Intelligent Medical Solutions

Utilization Review Plan

California Workers' Compensation

Effective April 1, 2026

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Table of Contents:

i. Definitions:....4

1.0 Introduction:....9

1.1 Filing and Maintenance of Utilization Review Plan:....9

1.2 Availability of Utilization Review Plan:....9

1.3 Update and Revision of Utilization Review Plan, Program, Policies and Procedures:....10

2.0 Organizational Structure:....10

2.1 Designation of Medical Director:....10

2.2 Statement of Compliance by IMS Medical Director:....11

2.3 Qualifications and Functions of Personnel:....12

2.3.1 Medical Director:....12

2.3.2 Vice President of Managed Care:....12

2.3.3 Utilization Review Coordinators and Supporting Staff:....13

2.3.4 Clinical Staff:....13

2.3.5 Physician Specialty Reviewer / Peer Reviewer Staff:....14

2.4 Description of Utilization Review Department Supporting Infrastructure:....14

2.4.1 Telephone / Fax Systems / Voicemail Systems:....14

2.4.2 After-Hours Response Team:....15

2.4.3 Records Keeping:....15

2.4.4 Confidentiality:....15

3.0 Description of Utilization Review Process:....17

3.1 Receipt of Requests for Authorization:....17

3.2 Intake Process:....18

3.2.1 Intake of Expedited Referrals:....20

3.3 Decision-Making:....20

3.3.1 Medical Treatment – First 30 Days of Injury....20

3.3.2 MTUS Drug Formulary....22

3.3.3 Timeframes for Decision-Making :....23

3.3.4. Timeframes for Decision-Making – MTUS Drug Formulary....24

3.3.5 RFI Process and Time Extensions for Lack of Information:....24

3.3.6 Additional Examinations, Tests, or Consultations by an Expert Review:....25

3.3.7 Decision-Making Timeframes after Receipt of Additional / Requested Information:....26

3.4 Notification Procedures, Timeframe and Notice Content:....26

3.4.1 Notifications for Expedited Referrals:....31

3.5 Deferred Utilization Review Treatment Requests: 31
3.6 Dispute Resolution, Internal Appeals and Consumer Complaints: 32
3.6.1 Independent Medical Review: 32
3.6.2 Internal Appeals Process: 35
3.6.3 Peer-to-Peer Discussion Process: 36
3.6.4 Alternate Dispute Resolution (ADR) Program 36
3.7 Quality Assurance Program: 37
3.7.1 Quality Assurance ("QA") Issues: 38
4.0 Description of Utilization Review Criteria: 39
4.1 MTUS Criteria and Medical Evidence Sequence Search: 40
4.2 MTUS Methodology for Evaluating Medical Evidence: 40
Appendix 1: Notification Letter Templates: 46
1.1 Initial Notification via Facsimile: 46
1.2 Approval Notification Letter: 47
1.3 Notification of Utilization Review Modification or Denial: 49
1.4 Notification of Utilization Review Deferral: 55
1.5 Request for Information ("RFI") Regarding Utilization Review: 57
1.6 Notice of Utilization Review Time Extension: 58
1.7 Sample Voluntary Appeal Response: 60
Appendix 2: URAC Accreditation Certificate: 62

i. Definitions:

As of the effective date of this Utilization Review Plan, the following definition sections of the California Code of Regulations are associated with the terminology used throughout this document:

- 8 CCR §9792.6.1 – Utilization Review Standards – Definitions
- 8 CCR §9792.20 – Medical Treatment Utilization Schedule – Definitions

The specific terms as they are used in this Utilization Review plan and their associated definitions are outlined below:

- ***"ACOEM:"*** means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines published by the Reed Group containing evidenced-based medical treatment guidelines for conditions commonly associated with the workplace. ACOEM guidelines may be obtained from the American College of Occupational and Environmental Medicine, 1450 American Lane, Suite 700, Schaumburg, IL 60173 (www.acoem.org).

- ***"Authorization:"*** means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed "Request for Authorization," as defined in this section, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1 through 9792.12.

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

- ***"Concurrent review:"*** means utilization review conducted during an inpatient stay.

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

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

- ***"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.

- ***"Disputed medical treatment:"*** means medical treatment that has been modified or denied by a utilization review decision.

- ***"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.

- ***"Evidence-based Medicine (EBM):"*** means a systematic approach to making clinical decisions which allows the integration of the best available research evidence with clinical expertise and patient values.

- ***"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.

- ***"Expert reviewer:"*** means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, whose consultation for a specialized review has been requested by the claims administrator or utilization review organization, necessitating an extension of time, under section 9792.9.6, prior to the determination of medical necessity.

- ***"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.

- ***"Immediate" or "Immediately:"*** means within one business day.

- ***"Material modification:"*** is when the claims administrator changes utilization review vendor(s); makes a change to the utilization review standards as specified in section 9792.7;or changes its medical director, address, company name or corporate structure

- ***"Medical director:"*** is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California. The medical director is responsible for all decisions made in the utilization review process.

- ***"Medical services:"*** means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

- ***"Medical treatment:"*** is care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20 – 9792.26.

- ***"Medical treatment guidelines:"*** means the most current version of written recommendations which are systematically developed by a multidisciplinary process through a comprehensive literature search to assist in decision-making about the appropriate medical treatment for specific clinical circumstances reviewed and updated within the last five years.

- ***"Medical Treatment Utilization Schedule (MTUS):"*** means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20.

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

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

- ***"Nationally recognized:"*** means published in a peer-reviewed medical journal; or developed, endorsed and disseminated by a national organization with affiliates based in two or more U.S. states and is the most current version.

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

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

- ***"ODG by MCG:"*** means the Official Disability Guidelines published by MCG Health Company containing evidence-based medical treatment guidelines for conditions commonly associated with the workplace. ODG by MCG guidelines may be obtained from MCG Health, 701 Fifth Avenue, Suite 4900, Seattle, WA 98104 (www.mcg.com/odg).

- ***"Peer reviewed:"*** means that a study's content, methodology and results have been evaluated and approved prior to publication by an editorial board of qualified experts.

- ***"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.

- ***"Request for authorization" or "RFA:"*** means a written request for a specific course of proposed medical treatment that meets all of the following criteria:

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

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

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

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

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

- ***"Scientifically based:"*** means based on scientific literature, wherein the body of literature is identified through performance of a literature search, the identified literature is evaluated, and then used as the basis to support a recommendation.

- ***"Strength of Evidence:"*** establishes the relative weight that shall be given to scientifically based evidence.

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

- ***"Utilization review decision:"*** means a decision pursuant to Labor Code section 4610 to approve, modify, or deny a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code sections 4600 or 5402(c).

- ***"Utilization Review Organization" or "URO:"*** means an organization performing Utilization Review Services for California Workers' Compensation, which has filed a Utilization Review Plan with the Administrative Director and does not administer claims.

- ***"Utilization review plan:"*** means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.

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

- ***"Working day:"*** as used in this article is the same as "business day" or "normal business day."

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

1.0 Introduction:

In accordance with Labor Code 4610(c) and 8 CCR §9792.7(a), Intelligent Medical Solutions (IMS) intends to implement a California Workers' Compensation Utilization Review Plan consisting of this document. Intelligent Medical Solutions' corporate office is located at One Spectrum Pointe Drive, Suite 200, Lake Forest, CA 96230.

The mission of IMS' Utilization Review Process is to promote the overall quality of healthcare delivered to injured workers in the State of California by facilitating the integration of the best available research evidence with clinical expertise and patient values in accordance with the Laws of the State of California. IMS understands that the expedient delivery of necessary healthcare services and the overall health of the injured worker are primary concerns and will strive to promote the best possible quality care according to the best available scientific evidence, while fraud, waste, abuse and inappropriate care is eliminated through these same processes.

The purpose of this utilization review plan is to outline the specific policies, procedures and processes by which utilization review work will be conducted by IMS while meeting all of the legal requirements promulgated by the State of California.

1.1 Filing and Maintenance of Utilization Review Plan:

As of 6/30/2017, Intelligent Medical Solutions has filed their initial Utilization Review plan with the Administrative Director in accordance with 8 CCR §9792.7(c).

Intelligent Medical Solutions, upon the filing of this plan, intends to operate as a Utilization Review Organization which will provide Utilization Review services to Claims Administrators and Employers requiring the services of a URO.

Upon any modification to this plan, any policy or procedure which affects the material basis of this plan, or any changes (addition, change or removal) to the clients on whose behalf IMS performs utilization review, a material modification will be filed with the Administrative Director within 30 days pursuant to subsection (c) of §9792.7.

IMS will provide proof of accreditation through the Workers' Compensation Utilization Management Accreditation program administered by URAC.

IMS may maintain separate "Operational Agreements" with clients which work out the specific operational details of how day-to-day work is conducted.

The most recent update of the Utilization Review plan is effective 04/01/2026 and has been updated in collaboration with the Division of Workers' Compensation.

1.2 Availability of Utilization Review Plan:

In accordance with 8 CCR §9792.7(m)(1), IMS' Utilization Review Plan will be disclosed to employees, physicians, and the public upon request through electronic means.

As per Labor Code 4610, subsection (g)(5), the final approved version of this plan and all subsequent approved updates will be posted on IMS' website at www.imscc.com. IMS reserves the right to modify a public version of the plan which does not contain proprietary information, and which contains plain and understandable language to assist in education of the public regarding Utilization Review Processes.

The plan will be disclosed to the public electronically by referring them to the most recent version of the plan on the IMS website.

Additionally, if a member of the public requests a hard copy of the Utilization Review Plan, IMS will provide a hard copy of the plan via ground-mail. IMS may charge reasonable copying and postage expenses not to exceed $0.25 per page.

1.3 Update and Revision of Utilization Review Plan, Program, Policies and Procedures:

IMS' Utilization Review Plan, Policies and Procedures, and overall program will be evaluated as a whole at least annually, and updated, if necessary, at that time. They are developed with the involvement of actively participating physicians, including but not limited to the IMS Medical Director as well as contributing members of IMS' physician specialty peer network. IMS will also update its Utilization Review program throughout the annual timeframe to correspond with relevant changes in legislation.

IMS will file a material modification of its utilization review plan with the Administrative Director within 30 calendar days of the material modification. The material modification shall include a DWC Form UR-01 set forth in section 9792.7.1, completed as applicable with an original signature by IMS's medical director, and an attached statement certifying that the utilization review plan, as modified, continues to be in compliance with the rules governing utilization review at sections 9792.6.1 through 9792.12. The modified utilization review plan shall be submitted in compact discs or flash drives, or other electronic format agreed to by the Administrative Director and IMS, in word searchable PDF format.

2.0 Organizational Structure:

2.1 Designation of Medical Director:

IMS designates William M. Barreto, M.D. as its Medical Director, who holds an unrestricted license to practice medicine in the State of California issued pursuant to Section 2050 or Section 2450 of the Business and Professions code:

Name:	William M. Barreto, M.D.
Street Address:	One Spectrum Pointe Dr., Suite 200
City, State, Zip:	Lake Forest, CA 92630
Phone Number:	(833) 814-3576
CA Medical License #:	A91430
Specialty:	PM&R, Pain Management

Dr. Barreto is ultimately responsible and accountable for the processes under IMS' Utilization Review plan. An overview of his responsibilities is outlined under Section 2.3.1

2.2 Statement of Compliance by IMS Medical Director:

As the Medical Director for IMS' Utilization Review Program, I do hereby certify the following:

- The process by which IMS, as well as all claims administrators under IMS' Utilization Review program, reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, shall comply at all times with Labor Code section 4610 and the regulations under §9792.6.1 – §9792.27.17.

- Decisions based on the medical necessity to cure and relieve of proposed medical treatment services shall be consistent with the schedule for medical treatment utilization adopted pursuant to Labor Code 5307.27.

William Barreto, M.D.
April 1, 2026

2.3 Qualifications and Functions of Personnel:

2.3.1 Medical Director:

The overall Utilization Review Program at IMS is overseen by the Medical Director. The Medical Director is primarily responsible and accountable to:

- Ensure that the process by which IMS, as well as the claims administrators represented under IMS' Utilization Review Plan, reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with Labor Code section 4610 and all implementing regulations under 8 CCR §9792.6.1 et seq as well as 8 CCR §9792.20 et seq

- Ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services shall be consistent with the schedule for medical treatment utilization adopted pursuant to Labor Code 5307.27

- Develop and approve IMS' Utilization Review Plan, Policy and Operational Framework

- Provide oversight of involved staff such as nurses, coordinators and managers to ensure activities are within framework

- Perform Utilization Review to Certify, Modify or Deny requests authorization where the review is within the Medical Director's scope of practice

- Provide oversight related to trends in medical science, scientific evidence, workers' compensation healthcare population analytics

- Provide oversight of all medical policy as well as medical criteria and evidence-based guidelines used in the decision-making process. Ensure that all Medical Criteria is consistent with the MTUS. Provide annual review of Medical Criteria

2.3.2 Vice President of Managed Care:

The Vice President of Managed Care is responsible and accountable to:

- Perform management responsibilities to include but are not limited to involved in hiring and termination decisions, coaching and development, rewards and recognition, performance management and staff productivity

- Plan, organize, staff, direct and control the day-to-day operations of the Utilization Management (UM) department, developing and implementing policies and programs as necessary

- Establish strategic directions and goals for all UM operations

- Participate in the establishment, monitoring, and reporting of key metrics to manage performance related to UM services processes and functions

- Accountable for achieving established outcomes goals relative to UM operations

- Lead and manage the oversight and preparedness of continuous regulatory compliance and quality management for the system

- Accountable for leadership and oversight of front-line UM operational organization, to include conducting quality management reviews on front-line UM personnel

2.3.3 Utilization Review Coordinators and Supporting Staff:

Utilization Review Specialists will be responsible and accountable for:

- Receipt of and response to communications with all key persons including physicians, service providers, claims adjusters, attorneys, and injured workers

- Management and referral of medical treatment requests

- Interface between Utilization Review Clinical Staff, Medical Director and Managers

- Preparation of finalized Notification Materials including but not limited to Initial Notifications and Written Notifications

- Submission of all Utilization Review Facsimile and Written Notifications to all parties

- Certify requests for authorization that meet certification criteria authorized by the Medical Director

2.3.4 Clinical Staff:

Clinical staff, including but not limited to Registered Nurses, will be responsible and accountable to:

- Assist as a resource to non-clinical staff regarding clinical issues

- Evaluate Requests for Authorization and supporting medical documentation

- Certify requests for authorization that meet certification criteria authorized by the Medical Director

- Preform preliminary criteria analysis and prepare requests for Medical Director evaluation

Clinical staff who are not a licensed physician reviewer may not modify or deny any request for authorization.

2.3.5 Physician Specialty Reviewer / Peer Reviewer Staff:

Physician peer reviewer staff will be responsible and accountable to:

- Evaluate requests for authorization considered within the scope of their practice
- Render Medical Necessity determinations on requests for authorization considered within the scope of their practice.

Physician peer reviewer staff may not modify or deny any request for authorization where the medical treatment services are not considered within the scope of the reviewer's practice.

IMS will at all times provide for adequate coverage of specialty physicians to address Requests for Authorization. IMS shall do so by contracting directly with Independent Review Organizations or Specialty Physicians to ensure adequate coverage is provided. At the present time, IMS utilizes Physician Based Medical Management, a URAC-accredited IRO based in Encino, CA. All reviewers shall comply with IMS' Utilization Review Plan and shall be licensed in the United States of America by any state or the District of Columbia, and competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice. Under no circumstances will a decision to Modify or Deny treatment be made by a reviewer where the medical treatment services are not considered within the scope of the reviewer's practice.

2.4 Description of Utilization Review Department Supporting Infrastructure:

2.4.1 Telephone / Fax Systems / Voicemail Systems:

The normal business hours of the IMS Utilization Review department are Monday through Friday, 9am to 5:30pm, Pacific Standard Time. IMS' Utilization Review Department observes regular State and Federal holidays.

IMS maintains a dedicated telephone, e-mail and fax system for requests for authorization for medical treatment 24 hours a day, 7 days a week. IMS processes requests for authorization, with staff immediately available to answer, during normal business hours. An IMS representative shall be personally available via telephone during these normal business hours.

For Utilization Review communications, IMS maintains a dedicated toll free telephone line at the following number:

- (833) 814-3576

Callers are presented with an interactive menu, in which the UR department is presented as a menu option. During normal business hours, this option will forward a caller directly to the Utilization Review department staff. All communications received outside the hours of 9am to 5:30pm Pacific Standard Time, Monday through Friday, are considered "after-hours" communications.

Peer-to-peer discussions are discussed in detail under Section 3.6.3. In general, if a caller requires a peer-to-peer discussion, Utilization Review department staff will coordinate the discussion between the requesting physician and the reviewing physician during an agreed-upon time by the physicians. If the

reviewing physician 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. IMS shall under all circumstances provide an opportunity to discuss the non-certification decision within one business day of a request by the attending physician or ordering provider. Physician reviewers are available to providers at least four (4) hours per week during normal business hours (9am to 5:30pm Pacific Standard Time, Monday through Friday).

Communications received after hours are forwarded to a voice message prompt. The prompt informs callers that they have reached the IMS Utilization Review department after-hours. Callers are informed that in order to render emergency medical treatment, pre-authorization is not required. The system allows for recording of normal voicemail messages. The system also provides a separate number for urgent communications regarding expedited referrals to be forwarded to the after-hours response team. Communications that are not delivered to the after-hours response team shall be responded to by the next business day. All communications from providers and patients shall be responded to within one (1) business day.

IMS maintains the below facsimile number for physicians to request authorization for medical services:

- (949) 465-7090

The facsimile number is configured to be available 24 hours a day, 7 days a week. All communications received outside IMS' normal business hours are considered "after-hours" communications. Unless a communication is received by the after-hours response team regarding an expedited referral, requests for authorization will be processed during normal business hours.

2.4.2 After-Hours Response Team:

IMS will select no less than two (2) Utilization Review department employees to be available for response to urgent after-hours communications. A separate option will be provided in the voice mail prompt for access to the after-hours response team.

2.4.3 Records Keeping:

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

2.4.4 Confidentiality:

IMS shall maintain a confidentiality program for its Utilization Review Process. IMS shall require all Utilization Review employees to sign a confidentiality agreement. IMS' confidentiality agreement and program for Utilization Review employees shall include provisions for the following:

- All information received in an employee's course of employment is to be regarded as PHI (Protected Health Information), as defined by the federal HIPAA of 1996, the HIPAA privacy rules required as of April 14, 2003, along with the HIPAA HITECH policy that was enacted into law

February 17, 2009. The HIPAA Privacy Rules describe PHI as any piece of information that can identify a patient. The following are those elements that are identifiers:

i. Name
ii. Geographic elements including street address, city, county, zip code
iii. All elements of dates (except year) that are directly related to and individual, including birth date, admission date, discharge date, date of death.
iv. Telephone and fax numbers
v. Electronic mail and other social media addresses
vi. Social Security numbers
vii. Health plan beneficiary numbers
viii. Account numbers
ix. Any other unique identifying number, characteristics, codes

- Employees shall safeguard computer passwords, which shall not be posted to any public place such as the computer monitor or a place it could be easily lost

- Employees shall not allow any other person including other employees to use their password to log on to the computer

- Employees shall safeguard their workstation and log off / secure the workstation upon leaving the proximity or leaving for the day, or as soon as they are finished using the computer, regardless of the location

- Employees shall not log on to a company computer system that currently exists or may exist in the future using a password other than their own

- Access to digital Utilization Review information, including network shares, shall be given to Utilization Review Employees based on business need. Access shall be restricted to Utilization Review department employees who have a valid and legitimate need to access the information to conduct Utilization Review work

- Employees other than those working in the Utilization Review department shall not be given access to, and shall not access any PHI, unless there is a need to know in order to perform their duties.

- Employees shall not disclose PHI regarding the client's patients to any person or entity via any medium, other than as necessary to perform their job duties, and only as permitted under the Company's HIPAA Policies

- Employees shall not take PHI from the premises of the Company in paper or electronic form without first receiving permission from the Department Manager who will confer first with the Privacy Officer or similar company representative

- Upon cessation of employment with the Company, the employee agrees to continue to maintain the confidentiality of any PHI learned while an employee and agrees to turn over any keys, access cards, or any other device that would provide access to the Company or its PHI

- All expired paperwork used in the UR process shall be destroyed by an ISO-compliant document destruction vendor:

    - IMS currently maintains, and shall continue to maintain for its UR program, compliant shredder bins to be collected and destroyed on a regular periodic basis by an ISO-compliant shredding vendor

    - Employees shall place any and all expired paperwork containing PHI relating to the UR process in the designated shredder bins

3.0 Description of Utilization Review Process:

3.1 Receipt of Requests for Authorization:

Requests for authorization may be submitted to IMS via:

- Electronic Interchanges Arranged via Operational Agreement from Claims Administrator to URO
- Fax / Fax to E-Mail System
- Electronic Mail through the use of an encrypted email system
- Ground Mail

In order for a request for authorization to be considered complete, the request for authorization must:

- Identify both the employee and the provider
- Identify with specificity all the recommended treatments in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used
- Be accompanied by documentation, issued or created no earlier than 30 days before the date of submission of the request for authorization, substantiating the need for the requested treatment, and
- Be signed by the treating physician
- A request for authorization shall be deemed completed following receipt of information, test results, or a specialized consultation requested under §9792.9.6

If IMS receives a request for authorization, or a Request for Authorization Form (DWC Form RFA) that:

- Does not identify the employee or provider, or
- Does not identify a recommended treatment, or
- Is not accompanied by documentation substantiating the medical necessity for the requested treatment, or
- Is not signed by the requesting physician, then:

Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), an IMS non-physician reviewer (as allowed by section 9792.7) or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it “not complete” and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt. The

timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

A request for authorization shall be deemed to have been received by the claims administrator or IMS by facsimile, electronic mail, or by electronic data interchange on the date the form was received if the receiving facsimile, electronic mail address, or clearinghouse electronically date stamps the transmission when received.

The copy of the request for authorization or the cover sheet accompanying the form transmitted by a facsimile transmission, electronic mail, or electronic data interchange shall bear a notation of the date, time and place of transmission and the facsimile telephone number, electronic mail address, or identity of the payor's clearinghouse to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax, or electronic mail, or electronic data interchange transmission report, which shall display the facsimile telephone number, electronic mail address, or clearinghouse to which the form was transmitted.

If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or its utilization review organization.

If the request for authorization is sent by mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator or by IMS five (5) business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.

In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the request for authorization shall be deemed to have been received by the claims administrator or by IMS five days after the latest date the sender wrote on the document.

A request for authorization transmitted by facsimile, electronic mail, or electronic data interchange after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review. In the case of an expedited or concurrent review, a request for authorization transmitted after 5:30pm Pacific Time will not be considered to be received on the next business day.

If the request for authorization is delivered via certified mail, with return receipt mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator or by IMS on the receipt date entered on the return receipt.

3.2 Intake Process:

Requests for authorization go through an intake process where a Utilization Review Coordinator evaluates their contents. The Utilization Review Coordinator is responsible to:

- First Evaluate for Expedited Reviews, and if so, move these into an Expedited queue for immediate evaluation by a clinical staff member

- Assesses whether or not a request for authorization is complete or incomplete, coordinate whether or not an incomplete request for authorization will be accepted based on the information as a whole

- Assess whether or not a request for authorization may be initially certified based on specific direction by the medical director

- Assess and assign the date the claims administrator received the referral, and route any time-sensitive requests through a time-sensitive queue

- Assess and coordinate with Claims Adjusters any dispute of liability for injury or treatment of the condition for which treatment is recommended

- *Assess and coordinate with clinical staff any request that has been previously denied or modified to determine if there is additional info submitted to support a documented change in the facts material to the basis of the utilization review decision

- Assess, coordinate, facilitate and handle communications for all remaining types of request for authorizations according to the procedures outlined in this plan and in IMS' policy and procedure

*A utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical necessity shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Both Claims Adjusters and Utilization Review Coordinators are allowed to authorize certain limited procedures based on specific direction by the Medical Director. Such procedures are decided by operational agreement between the Medical Director and the Claims Administrator.

IMS may utilize non-physician reviewers during the intake process to:

- Initially apply specified criteria to requests for authorization for medical services

- Approve requests for authorization of medical services

- Discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria

- Approve an amended request for treatment authorization, where the requesting physician voluntarily withdraws a portion or all of the treatment in question and submits an amended request for treatment authorization

- 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 9792.9.1(c) and (d)

Under no circumstances will a non-physician reviewer, whether clinical or non-clinical, deny or modify a request for authorization.

3.2.1 Intake of Expedited Referrals:

For a Request for Authorization to be considered an 'Expedited Referral,' which will be forwarded to a higher-priority queue to be addressed immediately by a clinical staff member:

- The requesting physician must indicate that there is the need for an expedited review on the Request for Authorization

- The requesting physician 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 normal prospective utilization review timeframe would be detrimental to the injured worker's condition, shall be reviewed by IMS on behalf of the claims administrator under the standard prospective timeframe.

3.3 Decision-Making:

3.3.1 Medical Treatment – First 30 Days of Injury

Notwithstanding the requirements of §9792.9.1 through §9792.9.6, a treating physician specified in Labor Code section 4610(b), may render medically necessary treatment or services to an injured worker without prospective utilization review for the first thirty (30) days after the date of injury, provided that:

- The treatment or service is for a body part or condition that has been accepted as compensable by the claims administrator.

- The treatment or service is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director under §5307.27.

- The initial treating physician timely submits the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, to the claims administrator, setting forth in detail the anticipated treatment plan for the injured worker.

- All treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, are set forth in a request for authorization provided to the claims administrator in accordance with §9785(h). The form shall be submitted to the claims administrator concurrent with the Doctor's First Report of Occupational Injury or Illness. Subsequent treating physicians during the 30-day period shall submit a request for authorization following their first visit with the injured worker indicating all treatment being rendered.

The following medical treatment services, unless previously authorized by the claims administrator or rendered as emergency medical treatment, shall require prospective utilization review:

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

- Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician's office. This includes all necessary and routine pre-operative, intra-operative, and post-operative services performed for the purpose of surgery including, but not limited to, related diagnostic tests or procedures, rehabilitation services, durable medical equipment or supplies, and routine post-surgical pain management treatment or services.

- Psychological or psychiatric treatment services, which includes diagnostic services, psychotherapy, and other services or procedures to an individual or group in all care settings provided by a physician or other qualified health care provider, and including psychiatric pharmaceuticals, to the extent they are not expressly exempt from prospective utilization review under the MTUS Drug Formulary.

- Home health care services, including health care and other medically necessary services provided to the injured worker in the residential setting.

- Imaging and radiology services, excluding X-rays.

- All durable medical equipment, prosthetics, orthotics, and supplies where the purchase or rental cost of the item with necessary supplies, if any, for the expected course of treatment is greater than $250.00 (as determined by the DWC Official Medical Fee Schedule (OMFS)), or, for an unlisted item, where the billed amount will be greater than $250.00.

- Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.

- Spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections.

- Any other service designated and defined through rules adopted by the administrative director.

Physician Reviewers are assisted in their decision-making by clinical RN staff. Clinical staff who are not a licensed physician reviewer may not modify or deny any request for authorization. Non-physician reviewers may be used to:

- Initially apply criteria specified by the Medical Director to requests for authorization for medical services

- Coordinate with Claims Adjusters and Claims Administrator staff for determination when a liability dispute exists for either the occupational injury for which the treatment is recommended or the recommended treatment itself

- Approve requests for authorization of medical services based on criteria specified by the Medical Director

- Discuss applicable criteria with the requesting physician, obtain voluntary withdrawals of portions or all of the treatment in question, and approve amended requests for treatment authorizations

- Request reasonable information that is necessary for a reviewer to render a decision

Physician Reviewers who are competent to evaluate the specific clinical issues involved in the medical treatment services, and where those services are within the reviewer's scope of practice, are utilized to evaluate referrals based on the Utilization Review Criteria and Medical Evidence Sequence Search Procedure outlined in Section 4.0. Such physician reviewers may make a decision to modify or deny a request for authorization where the requested treatment is within the scope of their practice.

In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.

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 subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.

3.3.2 MTUS Drug Formulary

Notwithstanding §9792.9.1 through §9792.9.7, the following drugs can be dispensed to an injured worker without obtaining authorization through prospective review. The following exempt drugs must still be submitted on a request for authorization:

- Drugs identified on the MTUS Drug List as exempt under §9792.27.15.

- Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Special Fill policy under section 9792.27.12

- Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Perioperative Fill policy under section 9792.27.13

For a drug that is not considered exempt, regardless of whether a drug is prescribed and dispensed within 30 days from the date of injury, the treating physician must request authorization through prospective utilization review by submitting a request for authorization.

A treating physician must request authorization through prospective review for a drug not listed on the MTUS Drug List by submitting a request for authorization, regardless of whether a drug is prescribed or dispensed within 30 days from the date of injury.

A request for authorization that requests both drugs and non-pharmaceutical treatment related to the same injury or illness shall be reviewed under the timeframes set forth in section 9792.9.3 and section 9792.9.6 and the requirements of sections 9792.9.4 and 9792.9.5.

3.3.3 Timeframes for Decision-Making :

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

- Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination.

    - The requesting physician 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 for a prospective or concurrent would be detrimental to the injured worker's condition, shall be reviewed under the timeframe set forth for prospective or concurrent review.

- Prospective or concurrent decisions to approve, modify, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed request for authorization.

- Retrospective decisions to approve, modify, or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and information regarding rendered medical treatment that is sufficient for a reviewer to make a determination as to whether the treatment was medically necessary.

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

- The timeframes for decisions outlined in this section may only be extended under one or more of the following circumstances:

    - The claims administrator or reviewer is not in receipt of all of the information reasonably necessary to make a determination.

- The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.

- The reviewer needs a specialized consultation and review of medical information by an expert reviewer.

- The above circumstances are outlined in detail in the next sections.

3.3.4. Timeframes for Decision-Making – MTUS Drug Formulary

- Prospective decisions to approve, modify, or deny a request for authorization for a non-exempt drug or a drug that is not on the formulary shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the request for treatment.

- Prospective decisions to approve, modify, or deny a request for authorization that requests both non-pharmaceutical treatment and drugs that are not on the formulary shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the request for treatment.

- The reviewer or non-physician reviewer may request the treating physician to provide additional information reasonably necessary to make a determination as follows:

  - An IMS reviewer or non-physician reviewer shall request the information from the treating physician within four (4) business days from the date of receipt of the request for authorization.

  - If the information is not received within five (5) business days from the date of the request for authorization of treatment, the IMS physician reviewer may deny the request in accordance with §9792.9.5, subdivision (e).

3.3.5 RFI Process and Time Extensions for Lack of Information:

Requests for authorization are evaluated for supporting documentation during the intake process. If the claims administrator or IMS is not in receipt of all the information reasonably necessary to make a determination, IMS will do the following:

- For normal, prospective review:

  - An IMS reviewer or non-physician reviewer will request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization using the Request for Information ("RFI") template in Appendix 1.5.

  - If IMS does not receive the requested information in a timely manner appropriate to the injured worker's condition and becomes aware that it cannot make a decision within five (5) business days from the date of receipt of the request for authorization, IMS will immediately

notify the physician, the injured worker, and the injured worker's attorney if applicable that a time extension is required using the "Time Extension" template in Appendix 1.6.

- The claims administrator will document all RFI and Time Extension notifications in their claim file for the Injured Worker. IMS will request only the information reasonably necessary to render a determination.

- For expedited review:

  - An IMS reviewer or non-physician reviewer will request the information from the treating physician within 72 hours from the date and time of receipt of the request for authorization using the Request for Information ("RFI") template in Appendix 1.5.

  - If IMS does not receive the requested information in a timely manner appropriate to the injured worker's condition and becomes aware that it cannot make a decision within 72 hours from the time of receipt of the request for authorization, IMS will immediately notify the physician, the injured worker, and the injured worker's attorney if applicable that a time extension is required using the "Time Extension" template in Appendix 1.6.

  - IMS may take other appropriate action dependent on the injured workers' condition, including scheduling an immediate peer-to-peer discussion or immediate attempts to contact the requesting physician via telephone or using the physician's exchange service to contact them after-hours

  - The claims administrator will document all RFI and Time Extension notifications in their claim file for the Injured Worker. IMS will request only the information reasonably necessary to render a determination.

Concurrent review will generally involve direct physician peer-to-peer discussion and real-time sharing of information; therefore, IMS does not anticipate the use of, and will not use, RFIs or Time Extensions in regard to requests for concurrent review at this time unless there is a reasonable circumstance warranting the use of these notifications.

If the information reasonably necessary to make a determination that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, an IMS physician reviewer shall deny the request and state the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam, or test or specialized consultation. (ref 9792.9.5(e)(7)(A). All relevant attempts to obtain information will be submitted to the claims administrator for documentation in the claim file.

3.3.6 Additional Examinations, Tests, or Consultations by an Expert Review:

If upon review of a request for authorization which is not an expedited referral, an IMS reviewer becomes aware that:

1. An additional examination or test is required to be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice, or

2. A specialized consultation and review of medical information by an expert reviewer is required

IMS will submit written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing using the time extension template in Appendix 1.6. The notice will explain either the additional examinations or tests required, or the specialty of the expert reviewer to be consulted, whichever is applicable. If consultation with an expert reviewer is needed, the specialty of the expert reviewer to be consulted will be identified.

If the results of the additional examination or test required, or if the specialized consultation that is requested by the reviewer are not received within thirty (30) days from the date of the request for authorization, an IMS physician reviewer shall deny the treating physician's request in accordance with applicable rules in §9792.9.5(e).

3.3.7 Decision-Making Timeframes after Receipt of Additional / Requested Information:

For normal prospective review or concurrent review, in any of the circumstances listed under which timeframes may be extended, an IMS reviewer shall make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the additional information received. This shall in no circumstances exceed fourteen (14) days from initial receipt of the request for authorization.

For prospective or concurrent decisions related to an expedited review, when additional information regarding a request for authorization is requested and received, an IMS reviewer shall make the decision to approve, modify, or deny the request for authorization no later than 72 hours of receipt of the information necessary to make a decision.

For retrospective review, in any of the circumstances listed under which timeframes may be extended, the claims administrator or reviewer, an IMS reviewer shall make the decision to approve, modify, or deny the request for authorization within thirty (30) calendar days of receipt of the information requested.

3.4 Notification Procedures, Timeframe and Notice Content:

- As mentioned under Section 3.3 and repeated for purposes of this section, the first day in counting any timeframe requirement is the day after the receipt of the request for authorization, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the request for authorization.

- Copies of all notifications will be submitted to the claims adjuster and the defense attorney on the file, via electronic means, or otherwise if determined differently via operational agreement.

- For prospective, concurrent, or expedited review, a decision to approve a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail, using the Initial Notification Template located in Appendix 1.1. If the initial communication is by telephone, written communication shall be issued to the requesting physician within 24

hours of the decision for concurrent review and within two (2) business days for prospective review, using the Initial Notification Template located in Appendix 1.1.

- For Approval Notifications, the initial notification via facsimile will be followed by notice in writing via ground-mail with proof of service to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review. The notice in writing will use the Approval Notification Letter Template located in Appendix 1.2, which contains the date the complete, or accepted as complete, request for authorization was received, the medical treatment service requested, the specific medical treatment service approved, and the date of the decision.

  - If applicable, the written decision shall also include the date the request for information, exam, or consultation was requested, and the date the information was received.

  - For approvals of a request for authorization of non-drug treatment that are exempt under the 30-day exemption, the written decision approving the request shall identify the exempt treatment as, "30-day exemption".

- Retrospective approvals will be submitted to the requesting physician in writing in a timely manner no later than 30 days after receipt of the request for authorization using the Approval Notification Letter Template located in Appendix 1.2. The notification will be copied via ground mail with proof of service to the Injured Worker and the Injured Worker's Attorney, if applicable.

- Payment, or partial payment, of a medical bill for services requested on a request for authorization 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.

- Prospective, concurrent, and expedited review decisions to Modify or Deny a request for authorization will be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail, using the Initial Notification Template located in Appendix 1.1.

- The initial notification for a Modify or Deny decision will be followed by notice in writing via ground mail with proof of service 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. The notice in writing will use the Notification of Utilization Review Modification or Denial template located in Appendix 1.3.

- The initial notification for a retrospective review to deny part or all of the requested medical treatment based on medical necessity will be sent within 30 days of receipt of the request for authorization, including the medical information that is reasonably necessary to make a determination, 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. The notice in writing will use the Notification of Utilization Review Modification or Denial template located in Appendix 1.3.

- If any type of request for authorization is being modified or denied, all IMS Utilization Review physicians will provide a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury in the Utilization Review decision letter:

  - The citation provided by the Utilization Review physician will be the primary source relied upon which he or she believes contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

  - If the Utilization Review physician provides more than one citation, then a narrative shall be included by the reviewing physician in the Utilization Review decision explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

  - The format of the citations provided by the physician reviewer shall include the following:

    (1) When citing the MTUS:
        (A) Indicate the MTUS is being cited and the effective year of the guideline;
        (B) Title of chapter (e.g., Low Back Complaints); and
        (C) Section of chapter (e.g., Surgical Considerations).
    (2) When citing other medical treatment guidelines:
        (A) Title of organization publishing the guideline (e.g., ACOEM or ODG);
        (B) Year of publication;
        (C) Title of chapter; and
        (D) Section of chapter.
    (3) When citing a peer-reviewed study:
        (A) First author's last name and first name initial;
        (B) Published article title;
        (C) Journal title (standard abbreviations may be used);
        (D) Volume number;
        (E) Year published; and
        (F) Page numbers.

- The above-mentioned relevant portion of the criteria or guidelines used shall be disclosed in written form to the requesting physician, the injured worker, and if counsel represents the injured worker, the injured worker's attorney, if used as the basis of a decision to modify or deny services in a specific case under review. This will be sent as a part of the Utilization Review Notification Letter. Neither IMS nor the claims administrator will charge the injured worker, the injured worker's attorney or the physician for the relevant portion of the criteria or guidelines used to modify or deny the treatment request.

- If any type of request for authorization is being modified or denied, the written notification shall contain or be accompanied by the following in writing:

  - The date on which the completed or accepted request for authorization was first received.

  - If the timeframe for decision was extended under §9792.9.6, a specific description of the information needed to make a medical necessity determination of the treatment request; the date(s) and time(s) the request(s) for information, exam, or consultation under subdivision (a)(1)(A), (B), or (C) of §9792.9.6 were requested; the manner in which the requests were made; and the date the information was first received.

  - The date on which the decision is made.

  - A description of the specific course of medical treatment set forth on the request for authorization.

  - A list of all medical records reviewed.

  - A specific description of the medical treatment service approved, if any.

  - A clear, concise, and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision as explained previously in this section. If a utilization review decision to modify or deny a medical service is due to incomplete or insufficient information, the decision shall specify that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation.

  - Where the requesting physician has expressly opined that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician shall provide an explanation for why the requesting physician's explanation is insufficient.

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

  - The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee, will be completed by IMS on behalf of the claims administrator. The written decision provided to the injured worker, will include an addressed envelope provided by IMS, which may be postage-paid for mailing to the Administrative Director or his or her designee.

  - A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated

by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

- The following mandatory language advising the injured employee:

  - "You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.). If you have questions about the information in this notice, please call the claims adjuster, <Claims Adjuster's Name> at <Claims Adjuster's Telephone Number>. However, if you are represented by an attorney, please contact your attorney instead of the claims adjuster.

  - "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."

- Details about IMS' internal utilization review appeals process for the requesting physician, if any, including with respect to disputes over the necessity of or availability of the requested information, as outlined in Section 3.6.2, and a clear statement that the internal appeals process is 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.

- For prospective review, if additional information is requested and received and a decision is made as outlined in Section 3.3.4, the requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision using the Initial Notification Template located in Appendix 1.1. The written decision will include the date the information was received and will be followed by notification in writing as outlined previously in this section.

- For expedited review, if additional information is requested and received and a decision is made as outlined in Section 3.3.4, the requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision using the Initial Notification Template located in Appendix 1.1. The written notice of decision will include the date the requested information was received, the date the decision was made, and be communicated as outlined previously in this section.

- For retrospective review, if additional information is requested and received and a decision is made as outlined in Section 3.3.4, the written notice of decision will include the date the decision was made and be communicated as outlined previously in this section.

- The written decision shall include the name, specialty of reviewer/expert reviewer, US telephone number and hours of availability to discuss the decision which shall be a minimum of four (4) hours between the hours of 9:00 a.m. to 5:30 p.m. Pacific Time.

- A utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical necessity shall remain effective for 12 months from the date of the

decision without further action by the claims administrator with regard to any further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

3.4.1 Notifications for Expedited Referrals:

- For normal prospective and retrospective review, IMS will choose to initially notify physicians via facsimile rather than via telephone. IMS will also opt not to communicate decisions via email at this time.

- For expedited referrals, due to the time-sensitive nature of such requests, approvals may be communicated initially by telephone and appropriately documented:

  - IMS utilization review staff may choose to approve a request for authorization during a telephone conversation or via voicemail.

  - In the communication via telephone, IMS utilization review staff will inform the physician or physician staff that a verbal approval must be followed by a written approval within 24 hours for concurrent review, or within 2 business days for prospective review

  - IMS utilization review staff will maintain a written record of all verbal approvals given, corresponding with a certification number that is given to the requesting physician or their staff.

3.5 Deferred Utilization Review Treatment Requests:

When it is determined by coordination with claims adjusters / claims administrator staff that a liability dispute exists for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity, the following processes occur:

- A written notification deferring utilization review is sent to the requesting physician, the injured worker and if the injured worker is represented by counsel, the injured worker's attorney. The notification is sent within five (5) business days. This written notice will use the notification of utilization review deferral template located in Appendix 1.4. The notification contains the following information specific to the request:

  - The date on which the request for authorization was first received.
  - A description of the specific course of proposed medical treatment for which authorization was requested.
  - A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.
  - A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.
  - The following mandatory language advising the injured employee: "You have a right to disagree with decisions affecting your claim. If you have questions about the information in

this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me." and

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

IMS will work with Claims Administrators to monitor and manage all requests submitted where there is a dispute regarding liability for the industrial injury or the treatment itself on grounds other than medical necessity.

If any liability dispute becomes resolved and it is finally determined that liability is accepted, the timeframe to conduct retrospective utilization review will begin on the date the determination of the employer's liability becomes final, and the timeframe to conduct prospective utilization review will commence from the date of receipt of a treatment recommendation after the determination of liability.

If the claims administrator determines that Labor Code section 4610(k) precludes the need for utilization review must comply with the requirements under this section. A request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change. This type of request will be reviewed by a physician reviewer and any modification or denial of the request must comply with the applicable requirements of §9792.9.5.

3.6 Dispute Resolution, Internal Appeals and Consumer Complaints:

3.6.1 Independent Medical Review:

In compliance with Labor Code 4610(g)(3)(A) and 8 §CCR 9792.10.1 et seq, the following standards apply to dispute resolution.

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

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

IMS will work with the clients, claims administrators and other appropriate entities represented under IMS' Utilization Review plan on the basis of an operational agreement in regard to how IMR communications are to be handled.

Upon receipt of any request for information by the Administrative Director, or "Notice of Assignment and Request for Information" by an Independent Medical Review Organization, which specifically directs IMS

or the claims administrator to produce information in regard to an Independent Medical review, IMS will do the following on behalf of the claims administrator, given the communication is directed at IMS or the claims administrator and warrants a response:

- Provide all relevant information to the Administrative Director to support a determination of IMR eligibility within five (5) business days following receipt of any such request

- Provide relevant information to an Independent Medical Review Organization to demonstrate that an IMR request is ineligible due to liability dispute or other circumstances, in the event that the Administrative Director has proceeded with an IMR and was not aware of the relevant information rendering the IMR ineligible, within five (5) business days following receipt of any such request

- Collaborate with the claims administrator to compile and provide all relevant medical records and information received by IMS and the claims administrator within 6 months from the date of receipt of the request for authorization, within fifteen (15) calendar days following receipt of any such request by mail, or within twelve (12) calendar days if the request was received electronically. For a dispute involving only a drug or drugs listed on the MTUS Drug Formulary, within ten (10) calendar days of the date designated on the notification. All relevant medical records and information includes the following:

  - A copy and list of all reports of the physician relevant to the employee's current medical condition produced within six months prior to the date of the request for authorization, including those that are specifically identified in the request for authorization or in the utilization review determination. If the requesting physician has treated the employee for less than six months prior to the date of the request for authorization, the claims administrator shall provide a copy and list of all reports relevant to the employee's current medical condition produced within the described six month period by any prior treating physician or referring physician.

  - A copy of the written Application for Independent Medical Review, DWC Form IMR, that was included with the written determination, issued under section 9792.9.5(e)(7), 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

  - Other than the written determination by the claims administrator issued under section 9792.9.5(e)(7), a copy of all information, including correspondence, provided to the employee by the claims administrator concerning the utilization review decision regarding the disputed treatment

  - 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

  - 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

- The claims administrator's response to any additional issues raised in the employee's application for independent medical review

- Submit the requested medical information to the appropriate parties in response to the request for information

In the event that the Independent Medical Review Organization requests additional necessary information to complete their review after the above has been submitted, IMS will submit the information to the IRO within five (5) business days and will submit a copy to the injured worker and their counsel or treating physician if applicable. For requests involving only a dispute regarding a drug listed on the MTUS Drug Formulary, IMS will submit the information to the IRO within two (2) business days and will submit copy to the injured worker and their counsel or treating physician. In the event that the request for authorization is an expedited or a concurrent request, any such information will be forwarded within 1 calendar day.

In the event that the review is considered expedited or concurrent, all relevant information will be forwarded to the Independent Medical Review Organization within 24 hours of receipt of the Notice of Assignment and Request for Information.

IMS will forward to the employee or the employee's representative a notification that lists all of the documents submitted to the independent medical review organization under subdivision (a). IMS will 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 IMS or the claims administrator after all documentation has already been provided to the Independent Medical Review Organization in response to a “Notice of Request and Assignment” will be forwarded immediately to the independent medical review organization by IMS on behalf of the claims administrator. IMS, on behalf of the claims administrator, will 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.

The above section does not prohibit the claims administrator from evaluating and responding to requests by the Administrative Director or the Independent Medical Review Organization as outlined if an operational agreement is worked out where the claims administrator wishes to do so.

Any treatment approved by IMR must be authorized within either five (5) business days of receipt of the determination, or sooner if appropriate for the employee’s medical condition, or five (5) business days from the date the determination is final if an appeal of the determination has been filed under Labor Code section 4610.6(h).

Reimbursement for services already rendered which have been found medically necessary by IMR must occur within twenty (20) days after receipt of the final determination, or within twenty (20) days from the date the determination is final if an appeal of the determination has been filed under Labor Code section 4610.6(h).

3.6.2 Internal Appeals Process:

IMS operates a voluntary internal appeals process, which may be utilized by treating physicians as well as injured workers if there is a dispute regarding a Utilization Review determination. The internal appeals process is voluntary and will neither trigger nor bar the use of the dispute resolution process under Labor Code section 4610.5 and 4610.6. Utilization Review decision letters containing a modify or deny determination will provide details to the injured worker about the IMS' internal utilization review appeals process for the requesting physician, and will contain a clear statement that the internal appeals process is 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.

If the requesting physician, injured worker, or injured worker's counsel wishes to dispute a determination using the internal appeals process:

- Any such dispute must be submitted in writing to IMS or the claims administrator within 10 days after receipt of the initial utilization review decision letter.

- A request for an internal utilization review appeal must be completed, and a determination issued by IMS on behalf of the claims administrator within thirty (30) days after receipt of the request for internal appeal.

- A request for an internal utilization review appeal for a drug listed on the MTUS Drug List, must be completed, and a determination issued by IMS on behalf of the claims administrator within ten (10) days after receipt of the request for internal appeal.

- If an internal appeal is related to a prior determination on an expedited referral, or raised where the employee's condition is one in which the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, the appeal will be considered an Expedited Appeal. Decisions regarding expedited appeals will be made within 72 hours of receipt by IMS or the claims administrator.

- If the IMR dispute resolution process under Labor Code sections 4610.5 and 4610.6 is utilized at the same time as an internal appeal, the appeal will be considered complete upon the issuance of a final Independent Medical Review determination that determines the medical necessity of the treatment. If this is the case, a separate notification will be sent to notify the party requesting the internal appeal informing them of the regulation under 8 CCR §9792.10.1(d)(2) and that their internal appeal is considered complete due to the final IMR determination.

- Internal appeals will use the same notification procedures and templates and will notify the same parties as outlined in Section 3.4, except the notification letters will be clearly marked that they are related to the voluntary internal Utilization Review appeals process.

- If a determination is issued following an internal Utilization Review appeal which modifies the requested medical treatment, the determination will 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 as outlined under Section 3.4. The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.1(e)(5)(G) will indicate that the decision is a modification after appeal.

3.6.3 Peer-to-Peer Discussion Process:

IMS frequently receives requests for "peer-to-peer" discussion, i.e., where a requesting or other physician wishes to have a telephone conversation with the reviewing physician. During such a discussion, a requesting physician may introduce evidence not previously known to a reviewing physician and/or provide information or opinion which affects the initial decision in some way.

Requests for peer-to-peer discussion are not required to be submitted on a DWC form RFA, which are to be used only for requesting medical treatment. In the event IMS receives a request for peer to peer discussion on a DWC form RFA, it will consider such a request as an internal appeal of the prior request and not a new request for authorization.

Peer-to-peer discussions can be considered both formal and informal. A formal request for peer-to-peer would be a request received in writing and communicating a dispute and would be considered and handled as an internal appeal. An informal request for peer-to-peer may be received by utilization review staff on the telephone, without communication of a dispute in writing, and may be coordinated at the convenience of the requesting party.

IMS coordinates peer-to-peer discussions primarily at the convenience of the requesting physicians due to their schedules involving patient treatment. As such:

- If a request for peer-to-peer discussion is received via telephone, a member of the Utilization Review staff will request the availability of the requesting physician and a callback number on which they may be reached. The appropriate IMS physician reviewer will then attempt to contact the requesting physician via the information provided and will repeat attempts at least 5 times during the same availability time. If the requesting physician is unable to be reached after 5 attempts, the peer-to-peer request will be considered concluded.

- The Utilization Review staff coordinating the discussion will obtain clarification if the request for peer-to-peer is informal, or if the requesting physician wishes to dispute the decision and initiate the internal appeals process as well as utilize the opportunity to discuss the decision with the reviewing physician. If the requesting physician formally wishes to dispute the decision as well as initiate the peer-to-peer process, they will be asked to provide the dispute in writing in accordance with the internal appeals process. A peer-to-peer discussion will be conducted within the appropriate appeal timeframe, and any additional evidence submitted via the peer-to-peer discussion process will be considered. A final decision will be issued in line with the internal appeals process.

3.6.4 Alternate Dispute Resolution (ADR) Program

IMS may have clients/employers whose claims fall under a separate management labor agreement and are subject to an alternative dispute resolution (ADR) program under CA Labor Code sections 3201.5 or

3201.7. For these clients/employers, IMS will implement the following procedures related to the ADR program:

- IMS will add the following paragraph to all determination letters:

  "Please note that the above Utilization Review letter is in an advisory capacity, and falls under a Labor Code 3201.5 / 3201.7 separate labor management agreement, including an alternative dispute resolution system. Any Utilization Review decision rendered is an advisory statement of the medical necessity / medical reasonableness of treatment."

- If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, the following additional paragraph will be added as per as per California Code of Regulations, Title 8, Section 9810.General Provisions (e)(2):

  Appeal / Dispute Resolution Process
  "You have a right to disagree with decisions affecting your claim. If you wish to dispute any decision, please contact your adjuster, <Claims Adjuster>, at <Claims Adjuster Phone Number> or the ombudsperson, <Ombudsperson Name> at <Ombudsperson Phone Number>."

3.7 Quality Assurance Program:

The Medical Director and the Vice President of Managed Care will oversee IMS' Quality Assurance program.

IMS shall, on a quarterly basis:

- Conduct a Quality Assurance Meeting, which shall include the Medical Director, the Vice President of Managed Care, the Utilization Review Coordinator, the Chief Executive Officer, the Vice President, and all Utilization Review Administrative Staff, wherein:

  - Utilization Review Process Data, including aggregate data for all request for authorizations processed by IMS from the last quarter, shall be reviewed in regard to quality metrics

  - A review of the following areas shall be conducted:
    - All Internal Utilization Review Appeals for the quarter shall be reviewed
    - All Utilization Review for which IMR was requested and has been completed during the last quarter, shall be reviewed while referencing the final IMR determination
    - All "QA Issues" received by all parties shall be reviewed
    - Any other form of Utilization Review Complaint which has been submitted to IMS shall be reviewed
    - The results of quarterly Sample-Size Audits shall be reviewed
    - The results of any routine Utilization Review Investigation completed during the last quarter shall be reviewed

  - Performance Goals related to Quality as well as Target Practices and Directives will be reasonably established and updated as a result of each quarterly meeting

- Quarterly meetings shall be documented in effective and approved meeting minutes

- IMS shall conduct a quarterly Sample-Size Audit of all Utilization Review request for authorizations processed in the last quarter, as mentioned above, with the findings presented in the quarterly Quality Assurance Meeting

- Performance Goals that are established during the Quality Assurance meeting will be overseen on a day-to-day basis by the Vice President of Managed Care and any established team leads

3.7.1 Quality Assurance ("QA") Issues:

- IMS shall maintain QA forms and a tracking log to manage the QA Issue Process. All QA issues regardless of the party reporting the occurrence of any issue, shall be tracked and logged using these mechanisms.

- Members of the public, including but not limited to physicians, injured workers or their attorneys or representatives, may register a "QA Issue" if it is not related to the specific clinical issues of the case including the medical determination or decision, the clinical rationale, or the guidelines utilized in a decision. QA issues may not be registered which are subject to the internal appeals or IMR processes. When a particular complaint or grievance is directed to an IMS representative by a member of the public, the IMS representative shall inform the complainant of the QA process and provide them with a QA form within 1-2 business days. The QA process shall be a voluntary process, which shall not bar or preclude any internal appeal, IMR appeal, or request to discuss a decision with a reviewing physician. The QA form shall contain the following:

  - Notification that complaints must be filed within a year of occurrence of an issue

  - Fields for the name, address, telephone number, and email address if applicable, of the party filing the complaint

  - A field for the complainant to outline the issue in his/her own words

  - A field for any other information the complainant wishes to offer, if there is not enough room, information may be attached to the form

  - A field for the signature of the complainant

  - Notice that complaints will receive a written response from IMS within 30 business days

- Any customer or client of IMS may, at any time, register a "QA Issue" due to any complaint about the service being delivered by IMS, including clinical issues:

  - Upon knowledge of a client complaint or issue, an IMS representative will determine if it is the client's wish to register a QA issue.

  - IMS agents shall complete a QA form on behalf of clients

- Client issues shall initially be submitted to the Vice President of Managed Care in a timely manner, no later than 1 business day. The Vice President of Managed Care will determine the appropriate response including follow up activities to be initiated no later than 7 business days

- QA issues from all parties will be evaluated as part of the quarterly Quality Assurance meeting, and their findings incorporated

4.0 Description of Utilization Review Criteria:

IMS' Medical Director remains responsible and accountable to ensure that the criteria or guidelines used in the utilization review process to determine whether to approve, modify, or deny medical treatment services shall be all of the following:

1. Developed with involvement from actively practicing physicians.
2. Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.
3. Evaluated at least annually and updated if necessary.
4. Disclosed to the physician and the employee, if used as the basis of a decision to modify or deny services in a specified case under review.
5. Available to the public upon request.

IMS' Treatment Protocols, Standards and Utilization Review Criteria shall remain consistent with the Medical Treatment Utilization Schedule adopted by the Administrative Director pursuant to Labor Code 5307.27 at all times.

The MTUS shall be the primary source of guidance for treating physicians and physician reviewers for the evaluation and treatment of injured workers.

Treatment may not be denied on the sole basis that the treatment is not addressed by the Medical Treatment Utilization Schedule. For all conditions or injuries not addressed by the Medical Treatment Utilization Schedule, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based or by peer-reviewed studies. These other evidence-based medical guidelines or peer-reviewed studies will be found by applying the Medical Evidence Search Sequence outlined in section 4.1 in accordance with 8 CCR §9792.21.1.

The recommended guidelines set forth in the MTUS are presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof. Therefore, the treating physician who seeks treatment outside of the MTUS bears the burden of rebutting the MTUS' presumption of correctness by a preponderance of scientific medical evidence.

If a treating physician provides different guidelines in rebuttal of the MTUS that are at variance with the guidelines cited by the IMS reviewer, or when competing recommendations are cited to guide medical care, the MTUS Methodology for Evaluating Medical Evidence outlined in section 4.2 and in accordance

with 8 CCR §9792.25.1 shall be applied by the reviewing physician to determine which one of the recommendations is supported by the best available evidence.

Employers and their representatives, at their discretion, may approve medical treatment beyond what is covered in the MTUS or supported by the best available medical evidence in order to account for medical circumstances warranting an exception. The treating physician should provide clear documentation of the clinical rationale focusing on expected objective functional gains afforded by the requested treatment and impact upon prognosis.

4.1 MTUS Criteria and Medical Evidence Sequence Search:

IMS reviewers conduct the following medical evidence search sequence when evaluating a request for authorization:

1. The Reviewers first search the recommended guidelines set forth in the current MTUS to find a recommendation applicable to the injured worker's medical condition or injury

2. When a medical condition or injury is not addressed by the MTUS or if the MTUS' presumption of correctness is being challenged, then the reviewers:

    A. Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then

    B. Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1. Medical treatment guidelines can be found in the National Guideline Clearinghouse that is accessible at the following website address: www.guideline.gov/. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then

    C. Search for current studies that are scientifically based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence. A search for peer-reviewed published studies may be conducted by accessing the U.S. National Library of Medicine's database of biomedical citations and abstracts that is searchable at the following website: www.ncbi.nlm.nih.gov/pubmed. Other searchable databases may also be used.

4.2 MTUS Methodology for Evaluating Medical Evidence:

The MTUS Methodology for Evaluating Medical Evidence provides a process to evaluate studies, not guidelines. Therefore, the reviewing physician shall evaluate the underlying study or studies used to support a recommendation found in a guideline. Medical care shall be in accordance with the recommendation supported by the best available evidence.

Please note, in accordance with its Financial Incentive policy, IMS shall not provide any financial incentive to any party (physician, provider, reviewer, employee, contractor or otherwise) related to non-certification of care or based on any specific Utilization Review decision.

Medical care shall be in accordance with the recommendation supported by the best available evidence. The MTUS Methodology for Evaluating Medical Evidence shall be applied as follows:

(1) The reviewing physician shall determine if different guidelines or studies were cited to guide the injured worker's medical care by the treating physician, the Utilization Review physician and/or the Independent Medical Review physician that contain recommendations that are at variance with one another.

(2) If different guidelines or studies were cited to guide the injured worker's medical care containing recommendations that are at variance with one another, the reviewing physician shall evaluate the quality of evidence by determining if the studies used to support the recommendations are applicable to the injured worker and his or her medical condition or injury. Applicability refers to the extent to which the individual patients, subjects, settings, interventions, and outcome measures of studies used to support a recommendation are similar to the worker and his or her medical condition or injury. A recommendation supported by inapplicable studies should not be used as the source to support, deny, or modify a request for authorization. Reviewing physicians shall provide an explanation of their rationale in the Utilization Review or Independent Medical Review decision if they conclude a recommendation is supported by studies inapplicable to the worker and his or her medical condition or injury.

> (A) The evaluation of medical evidence can end after this step if a citation to a guideline or a study contains a recommendation supported by inapplicable studies and the other citation contains a recommendation that is supported by studies applicable to the injured worker's medical condition or injury.

(3) If the guidelines or studies cited contain recommendations supported by studies applicable to the worker and his or her medical condition or injury, then the reviewing physician shall continue to evaluate the quality of evidence by determining what factors, if any, bias may have had in the studies used to support the recommendations. Factors to consider include, but are not limited to, vested interests such as financial interests, academic interests, industry influence, and the methodological safeguards to protect against biases related to the generation of the randomization sequence, concealment of allocation, blinding, selective outcome reporting, early stopping, intention to treat, and confounding bias. A recommendation supported by studies determined to be of poor quality due to the presence of bias should not be used as the source to support, deny or modify a request for authorization. Reviewing physicians shall provide an explanation of their rationale in the Utilization Review or Independent Medical Review decision if they conclude a recommendation is supported by studies determined to be of poor quality due to the presence of bias.

> (A) The evaluation of medical evidence can end after this step if a citation to a guideline or a study contains a recommendation supported by studies determined to be of poor quality due to the

presence of bias and the other citation contains a recommendation that is supported by studies determined to be of good quality due to the absence of bias.

(4) If the guidelines or studies cited contain recommendations supported by studies applicable to the worker and his or her medical condition or injury and if the recommendations are supported by studies that are determined to be of good quality due to the absence of bias, then the reviewing physician shall determine the strength of evidence used to support the differing recommendations by applying the Hierarchy of Evidence for Different Clinical Questions set forth in 9792.25.1(b). To apply the Hierarchy of Evidence for Different Clinical Questions, the following steps shall be taken:

(A) Determine the design of the study used to support the recommendation. Study designs are categorized as one of the following categories:

1. Systematic Review of:

(aa) Randomized Controlled Trials
(bb) Prospective or Cohort Studies

2. Randomized Controlled Trials

3. Observational studies:

(aa) Prospective study or Cohort Study
(bb) Cross-sectional study
(cc) Case-control study
(dd) Case-series
(ee) Uncontrolled or observational study
(ff) Case report

4. Published expert opinion

(B) Determine which of the four clinical questions in the MTUS Hierarchy of Evidence for Different Clinical Questions as set forth in Section 9792.25.1(b) the study is answering and then apply the corresponding hierarchy(ies) of evidence. The sequence to be followed for each of the four clinical questions is as follows:

1. If the original study answers the question “How useful is Treatment X in treating patients with Disease Y?” then the hierarchy of evidence set forth under Treatment Benefits shall apply.

2. If the original study answers the question “How useful is Test X in diagnosing patients with Disease Y?” then the hierarchy of evidence set forth under Diagnostic Test shall apply.

3. If the original study answers the question “What will happen to a patient with Disease Y if nothing is done?” then the hierarchy of evidence set forth under Prognosis shall apply.

4. If the original study answers the question “What are the harms of intervention (treatment or diagnostic test) X in patients with Disease Y?” then the hierarchy of evidence set forth under Treatment Harms shall apply.

(C) In each Clinical Question category, the levels of evidence are listed from highest to lowest, as defined by the principles of Evidence-Based Medicine. Levels of evidence shall be applied in the order listed. Recommendation for or against medical treatment based on a lower level of evidence shall be permitted only if every higher ranked level of evidence is inapplicable to the employee's medical condition.

1. The level of evidence for each published study (e.g., 1a, 1b, 2, etc.) shall be documented and included with the citation in the Utilization Review or Independent Medical Review decisions.

2. When relying on lower levels of evidence, a written statement shall be provided that states higher levels of evidence are absent.

(b) MTUS Hierarchy of Evidence for Different Clinical Questions shall apply:

Evidence Level	**Treatment Benefits** How useful is Treatment X in treating patients with Disease Y?	**Diagnostic Test** How useful is Test X in diagnosing patients with Disease Y?	**Prognosis** What will happen to a patient with Disease Y if nothing is done?	**Treatment Harms** What are the harms of intervention (treatment or diagnostic test) X in patients with Disease Y?
1a	Systematic review of randomized controlled trials with low risk of bias	Systematic review of high-quality prospective studies (homogeneous sample of patients, consecutively enrolled, all undergoing the index test and reference standard) or systematic review of randomized controlled trials with low risk bias	Systematic review of inception cohort studies or of control arms of randomized controlled trials with low risk of bias	Systematic review of randomized controlled trials with low risk of bias
1b	Randomized controlled trials with low risk of bias	High-quality prospective study or cohort study or randomized controlled trials with low risk of bias	Inception cohort study or control arm from one randomized controlled trial with low risk of bias	Randomized controlled trials with low risk of bias
1c	One or more randomized controlled trials with identified risks of bias (or systematic review of such trials)	Biased cross-sectional study	Cohort study or control arm of randomized controlled trials with identified risks of bias	Prospective study

2	Non-randomized cohort studies that include controls	Case-control study enrolling a broad spectrum of patients and controls with conditions that may be confused with the disease being considered	Case-series or case control studies	Randomized controlled trial(s) with identified risk of bias
3	Case-control studies or historically controlled studies	Case-control study using severe cases and healthy controls		Non-randomized controlled cohort/follow-up study (post-marketing surveillance)
4	Uncontrolled studies (case studies or case reports)		Uncontrolled studies (observational studies, case studies, or case reports)	Consistent case reports (for example, individual case safety reports from US Food and Drug Administration, which are available at the following website: www.fda.gov/For Industry/DataStandards/ IndividualCaseSafety Reports/default.htm
5	Published expert opinion	Published expert opinion	Published expert opinion	Toxicological or mechanistic data that demonstrate or support biologic plausibility

Appendix 1: Notification Letter Templates:

1.1 Initial Notification via Facsimile:

Intelligent Medical Solutions
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

INITIAL NOTIFICATION OF UTILIZATION REVIEW DECISION

Submitted via Facsimile to:
<Requesting Physician Name>
<Requesting Physician Fax Number>

Notice Date:	<Notice Date>
Date Complete RFA First Received:	<CA Receipt Date>
Review Type:	<Prospective / Retro>
Decision Date:	<Date of Decision>
UIN:	UIN

In Regard To:

Injured Worker Name:	<IW Name>
Date of Injury:	<IW DOI>
Claim Number:	<Claim Number>

Proposed Course of Treatment Requested:	**UIN:**
1. <Course of Treatment>	UIN

Dear Dr. <Physician's Last Name>,

This facsimile notification is being sent to initially inform you that the following decision has been made regarding your request for authorization of the above course of treatment:

Utilization Review Decision:	**<DECISION>**

Approved Treatment:	**Denied Treatment:**
1.	1.

Pursuant to Labor Code 4610(g) and 8 CCR §9792.9.4(b) and 8 CCR §9792.9.5(c), this notification is being sent to you initially via facsimile and will be followed by written notice to yourself, to the injured worker, and if the injured worker is represented by counsel, to the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.

Sincerely,

Intelligent Medical Solutions – Utilization Review Division
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

Intelligent Medical Solutions | *Initial Notification of UR Decision* | *Page 1 of 1*

1.2 Approval Notification Letter:

Intelligent Medical Solutions
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

NOTICE OF UTILIZATION REVIEW APPROVAL

Submitted via Ground-Mail to:
<Requesting Physician Name>
<Requesting Physician Address1>
<Requesting Physician Address 2>

Notice Date:	<Notice Date>
Date Complete RFA First Received:	<CA Receipt Date>
Date <Information/Exam/Consult> was Requested (if applicable):	<Date Requested>
Date <Information/Exam/Consult> was Received (if applicable):	<Date Received>
Review Type:	<Prospective / Retro>
Decision Date:	<Date of Decision>
UIN / Certification #:	<UIN>

In Regard To:

Injured Worker Name:	<IW Name>
Date of Injury:	<IW DOI>
Claim Number:	<Claim Number>

Proposed Course of Treatment Requested / Approved:
1. <Course of Treatment>

Dear Dr. <Physician's Last Name>,

Your request for authorization of the above course of medical treatment has been approved.

- Pursuant to Labor Code 4610(g) and 8 CCR §9792.9.2(b), this letter shall serve as written notice that Utilization Review has been approved for the above course of treatment.
- The recommendation for certification of any approved treatment will stand for a period of 12 months from the date of this letter.
- Should the services be required past the 12 months, please contact IMS at (833) 814-3576 between the hours of 9:00 a.m. and 5:30 p.m. (PST)
- Any service required beyond the certified service must be authorized through the utilization review process.

Approval Notification Letter (page 2):

Intelligent Medical Solutions
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

Sincerely,

IMS Utilization Review Division
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

CC: • Adjuster • Patient • ApplicantAt • DefenseAttorney

1.3 Notification of Utilization Review Modification or Denial:

Intelligent Medical Solutions
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

NOTICE OF UTILIZATION REVIEW <DENIAL or MODIFICATION>

Submitted via Ground-Mail to:
<Requesting Physician Name>
<Requesting Physician Address 1>
<Requesting Physician Address 2>

Notice Date:	<Notice Date>
Date Complete RFA First Received:	<CA Receipt Date>
Review Type:	<Prospective / Retro>
Date <Information/Exam/Consult> was Requested (if applicable):	<Date Requested>
Manner the <Information/Exam/Consult> was Requested:	<RFI Letter for Information/Exam/Consult>
Date <Information/Exam/Consult> was Received (if applicable):	<Date Received>
Decision Date:	<Date of Decision>
UIN:	<UIN>

In Regard To:

Injured Worker Name:	<IW Name>
Date of Injury:	<IW DOI>
Claim Number:	<Claim Number>

Proposed Course of Treatment Requested:	**UIN:**
1. <Course of Treatment>	

Dear Dr. <Physician's Last Name>,

The above-mentioned request for authorization has been reviewed pursuant to California Utilization Review regulations. The physician reviewer has made the following decisions:

Utilization Review Determination:	**MODIFY OR UNAPPROVED**

Approved Treatment:	**Unapproved Treatment:**
1. <Approved Treatment>	1. <Denied Treatment>

Medical Records Reviewed:

1. <Record 1>
2. <Record 2>

Explanation of Reasons for the Reviewing Physician's Decision:

<Rationale>

Notification of Utilization Review Modification or Denial (page 2):

Intelligent Medical Solutions One Spectrum Pointe Dr., Suite 200 Lake Forest, CA 92630 Toll-Free: (833) 814-3576 Fax: (949) 465-7090	IMS Utilization Review

Medical Criteria / Guidelines Utilized:

CA MTUS/ACOEM Guidelines
Title of Chapter: <Chapter Title>
Section of Chapter: <Chapter Section>
MTUS Effective Date: <Date>

ODG Treatment Guidelines
Title of Chapter: <Chapter Title>
Section of Chapter: <Chapter Section>
Last Review/update date: <Date>

Sincerely,

<Reviewer Signature>

<Reviewer Name>
<Reviewer Credentials>

IMS Utilization Review Division
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

The above-mentioned reviewer is available to discuss this decision during an agreed-upon scheduled time Monday through Friday, 9:00am through 5:30pm. To arrange a scheduled time for discussion, please contact IMS at the above toll-free number. 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.

Qualifications: I have the type of license that typically manages the medical condition, procedure, treatment or issue under review and current, relevant experience and/or knowledge to render a determination.

COI: To the best of my knowledge, I was not previously involved in reviewing this episode of care and do not have a material, personal, professional, or financial conflict of interest with the patient, health care providers, insurer/payer, referring entity, or the recommended treatment. I have not accepted compensation that is dependent in any way on the specific outcome of the case.

CC: • <Claims Adjuster (Electronic)> • <Injured Worker> • <Injured /Applicant Worker's Attorney>
• <Defense Attorney>

Intelligent Medical Solutions	*Notice of Utilization Review Denial*	*Page 2 of 3*

Notification of Utilization Review Modification or Denial (page 3):

Intelligent Medical Solutions
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

Notice to Injured Worker, Representative, or Attorney:

- If you have a dispute regarding the above Utilization Review decision, any dispute shall be resolved in accordance with the Independent Medical Review ("IMR") provisions of Labor Code section 4610.5 and 4610.6. An IMR form (Application for Independent Medical Review) is included with this notice and may be used to initiate the dispute resolution process.

- An objection to the utilization review decision must be communicated by yourself, the injured worker, your representative, or your attorney on behalf of yourself on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

- You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call the claims adjuster, <Adjuster Name> at <Adjuster Phone>. However, if you are represented by an attorney, please contact your attorney instead of the claims adjuster.

- 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.

Internal Appeals Process – Information for Requesting Physicians, Injured Workers or their Representatives:

- IMS offers an optional internal appeals process for requesting physicians, injured workers, or representatives of injured workers in addition to the Independent Medical Review process.

- If the requesting physician or injured worker wishes to appeal the decision utilizing the Internal Appeals Process, they may do so by submitting a request for internal appeal in writing via facsimile or ground mail to IMS using the contact information contained in this letter. Please include all relevant documentation to support your request for internal reconsideration. All internal appeals will be evaluated and responded to in accordance with California regulations.

- 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 (the "IMR Process"), but may be pursued on an optional basis.

- Any request by the injured worker or treating physician for an internal utilization review appeal process conducted under this subdivision must be submitted to IMS 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 (f)(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.

Notification of Utilization Review Modification or Denial (page 4):

DIVISION OF WORKERS' COMPENSATION
CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS

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

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

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

Regular ☒ | Expedited ☐ | Modification after Appeal ☐

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

Employee Information:
First Name: _____ Middle Initial: ____ Last Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____ Date of Injury: _____
Insurance Claim Number: _____ EAMS Case Number: _____
WCIS Jurisdictional Claim Number (if assigned): _____
Employee Attorney (if known): _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____

Requesting Physician Information:
Physician First Name: _____ Middle Initial: _____ Last Name: _____
Practice Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____ Specialty: _____

Claims Administrator Information:
Employer Name: _____
Name of Administrator: _____ Contact Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____

Disputed Medical Treatment:
Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter: _____

DWC Form IMR – Effective 4/1/26 - Page 1

Notification of Utilization Review Modification or Denial (page 5):

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

Reason:

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

1.
2.
3.
4.

Request for Review and Consent to Obtain Medical Records

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

Employee Signature _____ Date _____

Deadline for Filing IMR Application

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

IMR Application Filing Deadline:

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

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

DWC Form IMR – Effective 4/1/26 - Page 2

Notification of Utilization Review Modification or Denial (page 6):

INSTRUCTIONS FOR COMPLETNG THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

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

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

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

- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.
- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

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

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

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

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

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

DWC Form IMR – Effective 4/1/26 - Page 3

1.4 Notification of Utilization Review Deferral:

Intelligent Medical Solutions
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

NOTICE OF UTILIZATION REVIEW DEFERRAL

Submitted via Ground-Mail to:
<Requesting Physician Name>
<Requesting Physician Address1>
<Requesting Physician Address 2>

Notice Date:	<Notice Date>
Date Complete RFA First Received:	<CA Receipt Date>
Review Type:	<Prospective / Retro>
Decision Date:	<Date of Decision>
UIN:	UIN

In Regard To:

Injured Worker Name:	<IW Name>
Date of Injury:	<IW DOI>
Claim Number:	<Claim Number>

Proposed Course of Treatment:
1. <Course of Treatment>

Dear Dr. <Physician Name>,

Your request for authorization of the above course of medical treatment has been deferred due to a liability dispute for either the injury, claimed body part or the recommended treatment on grounds other than medical necessity.

Pursuant to Labor Code 4610(g)(7) and 8 CCR §9792.9.2(b), this letter shall serve as written notice that Utilization Review has been deferred for the above course of treatment.

The Claims Administrator currently disputes liability for either the injury, claimed body part or the recommended treatment on grounds other than medical necessity for the following reasons:

Reason for Utilization Review Deferral:
<Rationale for Deferral>

Notification of Utilization Review Deferral (page 2):

Intelligent Medical Solutions
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

Notice to Injured Worker:

- Any dispute listed above will be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.
- You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call the claims adjuster, <Adjuster Name> at <Adjuster Phone>. However, if you are represented by an attorney, please contact your attorney instead of the claims adjuster.
- 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.

Sincerely,

IMS Utilization Review Division
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

CC: • <Claims Adjuster (Electronic)> • <Injured Worker> • <Injured /Applicant Worker's Attorney>
• <Defense Attorney>

1.5 Request for Information ("RFI") Regarding Utilization Review:

Intelligent Medical Solutions
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

REQUEST FOR INFORMATION REGARDING UTILIZATION REVIEW

Submitted Via Facsimile To:
<Requesting Physician Name>
<Requesting Physician Fax Number>

Notice Date:	<Notice Date>
Date Complete RFA First Received:	<CA Receipt Date>
UIN:	<UIN>

In Regard To:

Injured Worker Name:	<IW Name>
Date of Injury:	<IW DOI>
Claim Number:	<Claim Number>

Proposed Course of Treatment Requested:
1. <Course of Treatment>

Dear Dr. <Physician Name>,

Regarding the above, this Request for Information is being sent to notify you that Utilization Review is not in receipt of all information reasonably necessary to make a determination.

We are in need of and are requesting the following information in order to make a determination:

Additional Information Requested:
<Information Required> Please fax the requested information to (949) 465-7090.

Sincerely,

IMS Utilization Review Division
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

Intelligent Medical Solutions | *Notice of Request for Information* | *Page 1 of 1*

1.6 Notice of Utilization Review Time Extension:

Intelligent Medical Solutions
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

NOTICE OF UTILIZATION REVIEW TIME EXTENSION

Submitted via Ground-Mail to:
<Requesting Physician Name>
<Requesting Physician Address1>
<Requesting Physician Address 2>

Also submitted via Facsimile to:
<Requesting Physician's Fax No>

Notice Date:	<Notice Date>
Date Complete RFA First Received:	<CA Receipt Date>
UIN:	<UIN>

In Regard To:

Injured Worker Name:	<IW Name>
Date of Injury:	<IW DOI>
Claim Number:	<Claim Number>

Proposed Course of Treatment Requested:	**UIN:**
<Course of Treatment>	

Dear Dr. <Physician Name>,

This letter is to notify you that Utilization Review cannot make a decision within the required timeframe due to the following:

- <The Claims Administrator or Reviewer is not in receipt of all of the information reasonably necessary and requested>
- <The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.>
- <The reviewer needs a specialized consultation and review of medical information by an expert reviewer.>

<If Time Extension due to Lack of Info §9792.9.6(a)(1)(A)>

Additional Information Requested:
1.

Attempts to Obtain the Requested Information:
1.

<If reviewer has requested for additional exam or text §9792.9. 9.6(a)(1)(B)>

Notice of Utilization Review Time Extension (page 2):

Intelligent Medical Solutions
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

Additional Examination or Test to be Performed:
1.

Rationale for Additional Examination or Test to be Performed:
1.

<If reviewer needs a specialized consultation and review of medical information by an expert reviewer 9792.9. 9.6(a)(1)(C)>

Specialty of Expert Reviewer to be Consulted:

Rationale for Specialized Consultation / Review of Medical Information by Expert Reviewer:

The anticipated date on which a decision will be rendered is: No later than <Anticipated Date> or sooner if requested information received.

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

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

Sincerely,

<Reviewer Signature>

<Reviewer Name>
<Reviewer Credentials>

IMS Utilization Review Division
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

CC: • <Claims Adjuster (Electronic)> • <Injured Worker> • <Injured /Applicant Worker's Attorney>
• <Defense Attorney>

1.7 Sample Voluntary Appeal Response:

Intelligent Medical Solutions
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

NOTICE OF UTILIZATION REVIEW APPROVAL
(NOTIFICATION AFTER INTERNAL APPEAL)

Submitted via Ground-Mail to:
<Requesting Physician Name>
<Requesting Physician Address1>
<Requesting Physician Address 2>

Notice Date:	<Notice Date>
Date Complete RFA First Received:	Receipt Date> Original Decision
Review Type:	<Prospective / Retro>
Decision Date:	Date of Original Decision
Date Internal Appeal Received:	CA Receipt Date for APPEAL
Date of Appeal Decision:	APPEAL Decision Date
UIN:	<UIN>

In Regard To:

Injured Worker Name:	<IW Name>
Date of Injury:	<IW DOI>
Claim Number:	<Claim Number>

Proposed Course of Treatment Requested / Approved:
1. <Course of Treatment>

Dear Dr. <Physician's Last Name>,

After consideration through the internal appeals process, your request for authorization of the above course of medical treatment has been approved.

- Pursuant to Labor Code 4610(g) and 8 CCR §9792.9.4(b), this letter shall serve as written notice that Utilization Review has been approved for the above course of treatment.
- The recommendation for certification of any approved treatment will stand for a period of 12 months from the date of this letter.
- Should the services be required past the 12 months, please contact IMS Utilization Review Division at (833) 814-3576 between the hours of 9:00 a.m. and 5:30 p.m. (PST)
- Any service required beyond the certified service must be authorized through the utilization review process.

Medical Records Reviewed:

1. <Record 1>
2. <Record 2>

Sample Voluntary Appeal Response (page 2):

Intelligent Medical Solutions
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

Explanation of Reasons for the Reviewing Physician's Decision:

<Rationale>

Medical Criteria / Guidelines Utilized:

CA MTUS / ACOEM Guidelines
Title of the Chapter: <Chapter Title>
Section of the Chapter: <Chapter Section>
MTUS Effective Date <Date>

ODG by MCG Guidelines
Title of the Chapter: <Title>
Section of the Chapter: <Section>
Last Review/update date: <Date>

Sincerely,

<Reviewer / Staff Signature>

<Reviewer / Staff Name>
<Reviewer / Staff Credentials>

Qualifications: I have the type of license that typically manages the medical condition, procedure, treatment or issue under review and current, relevant experience and/or knowledge to render a determination.

COI: To the best of my knowledge, I was not previously involved in reviewing this episode of care and do not have a material, personal, professional, or financial conflict of interest with the patient, health care providers, insurer/payer, referring entity, or the recommended treatment. I have not accepted compensation that is dependent in any way on the specific outcome of the case.

IMS Utilization Review Division
One Spectrum Pointe Dr., Suite 200
Lake Forest, CA 92630
Toll-Free: (833) 814-3576
Fax: (949) 465-7090

CC:
- <Claims Adjuster (Electronic)>
- <Injured Worker>
- <Injured /Applicant Worker's Attorney>
- <Defense Attorney>

Appendix 2: URAC Accreditation Certificate:

Certificate Number: WUM010023

urac®

CERTIFICATE OF AWARD

in recognition of

Intelligent Medical Solutions, Inc.
1 Spectrum Pointe Drive, Suite 200
Lake Forest, California 92630

for compliance with

Workers' Compensation Utilization Management 8.1
Accreditation Program

is awarded

Full Accreditation

Effective from 08/01/2024 through 08/01/2027

Shawn Griffin, MD
President & Chief Executive Officer

urac®
ACCREDITED

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

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

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