NORTH CAROLINA PREAUTHORIZATION PLAN

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INTRODUCTION

This plan is intended to outline the policies and procedures for the North Carolina preauthorization program of any workers compensation insurance carrier or self-insured employer which utilizes TJ Holdings LLC, dba PRIUM, as its preauthorization agent in North Carolina.

Throughout this document, TJ Holdings, LLC, dba PRIUM, shall be referred to as "PRIUM." Any references in this document to "Carrier" shall refer to any workers' compensation insurance carrier or self-insured employer that has nominated PRIUM as its preauthorization agent.

This plan may be updated to reflect process and policy changes that affect the preauthorization review process.

DESIGNATED PREAUTHORIZATION AGENT

The Carrier's designated preauthorization agent in North Carolina is TJ Holdings, LLC, dba PRIUM (PRIUM). PRIUM is a URAC-accredited Workers' Compensation Utilization Review company engaged in utilization review and physician review services.

PROCEDURES AND SERVICES REQUIRING PREAUTHORIZATION

The Carrier requires that **all surgeries and inpatient treatments** be subject to the preauthorization process as described in this plan. The Carrier requires that authorization be requested prior to the rendering of any surgery or inpatient service, in accordance with 04 NCAC 10A. 1001. Any request for authorization of a surgery or inpatient treatment shall be classified under this plan as a "mandatory request." **Additionally, treatment that is subject to a preauthorization under the rules of the North Carolina Industrial Commission** – including, but not limited to the Rules for the Utilization of Opioids, Related Prescriptions, And Pain Management Treatment in Workers' Compensation Claims – shall be classified under this plan as a "mandatory

request."

Though the Carrier does not require that preauthorization be requested for outpatient services prior to the rendering of those services, providers or prescribers of outpatient services may request preauthorization of those services separately from or contemporaneously with mandatory requests. Any request for a treatment not qualifying as a "mandatory request" shall be classified under this plan as a "voluntary request."

APPLICABILITY

The process, as described in this plan, shall apply to both mandatory requests and voluntary requests for authorization of treatment in North Carolina workers' compensation claims.

HOURS OF OPERATION

PRIUM's review staff is available from 8:00 am eastern standard time to 8:00 pm eastern standard time on all business days. PRIUM personnel are available via email, toll-free phone and fax during these hours.

REVIEW SERVICE COMMUNICATION

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

INITIATION OF THE REVIEW PROCESS

Mandatory requests and voluntary requests should be communicated directly to PRIUM by mail or fax. Requests may be mailed to PRIUM at PO Box 190, Duluth, GA 30096. Requests may be faxed to PRIUM at (877) 800-9513.

In compliance with 04 NCAC 10A .1001(k), all requests must be submitted on the Industrial Commission Form 25PR. This form may be provided by the North Carolina

Industrial Commission. Additionally, the provisional Form 25PR is located at http://www.ic.nc.gov/forms/form25pr.pdf.

All assigned Peer Review Physicians must hold professional qualifications, certifications, and fellowship training in a like specialty that is at least equal to that of the treating provider who is requesting preauthorization of surgery or inpatient treatment. Multiple requests may be submitted on the same request document; however, in order to ensure that each request is reviewed by a clinical professional who is both qualified and sufficiently familiar with the treatment under review, PRIUM may assign requests to separate reviewers, even if those requests originate from the same request document.

Voluntary requests and mandatory requests may be submitted on the same request document.

Upon receipt of a request for authorization, PRIUM will provide a notice of initiation to the requesting provider within two business days of the date that PRIUM received the request document. The notice shall provide PRIUM's name, and the telephone number, fax number, and email address at which the provider may contact PRIUM.

REVIEWS

Once a valid request for utilization management has been received, it is assigned to a Peer Review Physician.

When documents are provided to PRIUM during the review process, PRIUM issues a response within two business days of receipt of those documents to acknowledge receipt.

PREAUTHORIZATION

Preauthorization Reviews are performed by Peer Review Physicians that:

1. hold an active, unrestricted license or certification to practice medicine or a health profession in one or more of the following jurisdictions:
    a. North Carolina,

b. South Carolina,
c. Georgia,
d. Virginia, or
e. Tennessee;

2. are located within a state or territory of the United States while conducting the peer review;
3. are qualified, by the Medical Director, to render a clinical opinion about the medical condition, procedures, and treatment under review;
4. hold professional qualifications, certifications, and fellowship training in a like specialty that is at least equal to that of the treating provider who is requesting preauthorization of surgery or inpatient treatment.

Questions about the qualification of an individual Peer Review Physician should be directed to the PRIUM Compliance Department by sending an email to compliance@prium.net.

Peer reviewers shall be available to discuss their determinations with the ordering providers and attending physicians. The peer reviewer may approve, deny or modify a request.

RECONSIDERATIONS

When a determination is made to deny the request, PRIUM provides the opportunity for the requesting physician or service provider, within one business day of receiving the request to discuss the determination with the peer reviewer that made the determination; or with a different peer reviewer, if the original peer reviewer is unavailable.

This reconsideration differs from a formal appeal of the determination. Reconsiderations are an optional, pre-appeal measure that may be requested by the attending physician or ordering provider.

Because the reconsideration process is a pre-appeal process, the right to request a reconsideration expires (1) when an appeal has been requested or (2) when the deadline

for requesting an appeal has passed.

If a reconsideration does not result in certification of a request for authorization, the , and PRIUM shall inform the provider and the claimant of their right to appeal and the process necessary to initiate the appeal.

Peer Review Physicians performing reconsideration reviews shall be available to discuss their determinations with the requesting physician or service provider.

APPEALS

All determinations to modify or to deny a requested treatment are appealable through PRIUM's internal appeals process.

An appeal may be requested only within 30 days of the requestor's receipt of the determination from which appeal is sought.

Peer Review Physicians performing appeal level reviews shall be available to discuss their determinations with the requesting physician or service provider.

There are two types of appeals: standard and expedited. Expedited appeals are for those cases involving urgent care. All appeals follow PRIUM's internal appeals policies and procedure, which are outlined below.

INITIATION OF AN APPEAL

All determination documents which deny or modify a request contain the following, or similar language:

"If you wish to appeal this decision, please submit your request to PRIUM, with any additional supporting documentation within 30 days. All requests for a secondary review must be submitted in writing to the address, email address, or FAX number listed above. Your written appeal will be reviewed in accordance with PRIUM's Internal Utilization Review Appeals Process. Participation in this process is entirely on a voluntary basis. Authorization for the denied treatment may be sought from the North Carolina Industrial Commission."

PRIUM allows the physician, service provider facility, claimant or claimant's attorney to initiate the appeals procedure by submitting a written request for an appeal. Requests for appeal may be submitted to phone number, fax number, or email address provided in the determination letter.

An initial adverse determination may only be appealed once, regardless of the number of appeal requests received or the number of requestors seeking an appeal of that determination.

SUBSEQUENT APPEAL OR RECONSIDERATION

An appeal determination is not subject to further internal appeal. An appeal decision is not subject to reconsideration.

A determination rendered on appeal is not subject to further review under PRIUM's internal process, but authorization for the treatment denied on appeal may be sought from the workers' compensation insurance carrier or from the Industrial Commission.

APPEAL REVIEWER QUALIFICATIONS

Appeal reviewers for a specific case must meet the following requirements:

1. hold an active, unrestricted license or certification to practice medicine or a health profession in one or more of the following jurisdictions:
    a. North Carolina,
    b. South Carolina,
    c. Georgia,
    d. Virginia, or
    e. Tennessee;
2. be located within a state or territory of the United States while conducting the peer review;
3. be qualified, by the Medical Director, to render a clinical opinion about the medical condition, procedures, and treatment under review;
4. hold professional qualifications, certifications, and fellowship training in a like specialty that is at least equal to that of the treating provider who is requesting

preauthorization of surgery or inpatient treatment

5. may not be the same individual who made the original non-certification, or a subordinate of that individual

TIMEFRAMES

PROSPECTIVE REVIEW

1. Pursuant to 04 NCAC 10A .1001(l), determinations shall be rendered on requests for authorization within seven business days from the date that the request is received by PRIUM, unless an extension is granted, in which case, the determination shall be rendered prior to the expiration of the additional time permitted by the extension.

APPEALS

1. Standard Appeal Process Time Frame
    a. Standard appeals are completed, and written notification of the appeal decision issues within 30 calendar days of the receipt of the request for appeal to the patient or patient's attorney (if applicable), and to the attending physician or other ordering provider or facility rendering service.

2. Expedited Appeal Process Time Frame
    a. Expedited appeals are completed with verbal notification of determination to the requesting party within 72 hours of the request followed by a written confirmation of the notification within 3 calendar days to the patient or patient's attorney (if applicable) and attending physician or other ordering provider or facility rendering service.

EXTENSIONS

Pursuant to 04 NCAC 10A .1001(l), the Carrier/PRIUM may be granted an extension in the following two ways:

1. By grant of the Industrial Commission pursuant to GS 97-25.3(a)(3).
    a. Requests made in this way shall be directed to the Office of the Executive Secretary, and shall be simultaneously copied to the requesting health provider (if any) and to the claimant's attorney (if the claimant is represented) or the claimant (if the claimant is unrepresented).

2. By agreement between the Carrier (or PRIUM) and the individual or entity requesting authorization; however, by no means shall an extension granted in this way provide more than an additional seven business days.

DETERMINATION DOCUMENTS

All determination documents contain the demographic information necessary for the requesting party to identify the original requests and the claimant. They also contain a peer review (PR) number and/or a PRIUM file number assigned by PRIUM for tracking purposes.

Any adverse determination will provide a statement with supporting documentation of the substantive clinical justification for a denial of preauthorization, including the relevant clinical criteria upon which the denial is based. Denials based upon lack of information shall specify what information is needed to make a determination.

CERTIFICATIONS

If the certification is for continued hospitalization or continued services, the decision document shall include the number of days; units of service, the next anticipate review point, the new total number of days or services approved, and the date of admission or onset of services.

REVERSAL OF CERTIFICATION DETERMINATIONS

PRIUM does not reverse a certification determination unless it receives new information that is relevant to the certification which was not provided at the time of the original

certification.

NON-CERTIFICATIONS

Determination letters to modify or deny a requested treatment contain:

1. The principal reasons for the determination to deny or modify;
2. The clinical rationale used in making the determination or, alternatively, a statement that the clinical rationale used in making the decision will be provided upon request;
3. Instructions for
    a. Initiating an appeal of the determination; and
    b. Requesting the clinical rationale for the determination
4. Any other disclaimers required by law.

The Compliance Department is responsible for maintaining up to date delivery and notification rules for all types of determination documents.

APPEAL DETERMINATION DOCUMENTS

The appeal determination document will state:

1. The principal reasons for the determination;
2. The clinical rationale used in making the determination or, alternatively, a statement that the clinical rationale used in making the decision will be provided upon request;
3. Any other disclaimers required by law.

MEDICAL TREATMENT GUIDELINES

PRIUM utilizes scientifically valid, evidence-based medical treatment guidelines in the review of workers compensation treatment requests to determine medical necessity and appropriateness. The most current edition of the *Official Disability Guidelines-Treatment in Workers' Comp* (ODG) published by MCG, is the primary source of treatment guidelines used by PRIUM. The American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines are utilized as a secondary source of guidelines.

In compliance with 04 NCAC 10A .1001(c), PRIUM or the Carrier shall upload a link to the guidelines used by PRIUM to ftp://ftp.ic.nc.gov by July 1 of each year. In the event that the Industrial Commission's site is unable to receive this submission, a link to the guidelines may be provided, upon request by contacting PRIUM.

Additionally, the Official Disability Guidelines may be found at http://www.odgtreatment.com/. The ACOEM Practice Guidelines may be found at https://www.mdguidelines.com/acoem.

SCOPE OF REVIEW INFORMATION

In order to maintain an effective and efficient review process, PRIUM accepts additional information that will assist in the review process. Such information may be provided by the party requesting authorization or by the insurance carrier.

PRIUM attempts to collect only the information needed to evaluate the request and does not request all of the medical records on the patient. Often times, the physician's office, or insurance carrier, will provide PRIUM with the complete medical file on the claimant. In that case, PRIUM staff will sort and categorize the documents needed to make the determination and return or destroy the remaining documentation.

LACK OF INFORMATION

There may be times when there is not enough information to make a determination on a request. In those instances, prior to issuing a denial for lack of information, PRIUM staff must contact the Carrier or access the Carrier's claim system to attempt to obtain the required information.

Additionally, PRIUM shall make the reviewers available for discussion with the requesting provider, in compliance with URAC requirements.

If none of these options are successful in producing the information necessary to make a determination, PRIUM shall deny the request for lack of information. This denial must contain the standard appeals language as well as the process for reconsideration. A

denial for lack of information is submitted in the same manner as any other denial with the exception that denials based upon lack of information shall specify what information is needed to make a determination.

The timeframe for a denial for lack of information is the same as the required timeframe for any other denial.

MEDICAL DIRECTOR

PRIUM's Medical Director, is responsible for all preauthorization determinations rendered by PRIUM. PRIUM's Medical Director is identified below:

Name: Dr. Joseph Hayes
Phone: 888-588-4964
Fax: 877-918-1888
Email: customersupport@prium.net
Hours: 9:00 a.m. – 5:00 p.m.
Time zone: Eastern

FINANCIAL INCENTIVE POLICY

PRIUM does not employ a system of reimbursement, bonuses or incentives to staff or contractors based directly on consumer utilization of services.

REVISION APPROVAL PAGE

The preceding Preauthorization Plan, having been reviewed in its entirety by the appropriate personnel PRIUM, is hereby approved, effective as of the date signed below, and shall be utilized in the conduct of the business of the company until such time as it is revoked, unless further modified on an interim basis in accordance with the requirements of PRIUM or the requirements of the Carrier as communicated to PRIUM by the Carrier.

June 28, 2018

Ben Roberts,
Executive Vice President