims administrator shall concurrently provide a copy of medical records required by this subdivision to the employee, or the employee's representative, or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law.

At any time following the submission of documents under subdivision (a) and (b), the independent review organization may reasonably request appropriate additional documentation or information necessary to make a determination that the disputed medical treatment is medically necessary. Additional documentation or other

information requested under this section shall be sent by the party to whom the request was made, with a copy forwarded to all other parties, within five (5) business days after the request is received in routine cases or one (1) calendar day after the request is received in expedited cases.

STANDARDS AND TIMEFRAMES

The independent medical review process may be terminated at any time upon notice by the claims administrator to the independent review organization that the disputed medical treatment has been authorized.

If a claims administrator fails to submit the documentation required under section 9792.10.5(a)(1), a medical reviewer may, issue a determination as to whether the disputed medical treatment is medically necessary based on both a summary of medical records listed in the utilization review determination issued under section 9792.9.1(e)(5), and documents submitted by the employee or requesting physician under section 9792.10.5(b) or (c). No independent medical review determination shall issue based solely on the information provided by a utilization review determination.

The independent review organization shall provide the Administrative Director, the claims administrator, the employee, if represented the employee's attorney, and the employee's provider with a final determination regarding the medical necessity of the disputed medical treatment. With the final determination, the independent review organization shall provide a description of the qualifications of the medical reviewer or reviewers and the determination issued by the medical reviewer.

For regular review, the independent review organization shall complete its review and make its final determination within thirty (30) days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information provided under section 9792.10.5. If two (2) or more requests for independent medical review are consolidated under section 9792.10.4(a), the thirty (30) day period for the independent review organization to complete its review and make its final determination shall begin upon receipt of the last filed application for independent medical review that was consolidated for determination and the supporting documentation and information for that application. For expedited review where the disputed medical treatment has not been provided, the independent review organization shall complete its review and make its final determination within three (3) days of the

receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information provided under section 9792.10.5. Subject to the approval of the Administrative Director, the deadlines for final determinations from the independent review organization, involving both regular and expedited reviews, may be extended for up to three days in extraordinary circumstances or for good cause.

If, under section 9792.10.1(d)(3), an internal utilization review appeal modifies a utilization review determination for which an application for independent medical review was previously filed under section 9792.10.1(b), the thirty (30) day period for the independent review organization to complete its review and make its final determination shall begin upon receipt of the application for independent medical review requesting review of the modified treatment, and the supporting documentation and information for that application.

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

IMPLEMENTATION AND DETERMINATION OF APPEAL

Upon receiving the final determination of the Administrative Director that a disputed medical treatment is medically necessary, the claims administrator shall, unless an appeal is filed under subdivision (c) or liability for the treatment is disputed as described in subdivision (a)(3), promptly implement the determination.

The parties may appeal a final determination of the Administrative Director by filing a petition with the Workers' Compensation Appeals Board. The only situations in which appeal is if there is clear and convincing evidence that:

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

If the Workers' Compensation Appeals Board (WCAB) reverses the final determination, the WCAB returns the dispute to the Administrative Director for one of the following actions:

1. Assignment to a different IMRO.
2. Assignment to a different medical reviewer where a different IMRO is not available.

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

CONFIDENTIALITY AND INFORMATION SECURITY

Arbicare has a strong commitment to maintaining the confidentiality of individually identifiable health information of our employees, clients, injured workers, treating physicians, and all parties associated with our organization. This is done in accordance with federal and state regulations, business partner contracts, ethical standards established by our management team, industry experts, quality oversight organizations, and professional associations where applicable.

We perform periodic audits to assure compliance. Strong computer security measures are adopted to assure no breaches or unintended releases of data occur. Audits include an assessment of data accuracy, since important decisions are based on health information in our claims systems. Arbicare has clear policies adopted and maintained to protect and preserve the confidentiality of all parties personally identifiable health information. In addition to strong policies and procedures, Arbicare. also monitors accountability and compliance with its confidentiality policy and procedures. Arbicare requires its employees, providers, and contracted entities maintain the confidentiality of medical claim information. We monitor compliance through the use of contract requirements, strong executive oversight, and through sanctions if employees, providers or contracted entities are found to violate our confidentiality policies and procedures.

Upon employment with Arbicare, each employee training that involves protecting trade secrets, competitive, and medical information. During the training, our employees learn the basic guidelines to protect confidential information:

- Any confidential information employees have access to should be discussed with others only on a need to know basis
- Confidential information may not be disclosed to any outside persons without the appropriate confidential information disclosure agreement from legal counsel
- Sensitive and confidential information should not be discussed, even with fellow employees in public places.

Employees are advised by their management of special requirements to maintain the confidentiality of information in their specific workplace, depending on the type of job and access to information. Those requirements are outlined in these Corporate Security Policies:

- Confidentiality Information and Privacy Policy
- Security and Uses Policy

In accordance with sound business practices and in compliance with federal and state regulations, Arbicare maintains all data employed in its business in strict confidence. Confidential information will be provided only on a need-to-know basis, and only to those with authorized access.

Officers and management are responsible for establishing controls to protect confidential information from access by unauthorized parties. All management personnel are responsible for informing employees who handle or process confidential information in the conduct of business of the requirements for confidentiality and non-disclosure.
All persons authorized to access data through established communications networks must comply with all corporate security policies, standards, and procedures. All persons and organizations so authorized must protect information from unauthorized disclosure, disruption, modification, or use.

All persons authorized, all full-time and auxiliary employees, and all contracting or consulting individuals or groups must sign the appropriate "Non-Disclosure" or "Confidential Information and Privacy" with the Corporation.

All sensitive or classified information either generated by Arbicare or made available by Arbicare for purposes of conducting its business operations including, but not limited to,

utilization review, performance measurement, customer service, quality management, sales/marketing, data processing, research, and account administration remains strictly confidential.

PATIENT SAFETY

Reviewers and employees should be aware of potential safety issues, including; contradicting treatment, adverse drug interactions and inappropriate treatment. Every effort should be made to ensure patient safety and health. Where an Arbicare reviewer or Arbicare staff member identifies potential danger to any patient, they should immediately notify their supervisor and the Medical Director. Arbicare nurses and reviewers are instructed to use their clinical judgment and the evidence-based guidelines in determining whether or not patient safety is at risk. The Supervisor and Medical Director will then work in conjunction to contact the Customer to apprise them of the situation and seek their direction.

Whenever a known safety issue has been identified (example: an adverse drug reaction), the identifying employee should immediately contact their supervisor who will escalate the issue to the appropriate personnel and to the Arbicare customer.

Arbicare's Medical Director may assign the research of the issue to an Arbicare reviewer with the appropriate background and experience needed to properly address it. After an issue has been identified and researched, a determination will be made by the Medical Director, Customer and any other relevant parties. Ultimately, the Medical Director has the clinical responsibility to make decisions related to patient safety issues, unless his or her authority is limited by jurisdictional requirements in which case, the rules dictated by the at jurisdiction shall govern the process. A report outlining the issue will be prepared by the Medical Director, and it will be attached to the patient's file in Arbicare's utilization review software for future reference.

FINANCIAL INCENTIVE POLICY

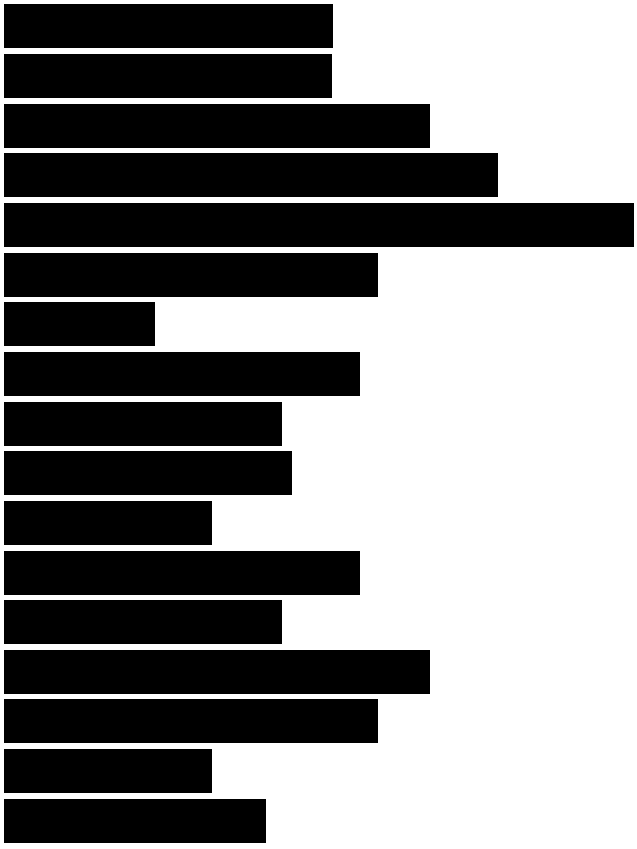
Arbicare does not employ a system of reimbursement, bonuses or incentives to staff or contractors based directly on consumer utilization of services. Additionally, Arbicare's contractors may not employ a system of reimbursement, bonuses, or incentives to their

staff of sub-contractors (where further delegation is authorized) based directly on consumer utilization of services.

Arbicare Quality Review Program ensures that all utilization review decisions are based upon accepted Workers Compensation Medical Treatment Guidelines and Evidence-based standards of care.

CLIENTS

Arbicare's current client list should remain confidential but is listed below:



ARBICARE

Review completed by
Arbicare on behalf of
@clientname

Phone: 800-716-8295
Fax: 404-631-6387
Email: support@arbicare.com

Utilization Review Administrative Approval

Dear @employeename,

With the intent of maintaining a high standard of care, Arbicare has been requested by @clientname to perform utilization review of the appropriateness and necessity of the below listed health care treatments.

Claimant	Treating Provider	Review Type
@employeename	@providername	@reviewtype

Claim #	@clm#	**Address**	@provaddress1	**Client**	@clientname
Case #	@case#		@provaddress2	**Referrer**	@referrername
Birth Date	@dob		@provcity	**RFA First Received**	@receiveddate
Injury Date	@doi		@provstate	**Decision Date**	@revieweddate
Jurisdiction	@state		@provzip		

Request Determination(s)

1. @request1 is approved. Valid @start1 - @end1.
2. @request2 is approved. Valid @start2 – @end2.
3. @request3 is approved. Valid @start3 - @end3.

Diagnosis

1. Diagnosis 1
2. Diagnosis 2

Determination Summary

1. **@request1 is approved. Valid @start1 - @end1.**
   [Brief summary statement including reviewer determination and rationale.]

2. **@request2 is approved. Valid @start2 - @end2.**
   [Brief summary statement including reviewer determination and rationale.]

3. **@request3 is approved. Valid @start3 - @end3.**
   [Brief summary statement including reviewer determination and rationale.]

Reviewer

Address Arbicare
1175 Peachtree St. NE Ste 1000
Atlanta GA 30361

Email	support@arbicare.com
Phone	(800) 716-8295
Fax	(404) 631-6387

If you have any questions about this determination, the reconsideration process, or need further information concerning available next steps, please contact our support staff by calling our Toll-Free number 1-800-716-8295 or by emailing us at support@arbicare.com.

CC:
@providername
@applicantattorneyname

ARBICARE

Review completed by
Arbicare on behalf of
@clientname

Phone: 800-716-8295
Fax: 404-631-6387
Email: support@arbicare.com

Utilization Review Certification

Dear @employeename,

With the intent of maintaining a high standard of care, Arbicare has been requested by @clientname to perform utilization review of the appropriateness and necessity of the below listed health care treatments.

Claimant		**Treating Provider**		**Review Type**	
@employeename		@providername		@reviewtype	
Claim #	@clm#	**Address**	@provaddress1	**Client**	@clientname
Case #	@case#		@provaddress2	**Referrer**	@referrername
Birth Date	@dob		@provcity	**RFA First Received**	@receiveddate
Injury Date	@doi		@provstate	**Decision Date**	@revieweddate
Jurisdiction	@state		@provzip		

Request Determination(s)

1. @request1 is approved. Valid @start1 - @end1.
2. @request2 is approved. Valid @start2 – @end2.
3. @request3 is approved. Valid @start3 - @end3.

Diagnosis

1. Diagnosis 1
2. Diagnosis 2

Clinical History

[Brief summary of medical history.]

Determination Summary

1. **@request1 is approved. Valid @start1 - @end1.**
   [Brief summary statement including reviewer determination and rationale.]

2. **@request2 is approved. Valid @start2 - @end2.**
   [Brief summary statement including reviewer determination and rationale.]

3. **@request3 is approved. Valid @start3 - @end3.**
   [Brief summary statement including reviewer determination and rationale.]

Determination Rationale

1. **@request1 is @decision1.**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

2. **@request2 is @decision2.**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

[Reviewer detailed comments regarding listed treatment request including determination and rationale.]

3. **@request3 is @decision3**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

[Reviewer detailed comments regarding listed treatment request including determination and rationale.]

Outreach Summary

Attempt	Respondent / Role	Dialogue
mm/dd/yyyy, hh:mm PM EDT	Name, role	[summary statement of conversation by reviewing physician.]
mm/dd/yyyy, hh:mm PM EDT	Name, role	[summary statement of conversation by reviewing physician.]

Records Reviewed

Date	Type	Source
mm/dd/yyyy		[Name]
mm/dd/yyyy		[Name]
mm/dd/yyyy		[Name]

Conflict of Interest Attestation

I certify that no material professional, familial, or financial conflict of interest regarding the determination made in review of this case. Further, no conflict of interest exists between myself or any of the following: the referring entity; any prior involvement with the case; the insurance issuer or group health plan/carrier for the case under review; a management role in a health plan of an insurance issuer or group health plan that is the subject of a review which includes participation on the board of directors or any sub-committee of that board and in advisory groups that provide guidance to a provider network, including credentialing, medical policy and quality management committees; the covered person or the covered person's authorized representative; any officer, director, or management employee of an insurance issuer; the group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the review.

I attest that I have a scope of licensure or certification and professional experience that typically manages the medical condition, procedure, treatment, or issue under review.

Reviewer

@reviewersignature
@reviewername, @reviewersuffix
@reviewerspecialty
@reviewersubspecialty
@statelicensenumber
@reviewdate

CC:
@providername
@applicantattorneyname

ARBICARE

Review completed by
Arbicare on behalf of
@clientname

Phone: 800-716-8295
Fax: 404-631-6387
Email: support@arbicare.com

Utilization Review Determination

Dear @employeename,

With the intent of maintaining a high standard of care, Arbicare has been requested by @clientname to perform utilization review of the appropriateness and necessity of the below listed health care treatments.

Claimant		**Treating Provider**		**Review Type**	
@employeename		@providername		@reviewtype	
Claim #	@clm#	**Address**	@provaddress1	**Client**	@clientname
Case #	@case#		@provaddress2	**Referrer**	@referrername
Birth Date	@dob		@provcity	**RFA First Received**	@receiveddate
Injury Date	@doi		@provstate	**Decision Date**	@revieweddate
Jurisdiction	@state		@provzip		

Request Determination(s)

1. @request1 is @decision1. Valid @start1 - @end1.
2. @request2 is @decision2. Valid @start2 – @end2.
3. @request3 is @decision3. Valid @start3 - @end3.

Diagnosis

1. Diagnosis 1
2. Diagnosis 2

Clinical History

[Brief summary of medical history.]

Determination Summary

1. **@request1 is @decision1. Valid @start1 - @end1.**
   [Brief summary statement including reviewer determination and rationale.]

2. **@request2 is @decision2. Valid @start2 - @end2.**
   [Brief summary statement including reviewer determination and rationale.]

3. **@request3 is @decision3. Valid @start3 - @end3.**
   [Brief summary statement including reviewer determination and rationale.]

Determination Rationale

1. **@request1 is @decision1.**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

2. **@request2 is @decision2.**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

[Reviewer detailed comments regarding listed treatment request including determination and rationale.]

3. **@request3 is @decision3**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

[Reviewer detailed comments regarding listed treatment request including determination and rationale.]

Outreach Summary

Attempt	Respondent / Role	Dialogue
mm/dd/yyyy, hh:mm PM EDT	Name, role	[summary statement of conversation by reviewing physician.]
mm/dd/yyyy, hh:mm PM EDT	Name, role	[summary statement of conversation by reviewing physician.]

Records Reviewed

Date	Type	Source
mm/dd/yyyy		[Name]
mm/dd/yyyy		[Name]
mm/dd/yyyy		[Name]

Conflict of Interest Attestation

I certify that no material professional, familial, or financial conflict of interest regarding the determination made in review of this case. Further, no conflict of interest exists between myself or any of the following: the referring entity; any prior involvement with the case; the insurance issuer or group health plan/carrier for the case under review; a management role in a health plan of an insurance issuer or group health plan that is the subject of a review which includes participation on the board of directors or any sub-committee of that board and in advisory groups that provide guidance to a provider network, including credentialing, medical policy and quality management committees; the covered person or the covered person's authorized representative; any officer, director, or management employee of an insurance issuer; the group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the review.

I attest that I have a scope of licensure or certification and professional experience that typically manages the medical condition, procedure, treatment, or issue under review.

Physician Reviewer

@reviewersignature
@reviewername, @reviewersuffix
@reviewerspecialty
@reviewersubspecialty
@statelicensenumber
@reviewdate

CC:
@providername
@applicantattorneyname

Decision Effective Dates

Pursuant to Title 8, CCR §9792.9.1 (h), 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.

Reviewer Availability

Should discussion concerning the decision be needed, Arbicare will make a consulting reviewer available for follow-up discussion during normal business hours (between 9:00am and 5:30pm Pacific Time) for at least four (4) hours over the course of the subsequent five (5) business days of the request for discussion. Within this conversation the consulting reviewer will contemplate any new information presented and either uphold or overturn the determination. Please contact Arbicare at (800) 716-8295 to schedule physician availability.

Conditional Denial

When a determination is made to deny or modify the request because insufficient medical information was available, Arbicare provides the opportunity for the ordering provider, within 1 business day of receiving the denial or modification, to discuss the determination with the peer reviewer that made the determination; or with a different peer reviewer, if the original peer reviewer is unavailable. A reconsideration will be accepted by Arbicare from the ordering provider through a discussion or written response.

Internal Appeals Process

Arbicare maintains an internal appeals process for the requesting physician that is entirely voluntary 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 expedited basis. Any additional appeal request after completion of the voluntary Internal Appeals process must be made by using the Independent Medical Review process detailed in Labor Code section 4610.5 and 4610.6.

Standard Appeal

Per Title 8, CCR §9792.10.1(d)(1-3), Arbicare has in place procedures for internal appeals of decisions to deny or modify a utilization review determination. If you wish to appeal this decision, please submit your request for appeal to Arbicare with any supporting documentation and/or a written statement by the attending physician within ten (10) days of receipt of the decision. Any request for an appeal of the utilization review decision must be submitted either by telephone or in writing to the address, phone number, fax number, or email listed below. Participating in this process is entirely voluntary. Any appeal request will be completed as soon as is practicable but will be completed no later than thirty (30) days upon receipt of request and all applicable medical documentation. The appeal will be completed by a different reviewer of at least the same qualifications as the initial reviewer. As part of the appeal process please provide any additional medical records that are relevant to the completion of the reconsideration. Notification of the completed appeal determination will be delivered in writing to the patient or representative and the attending provider. In the event that the determination remains to deny, the written notification will include an explanation of the principal reason(s) for the determination.

Expedited Appeal

Arbicare has in place procedures for expedited appeals of decisions to deny a utilization review determination. If you wish to appeal this decision on an expedited basis, please submit your request for appeal to Arbicare with any supporting documentation and/or a written statement to be submitted either by telephone or in writing to the address, phone number, fax number, or email listed below. Participating in this process is entirely voluntary. Any expedited appeal request will be completed as soon as is practicable but will result in verbal notification of determination to the attending physician no later than 72 hours following receipt of the expedited appeal request. The verbal notification will be followed by written confirmation of the notification delivered to the patient and attending physician within three (3) calendar days. In the event that the determination remains to deny, the written notification will include an explanation of the principal reason(s) for the determination.

Address	Arbicare 1175 Peachtree St. NE Ste 1000 Atlanta GA 30361
Email	support@arbicare.com
Phone	(800) 716-8295
Fax	(404) 631-6387

If you have any questions about this determination, the reconsideration process, or need further information concerning available next steps, please contact our support staff by calling our Toll-Free number 1-800-716-8295 or by emailing us at support@arbicare.com.

Dispute Resolution Procedures

It is your right to disagree with the included utilization review decision. Any dispute that you do not wish to take up with the voluntary internal appeals process outlined above may be resolved in accordance with the independent medical review provisions of Labor Code Section 4610.5 and 4610.6. Any objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent medical Review, DWC Form IMR, within:

- 10 days after the service of the utilization review decision to the employee for formulary disputes; and
- 30 days after the service of the utilization review decision to the employee for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me @adjustername at @adjusterphone. 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.

State of California, Division of Workers' Compensation

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

DWC Form IMR

TO REQUEST INDEPENDENT MEDICAL REVIEW:

1. **Sign and date this application and consent to obtain medical records.**
2. **Mail or fax the application and a copy of the written decision you received that denied or modified the medical treatment requested by your physician to:**
   DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
   FAX Number: (916) 605-4270
3. **Mail or fax a copy of the signed application to your Claims Administrator.**

Type of Utilization Review: ☐ Regular ☐ Expedited	Modification after Appeal ☐

Employee Name (First, MI, Last):	
Address:	
Phone Number:	Employer Name:
Claim Number:	Date of Injury (MM/DD/YYYY):
WCIS Jurisdictional Claim Number (if assigned):	EAMS Case Number (if applicable):
Employee Attorney (if known):	
Address:	
Phone Number:	Fax Number:
Requesting Physician Name (First, MI, Last):	
Practice Name:	Specialty:
Address:	
Phone Number:	Fax Number:
Claims Administrator Name:	
Adjuster/Contact Name:	
Address:	
Phone Number:	Fax Number:
Disputed Medical Treatment (complete below section)	
Primary Diagnosis (Use ICD Code where practical):	
Date of Utilization Review Determination Letter:	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☐ No Reason:	
List each specific requested medical services, goods, or items that were denied or modified in the space 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 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:

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation claims administrator sent you a written 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, DELAY, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE ONE OF THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this form with a copy of the written 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. This person may sign the application for you and submit documents on your behalf.
- If the recommended medical treatment that was denied or modified must 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 to:

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

- **Your IMR application, along with a copy of the written determination letter, must be received by Maximus Federal Services, Inc. within thirty-five (35) days from the mailing date of the written determination letter informing you that the medical treatment requested by your treating physician was denied or modified.**
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written determination letter.

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:

ARBICARE

Review completed by
Arbicare on behalf of
@clientname

Phone: 800-716-8295
Fax: 404-631-6387
Email: support@arbicare.com

Utilization Review Reconsideration Certification

Dear @employeename,

With the intent of maintaining a high standard of care, Arbicare has been requested by @clientname to perform utilization review of the appropriateness and necessity of the below listed health care treatments.

Claimant		Treating Provider		Review Type	
@employeename		@providername		@reviewtype	
Claim #	@clm#	**Address**	@provaddress1	**Client**	@clientname
Case #	@case#		@provaddress2	**Referrer**	@referrername
Birth Date	@dob		@provcity	**RFA First Received**	@receiveddate
Injury Date	@doi		@provstate	**Decision Date**	@revieweddate
Jurisdiction	@state		@provzip		

Request Determination(s)

1. @request1 is @decision1. Valid @start1 - @end1.
2. @request2 is @decision2. Valid @start2 – @end2.
3. @request3 is @decision3. Valid @start3 - @end3.

Diagnosis

1. Diagnosis 1
2. Diagnosis 2

Clinical History

[Brief summary of medical history.]

Determination Summary

1. **@request1 is @decision1. Valid @start1 - @end1.**
   [Brief summary statement including reviewer determination and rationale.]

2. **@request2 is @decision2. Valid @start2 - @end2.**
   [Brief summary statement including reviewer determination and rationale.]

3. **@request3 is @decision3. Valid @start3 - @end3.**
   [Brief summary statement including reviewer determination and rationale.]

Determination Rationale

1. **@request1 is @decision1.**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

2. **@request2 is @decision2.**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

[Reviewer detailed comments regarding listed treatment request including determination and rationale.]

3. **@request3 is @decision3**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

[Reviewer detailed comments regarding listed treatment request including determination and rationale.]

Outreach Summary

Attempt	Respondent / Role	Dialogue
mm/dd/yyyy, hh:mm PM EDT	Name, role	[summary statement of conversation by reviewing physician.]
mm/dd/yyyy, hh:mm PM EDT	Name, role	[summary statement of conversation by reviewing physician.]

Records Reviewed

Date	Type	Source
mm/dd/yyyy		[Name]
mm/dd/yyyy		[Name]
mm/dd/yyyy		[Name]

Conflict of Interest Attestation

I certify that no material professional, familial, or financial conflict of interest regarding the determination made in review of this case. Further, no conflict of interest exists between myself or any of the following: the referring entity; any prior involvement with the case; the insurance issuer or group health plan/carrier for the case under review; a management role in a health plan of an insurance issuer or group health plan that is the subject of a review which includes participation on the board of directors or any sub-committee of that board and in advisory groups that provide guidance to a provider network, including credentialing, medical policy and quality management committees; the covered person or the covered person's authorized representative; any officer, director, or management employee of an insurance issuer; the group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the review.

I attest that I have a scope of licensure or certification and professional experience that typically manages the medical condition, procedure, treatment, or issue under review.

Physician Reviewer

@reviewersignature
@reviewername, @reviewersuffix
@reviewerspecialty
@reviewersubspecialty
@statelicensenumber
@reviewdate

CC:
@providername
@applicantattorneyname

Address Arbicare
1175 Peachtree St. NE Ste 1000
Atlanta GA 30361

Email support@arbicare.com

Phone (800) 716-8295

Fax (404) 631-6387

If you have any questions about this determination or need further information please contact our support staff by calling our Toll-Free number 1-800-716-8295 or by emailing us at support@arbicare.com.

ARBICARE

Review completed by
Arbicare on behalf of
@clientname

Phone: 800-716-8295
Fax: 404-631-6387
Email: support@arbicare.com

Utilization Review Reconsideration Determination

Dear @employeename,

With the intent of maintaining a high standard of care, Arbicare has been requested by @clientname to perform utilization review of the appropriateness and necessity of the below listed health care treatments.

Claimant		Treating Provider		Review Type	
@employeename		@providername		@reviewtype	
Claim #	@clm#	**Address**	@provaddress1	**Client**	@clientname
Case #	@case#		@provaddress2	**Referrer**	@referrername
Birth Date	@dob		@provcity	**RFA First Received**	@receiveddate
Injury Date	@doi		@provstate	**Decision Date**	@revieweddate
Jurisdiction	@state		@provzip		

Request Determination(s)

1. @request1 is @decision1. Valid @start1 - @end1.
2. @request2 is @decision2. Valid @start2 – @end2.
3. @request3 is @decision3. Valid @start3 - @end3.

Diagnosis

1. Diagnosis 1
2. Diagnosis 2

Clinical History

[Brief summary of medical history.]

Determination Summary

1. **@request1 is @decision1. Valid @start1 - @end1.**
   [Brief summary statement including reviewer determination and rationale.]

2. **@request2 is @decision2. Valid @start2 - @end2.**
   [Brief summary statement including reviewer determination and rationale.]

3. **@request3 is @decision3. Valid @start3 - @end3.**
   [Brief summary statement including reviewer determination and rationale.]

Determination Rationale

1. **@request1 is @decision1.**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

2. **@request2 is @decision2.**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

[Reviewer detailed comments regarding listed treatment request including determination and rationale.]

3. **@request3 is @decision3**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

[Reviewer detailed comments regarding listed treatment request including determination and rationale.]

Outreach Summary

Attempt	Respondent / Role	Dialogue
mm/dd/yyyy, hh:mm PM EDT	Name, role	[summary statement of conversation by reviewing physician.]
mm/dd/yyyy, hh:mm PM EDT	Name, role	[summary statement of conversation by reviewing physician.]

Records Reviewed

Date	Type	Source
mm/dd/yyyy		[Name]
mm/dd/yyyy		[Name]
mm/dd/yyyy		[Name]

Conflict of Interest Attestation

I certify that no material professional, familial, or financial conflict of interest regarding the determination made in review of this case. Further, no conflict of interest exists between myself or any of the following: the referring entity; any prior involvement with the case; the insurance issuer or group health plan/carrier for the case under review; a management role in a health plan of an insurance issuer or group health plan that is the subject of a review which includes participation on the board of directors or any sub-committee of that board and in advisory groups that provide guidance to a provider network, including credentialing, medical policy and quality management committees; the covered person or the covered person's authorized representative; any officer, director, or management employee of an insurance issuer; the group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the review.

I attest that I have a scope of licensure or certification and professional experience that typically manages the medical condition, procedure, treatment, or issue under review.

Physician Reviewer

@reviewersignature
@reviewername, @reviewersuffix
@reviewerspecialty
@reviewersubspecialty
@statelicensenumber
@reviewdate

CC:
@providername
@applicantattorneyname

Decision Effective Dates

Pursuant to Title 8, CCR §9792.9.1 (h), 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.

Reviewer Availability

Should discussion concerning the decision be needed, Arbicare will make a consulting reviewer available for follow-up discussion during normal business hours (between 9:00am and 5:30pm Pacific Time) for at least four (4) hours over the course of the subsequent five (5) business days of the request for discussion. Within this conversation the consulting reviewer will contemplate any new information presented and either uphold or overturn the determination. Please contact Arbicare at (800) 716-8295 to schedule physician availability.

Internal Appeals Process

Arbicare maintains an internal appeals process for the requesting physician that is entirely voluntary 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 expedited basis. Any additional appeal request after completion of the voluntary Internal Appeals process must be made by using the Independent Medical Review process detailed in Labor Code section 4610.5 and 4610.6.

Standard Appeal

Per Title 8, CCR §9792.10.1(d)(1-3), Arbicare has in place procedures for internal appeals of decisions to deny or modify a utilization review determination. If you wish to appeal this decision, please submit your request for appeal to Arbicare with any supporting documentation and/or a written statement by the attending physician within ten (10) days of receipt of the decision. Any request for an appeal of the utilization review decision must be submitted either by telephone or in writing to the address, phone number, fax number, or email listed below. Participating in this process is entirely voluntary. Any appeal request will be completed as soon as is practicable but will be completed no later than thirty (30) days upon receipt of request and all applicable medical documentation. The appeal will be completed by a different reviewer of at least the same qualifications as the initial reviewer. As part of the appeal process please provide any additional medical records that are relevant to the completion of the reconsideration. Notification of the completed appeal determination will be delivered in writing to the patient or representative and the attending provider. In the event that the determination remains to deny, the written notification will include an explanation of the principal reason(s) for the determination.

Expedited Appeal

Arbicare has in place procedures for expedited appeals of decisions to deny a utilization review determination. If you wish to appeal this decision on an expedited basis, please submit your request for appeal to Arbicare with any supporting documentation and/or a written statement to be submitted either by telephone or in writing to the address, phone number, fax number, or email listed below. Participating in this process is entirely voluntary. Any expedited appeal request will be completed as soon as is practicable but will result in verbal notification of determination to the attending physician no later than 72 hours following receipt of the expedited appeal request. The verbal notification will be followed by written confirmation of the notification delivered to the patient and attending physician within three (3) calendar days. In the event that the determination remains to deny, the written notification will include an explanation of the principal reason(s) for the determination.

Address	Arbicare 1175 Peachtree St. NE Ste 1000 Atlanta GA 30361
Email	support@arbicare.com
Phone	(800) 716-8295
Fax	(404) 631-6387

If you have any questions about this determination, the reconsideration process, or need further information concerning available next steps, please contact our support staff by calling our Toll-Free number 1-800-716-8295 or by emailing us at support@arbicare.com.

Dispute Resolution Procedures

It is your right to disagree with the included utilization review decision. Any dispute that you do not wish to take up with the voluntary internal appeals process outlined above may be resolved in accordance with the independent medical review provisions of Labor Code Section 4610.5 and 4610.6. Any objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent medical Review, DWC Form IMR, within:

- 10 days after the service of the utilization review decision to the employee for formulary disputes; and
- 30 days after the service of the utilization review decision to the employee for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me @adjustername at @adjusterphone. 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.

State of California, Division of Workers' Compensation

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

DWC Form IMR

TO REQUEST INDEPENDENT MEDICAL REVIEW:

1. **Sign and date this application and consent to obtain medical records.**
2. **Mail or fax the application and a copy of the written decision you received that denied or modified the medical treatment requested by your physician to:**
   DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
   FAX Number: (916) 605-4270
3. **Mail or fax a copy of the signed application to your Claims Administrator.**

Type of Utilization Review: ☐ Regular ☐ Expedited	Modification after Appeal ☐

Employee Name (First, MI, Last):	
Address:	
Phone Number:	Employer Name:
Claim Number:	Date of Injury (MM/DD/YYYY):
WCIS Jurisdictional Claim Number (if assigned):	EAMS Case Number (if applicable):
Employee Attorney (if known):	
Address:	
Phone Number:	Fax Number:
Requesting Physician Name (First, MI, Last):	
Practice Name:	Specialty:
Address:	
Phone Number:	Fax Number:
Claims Administrator Name:	
Adjuster/Contact Name:	
Address:	
Phone Number:	Fax Number:
Disputed Medical Treatment (complete below section)	
Primary Diagnosis (Use ICD Code where practical):	
Date of Utilization Review Determination Letter:	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☐ No Reason:	
List each specific requested medical services, goods, or items that were denied or modified in the space 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 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:

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation claims administrator sent you a written 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, DELAY, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE ONE OF THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this form with a copy of the written 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. This person may sign the application for you and submit documents on your behalf.
- If the recommended medical treatment that was denied or modified must 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 to:

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

- **Your IMR application, along with a copy of the written determination letter, must be received by Maximus Federal Services, Inc. within thirty-five (35) days from the mailing date of the written determination letter informing you that the medical treatment requested by your treating physician was denied or modified.**
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written determination letter.

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:

ARBICARE

Review completed by
Arbicare on behalf of
@clientname

Phone: 800-716-8295
Fax: 404-631-6387
Email: support@arbicare.com

Utilization Review Appeal Certification

Dear @employeename,

With the intent of maintaining a high standard of care, Arbicare has been requested by @clientname to perform utilization review of the appropriateness and necessity of the below listed health care treatments.

Claimant		Treating Provider		Review Type	
@employeename		@providername		@reviewtype	
Claim #	@clm#	**Address**	@provaddress1	**Client**	@clientname
Case #	@case#		@provaddress2	**Referrer**	@referrername
Birth Date	@dob		@provcity	**RFA First Received**	@receiveddate
Injury Date	@doi		@provstate	**Decision Date**	@revieweddate
Jurisdiction	@state		@provzip		

Request Determination(s)

1. @request1 is @decision1. Valid @start1 - @end1.
2. @request2 is @decision2. Valid @start2 – @end2.
3. @request3 is @decision3. Valid @start3 - @end3.

Diagnosis

1. Diagnosis 1
2. Diagnosis 2

Clinical History

[Brief summary of medical history.]

Determination Summary

1. **@request1 is @decision1. Valid @start1 - @end1.**
   [Brief summary statement including reviewer determination and rationale.]

2. **@request2 is @decision2. Valid @start2 - @end2.**
   [Brief summary statement including reviewer determination and rationale.]

3. **@request3 is @decision3. Valid @start3 - @end3.**
   [Brief summary statement including reviewer determination and rationale.]

Determination Rationale

1. **@request1 is @decision1.**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

2. **@request2 is @decision2.**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

[Reviewer detailed comments regarding listed treatment request including determination and rationale.]

3. **@request3 is @decision3**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

[Reviewer detailed comments regarding listed treatment request including determination and rationale.]

Outreach Summary

Attempt	Respondent / Role	Dialogue
mm/dd/yyyy, hh:mm PM EDT	Name, role	[summary statement of conversation by reviewing physician.]
mm/dd/yyyy, hh:mm PM EDT	Name, role	[summary statement of conversation by reviewing physician.]

Records Reviewed

Date	Type	Source
mm/dd/yyyy		[Name]
mm/dd/yyyy		[Name]
mm/dd/yyyy		[Name]

Conflict of Interest Attestation

I certify that no material professional, familial, or financial conflict of interest regarding the determination made in review of this case. Further, no conflict of interest exists between myself or any of the following: the referring entity; any prior involvement with the case; the insurance issuer or group health plan/carrier for the case under review; a management role in a health plan of an insurance issuer or group health plan that is the subject of a review which includes participation on the board of directors or any sub-committee of that board and in advisory groups that provide guidance to a provider network, including credentialing, medical policy and quality management committees; the covered person or the covered person's authorized representative; any officer, director, or management employee of an insurance issuer; the group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the review.

I attest that I have a scope of licensure or certification and professional experience that typically manages the medical condition, procedure, treatment, or issue under review.

Physician Reviewer

@reviewersignature
@reviewername, @reviewersuffix
@reviewerspecialty
@reviewersubspecialty
@statelicensenumber
@reviewdate

CC:
@providername
@applicantattorneyname

Notice of Appeal Decision

This appeal decision was made by a board eligible or certified physician in the appropriate specialty and meets all requirements of Title 8, CCR §9792.9.1. If any dispute remains concerning the utilization review decision, please pursue the Independent Medical Review process outlined below. If you have any questions about this determination, the reconsideration process, or need further information concerning available next steps, please contact our support staff by calling our Toll-Free number 1-800-716-8295 or by emailing us at support@arbicare.com.

Address Arbicare
1175 Peachtree St. NE Ste 1000
Atlanta GA 30361

Email support@arbicare.com

Phone (800) 716-8295

Fax (404) 631-6387

ARBICARE

Review completed by
Arbicare on behalf of
@clientname

Phone: 800-716-8295
Fax: 404-631-6387
Email: support@arbicare.com

Utilization Review Appeal Determination

Dear @employeename,

With the intent of maintaining a high standard of care, Arbicare has been requested by @clientname to perform utilization review of the appropriateness and necessity of the below listed health care treatments.

Claimant	Treating Provider	Review Type
@employeename	@providername	@reviewtype

Claim #	@clm#	**Address**	@provaddress1	**Client**	@clientname
Case #	@case#		@provaddress2	**Referrer**	@referrername
Birth Date	@dob		@provcity	**RFA First Received**	@receiveddate
Injury Date	@doi		@provstate		
Jurisdiction	@state		@provzip	**Decision Date**	@revieweddate

Request Determination(s)

1. @request1 is @decision1. Valid @start1 - @end1.
2. @request2 is @decision2. Valid @start2 – @end2.
3. @request3 is @decision3. Valid @start3 - @end3.

Diagnosis

1. Diagnosis 1
2. Diagnosis 2

Clinical History

[Brief summary of medical history.]

Determination Summary

1. **@request1 is @decision1. Valid @start1 - @end1.**
   [Brief summary statement including reviewer determination and rationale.]

2. **@request2 is @decision2. Valid @start2 - @end2.**
   [Brief summary statement including reviewer determination and rationale.]

3. **@request3 is @decision3. Valid @start3 - @end3.**
   [Brief summary statement including reviewer determination and rationale.]

Determination Rationale

1. **@request1 is @decision1.**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

2. **@request2 is @decision2.**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

[Reviewer detailed comments regarding listed treatment request including determination and rationale.]

3. **@request3 is @decision3**

[Guideline Referenced]

[Guideline detail text e.g.,]

[Guideline Referenced]

[Guideline detail text e.g.,]

Reviewing Physician's Conclusions & Comments

[Reviewer detailed comments regarding listed treatment request including determination and rationale.]

Outreach Summary

Attempt	Respondent / Role	Dialogue
mm/dd/yyyy, hh:mm PM EDT	Name, role	[summary statement of conversation by reviewing physician.]
mm/dd/yyyy, hh:mm PM EDT	Name, role	[summary statement of conversation by reviewing physician.]

Records Reviewed

Date	Type	Source
mm/dd/yyyy		[Name]
mm/dd/yyyy		[Name]
mm/dd/yyyy		[Name]

Conflict of Interest Attestation

I certify that no material professional, familial, or financial conflict of interest regarding the determination made in review of this case. Further, no conflict of interest exists between myself or any of the following: the referring entity; any prior involvement with the case; the insurance issuer or group health plan/carrier for the case under review; a management role in a health plan of an insurance issuer or group health plan that is the subject of a review which includes participation on the board of directors or any sub-committee of that board and in advisory groups that provide guidance to a provider network, including credentialing, medical policy and quality management committees; the covered person or the covered person's authorized representative; any officer, director, or management employee of an insurance issuer; the group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the review.

I attest that I have a scope of licensure or certification and professional experience that typically manages the medical condition, procedure, treatment, or issue under review.

Physician Reviewer

@reviewersignature
@reviewername, @reviewersuffix
@reviewerspecialty
@reviewersubspecialty
@statelicensenumber
@reviewdate

CC:
@providername
@applicantattorneyname

Decision Effective Dates

Pursuant to Title 8, CCR §9792.9.1 (h), 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.

Reviewer Availability

Should discussion concerning the decision be needed, Arbicare will make a consulting reviewer available for follow-up discussion during normal business hours (between 9:00am and 5:30pm Pacific Time) for at least four (4) hours over the course of the subsequent five (5) business days of the request for discussion. Within this conversation the consulting reviewer will contemplate any new information presented and either uphold or overturn the determination. Please contact Arbicare at (800) 716-8295 to schedule physician availability.

Conditional Denial

When a determination is made to deny or modify the request because insufficient medical information was available, Arbicare provides the opportunity for the ordering provider, within 1 business day of receiving the denial or modification, to discuss the determination with the peer reviewer that made the determination; or with a different peer reviewer, if the original peer reviewer is unavailable. A reconsideration will be accepted by Arbicare from the ordering provider through a discussion or written response.

Notice of Appeal Decision

This appeal decision was made by a board eligible or certified physician in the appropriate specialty and meets all requirements of Title 8, CCR §9792.9.1. If any dispute remains concerning the utilization review decision, please pursue the Independent Medical Review process outlined below. If you have any questions about this determination, the reconsideration process, or need further information concerning available next steps, please contact our support staff by calling our Toll-Free number 1-800-716-8295 or by emailing us at support@arbicare.com.

Address	Arbicare 1175 Peachtree St. NE Ste 1000 Atlanta GA 30361
Email	support@arbicare.com
Phone	(800) 716-8295
Fax	(404) 631-6387

Dispute Resolution Procedures

It is your right to disagree with the included utilization review decision. Any dispute that you do not wish to take up with the voluntary internal appeals process outlined above may be resolved in accordance with the independent medical review provisions of Labor Code Section 4610.5 and 4610.6. Any objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within:

- 10 days after the service of the utilization review decision to the employee for formulary disputes; and
- 30 days after the service of the utilization review decision to the employee for all other medical treatment disputes.

The voluntary appeal process neither triggers nor bars the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me @adjustername at @adjusterphone. 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.

State of California, Division of Workers' Compensation

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

DWC Form IMR

TO REQUEST INDEPENDENT MEDICAL REVIEW:

1. **Sign and date this application and consent to obtain medical records.**
2. **Mail or fax the application and a copy of the written decision you received that denied or modified the medical treatment requested by your physician to:**
   DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
   FAX Number: (916) 605-4270
3. **Mail or fax a copy of the signed application to your Claims Administrator.**

Type of Utilization Review: ☐ Regular ☐ Expedited	Modification after Appeal ☐

Employee Name (First, MI, Last):	
Address:	
Phone Number:	Employer Name:
Claim Number:	Date of Injury (MM/DD/YYYY):
WCIS Jurisdictional Claim Number (if assigned):	EAMS Case Number (if applicable):
Employee Attorney (if known):	
Address:	
Phone Number:	Fax Number:
Requesting Physician Name (First, MI, Last):	
Practice Name:	Specialty:
Address:	
Phone Number:	Fax Number:
Claims Administrator Name:	
Adjuster/Contact Name:	
Address:	
Phone Number:	Fax Number:
Disputed Medical Treatment (complete below section)	
Primary Diagnosis (Use ICD Code where practical):	
Date of Utilization Review Determination Letter:	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☐ No Reason:	
List each specific requested medical services, goods, or items that were denied or modified in the space 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 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:

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation claims administrator sent you a written 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, DELAY, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE ONE OF THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this form with a copy of the written 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. This person may sign the application for you and submit documents on your behalf.
- If the recommended medical treatment that was denied or modified must 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 to:

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

- **Your IMR application, along with a copy of the written determination letter, must be received by Maximus Federal Services, Inc. within thirty-five (35) days from the mailing date of the written determination letter informing you that the medical treatment requested by your treating physician was denied or modified.**
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written determination letter.

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:

ARBICARE

Review completed by
Arbicare on behalf of
@clientname

Phone: 800-716-8295
Fax: 404-631-6387
Email: support@arbicare.com

Utilization Review – Request for Additional Information

Dear @employeename / @providername / @applicantattorney,

With the intent of maintaining a high standard of care, Arbicare has been requested by @clientname to perform utilization review of the appropriateness and necessity of the below listed health care treatments.

Claimant		Treating Provider		Review Type	
@employeename		@providername		@reviewtype	
Claim #	@clm#	**Address**	@provaddress1	**Client**	@clientname
Case #	@case#		@provaddress2	**Referrer**	@referrername
Birth Date	@dob		@provcity	**RFA First Received**	@receiveddate
Injury Date	@doi		@provstate		
Jurisdiction	@state		@provzip		

Request(s)

1. @request1
2. @request2
3. @request3

Arbicare has been requested to provide a utilization review decision on behalf of @clientname, for the treatments listed above. The purpose of this review process is to determine whether the requested treatments are medically appropriate and necessary and conform with best-practice care.

To perform that review, Arbicare is requesting additional information to assist our physician reviewer in making the appropriate decision regarding your medical care. Arbicare requires that the requesting provider (treating provider) submit the following information in order for Arbicare to complete this review.

Please supply this information within the below described timeframes. This review falls under the @reviewtype designation.

Prospective	14 days of the date of this letter
Concurrent	14 days of the date of this letter
Retrospective	30 days of the date of this letter

Pursuant to Title 8, CCR § 9792.9.1(f)(3)(A), if the requested information is not provided within the above timeframes, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

If the request for information for an additional examination or test required under subdivision (f)(1)(B), or specialized consultation under subdivision (f)(1)(C), requested by the physician reviewer is not received within thirty (30) days from the date of the request for authorization, the physician reviewer shall deny the treating physician's request with the stated condition that the request will be reconsidered upon receipt of the information.

Information Being Requested

Delivery Instructions

This information may be emailed, faxed, or mailed to Arbicare per the contact information listed below. Please feel free to contact Arbicare with any questions.

Address	Arbicare 1175 Peachtree St. NE Ste 1000 Atlanta GA 30361
Email	support@arbicare.com
Phone	(800) 716-8295
Fax	(404) 631-6387

Sincerely,

[Arbicare Clinical Reviewer]

[License]

CC:

@providername
@applicantattorneyname