



California Workers' Compensation
Utilization Review Plan

Rev 6_2018

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Utilization Review Standards- Definitions

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

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

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

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

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

(f) "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.

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

(h) "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.

(i) "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.

(j) "Expert reviewer" means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of

Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.

(k) "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.

(l) "Immediately" means within one business day.

(m) "Material modification" is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

(n) "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.

(o) "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.

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

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

(r) "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

(s) "Request for authorization" means a written request for a specific course of proposed medical treatment.

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

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

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

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

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

(v) "Utilization review decision" means a decision pursuant to Labor Code section 4610 to approve, modify, delay, 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).

(w) "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.

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

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

Source: 8 CCR § 9792.6.1

Utilization Review Program Structure

Program Objectives

Utilization review (UR) is the process used by employers or claims administrators to review treatment to determine if it is medically necessary and appropriate for an accepted injury. All employers or their workers' compensation claims administrators are required by law to have a UR program. PRIUM provides Utilization Management services for claims administrators responsible for the management of Workers' Compensation claims in California, helping to ensure the delivery of quality medical care that is consistent with evidence-based guidelines and standards.

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

A copy of PRIUM's Utilization Review Plan, policies and procedures will be made available to the public upon request.

Quality Management Committee (QMC)

Reporting directly to the Executive Vice President, the Quality Management Committee meets quarterly to identify problems and trends and discuss solutions for identified program deficiencies and compliance with regulatory and URAC requirements.

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

Composition: The QMC is composed of the following individuals:

- PRIUM's Medical Director
- PRIUM's Director of Operations
- PRIUM's Director of Utilization Review

Procedures:

1. The Quality Management Committee reports directly to the Executive Vice President.
2. The Quality Management Committee will meet quarterly and maintain minutes of the scheduled meeting for review and approval at subsequent meetings.

3. The Committee will:

- Evaluate the effectiveness of the quality management program annually
- Approve quality improvement projects
- Monitor quality improvement initiatives
- Provide staff guidance on quality management projects and priorities

Medical Director

PRIUM's Medical Director is:

Dr. Stanley Katz, M.D.
American Board of Orthopaedic Surgery
CA License Number: G49280
NV License Number: 6675
1717 E Lincoln Ave
Anaheim, CA 92805
Telephone: (714)635-2642

PRIUM's Medical Director ensures that the processes by which PRIUM 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 the Workers' Compensation Utilization Review regulations. The Medical Director is responsible for all decisions made in the utilization review process.

Other responsibilities of PRIUM's Medical Director include but are not limited to:

- Oversight of the CA Workers' Compensation Utilization Review program;
- Responsibility for the overall quality of physician reviews;
- Serving on the Quality Management Committee, actively participating in the review of complaints and grievances and policy and procedure review and development;
- Assisting in the evaluation of outcomes data; and
- Assisting in guideline training.

Utilization Review Staff

Utilization Review Nurse: PRIUM's Utilization Review nurses are licensed registered nurses who are trained in the interpretation and application of the Medical Treatment Utilization Schedule (MTUS) or other evidence-based treatment guidelines utilized for the assessment of the medical

appropriateness of requested treatments or services. If the requested treatment or services cannot be approved, the nurse reviewer may request additional information or discuss the applicable criteria with requesting provider, who may withdraw or amend the request. The request is forwarded to a physician reviewer if Utilization Review Nurse determines that the requested treatment is found to be inconsistent with the guidelines and cannot be approved.

Reviewer: PRIUM contracts with licensed medical doctors, doctors of osteopathy, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners, who are competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the reviewer’s scope of practice. The physician reviewer may approve, delay, modify or deny requests for authorization of medical treatment for reasons of medical necessity. Internally, PRIUM references these Reviewers as “Physician Reviewers.”

Expert Reviewer: PRIUM contracts with Board Certified specialists who may consult with PRIUM’s physician reviewers or Medical Director to provide specialized review services where required.

PRIUM utilizes onsite and off-site Expert Reviewers, who conduct utilization review in accordance with MTUS. All Utilization Review services are in strict compliance with California law and meet the highest standards of quality in decision-making.

All off-site contractors have a secure web-based system to access appropriate medical records for processing or to accept supporting documentation directly from the provider.

Additionally, all PRIUM’s physician reviewers make available a minimum of four (4) hours of availability per week during normal business hours, 9:00 a.m. to 5:30 p.m. Pacific Time, to discuss decisions with requesting providers. PRIUM’s provider notification letters direct the provider to contact PRIUM to facilitate the discussion at an agreed upon scheduled time.

Utilization Review Process

Telephone and Facsimile Access

PRIUM provides telephone and facsimile access from 9:00 AM to 5:00 PM Pacific Time Monday through Friday for health care providers to request authorization for medical services. Additionally, PRIUM can receive communications from health care providers after business hours, either by

facsimile or PRIUM's voicemail system that records messages and provides contact information and hours of operation.

Utilization Review Requests

Requests for authorization for a course of medical treatment must be submitted on a Request for Authorization for Medical Treatment (DWC Form RFA-1), completed by the treating physician with information specific to the request provided by the requesting treating physician for all mandatory fields indicated on the form. The form must be signed by the physician and may be mailed, faxed or e-mailed.

If the DWC Form RFA is not completed as defined in section 9792.6.1.(t)(2), a non-physician reviewer or reviewer may either treat the form as complete and comply with the timeframes for decision or return it to the requesting physician marked "not complete" no later than five (5) business days from receipt. The timeframe for a decision on that returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

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

Utilization Review of Treatment Requests Deferred Due to Liability Disputes

Utilization Review of a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity. If the claims administrator disputes its liability for the requested medical treatment, it may, no later than five (5) business days from receipt of the request for authorization, issue a written decision deferring utilization review of the requested treatment. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall only contain the following information specific to the request:

- (A) The date on which the request for authorization was first received.
- (B) A description of the specific course of proposed medical treatment for which authorization was requested.
- (C) A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for the injury, claimed body part or parts, or the recommended treatment.

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

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

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

and

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

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

Administrative Authorization

Workers' compensation insurance carriers and self-insured employers may choose to administratively approve requests for authorization without submitting the request to PRIUM for review under PRIUM's UR Plan.

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

Retrospective Review

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

Treatment Guidelines

The Medical Treatment Utilization Schedule (MTUS) provides medical treatment guidelines for utilization review and an analytical framework for the evaluation and treatment of injured workers. The MTUS is promulgated by the DWC administrative director under Labor Code sections 5307.27 and 4604.5, and can be found in sections 9792.20 et seq. of Title 8, California Code of Regulations.

The MTUS lays out treatments scientifically proven to cure or relieve work-related injuries and illnesses. It also deals with how often the treatment is given (frequency), extent of treatment (intensity), and for how long (duration), among other things.

PRIUM reviewing physicians follow the medical evidence search sequence required by in 8 CCR § 9792.21.1. PRIUM utilizes the Medical Treatment Utilization Schedule for the review of treatment requests. If the MTUS is not applicable, the reviewer shall 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 set forth in section 9792.25.1. If no applicable recommendation is found, or if the reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then the reviewing physician shall 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. 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 the reviewing physician shall 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 set forth in section 9792.25.1.

Guidelines used in the utilization review process to determine whether to approve, modify, or deny medical treatment services are developed with involvement from actively practicing physicians. These guidelines must be consistent with the MTUS, including the drug formulary adopted pursuant to Cal. Lab. Code § 5307.27. These guidelines are evaluated annually and updated, if necessary.

Additionally, these guidelines are disclosed to the physician and to the employee within the utilization review determination if they are used as the basis of a decision to modify or deny services in a specified case under review. PRIUM's guidelines are available to the public upon request. A charge shall not be required for an employee whose physician's request for medical treatment services is under review.

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

Citation of Guidelines and Other Authority

Citations provided by the PRIUM reviewers include the following elements.

- When citing the MTUS, the citation shall include:
 - the term "MTUS" or "Medical Treatment Utilization Schedule";
 - the effective year of the guideline;
 - the title of the chapter referenced (e.g., Low Back Complaints);
 - the section referenced within the chapter (e.g., Surgical Considerations).

- When citing other medical treatment guidelines, the citation shall include:
 - the name or abbreviated name of the guidelines being cited (e.g., Official Disability Guidelines; ODG);
 - the name of the organization publishing the guidelines (e.g., Work Loss Data Institute);
 - the year of publication;
 - the title of the chapter
 - the section referenced within the chapter (if applicable)

- When citing a peer-reviewed study, the citation shall include:
 - the last name and first initial of the first author listed in the study;
 - the published article's title
 - journal title (standard abbreviations may be used)
 - volume number

- year published
- page numbers

Clinical Review (First Level Review)

PRIUM utilizes Licensed Registered Nurses to apply specified criteria in the evaluation of treatment requests and supporting documentation, to determine if the request falls within the guidelines. The Utilization Review Nurse may approve the request or request additional information that is necessary to render a decision within five (5) working days of receipt of the request. If the requested documentation is not received timely, the nurse will refer the request to a PRIUM reviewer. If the Reviewer is unsuccessful in obtaining the information necessary to evaluate the request, the physician reviewer may deny the requested treatment with the stated condition that the request will be reconsidered upon receipt of the information requested. In no event shall the determination be made more than 14 days from the date of receipt of the original request.

The Utilization Review Nurse may also discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization which may be approved by the nurse.

Physician Review (Peer Review)

If the Utilization Review Nurse cannot certify the requested treatment, the request is evaluated by a Reviewer. Only a Reviewer who is competent to evaluate the specific clinical issues, which are within the scope of the physician's practice, may modify or deny treatment requests. PRIUM's Reviewer will attempt to contact the prescribing physician twice within two (2) business days in cases where the medical documentation does not support the request or additional documentation is necessary to render a decision.

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

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

- Clinical reasons regarding medical necessity

Requests for Additional Information

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

PRIUM First-Level Reviewers are non-physician reviewers. PRIUM First-Level Reviewers do not issue adverse determinations. If a First-Level reviewer determines that additional information is required, the review is escalated to Peer Review status so that the Peer Review Physician may confirm that the additional information is reasonably necessary and may attempt to contact the provider to request the information as part of a Peer Review. (Peer Review process discussed below.)

- (Peer Review):
 - Once escalated from First Level Review (if applicable) or referred for immediate Peer Review, a Peer Review Physician is assigned to the review. The Peer Review Physician assigned to the review shall be a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and whose scope of practice includes performing or ordering services such as those under review.
 - Prior to issuing a denial for incomplete or insufficient information, the Peer Review Physician will attempt to contact the provider at least twice in order to obtain additional reasonably necessary information. The dates, times, and manner (phone, voicemail, fax) of the attempts will be documented in the determination letter.

- If the reviewer has asked that an additional examination or test be performed upon the injured worker, such a request must be reasonable and consistent with professionally recognized standards of medical care pursuant to 8 CCR § 9792.9.1(f)(1)(B). The reviewer may also seek a specialized consultation and review of medical information by an expert reviewer pursuant to 8 CCR § 9792.9.1(f)(1)(C). If either of these situations applies, following the receipt of a DWC Form RFA or accepted request for authorization, the reviewer shall within five (5) business days from the date of receipt of the request for authorization notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered, pursuant to 8 CCR § 9792.9.1(f)(2)(B).

Pursuant to 8 CCR § 9792.9.1(f)(3)(B), if the results of the additional examination, test, or the requested specialized consultation have not been received within thirty (3) 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, test, or specialized consultation.

- If the Peer Review Physician cannot approve/certify the treatment under review based on the information provided, and attempts to obtain additional information within the standard applicable timeframe have failed, the next steps depend on whether the treatment under review is subject to the formulary, whether the review is retrospective or prospective/concurrent.
 - **In the case of treatment subject to the formulary – non-expedited prospective or concurrent review:**

The Peer Review Physician will issue a denial for insufficient information within five working days from the receipt of the medical treatment request.

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

receipt of the medical treatment request.

- **In the case of other treatment – non-expedited prospective or concurrent review:**

In addition to the telephonic requests, the Peer Review Physician will issue a written request for additional information within five working days of receipt of the request for authorization, pursuant to 8 CCR 9792.9.1(f)(2)(A). If the information is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, the Peer Review Physician shall deny the request for insufficient information, pursuant to 8 CCR 9792.9.1(f)(3)(A) with the stated condition that the request will be reconsidered upon receipt of the information.

- **In the case of expedited prospective or concurrent review:**

The Peer Review Physician will issue a denial for insufficient information within 72 hours from the receipt of the medical treatment request, pursuant to 8 CCR 9792.9.1(c)(4).

- **In the case of retrospective review:**

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

- Where a Peer Review Physician issues a denial for insufficient information, the determination letter will include -- in addition to the requirements applicable to all UR denials – the following items:
 - the reason for the decision;
 - a specific description of the information that is needed;
 - the date(s) and times of the attempts (at least two) made to contact the physician to obtain the necessary information;
 - a description of the manner in which the requests for additional information were communicated;
 - and a stated condition that the request will be reconsidered upon receipt of the requested information.

- If the required information is provided for reconsideration following a denial for insufficient information, a new determination is issued within five working days of receipt of the information (in the case of non-expedited prospective or concurrent reviews), within 72 hours of receipt of the information (in the case of expedited prospective or expedited concurrent reviews), or within 30 days of receipt of the information (in the case of retrospective reviews), pursuant to 8 CCR 9792.9.1(f)(4), (5), and (6).

Decision Timeframes

- Prospective and Concurrent Reviews (imminent and serious threat) – if the employee’s condition is one in which the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the employee’s life or health or could jeopardize the employee’s ability to regain maximum function, decisions to approve, modify, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee’s condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.
- Prospective and Concurrent Reviews (Formulary Requests) - decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of receipt of the medical treatment request.
- Prospective and Concurrent Reviews (Other Than Formulary Requests) - the decision to approve, modify or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured workers’ condition, not to exceed five (5) business days from the date of receipt of the completed DWC Form RFA, but in no event more than 14 calendar days from the initial receipt of the complete form DWC Form RFA.
 1. If appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) business days from the date of receipt of the DWC Form RFA to make the proper determination.

2. If the reasonable information is not received within 14 days from the receipt of the completed DWC Form RFA, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.

The timeframe for decisions specified above may only be extended where the Reviewer is not in receipt of all of the necessary medical information reasonably requested.

In such a case, the Reviewer shall immediately notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the claims administrator cannot make a decision within the required timeframe, and specify the information requested but not received. The claims administrator shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered. Additionally, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision to extend the timeframe and the anticipated date on which the decision will be rendered. The written notification shall **not** include the rationale, criteria or guidelines used for the decision.

Upon receipt of the information requested pursuant to the above, the claims administrator of reviewer, for prospective or concurrent review, shall make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information, but in no event more than 14 calendar days from the initial receipt of the complete form DWC Form RFA. The requesting physician will be notified by telephone, facsimile or electronic mail within 24 hours of making the decision. The written decision will include the date the information was received and the decision shall be communicated according to the appropriate notification requirements.

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

- Retrospective Reviews - Decision will be communicated within thirty (30) days of receipt of the information that is reasonably necessary to make the decision.

Upon receipt of the information requested for retrospective reviews, the claims administrator or 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. The decision shall include the date it was made and shall be communicated according to the appropriate notification requirements.

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

Effective Duration of Adverse Determinations

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

Notification Requirements

Decisions to Approve a Request for Authorization

- All decisions to approve a request for authorization set forth in a DWC Form RFA shall specify the specific medical treatment service requested, the specific medical treatment service approved, and the date of the decision.
- For prospective, concurrent, or expedited review, approvals shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.
- For retrospective review, a written decision to approve shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.

- Payment, or partial payment consistent with the provisions of California Code Regulations, title 8, section 9792.5, of a medical bill for services requested on the DWC For RFA, within the 30-day timeframe set forth in subdivision (c)(4), 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.

Decision to Modify or Deny a Request for Authorization

- For prospective, concurrent, or expedited review, a decision to modify or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail.
- The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request.
- 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. The non-physician provider of goods or services identified in the request for authorization, and for who contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall **not** include the rationale, criteria or guidelines used for the decision.
- For retrospective review, a written decision to deny part or all of the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of information that is reasonably necessary to make this determination.

- The written decision modifying or denying treatment authorization shall be provided to the requesting physician, the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney and shall only contain the following information specific to the request:
 - (A) The date on which the DWC Form RFA was first received.
 - (B) The date on which the decision is made.
 - (C) A description of the specific course of proposed medical treatment for which authorization was requested.
 - (D) A list of all medical records reviewed.
 - (E) A specific description of the medical treatment service approved, if any.
 - (F) A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision.
 - If a utilization review decision to modify or deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.
 - (G) The Application for Independent Medical Review, DWC Form IMR, with all fields, except for the signature of the employee, to be completed by the claims administrator.
 - The application, set forth at section 9792.10.1, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.
 - (H) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days of receipt of the decision.

(I) Include the following mandatory language advising the injured employee:

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

And

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

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

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

- Withdrawal- If a treatment request falls outside of the MTUS guidelines, the prescribing physician may voluntarily withdraw a portion or all of the requested treatment and submit in writing an amended request or complete the Notification of Withdrawal/Amended Treatment Request initiated by PRIUM’s Utilization Review Nurse.

Reconsideration / Appeals Process

Appeals

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

Within 10 calendar days of receipt of the adverse determination, the prescribing physician may submit a written appeal to PRIUM. The appeal should include any documentation the prescribing physician would like the appellate reviewer to consider. A Board Certified specialty matched reviewer will be assigned to review the request and all submitted documentation. This PRIUM peer reviewer must not have been involved in any previous non-certification determination pertaining to this particular episode of care, nor can the appellate reviewer report to the clinician who performed the original review. PRIUM will complete the appeal and notify the prescribing physician of the results within thirty (30) calendar days.

Reconsiderations

If an adverse determination was rendered due to insufficient information, and previously requested information is subsequently provided, PRIUM will reconsider the adverse determination within five (5) working days of receipt of the requested information. The PRIUM reviewer may be the Reviewer originally assigned to the review. The Utilization Review decision shall be communicated as per the notification requirements.

Disputes

If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6.

Neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review or the Workers' Compensation Appeals Board.

A request for independent medical review must be communicated by the employee, the employee's representative, or the employee's attorney by mail, facsimile, or electronic transmission to the Administrative Director, or the Administrative Director's designee, within 30 days of service of the utilization review decision. The request must be made on the Application for Independent Medical

Review, DWC Form IMR, and submitted with a copy of the written decision delaying, denying, or modifying the request for authorization of medical treatment.

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

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

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

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

Financial Incentive Policy

PRIUM does not offer or provide any financial incentive or consideration to physicians based on the number of modifications or denials made by the physician in performing utilization review.

Independent Medical Review

Following receipt of the Application for Independent Medical Review, DWC Form IMR, the Administrative Director shall determine whether the disputed medical treatment identified in the application is eligible for independent medical review. The Administrative Director may reasonably request additional appropriate information from the parties in order to make a determination that a disputed medical treatment is eligible for independent medical review. The Administrative Director shall advise the claims administrator, the employee, and the employee's provider, as appropriate, by the most efficient means available. The parties shall respond to any reasonable request made within fifteen (15) days following receipt of the request. Following receipt of all

information necessary to make a determination, the Administrative Director shall either immediately inform the parties in writing that a disputed medical treatment is not eligible for independent medical review or assign the request to independent medical review.

A request for independent medical review shall be deferred if at the time of a utilization review decision, the claims administrator is also disputing liability for the treatment for any reason besides medical necessity.

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

Within one business day following a finding that the disputed medical treatment is eligible for independent medical review, the independent review organization delegated the responsibility by the Administrative Director to conduct independent medical review.

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

- A. A copy of all reports of the employee's treating physician relevant to the employee's current medical condition produced within one year 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.
- B. A copy of the adverse determination by the claims administrator notifying the employee and the employee's treating physician that the disputed medical treatment was denied, delayed or modified.
- C. A copy of all information, including correspondence, provided to the employee by the claims administrator concerning the utilization review decision regarding the disputed treatment.
- D. A copy of any materials the employee or the employee's provider submitted to the claims administrator in support of the request for the disputed medical treatment.
- E. A copy of any other relevant documents or information used by the claims administrator in determining whether the disputed treatment should have been provided, and any statements by the claims administrator explaining the reasons for the decision to deny, modify, or delay the recommended treatment on the basis of medical necessity.
- F. The claims administrator's response to any additional issues raised in the employee's application for independent medical review.

The claims administrator shall send the employee or the employee's representative a notification that lists all of the documents submitted to the independent review organization and provide a copy of all documents that were not previously provided to the employee or the employee's representative. Any newly developed or discovered relevant medical records forwarded to the independent review organization the claims administrator shall also be sent to the employee or the employee's representative, or the employee's treating physician unless declined or prohibited by law.

The independent review organization may reasonably request appropriate additional documentation or information necessary to make a determination that the disputed medical treatment is medically necessary. Additional documentation or other information requested shall be sent by the party to whom the request was made, with service on all other parties, within five (5) business days after the request is received in routine cases or one (1) calendar day after the request is received in expedited cases.

The independent medical review process may be terminated at any time upon the claims administrator's written authorization of all disputed medical treatment.

The independent review organization shall provide the Administrative Director, the claims administrator, the employee, and the employee's provider with a final determination regarding the medical necessity of the disputed medical treatment.

For regular review, the independent review organization shall complete its review and make its final determination within thirty (30) days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information. For expedited review where the disputed medical treatment has not been provided, the independent review organization shall complete its review and make its final determination within three (3) days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation and information provided.

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

The parties may appeal an eligibility determination by the Administrative Director by filing a petition with the Workers' Compensation Appeals Board if there is clear and convincing evidence that:

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

If the final determination of the Administrative Director is reversed by the Workers' Compensation Appeals Board, the dispute shall be remanded to the Administrative Director. The Administrative Director shall:

1. Submit the dispute to independent medical review by a different independent review organization, if available;
2. If a different independent medical review organization is not available after remand, the Administrative Director shall submit the dispute to the original independent review organization for review by a different reviewer in the organization.

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

Confidentiality and Information Security Policy

This policy affects all PRIUM employees and contractors who perform utilization management operations, and all others who serve on committees or boards.

The policy of PRIUM is to handle all information in a manner that ensures the privacy and security of the records. All information that identifies a specific individual shall be kept confidential and shall not be disclosed to any individual or organization outside of disclosures permitted or required by law. The release or re-release of confidential information to unauthorized persons is strictly prohibited.

All PRIUM employees and contractors, who perform utilization management operations, as well as all committee members and board members, shall sign a confidentiality agreement to ensure protection of patients' health information.

All PRIUM employees and contractors, who respond to communications, shall undergo training regarding this policy, these procedures and their implementation.

All information that identifies a specific individual shall be kept confidential and shall not be disclosed to any individual or organization outside of disclosures permitted or required by law.

To the extent permitted by state and federal law, the release of information on a specific review is restricted to the following people:

- PRIUM employee's or contractors who require the information to perform utilization management operations;

- The patient whose information is at issue;
- The patient's legal counsel;
- The claims administrator for the claim at issue;
- Client appointed personnel specified by the client as being involved in the claim and/or review (e.g. nurse case manager);
- The defense attorney;
- The requesting physician, or their office staff;
- The attending physician, or their office staff;
- The secondary physicians, or their office staff;
- The non-physician provider of goods and/or services at issue.

If a PRIUM employee or contractor receives a request for information regarding a specific claim or review, they shall verify that the requestor is one of the parties listed above. If it cannot be established that the requestor is such a party, the requestor shall be referred to the claims administrator for further help.

The release of patient information, such as social security number, date of birth, contact information that does not specifically bear upon the utilization management determination shall be prohibited. If any person requests this information, the requestor shall be referred to the claim administrator for further help.

The release of provider information, such as federal tax id number or contact information, which does not specifically bear upon the utilization management determination, shall only be accessible to the client for purposes of billing and bill review. Any other release of this information shall be prohibited. If any person requests this information, the requestor shall be referred to the claim administrator for further help.

In the event that PRIUM publishes data, such as quality review studies or performance tracking, in every instance where such publication includes data which identifies a particular physician or health care provider, the physician or health care provider shall be provided written notice of the publication.

Notification Letters



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

In Progress Notification

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:
«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Dear «FullName»,

We have received a request for authorization for the above referenced claim.

Physician requesting authorization:

«physician.FullName»

Specific Treatment Plan Requested

«requestedtreatmentplan_without_dates»

Listed below is the applicant attorney we have on file. If this information is correct, no further action is necessary. If this information is incorrect, please notify us immediately so we can update our records. Please note if the fields below are blank then we have no attorney on file.

Applicant Attorney: «claim.applicantattorney.FullName»

Address: «claim.applicantattorney.address.street1»

«claim.applicantattorney.address.city», «claim.applicantattorney.address.state»

«claim.applicantattorney.address.postalcode»

Phone: «claim.applicantattorney.telephone»

Fax: «claim.applicantattorney.fax»

Please feel free to contact us should you have any additional questions regarding this review.

Respectfully,

PRIUM

«CC»

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

Recommendation: CERTIFY

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:

«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the following health care services are certified as medically necessary:

Specific Treatment Plan Requested

«requestedtreatmentplan_without_dates»

UR Determination

«authorizedtreatmentplan» (Specific medical treatment or service approved)

Clinical Rationale

«clinical_rationale» (Reviewer's rationale listed here)

Criteria/Guidelines Applied

«guidelines»

Please feel free to contact us should you have any additional questions regarding this claim or if medical necessity substantiates further treatment.

Respectfully,

(Reviewer's signature)

(Reviewer's printed name)

Reviewer's state license number)
(Reviewer's board certification)

«cc» Attorney (if applicable)
Injured Worker

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

Recommendation: NON-CERTIFY

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:

«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if the requested health care services are medically necessary and appropriate for this claim. This letter is to notify you that the following health care services did not meet the established criteria for medical necessity:

Specific Treatment Plan Requested

«requestedtreatmentplan»

UR Determination

«authorizedtreatmentplan»

Clinical Rationale

«clinical_rationale» (Reviewer's rationale listed here)

Criteria/Guidelines Applied

«guidelines»

Information regarding our optional internal appeals process is attached to this determination letter.

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact PRIUM at «project.doc_phone» so that a convenient time may be arranged for this discussion. All reviewers are available for at least four hours per week during normal business days from

9:00 a.m. to 5:30 p.m. PST. Additionally, please feel free to contact us should you have any additional questions regarding this claim.

Respectfully,

(Reviewer's signature)

(Reviewer's printed name)

Reviewer's state license number)

(Reviewer's board certification)

Enclosures: IMR form sent to: injured worker; requesting provider; applicant attorney, if applicable.

«cc» Attorney (if applicable)
Injured Worker

Attached: DWC Form IMR

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***

PRIUM Optional Internal UR Appeals Process

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

1. Be in writing; and
2. Be received by PRIUM within 10 days of the date of the original determination; and
3. Indicate if the appeal warrants an expedited review*; and
4. Contain either:
 - a. Additional information supporting the request; or
 - b. The basis or rationale for disagreement with the denial.

Appeal requests which do not match the above requirements will not be considered.

Appeals and information may be faxed to «project.doc_fax» or may be submitted via mail to «project.doc_address», «project.doc_city», «project.doc_state» «project.doc_zip».

* *Expedited appeals shall only be granted if:*

1. *the timeline for making a determination could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or*
2. *the patient would be in severe pain that could not be adequately managed without the care or treatment under review.*

Additional Language required by California Labor Code and Regulations:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me «claim.examiner.FullName» at «claim.examiner.telephone». However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision. Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Medical Records Reviewed

The following is a list of documents reviewed:
«DocumentsReviewed»



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

Request for Additional Information

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:
«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the reviewer has determined that additional information is required to make a determination of medical necessity. We are requesting that the requesting provider submit the following information in order to allow us to complete this review:

Please provide this information within 14 days of the date of this document (in the case of a prospective or concurrent review) or within 30 days of the date of this document (in the case of a retrospective review). Pursuant to 8 CCR § 9792.9.1(f)(3)(A), if the requested information is not provided within that timeframe, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

Physician requesting authorization:

«physician.FullName»

Specific Treatment Plan Requested:

«requestedtreatmentplan_without_dates»

Information Being Requested:

«MostRecentRequestForMoreInfo.moreinforeq»

This information may be faxed to PRIUM at «project.doc_fax» or mailed to «project.doc_address» «project.doc_city», «project.doc_state» «project.doc_zip».

Please feel free to contact us with any questions.

Respectfully,
PRIUM

«cc» Attorney (if applicable)
Injured Worker

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

**Recommendation: CONDITIONALLY NON-CERTIFY
(INSUFFICIENT INFORMATION)**

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:

«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if requested health care services are medically necessary and appropriate for this claim. This letter is to notify you that the reviewer has determined that additional information is necessary prior to making a determination of medical necessity. The requesting physician has been contacted for the necessary information; however as of this date we have not received it.

At this time, we are closing this review due to lack of information. Pursuant to 8 CCR § 9792.9.1(f)(3)(A) – If the requested information, exam, test, specialized consultation, or review of medical information under 8 CCR § 9792.9.1(f)(1)(A-C) is not received, the reviewer shall deny the treating physician’s RFA with the stated condition that the requested will be reconsidered upon receipt of the requested information.”

If the requesting provider does submit the requested information in the future, we will reconsider the request.

Specific Treatment Plan Requested

«requestedtreatmentplan»

UR Determination

«authorizedtreatmentplan»

Clinical Rationale

«clinical_rationale» (Reviewer’s rationale listed here)

Criteria/Guidelines Applied

«guidelines»

Information regarding our optional reconsiderations process is attached to this determination letter.

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact PRIUM at «project.doc_phone» so that a convenient time may be arranged for this discussion. All reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. PST. Please feel free to contact us should you have any additional questions regarding this claim.

Respectfully,

(Reviewer's signature)

(Reviewer's printed name)

(Reviewer's state license number)

(Reviewer's board certification)

Enclosures: IMR form sent to: injured worker; requesting provider; applicant attorney, if applicable.

«cc» Attorney (if applicable)

Injured Worker

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***

PRIUM Reconsiderations Process

For any treatment request which was ***conditionally denied***, the treatment request will be reconsidered upon receipt of the requested information. The information may be faxed to PRIUM at «project.doc_fax» or may be submitted via mail to «project.doc_address» «project.doc_city», «project.doc_state» «project.doc_zip».

Additional Language required by California Labor Code and Regulations:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me «claim.examiner.FullName» at «claim.examiner.telephone». However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision. Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Medical Records Reviewed

The following is a list of documents reviewed:

«DocumentsReviewed»



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

Recommendation: MODIFY

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:

«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if the requested health care services are medically necessary and appropriate for this claim. This letter is to notify you of our determination regarding medical necessity:

Specific Treatment Plan Requested

«requestedtreatmentplan»

UR Determination

«authorizedtreatmentplan»

Clinical Rationale

«clinical_rationale» (Reviewer's rationale listed here)

Criteria/Guidelines Applied

«guidelines»

Information regarding our optional internal appeals and reconsiderations processes is attached to this determination letter.

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact PRIUM at «project.doc_phone» so that a convenient time may be arranged for this discussion. All reviewers are available for at least four hours per week during normal business days from

9:00 a.m. to 5:30 p.m. PST. Please feel free to contact us should you have any additional questions regarding this claim.

Respectfully,

(Reviewer's signature)

(Reviewer's printed name)

(Reviewer's state license number)

(Reviewer's board certification)

Enclosures: IMR form sent to: injured worker; requesting provider; applicant attorney, if applicable.

«cc» Attorney (if applicable)
Injured Worker

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***

PRIUM Reconsiderations Process

For any treatment request which was ***conditionally denied***, the treatment request will be reconsidered upon receipt of the requested information.

PRIUM Optional Internal UR Appeals Process

If the provider has not previously submitted an appeal for any treatment request which was ***modified*** or ***denied*** in this review, the patient or requesting provider has the option of submitting a request for an internal appeal on a voluntary basis. Participation in this optional internal appeals process neither triggers nor bars the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6. The request for the optional internal appeal must:

1. Be in writing; and
2. Be received by PRIUM within 10 days of the date of the original determination; and
3. Indicate if the appeal warrants an expedited review*; and
4. Contain either:
 - a. Additional information supporting the request; or
 - b. The basis or rationale for disagreement with the denial.

Appeal requests which do not match the above requirements will not be considered.

Appeals and/or Reconsiderations may be faxed to «project.doc_fax» or may be submitted via mail to «project.doc_address», «project.doc_city», «project.doc_state» «project.doc_zip».

* *Expedited appeals shall only be granted if:*

1. *the timeline for making a determination could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or*
2. *the patient would be in severe pain that could not be adequately managed without the care or treatment under review.*

Additional Language required by California Labor Code and Regulations:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me «claim.examiner.FullName» at «claim.examiner.telephone». However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the

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

Medical Records Reviewed

The following is a list of documents reviewed:

«DocumentsReviewed»



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

**Reconsideration Review
Recommendation: CERTIFY**

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:

«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if the requested health care services are medically necessary and appropriate for this claim. On «appealreview.decisionrendereddate», we completed Review «appealreview.Id» at which time a physician reviewer determined that we did not have enough information to make a determination on medical necessity.

Subsequent to that decision, we have received additional information and therefore asked a physician to re-review the treatment request. This letter is to notify you that based upon this reconsideration review the reviewer is recommending that the following health care services are certified as medically necessary:

Specific Treatment Plan Requested

«requestedtreatmentplan_without_dates»

UR Determination

«authorizedtreatmentplan» (Specific medical treatment or service approved)

Clinical Rationale

«clinical_rationale» (Reviewer's rationale listed here)

Criteria/Guidelines Applied

«guidelines»

Please feel free to contact us should you have any additional questions regarding this claim or if medical necessity substantiates further treatment.

Respectfully,

(Reviewer's signature)

(Reviewer's printed name)

(Reviewer's state license number)

(Reviewer's board certification)

«cc» Attorney (if applicable)
Injured Worker

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

**Reconsideration Review
Recommendation: NON-CERTIFY**

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:

«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if requested health care services are medically necessary and appropriate for this claim. On «appealtoreview.decisionrendereddate», we completed Review «appealtoreview.Id» at which time a physician reviewer determined that we did not have enough information to make a determination on medical necessity.

Following that decision, we received additional information and therefore asked a physician to re-review the treatment request. This letter is to notify you that the following health care services did not meet the established criteria for medical necessity:

Specific Treatment Plan Requested

«requestedtreatmentplan»

UR Determination

«authorizedtreatmentplan»

Clinical Rationale

«clinical_rationale» (Reviewer's rationale listed here)

Criteria/Guidelines Applied

«guidelines»

Information regarding our optional internal appeals process is attached to this determination letter.

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact PRIUM at «project.doc_phone» so that a convenient time may be arranged for this discussion. All reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. PST. Please feel free to contact us should you have any additional questions regarding this claim.

Respectfully,

(Reviewer's signature)

(Reviewer's printed name)

(Reviewer's state license number)

(Reviewer's board certification)

«cc» Attorney (if applicable)
Injured Worker

Attached: DWC Form IMR

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***

PRIUM Optional Internal UR Appeals Process

If the provider has not previously submitted an appeal for any treatment request which was **modified** or **denied** in this review, the patient or requesting provider has the option of submitting a request for an internal appeal on a voluntary basis. Participation in this optional internal appeals process neither triggers nor bars the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6. The request for the optional internal appeal must:

1. Be in writing; and
2. Be received by PRIUM within 10 days of the date of the original determination; and
3. Indicate if the appeal warrants an expedited review*; and
4. Contain either:
 - a. Additional information supporting the request; or
 - b. The basis or rationale for disagreement with the denial.

Appeal requests which do not match the above requirements will not be considered.

Appeals and information may be faxed to «project.doc_fax» or may be submitted via mail to «project.doc_address», «project.doc_city», «project.doc_state» «project.doc_zip».

** Expedited appeals shall only be granted if:*

- 1) *the timeline for making a determination could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or*
- 2) *the patient would be in severe pain that could not be adequately managed without the care or treatment under review.*

Additional Language required by California Labor Code and Regulations:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me «claim.examiner.FullName» at «claim.examiner.telephone». However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision. Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Medical Records Reviewed

The following is a list of documents reviewed:

«DocumentsReviewed»



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

**Reconsideration Review
Recommendation: MODIFY**

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:

«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if the requested health care services are medically necessary and appropriate for this claim. On «appealreview.decisionrendereddate», we completed Review «appealreview.Id» at which time a physician reviewer determined that we did not have enough information to make a determination on medical necessity.

Following that decision, we received additional information and therefore asked a physician to re-review the treatment request. This letter is to notify you of our determination regarding medical necessity:

Specific Treatment Plan Requested

«requestedtreatmentplan»

UR Determination

«authorizedtreatmentplan»

Clinical Rationale

«clinical_rationale» (Reviewer's rationale listed here)

Criteria/Guidelines Applied

«guidelines»

Information regarding our optional internal appeals and reconsiderations processes is attached to this determination letter.

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact PRIUM at «project.doc_phone» so that a convenient time may be arranged for this discussion. All reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. PST. Please feel free to contact us should you have any additional questions regarding this claim.

Respectfully,

(Reviewer's signature)

(Reviewer's printed name)

(Reviewer's state license number)

(Reviewer's board certification)

«cc» Attorney (if applicable)
Injured Worker

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***

PRIUM Reconsiderations Process

For any treatment request which was ***conditionally denied***, the treatment request will be reconsidered upon receipt of the requested information

PRIUM Optional Internal UR Appeals Process

If the provider has not previously submitted an appeal for any treatment request which was ***modified*** or ***denied*** in this review, the patient or requesting provider has the option of submitting a request for an internal appeal on a voluntary basis. Participation in this optional internal appeals process neither triggers nor bars the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6. The request for the optional internal appeal must:

1. Be in writing; and
2. Be received by PRIUM within thirty (30) days of the date of the original determination; and
3. Indicate if the appeal warrants an expedited review*; and
4. Contain either:
 - a. Additional information supporting the request; or
 - b. The basis or rationale for disagreement with the denial.

Appeal requests which do not match the above requirements will not be considered.

Appeals and/or Reconsiderations may be faxed to «project.doc_fax» or may be submitted via mail to «project.doc_address», «project.doc_city», «project.doc_state» «project.doc_zip».

* *Expedited appeals shall only be granted if:*

1. *the timeline for making a determination could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or*
2. *the patient would be in severe pain that could not be adequately managed without the care or treatment under review.*

Additional Language required by California Labor Code and Regulations:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me «claim.examiner.FullName» at «claim.examiner.telephone». However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the

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

Medical Records Reviewed

The following is a list of documents reviewed:

«DocumentsReviewed»



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

Review Cancelled

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:

«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if the requested health care services are medically necessary and appropriate.

Physician requesting authorization:

«physician.FullName»

Specific Treatment Plan Requested

«requestedtreatmentplan_without_dates»

We are hereby notifying you that we are canceling this review:

Person requesting the review be cancelled:

«LatestWithdrawal.Initiator», «LatestWithdrawal.Role»

Reason for the cancellation:

«LatestWithdrawal.Reason.Reason»

Please feel free to contact us with any questions.

Respectfully,

PRIUM

«cc» Attorney (if applicable)

Injured Worker

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

**Appeal Review
In Progress Notification**

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:

«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Dear «FullName»,

We have received a request for an appeal for the above referenced claim.

Physician requesting authorization:

«physician.FullName»

Specific Treatment Plan Requested

«requestedtreatmentplan_without_dates»

Please feel free to contact us should you have any additional questions regarding this review.

Respectfully,

PRIUM

«CC»

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

**Appeal Review
Recommendation: CERTIFY**

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:

«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if the requested health care services are medically necessary and appropriate for this claim. On «appealreview.decisionrendereddate», we completed Review «appealreview.Id» at which time a physician reviewer determined that the requested care did not fully meet the criteria for medical necessity.

Following that decision, we received an appeals request and therefore asked a different physician to re-review the treatment request. This letter is to notify you that based upon this appeal review, the reviewer is recommending that the previous determination be overturned, and that the following health care services are certified as medically necessary:

Specific Treatment Plan Requested

«requestedtreatmentplan_without_dates»

UR Determination

«authorizedtreatmentplan»

Clinical Rationale

«clinical_rationale» (Reviewer's rationale listed here)

Criteria/Guidelines Applied

«guidelines»

Please feel free to contact us should you have any additional questions regarding this claim or if medical necessity substantiates further treatment.

Respectfully,

(Reviewer's signature)

(Reviewer's printed name)

(Reviewer's state license number)

(Reviewer's board certification)

«cc» Attorney (if applicable)
Injured Worker

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

**Appeal Review
Recommendation: NON-CERTIFY**

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:

«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if requested health care services are medically necessary and appropriate for this claim. On «appealreview.decisionrendereddate», we completed Review «appealreview.Id» at which time a physician reviewer determined that the requested care did not fully meet the criteria for medical necessity.

Following that decision, we received an appeal request and therefore asked a different physician to re-review the treatment request. This letter is to notify you that the following health care services did not meet the established criteria for medical necessity:

Specific Treatment Plan Requested

«requestedtreatmentplan»

UR Determination

«authorizedtreatmentplan»

Clinical Rationale

«clinical_rationale» (Reviewer's rationale listed here)

Criteria/Guidelines Applied

«guidelines»

This decision completes the internal appeals process. You may contact your claims representative for information regarding any further appeal mechanisms.

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact PRIUM at «project.doc_phone» so that a convenient time may be arranged for this discussion. All reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. PST. Please feel free to contact us should you have any additional questions regarding this claim.

Respectfully,

(Reviewer's signature)

(Reviewer's printed name)

(Reviewer's state license number)

(Reviewer's board certification)

«cc» Attorney (if applicable)
Injured Worker

Attached: DWC Form IMR

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***

Additional Language required by California Labor Code and Regulations:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me «claim.examiner.FullName» at «claim.examiner.telephone». However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the Application for Independent Medical Review, DWC Form IMR-1 which was enclosed with the original decision letter. This form must be submitted within 30 calendar days of receipt of the original decision. Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Medical Records Reviewed

The following is a list of documents reviewed:

«DocumentsReviewed»



«CurrentDate»

«FullName»

«address.street1» «address.street2»

«address.city» «address.state» «address.postalcode»

**Appeal Review
Recommendation: MODIFY**

RE: Patient: «claim.patient.FullName»

Claim: «claim.claimnumber»

Date request was first received by «claim.organization.clientname»:

«receivedbyclienttimestamp_string»

Date request received by PRIUM: «DateReceivedByUR_string»

Date additional information received, if applicable: «DateAdditionalInfoReceived»

Decision date: «decisionrendereddate_string»

Dear «FullName»,

We have been requested by «claim.organization.clientname», to perform utilization review to determine if the requested health care services are medically necessary and appropriate for this claim. On «appealreview.decisionrendereddate», we completed Review «appealreview.Id» at which time a physician reviewer determined that the requested care did not fully meet the criteria for medical necessity.

Following that decision, we received an appeals request and therefore asked a different physician to re-review the treatment request. This letter is to notify you of our determination regarding medical necessity:

Specific Treatment Plan Requested

«requestedtreatmentplan»

UR Determination

«authorizedtreatmentplan»

Clinical Rationale

«clinical_rationale» (Reviewer's rationale listed here)

Criteria/Guidelines Applied

«guidelines»

Information regarding our optional reconsiderations processes is attached to this determination letter.

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact PRIUM at «project.doc_phone» so that a convenient time may be arranged for this discussion. All reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. PST. Please feel free to contact us should you have any additional questions regarding this claim.

Respectfully,

(Reviewer's signature)

(Reviewer's printed name)

(Reviewer's state license number)

(Reviewer's board certification)

Enclosures: IMR form sent to: injured worker; requesting provider; applicant attorney, if applicable.

«cc» Attorney (if applicable)
Injured Worker

***Utilization Review strictly analyzes the medical necessity of treatment requests.
PRIUM does not affirm the acceptance of this workers compensation claim.***

PRIUM Reconsiderations Process

For any treatment request which was ***conditionally denied***, the treatment request will be reconsidered upon receipt of the requested information. The information may be faxed to PRIUM at «project.doc_fax» or may be submitted via mail to «project.doc_address» «project.doc_city», «project.doc_state» «project.doc_zip».

PRIUM Optional Internal UR Appeals Process

For any treatment request which was ***modified*** or ***denied***, this completes the appeals process. Please contact the claims administrator with any questions.

Additional Language required by California Labor Code and Regulations:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me «claim.examiner.FullName» at «claim.examiner.telephone». However, if you are represented by an attorney, please contact your attorney instead of me.

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

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the Application for Independent Medical Review, DWC Form IMR-1 which was enclosed with the original decision letter. This form must be submitted within 30 calendar days of receipt of the original decision. Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Medical Records Reviewed

The following is a list of documents reviewed:

«DocumentsReviewed»

Customer Listing

Arrowpoint Capital
3600 Arco Corporate Drive
Charlotte, NC 28273

Robert Baer
(704) 522-2781

Murphy & Beane
5901 Green Valley Circle
Suite 145
Culver City, CA 90230

Rose De Leon
(310) 649-4470

Sierra Health and Life Insurance, Inc.
2716 N. Tenaya Way,
Las Vegas, NV 89128

Barbara Chakos
(702) 838-8241

Benchmark Administrators
(via Sierra Health and Life Insurance, Inc.)
430 N. Vineyard Ave
Ste 230
Ontario, CA 97764

Barbara Chakos
(702) 838-8241