Workers' Compensation Utilization Management Plan

State of California

July 2024

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OVERVIEW

CorVel is an organization that provides services to the employer community and insurance industry, focusing on workers' compensation claims. Our Utilization Management Program provides prospective, retrospective, and concurrent review of treatments and services to determine the medical appropriateness of care, as well as the frequency, duration and setting. We are able to provide outstanding Utilization Management services due to our experienced staff, which includes our Medical Director, Utilization Review Case Managers and a large panel of Board-Certified Physician Reviewers. Our program is enhanced by our technology and the use of nationally recognized medical treatment protocols. The goal of our utilization management program is to provide medical care that renders positive outcomes and ensures high quality, timely, cost-effective medical care for injured workers, while avoiding unnecessary, unsafe or inappropriate medical treatment. This Utilization Plan is available to the public upon request and is also available on CorVel's website, www.corvel.com.

UTILIZATION REVIEW PROCESS

Utilization Review, Utilization Management and Pre-certification are all terms commonly used interchangeably within the industry when denoting processes for the review of medical necessity and appropriateness of medical treatment. California LC §4610 states "utilization review process" means utilization review or 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." Utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were actually billed.

CorVel complies with all aspects of the utilization review standards established by California Labor Code regarding Utilization Review Standards within the state of California for workers' compensation. CorVel monitors these standards and will make material modifications to our Utilization Review Plan and processes when indicated by change(s) in the Utilization Review Standards for California workers' compensation or as influenced by best practices within our organization and the industry. CorVel will submit a modified utilization review plan to the Administrative Director within 30 calendar days of any material modification to our plan.

Where CorVel utilizes vendors for clinical expertise such as physician case review within the Utilization Review process, CorVel does not offer, provide, nor accept any incentive or consideration from any party based on the number of modifications, denials or outcomes from the Utilization Review process. Full disclosure is noted in Appendix A.

KEY UTILIZATION MANAGEMENT FEATURES

- The CorVel Medical Director has direct oversight and responsibility for all UR decisions and processes. The CorVel Medical Director oversees all aspects of this plan, including auditing and answering questions from case managers and peer review physicians. The Medical Director is available to discuss all Utilization Review determinations with providers.
- The CorVel Medical Director is Board Certified, see appendix B.
- The CorVel Medical Director can be reached Monday through Friday from the hours of 9:00am – 5:30pm via telephone at 714.385.8500.
- The mailing address to contact the Medical Director is:

  1920 Main Street, Ste 900

  Irvine, CA 92614
- In accordance with regulation 9792.9.1(e)(5)(k) should the requesting physician wish to speak to the reviewing physician regarding a determination; they can call 714.385.8500 from 9:00 AM – 5:30pm PST, Monday through Friday. Should the reviewing physician be unable to speak with you, another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services will be made available.
- Medical treatment plans are initially reviewed by a Utilization Reviewer using evidence based Medical Guidelines and the clinical findings as outlined by the treating provider. All Guidelines utilized will be the most current versions available. As the state of California amends or changes the guidelines approved for Utilization Review, CorVel will automatically update guidelines accordingly. CorVel utilizes Medically Based Guidelines online via a web-based browser; these guidelines are automatically updated by the vendors. Any guidelines utilized that are not available online will be reviewed annually and updated as new editions become available.
- Guidelines utilized include, but are not limited, to the following:
  - Medical Treatment Utilization Schedule (MTUS) is utilized as primary guideline, unless "silent" on requested treatment or condition, then below guidelines are utilized.
  - ACOEM – Medical Practice Guidelines, American College of Occupation & Environmental Medicine.
  - Official Disability Guidelines – Work Loss Data Institute.
  - Other evidenced based guidelines as deemed relevant.
- Any treatment request initially reviewed by a utilization reviewer that fails to meet Standards of Care / evidence-based guidelines is referred to a peer review physician.
- Only a Physician Reviewer will make a determination to deny or modify a treatment request by a treating provider.
- Physician reviewers will base their decisions on the California Medical Treatment Utilization Schedule (MTUS). If the treatment or condition is not addressed by the MTUS Guideline, the Physician Reviewers will base their decisions on other evidence based, scientific, nationally recognized treatment guidelines.
- Treatment requests that are certified will be eligible for reimbursement based on the fee schedule and/or contacted rates by the payor or their designate.

- Patient channeling may occur to Diagnostic Imaging, DME and other select preferred provider organizations when indicated by client instructions or in the event the employer has an active MPN in place.
- The Utilization Review process is mandatory and has been done in accordance with California Labor Code §4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.6.1.
- When a treatment is denied during a concurrent review, the treatment will continue until the treating physician is notified of the denial, and an alternative care plan is agreed on that is appropriate for the injured worker's medical condition.
- Utilization Review letters of determination are sent to the provider, claimant, applicant attorney and claims administrator in accordance with the California Utilization Review Regulations noted in §9792.9.1(d) (2) for approvals (physician) and (e) (5) for denials (physician, employee, employee's representative or counsel).
- Should a requesting physician seek authorization for treatment that may be appropriate however, the specific request appears to exceed the recommended treatment under MTUS, the Utilization Review Reviewer may offer a choice to the requesting physician: The requesting physician may voluntarily resubmit the authorization request for (the number of treatments) within the CA Medical Treatment Utilization Schedule (MTUS), or the request can be forwarded to the Physician Reviewer for review.
- Where the DWC Form RFA is lacking information as required in 9792.9.1(c)(2)(A) and the information that is missing or incorrect prevents the UR process from continuing within the timeframes provided, the UR department will mark it "not complete" and return the RFA Document to the adjuster/customer advising the need to notify provider of missing information no later than 5 business days from receipt. In no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization by the health care provider. If the reasonable information requested by the claims adjuster is not received within 14 days from date of the original written request by the requesting physician, a reviewer may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested. Prior Authorization is the claims administrator's practice of any prior authorization process, including but not limited to where authorization is provided without the submission of the RFA or DWC Form RFA.
- Below is Corvel's Prior Authorization Process:

Employer approved:

Upon confirmation with the employer (*specific contact*) designated provider is approved to initiate the following medical treatment without submitting a Request for Authorization form. Subsequent treatment requests beyond initial visits will be submitted to CorVel in compliance with the California Utilization Review plan.

Criteria for Initial Treatment:

- Initial 6 visits of Physical therapy, acupuncture, chiropractic treatment
- X rays performed on site at provider facilities
- Soft DME or medical supplies required to stabilize patient pending referral to consult or for immediate medical needs.
- First fill (4-day supply) of medications reasonable to cure or relieve acute injury.
- Referrals to specialists for emergency evaluation or treatment
- Any procedures needed for wound care, inclusive of emergency surgery, sutures, casting or splinting as medically appropriate.

- Injections: anesthetic as needed for procedures above, or tetanus booster

- For orthopedic injuries, a provider specifically designated for this purpose is approved to order MRIs without submitting a request for authorization.

- Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

- Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

INITIATING UTILIZATION REVIEW AND REPORTING PROCEDURES

When Utilization Review Activities Should Be Initiated

Utilization review activities should be initiated immediately when the claims administrator receives a request to authorize inpatient or outpatient services identified in the employer's policies and procedures as requiring utilization review. The types of requests may include, but are not limited to:

- Diagnostic Studies (CT, MRI, EMG, etc.)
- Physical and Occupational Therapies
- Durable Medical Equipment
- Chiropractic Care
- Surgery
- Assistant Surgeons

Please see attached 'Sample Recommended Utilization Review Criteria'.

Process for Initiating and Ending the Activity

The process can be initiated via telephone (followed by faxed or emailed medicals and RFA within 24 hours), facsimile, electronic data interface or via email by the claims professional, employer, requesting provider, or facility; whichever method is most convenient and efficient on a case-by-case basis. The initial screening is completed by our administrative staff who will complete the data entry part of the process in Care MC. They will then assign it to a UR nurse for review. The UR nurse will review the RFA and approve at the nurse's level if medical necessity is established. If the UR nurse is unable to approve, it will be referred to a Peer Physician for review. Once the Physician Reviewer makes the UR decision, they send the report over to the UR nurse to upload into the case. This report will be attached to the determination letter that is generated through Care MC. The activity is ended once the utilization determination is made and all parties are notified of determination.

Reporting Procedures and Frequency

Once a utilization review determination has been made the requesting provider will be notified of the utilization review decision via phone or fax within 24 hours of the UR determination. Letters of determination will be sent to the claims professional, provider, applicant attorney and claimant within 24 -hours for concurrent review determination and within two (2) business days for prospective and retrospective review determinations.

TIMEFRAMES FOR NOTIFICATIONS

Prospective or concurrent determinations shall be made in a timely fashion that is appropriate for the nature of injured worker's condition, not to exceed five (5) working days from the date of receipt of the written request.

CorVel will only request the reasonable and pertinent medical information necessary to determine medical appropriateness and necessity of the treatment being requested by a treating physician.

Section 9792.9.1 (f) states:

(f)(1) The timeframe for decisions specified in subdivision (c) may only be extended under one or more of the following circumstances:

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

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

(C) The reviewer needs a specialized consultation and review of medical information by an expert reviewer.

(2)(A) If the circumstance under subdivision (f)(1)(A) applies, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization.

(B) If any of the circumstances set forth in subdivisions (f)(1)(B) or (C) are deemed to apply 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.

(3)(A) If the information reasonably necessary to make a determination under subdivision (f)(1)(A) that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

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

(4) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or 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. The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision The written decision shall include the date the information was received and the decision shall be communicated in the manner set out in section 9792.9.1(d) or (e), whichever is applicable to the requesting physician, injured worker, applicant attorney, defense attorney, and the claims administrator.

(5) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent decisions related to an expedited review, shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information. The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision. The written notice of decision shall include the date the requested information was received and be communicated pursuant to subdivisions (d)(2) or (e)(3), whichever is applicable.

(6) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or reviewer, for retrospective review, 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 be communicated pursuant to subdivisions (d)(3) or (e)(4), whichever is applicable.

(7) As per §9792.9.1(c)(1)&(2)(A), unless additional information is requested necessitating an extension under subdivision (f), the utilization review process shall meet the following timeframe requirements:
(1) The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA.

TYPES OF UTILIZATION REVIEW SERVICES

EMERGENCY HEALTH CARE SERVICES

Emergency health care services refers to 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.

Emergency admissions and/or Emergency Outpatient Treatment do not require pre-certification, emergency care should be sought immediately by dialing 9-1-1 or by sending the injured worker to the closest emergency room in the most expeditious manner possible. Emergency Care Services may be reviewed retrospectively.

EXPEDITED REVIEWS

Expedited review applies to utilization review conducted where 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. Expedited reviews will be completed within 72 hours or less if the injured worker's condition warrants a shorter timeframe.

CONCURRENT REVIEW

Concurrent review applies to utilization review conducted during an inpatient stay. Review is initiated upon notification to the utilization reviewer of the admission. Plan of care must be submitted by the provider, hospital or reasonable alternative care provider, in writing and signed by a physician. Once notification of an inpatient admission has been received by CorVel, the following will occur:

- 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. If they don't agree, the requesting physician may request for an appeal within 10 calendar days from the date of the decision.
- Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.

RETROSPECTIVE REVIEW

Retrospective review of admission/treatment can be provided at the request of the claims administrator when a patient has had medical treatment, which was not pre-certified.

- Request for retrospective review may be received by the utilization reviewers by telephone (followed by emailed/ or faxed RFA and medicals to support treatment within 24 hours), FAX, or electronic means.
- The utilization reviewer requests copies of pertinent medical records for review, limiting the information to only that necessary for the medical necessity determination.
- The medical records are sent to a physician consultant who is Board Certified in the same medical specialty as the attending physician, or in a similar specialty that typically manages or treats the medical situation in question. Only a physician consultant may modify or deny these requests for authorization.

When review is retrospective, decisions 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 the request for authorization and medical information that is reasonably necessary to make this determination.

All retrospective utilization review requests will be reviewed in accordance with the California Medical Treatment Utilization Schedule (MTUS) as primary guideline. If treatment or condition is not addressed by MTUS, other nationally recognized evidence-based standards of care guidelines will be utilized.

PROSPECTIVE REVIEW

"Prospective review" means any utilization review conducted, except for those outlined above, prior to the delivery of the requested medical services.

Letters certifying, denying, or modifying the proposed treatment or service shall be sent within 24-hours from the decision for urgent/emergent treatment, and within two (2) business days for prospective requests and will have the date the decision was made by the physician.

MEDICATION REVIEW

Requests for medication reviews will be performed at the request of the claims payer. The requested medication will be reviewed in accordance with the CA Medical Treatment Utilization Schedule (MTUS) and MTUS Drug Formulary guidelines. "MTUS Drug Formulary" means the MTUS Drug List set forth in section 9792.27.15 and the formulary rules set forth in sections 9792.27.1 through 9792.27.23. If the treatment or condition is not addressed by MTUS, other nationally recognized evidence-based standards of care guidelines will be utilized. Medications recommended in the CA Medical Treatment Utilization Schedule (MTUS), or other nationally based standards of care guidelines, may be approved by a Registered Nurse Reviewer.

All requests for narcotics or other scheduled medications not addressed in the MTUS Formulary will be referred to a Physician Reviewer for determination of appropriateness. In the event that a Physician Reviewer determines the medication is not medically necessary or appropriate he or she will attempt to contact the requesting provider to discuss an alternate plan of care.

Where a recommendation of non-certification of a medication is issued, the mandatory language noted within the Utilization Review regulations will be addressed. Where cessation of the medication is identified by the reviewing physician as having potential safety/adverse consequence, the determination will also include language advising against abrupt cessation and requirement to follow standards of care.

A generic may be substituted for therapeutic equivalent brand name drug pursuant to state and federal law. Brand name drugs must be authorized through prospective review prior to being prescribed. Exempt medications may be prescribed without authorization through prospective review if they are prescribed in accordance with the MTUS Treatment Guidelines. Access to medications not listed as exempt on the MTUS Drug Formulary is allowed if the prescribing physician seeks authorization through prospective review and demonstrates appropriate medical necessity.

Non-exempt drugs and unlisted drugs require authorization through prospective review. The MTUS Drug List identifies drugs that are subject to the Special Fill policy. Under this policy, a drug that usually requires prospective review because it is "Non-Exempt," will be allowed without prospective review as specified in subdivision pursuant to section 9792.27.12 may waive prospective utilization review requirements.

LETTERS OF UTILIZATION REVIEW DETERMINATION

In compliance with California Labor Code §4610, written communication regarding pre-certified treatments or services shall clearly specify the treatment service approved. Letters of approval will be indicated by a certification determination. For all decisions, (including approvals, denials, and modifications) the requesting physician will be notified by phone or fax within 24 hours of the determination. Facilities are considered non-physician providers of goods and services, and therefore will be provided a "decision" only, without rationale or guidelines. For approvals, the communication by telephone or fax 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 and for expedited review within 72 hours of receipt of the request. Any decision to modify or deny will be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, with the same timeframes above applied. When the review is retrospective, all decisions 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 the medical information that is reasonably necessary to make this determination (Section 9792.6.1(d)&(e)). "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.

Written notices will include the following information:

- The date on which the DWC Form RFA was first received.
- The date on which the decision is made.
- A description of the specific course of proposed medical treatment for which authorization was requested.
- A list of all medical records reviewed.
- A description of the specific course of proposed medical treatment for which authorization was approved, if any.
- A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section 9792.8. If a utilization review decision to modify or deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.
- The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee, must be completed by the claims administrator. The written decision provided to the injured worker, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee. Prior to March 1, 2014, any version of the DWC Form IMR adopted by the Administrative Director under section 9792.10.2 may be used by the claims administrator in a written decision modifying or denying treatment authorization.

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

- Include the following mandatory language advising the injured employee:

  "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me." And "For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

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

- 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.

NON-CERTIFICATION PROCEDURES (DENIALS)

Only a CorVel Physician Reviewer will make a determination to deny or modify a treatment request by a treating provider.

- The requesting physician/physician office is contacted via phone or fax and notified of the non-certification determination; medical rationale and the letters will be sent with the CorVel appeals process within 24-hours in the case of Concurrent Hospital Review or within two (2) business days for Prospective Reviews.

- CorVel will send formal non-Certification letters to the requesting physician, facility, claims administrator, claimant and applicant attorney within 24-hours for concurrent reviews, and within two (2) business days for prospective review determinations.

- Non-Certification determination letters sent to the facility will not include medical rationale or medical information.

- The letters of non-certification will have all the mandated language noted under Labor Code §4610.

- All letters to modify or deny a treatment request will include the name, phone number, contact information and the hours of availability of the Physician Reviewer that rendered the determination.

- The written UR denial or modification of treatment request must be sent to the IW, requesting physician and all parties with an "Application for Independent Medical Review", DWC Form IMR with all fields, except for the signature of the employee. We will also include an addressed envelope to the injured worker.

Efforts to obtain the necessary and reasonable information (including a request for a test, exam or specialty consultation) from the requesting physician prior to a UR denial will be documented in accordance with 8 CCR9792.9.1(g).

CORVEL UTILIZATION REVIEWER RECOMMENDATIONS

CorVel utilization reviewers are trained to make recommendations to claims examiners regarding necessity of treatment utilizing nationally accepted, medically based criteria. Medical Criteria will be evidenced based, evaluated at least annually and will be the most current edition available to the public. CorVel's criteria used in the utilization management process may include, but is not limited to:

- California Medical Treatment Utilization Schedule (MTUS) is utilized as the primary guideline, unless silent on a requested treatment or condition, then the guidelines below will be utilized.
- ACOEM – Medical Practice Guidelines, American College of Occupation & Environmental Medicine.
- Official Disability Guidelines – Work Loss Data Institute.
- Other evidence-based guidelines as deemed relevant.

When the utilization reviewers question the medical necessity of the treatment, the case is referred to a Physician Reviewer for review. The Physician Reviewer makes a determination to approve, modify or deny treatment.

INTERNAL APPEALS PROCESS

The appeals process is on a voluntary basis 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. Should the requesting medical provider wish to appeal the non- certification or modification decision, and/or have additional pertinent clinical information, which has not previously been submitted for review, you may submit a request for appeal to CorVel Corporation or the claims administrator. This will be reviewed by a different reviewing physician. Requests for appeal need to be sent to CorVel Corporation or the claims administrator immediately in order to render a decision on appeal within (10) ten days of the date of the original utilization review decision. A response to your appeal will be rendered within the 30 calendar days' timeframe as allowed by 9792.10.1(d). Requests for appeal do not replace the objection process noted above (IMR) and are voluntary. We will not accept a request for appeal that has exceeded the 10 days from the original utilization review decision.

INDEPENDENT MEDICAL REVIEW PROCESS

For injuries occurring on or after January 1, 2013, and for all requests made on or after July 1, 2013 for all dates of injury, the language on adverse determination letters will reflect the current Labor Code or Regulation requirements:

- Please note the utilization review process is mandatory and has been done in accordance with California Labor Code §4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.6.1.
- Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 10 calendar days after the service of utilization review decision to the employee for formulary disputes, and within 30 calendar days after the service of the utilization review decision to the employee for all other medical treatment disputes.

- You have the right to disagree with the decision affecting your claim. If you have questions about the information in this notice, please call your adjuster, {name}, at {number}. However, if you are represented by an attorney, please contact your attorney instead of your Adjuster.
- For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.
- 9792.10.1(d) states:

  "Nothing in this section precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the employee and, if the employee is represented by counsel, the employee's attorney, have been notified of the 30 -day time limit to file an objection to the utilization review decision in accordance with Labor Code sections 4610.5 and 4610.6. Any internal utilization review appeal process conducted under this subdivision must be completed within (ten) 10 of the date of utilization review decision."
- You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.
- Should the requesting physician wish to speak to the reviewing physician regarding this determination, you can call (714) 385-8500 to arrange an agreed upon scheduled time between the hours of 9:00 a.m. and 5:30 p.m. Monday through Friday (PST). Should the reviewing physician be unable to speak with you, another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services will be made available.

CONFIDENTIALITY

It is the policy of CorVel that all patient specific information collected be limited to that information reasonably necessary for the claims administrator to adjudicate the claim and used solely for the purpose of Utilization Review, Quality Management, Discharge Planning and Case Management. Such medical information shall be kept confidential in accordance with applicable federal and state law.

Patient-specific information is shared with only those agents who have authority to receive such information. Patient specific information is defined as that information sufficient to allow identification of the individual patient/claimant.

Procedures to ensure confidentiality include:

- Each utilization reviewer is given access to CorVel's Care^{MC} system through the use of a sign-on and a user-specific password.
- Patient-specific information is entered into the system for utilization review, discharge planning, case management and quality management purposes only.
- Patient specific information is released only to the claims administrator and to treating and consulting physicians. Any other request for patient-specific information is referred to the claims administrator.

- Any hard copy of claimant/patient information is managed electronically to authorized users.

Each person performing utilization review services signs a confidentiality statement on the date of hire. This information is maintained in the personnel file of the employee.

RETENTION OF RECORDS

CorVel maintains the records generated by its staff in the utilization review process, any correspondence sent to or received from involved parties, and all reasonably necessary medical records received by CorVel to complete the requested review, for a period of not less than five (5) years. These records are stored by using electronic means, including storage in our Care^{MC} software.

STAFF QUALIFICATIONS

CorVel quality assurance begins with the hiring of the appropriate individuals for its utilization review staff. CorVel employs only professional utilization reviewers to perform utilization review services.

The goals are to:

- Assist in the continuing development and operation of the CorVel pre-certification and utilization review services.
- Meet quality standards for utilization management to ensure delivery of an accurate, cost-effective service for CorVel customers.

The following are the qualifications:

Utilization Review Department Nurses:

- Minimum Licensure Requirements: Current, Active Nursing License
- Minimum of three years clinical experience in one or more of the following fields of nursing:
  - Medical/Surgical
  - Occupational Health
  - Orthopedic
  - Psychiatric
  - Neurosurgical
  - Utilization Review
- CorVel urges all professional staff to obtain certification in one of the nationally recognized nursing and/or case management fields.

Peer Reviewer: Physician Consultants

CorVel contracts on a case-by-case basis with Physicians Advisors, who have a current active medical practice, 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 are Board Certified in a medical specialty (ies), and who meet our credentialing requirements. These Physician Reviewers or Consultants perform reviews of requests for authorization within their specialty areas.

CorVel verifies URAC accreditation for all Peer Reviewer, Physician Consultants. The following are our current reviewing companies:

- Physicians and Surgeons, Network, Inc
- Dane Street
- Network Medical Review Co.
- PBMM (Physician Based Medical Management)

Physician disclosures to confirm no remuneration based on outcomes of UR as stated in Appendix C.

CREDENTIALING

Peer Review Physician groups that provide Physician Review services to CorVel are responsible for the credentialing process of its providers and ensuring that all of its members meet the above noted minimum criteria. Each Physician Group will be required to supply updated credentialing information to the CorVel office they provide services to when a change in provider status occurs.

Each CorVel office that utilizes Peer Review services will be responsible for the credentialing process noted above and for having a copy of the most recent Physician and Peer Group Provider credentialing information on file.

Duties of the Physician Reviewer include:

- Conduct clinical review of medical records to determine the medical necessity of treatment and or length of stay (Prospective, concurrent, retrospective) based on the pertinent guidelines.
- Communicate with attending physicians by telephone or fax as requested.
- Provide CorVel with a written report of the review within one business day.
- Provide clinical consulting to the utilization review staff as requested.
- Be reasonably available to discuss by telephone the determination with the attending physician and/or other ordering providers.
- Adherence to California Labor Code and other standards, including review procedures, time frames for reviews, accessibility, and confidentiality.

TRAINING PROGRAM FOR UTILIZATION REVIEW STAFF

CorVel has a formal orientation and training program for utilization reviewers. Topics included are:

- California Labor Code and Other Standards
- Utilization Review Process and CorVel Methodology
- Care[MC] Software Used in Utilization Review
- Protocols/Guidelines Used in Utilization Review
- Training Manual (includes Policies and Procedures)
- CorVel Customers

The time frame for orientation may vary according to the experience and ability of each individual. It is expected that the individual will be proficient and productive within one month of hire or contract date.

CONTINUING EDUCATION

CorVel provides continuing education for its employees, including utilization review staff, through formal staff meetings and informal in-service presentations to address company policy, utilization review processes, new customer information, and staff needs as identified by the Quality Management program.

CorVel posts notification of community based continuing education programs. CorVel will assist with tuition according to procedure published in the CorVel Employee Handbook.

The CorVel Medical Director is available to discuss specific cases, diagnoses, and procedures for individual utilization review reviewers as requested.

QUALITY MANAGEMENT PROGRAM

GOAL

To ensure the competency of CorVel utilization reviewers and the review decisions made so that the service provided to CorVel customers meets their specific needs without reduction in the quality of care and medical service provided to the patients. Results of Quality Assurance Reviews are communicated to the Quality Assurance Committee.

OBJECTIVES

- Establish a mechanism for monitoring the service provided
- Promote a high level of professionalism among the utilization review staff
- Document patterns of review decisions that impact on patient treatment and care
- Identify problem areas, establish priorities for investigation and recommend corrective action plans

KEY FUNCTIONS

- Assure general overall quality of the program
- Monitor and evaluate reviewers, review results and impact on aspects of care through use of measurable indicators
- Take actions to improve service, solve problems and evaluate the effectiveness of these actions

PROCEDURE FOR REVIEWS

- Quality assurance reviews are done monthly by office, based on the following criteria:
    - Adherence to time standards
    - Adjuster, employer, date of injury noted
    - Name of person providing clinical information noted
    - Referral entered correctly
    - Closure information complete with correct number of days requested, certified, actual and saved entered
    - Clear explanation of any unusual situations
    - Adherence to customer special handling guidelines
- At least five referrals per month are selected at random for review per UR nurse
- The reviewer completes a Quality Assurance Review form on each case
- Review results are assessed by the Department Manager
- The Department Manager discusses overall results with utilization review reviewers at staff meeting and with individual utilization reviewer in private interview
- QA reviews are retained for comparison and follow up to assure correction of any problems

OPERATIONAL INFORMATION

Hours

The hours of operation for performing utilization review service are:

Monday – Friday 9:00 AM to 5:30 PM PST/PDT

For calls received outside of business hours, a voicemail message option is provided. The fax and email options are provided below for after-hours contact as well.

Telephone

Each CorVel Utilization Review office maintains a toll-free telephone number for performing utilization review services. The toll-free numbers are:

Northern California

Phone: 800-758-5866
Fax: 866-739-4352

Email: sacramento_ur@corvel.com

Southern California

Phone: 800-966-5307
Fax: 866-910-4423

Email: urorange@corvel.com

PROFESSIONAL LICENSES

CorVel is properly licensed to do business in all jurisdictions in which business is conducted. All professionals are properly licensed and certified as required by law.

CorVel has maintained URAC Accreditation since 2012 and can be verified at www.urac.org as follows:

urac

CERTIFICATE OF AWARD

in recognition of

CorVel Corporation
2999 Douglas Blvd., Suite 275
Roseville, California 95661

For compliance with

Workers' Compensation Utilization Management 8.1
Accreditation Program

is awarded

Full Accreditation

Effective from 03/01/2024 through 02/01/2027

Shawn Griffin MD

Shawn Griffin, MD
President & Chief Executive Officer

Certificate Number: WUM010012-3

urac®
ACCREDITED

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

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

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

Certificate Number: WUM010012-6

CERTIFICATE OF AWARD

in recognition of

Corvel Corporation - Orange Site
1920 Main Street
Irvine , California 92705

For compliance with

Workers' Compensation Utilization Management 8.1
Accreditation Program

is awarded

Full Accreditation

Effective from 03/01/2024 through 02/01/2027

Shawn Griffin, MD
President & Chief Executive Officer

ACCREDITED

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

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

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

RECOMMENDED UTILIZATION REVIEW CRITERIA

CorVel customers may develop criteria for Utilization Review and manage the scope of care or direct authorization provided to preferred providers. Where the customer has not indicated a specific criteria, CorVel recommends the following treatment to be submitted for Utilization Review:

- All surgical requests, especially inpatient hospitalization
- Post-surgery DME including stimulators, cold therapy units, CPU
- Assistant Surgeons
- Pain Pump Trial Implants
- All repeat diagnostic procedures over $350.00
- Diagnostic MRI – CT scans prior to 6 weeks post injury; without significant neurological deficits
- Myelogram, Discograms, Arthrograms, Surface electromyograms
- Nerve conduction studies
- Bone, Doppler, Sonogram and CT Scans
- Biopsies
- Epidural steroid injections
- Facet injections
- IDET
- Botox injections
- Ablation/Neurotomies/RFA lesioning
- Visco supplementation injections
- Home health services, therapies
- Physical therapy, occupational therapy in excess of 12 visits
- Nature therapy, alternative treatments and gym memberships
- Chiropractic manipulation in excess of 12 sessions
- Chronic pain management/interdisciplinary pain rehabilitation, drug dependency/ detox programs, work hardening/conditioning, or other outpatient rehabilitation programs.
- Biofeedback, except as part of a pre-authorized rehabilitation program
- Shock Wave therapies
- Reflexology, Personal Trainers, Aqua therapy, Pool Therapy, Massage therapy
- Acupuncture/Acupressure beyond 6 visits
- Prescription Meds indicated as non-exempt; beyond 90 days in duration, or brand name medications with generic equivalent
- Compound medications/ Opioids/Narcotics

- Herbal supplements, medical foods, OTC medications not medically substantiated
- Non-Medical Home Services - including nursing, housekeeping, landscaping services
- Weight loss programs
- Bone Growth Stimulators
- Durable medical equipment with a purchase price over $350.00, proposed rental period beyond two months in duration, or brand specific equipment
- All treatment requests that exceed or are not recommended in MTUS/ ACOEM guidelines.

APPENDIX A

CorVel Healthcare Corporation (CHC) performs utilization review services within the process outlined in the CorVel Corporation Utilization Review Plan, which is on file with the Division of Workers Compensation. CHC's sister company, CorVel Enterprise Comp, Inc. (CEC) utilizes services provided by CHC to facilitate delivery of appropriate medical treatment and incorporates medical information and records for accuracy. CHC and CEC are both subsidiaries of a common parent corporation, CorVel Corporation. The entity conducting utilization review services is CHC/URAC Accreditation (reference). Where CHC utilizes vendors for clinical expertise such as physician case review within the Utilization Review process, neither CHC or CEC have any financial interest in those entities and agreements are in place to clarify such if requested by the administrative director. CHC does not offer, provide nor accept any incentive or consideration from any party based on the number of modifications, denials or outcomes from the Utilization Review process.

APPENDIX B: DR. ROBERT BLINKS' CURRICULUM VITAE (CV)

CorVel's designated Medical Director is Robert C. Blink, M.D., M.P.H. He holds a current, valid, unrestricted license to practice medicine in the state of California. Dr. Blink is board-certified in Occupational and Environmental Medicine, is a Fellow of both the American College of Occupational and Environmental Medicine and Western Occupational and Environmental Medicine Association, and has over 25 -years of clinical experience in Occupational Health and Environmental Medicine. He provides direct evaluation and treatment of employees, and consultation to employers on issues of health, environmental/toxicology, risk management, governmental mandated procedures and medical-legal issues.

WORKSITE PARTNERS MEDICAL GROUP, INC.

Robert C. Blink, MD, MPH, FACOEM
Occupational and Environmental Medicine
Board Certified, ABPM
58 West Portal Ave., San Francisco, CA 94127
(415) 806-2276 ♦ RBLINK@WORKSITE-OCCMED.COM

Curriculum Vitae

EDUCATION

University of California, Berkeley, California, M.P.H. (Environmental Health), 1988
Intensive Residency - Occupational Medicine, Univ. of California-San Francisco, 1985-1986
Methodist Hospitals of Dallas, Texas, Internship (Surgery-Diversified), 1978-1979
University of Wisconsin, Madison, Wisconsin, M.D., 1978
Northwestern University, Evanston, Illinois, B.A. (Biology), 1974

CERTIFICATIONS AND LICENSURE

California Licensed Physician, #G43947
New York Licensed Physician #242593
Diplomate in Occupational Medicine, American Board of Preventive Medicine, 1988 – current

PROFESSIONAL HISTORY

Primary Employment:

President and Medical Director, Worksite Partners Medical Group (WPMG), 1988 - current
Vice President and Medical Director, WorkCare, 2004 - 2009
Medical Director, Concentra Managed Care/ Occupational Medicine Associates, 1996-2002
Medical Director, Hughes-Lewis Assoc's. / WPI / AmHealth, Oakland, CA, 1984-1996
Clinic Physician, Sutter Medical Group, San Francisco, CA, 1981-1984
Emergency Dept. Physician, Emergency Medical Systems, San Francisco, CA, 1980-1981
Emergency Dept. Physician, Mid-America Medical Services, Madison, WI, 1979-1980

Principal Clients Currently Served as Medical Director/ Occupational Medicine Advisor:

WPMG, Medical Director and Consultant for numerous clients; 1988 - present
Contra Costa County Employees' Retirement Association, 2004 – present
CorVel Corp. (National Credentialing and Quality Assurance, Medical Provider Network, Utilization Review, Case Management), 2007 – present
West Lake/ Boral Industries/ Owens-Corning Masonry and Roofing Products, 2008 – present
Sutter Health Employee Heath Service, 2011 – present
Birla Carbon/ Columbia Chemicals, (nationwide locations), 2015 – present
International Carbon Black Association – Scientific Advisory Group, 2015 - present
Free State Electric, 2018 - present

► **Governmental Positions:**

- Member of the California Occupational Safety and Health (Cal-OSHA) Standards Board by appointment of the Governor; served 2015-2016
- Medical Director to RETAIN - California (Retaining Employment and Talent After Injury/Illness Network), California EDD/ SDSU, 2019-2021

► **Return to Work/ Stay at Work Experience:**

- RETAIN-California, 2019-2021
- President, Western Occupational and Environmental Medicine Association (WOEMA), 2017
- Co-Chair, American College of Occupational and Environmental Medicine (ACOEM) Council on OEM Clinical Practice, current
- Member, ACOEM Council on Government Affairs, current
- Member, ACOEM working group on Preventing Needless Work Disability by Helping People Stay Employed, current
- Steering Committee, Northern California Summit for Promoting Stay at Work/ Return to Work, 2007
- Co-author, Fitness-for-Duty Evaluation: Walking the Medical-Legal Tightrope, Journal of Chemical Health and Safety Volume 14, Issue 2, March–April 2007, pp 9–13
- Qualified Medical Evaluator (QME), California Workers' Compensation system, 1995-2001
- Experience as reviewing physician regarding disability applications for:
    - Contra Costa County Employees' Retirement Association
    - Alameda County Employees' Retirement Association
    - City of Oakland, CA
    - Social Security Disability Insurance (SSDI)
    - Western States Insulators and Allied Workers Pension Fund
    - International Longshore and Warehouse Union (ILWU)
    - United States Mint - San Francisco, CA
    - USS-POSCO

► **Occupational and Environmental Toxicology Experience**

- Presenter and participant, Preventing Silicosis conference, Department of Environmental Health Sciences, Center for Occupational & Environmental Health, UCLA Fielding School of Public Health: May 16-17, 2024
- Numerous evaluations and causation opinions regarding environmental and workplace exposures:
    - Pesticides
    - Spent petroleum-cracking catalyst
    - Isocyanides
    - Inhalation: Carbon black, Silica, asbestos, sandblasting, grain dust
    - Heavy metals: Lead, Chromium VI, Arsenic, Cadmium
    - Pharmaceuticals: Antineoplastics, Botulinum toxin, Monoclonal antibodies, Antibiotics
    - Biotech: Animal care, endotoxin
    - Indoor air quality: molds, CO2
    - Contact dermatitis/ sensitization
    - Infectious diseases
- Ionizing radiation

Other/ Previous Clients served as Medical Director/ Consultant:

AMD Corporation, Austin, TX (and nationwide locations)
Applied Bio/ Life Technologies
Bayer Healthcare - Berkeley, Emeryville, and Sunnyvale, CA
Boehringer Ingelheim/ Amgen – Fremont, CA
Clorox Corporation
Construction Risk Solutions (& nationwide construction company clients)

DPR Construction, Vacaville, CA
Fluor Corporation, Vacaville, CA
Fresenius USA Manufacturing, Concord, CA

Genentech, South San Francisco and Vacaville
Novartis Pharmaceuticals & Vaccines/ Diagnostics, Emeryville and Vacaville, CA
Owens-Corning, Santa Clara, CA

Pacific Gas & Electric (Fitness for Duty program), San Francisco, CA
Tesoro Refinery – Martinez, CA
USS-POSCO Industries (cold rolling steel mill), Pittsburg, CA
WorkHealth Occupational Health Care Services, Napa, CA
United States Mint - San Francisco, CA
West Valley Demonstration Project (nuclear waste cleanup, New York state)
Western States Insulators and Allied Workers Health Plan
Western States Insulators and Allied Workers Pension Fund
Zymergen, Emeryville, CA, 2019 – 2023

REPRESENTATIVE EXPERIENCE

► Expert Witness:
Dr. Blink has provided litigation support, been deposed, and testified on medical-legal issues including toxic tort and related medical surveillance, injury causation, workers' compensation, disease causation, product liability, medical disability, HIPAA, GINA, ADA, insurance fraud, medical malpractice, and other matters of occupational and environmental medicine.

► Designing and Implementing Systems to Minimize Needless Work Disability:
Dr. Blink has been helping workers, employers, insurers and medical providers to minimize work disability for many years, via multiple vantage points. First as a treating physician in Emergency Departments, then in urgent care and finally Occupational Medicine clinics (both independent and employer-based), he saw first-hand the need for compassionate understanding by providers of the powerful negative impact of employment loss, even temporary, on his patients.

Lack of coordination among key stakeholders is a formidable barrier to best outcomes for patient health. Early assessment of functional ability, knowledge of job requirements from a physical standpoint, interaction with employers to optimize treatment goals and work flexibility, and attention to the real-world needs of patients including financial and emotional support in difficult circumstances, are all critical.

Dr. Blink has extensive experience in bringing together answers to these needs for his own patients as well as through designing and implementing protocols and procedures for large employer systems, educating, supervising and guiding other health care providers in this realm.

As one of the original Qualified Medical Evaluators certified by California's workers' compensation system and as author and frequent lecturer on Fitness-for-Duty issues, Dr. Blink has made this topic a central point of his career in Occupational and Environmental Medicine.

Prevention of injuries in the first place is of course the best way to avoid work-injury disability; appointment and service on the Cal-OSHA Standards Board provided excellent experience in governmental approaches to these issues.

As medical director of Bay Area clinics with various reporting structures, Dr. Blink has led teams of doctors, nurses, PT's, OT's, Psychologists and other providers in the evaluation and treatment of patients with continuous attention to maximizing quality care and minimizing work disability. He finds coordination of these providers' efforts to partner with other entities such as hospitals, employers, insurers, and governmental entities to be a challenging and rewarding endeavor.

His current role as Medical Director of a large (over 100,000 providers) medical network gives him the opportunity to imbue the system with requirements for attention to functional and employment concerns by providers, via education and guidance.

He served as Medical Director of California-RETAIN, a large federally funded research project to prevent needless work disability by educating and supporting providers, patients and providers

► Experience with Workers' Compensation and Utilization Review:

Dr. Blink has expertise in Workers' Compensation from multiple vantage points. He has been a treating physician, viewed as effective and fair by both patients and employers. He has been a medical director and advisor to employers, coordinating collaborative efforts among HR, Risk Management, Benefits, Safety, Legal and Production constituencies to optimize results by working with insurers and TPA's. He has been an impartial Qualified Medical Evaluator under the California Workers' Compensation system, reviewing files and examining claimants to issue reports on his opinions. He has organized and supervised multi-specialty physician groups to provide care to and impartial evaluations of workers' compensation claimants.

He serves as the medical director of a multi-state UR and claims management company, including its Medical Provider Network. He has advised many employers in a wide variety of businesses and industries on issues of concern to workers' comp administrators and insurers. He has served on California state government and professional organization panels to devise appropriate and legally defensible criteria and protocols for evaluation and treatment of claims of work-related injury. He has trained and supervised physicians, NP's, PA's and PT's engaged in evaluation and treatment of work-related injury claims. He has worked with employees and management to prevent injury, and to minimize disability by coordination of immediate intervention after possible injury, and of Return-to-Work programs.

► Medical director duties:
Dr. Blink has served as medical director or principal occupational medicine consultant of a wide variety of business across industries, including:

Health Care:

- Reorganized and supervised hospital-based Occupational Health programs and Employee Health programs for several large hospitals including injury evaluation and treatment, fitness for duty, immunizations, governmental requirements, and other Employee Health issues.

- Responsible for supervision and management of providers in several hospital-based on-site Occupational Health clinics, with significant reduction in workers' compensation costs, achieved via a combination of quality care and partnership with Safety, HR/ Benefits and other management.

Manufacturing and Petroleum Industries:

- Designed and implemented and/ or reorganized on-site medical departments at various industries: oil refinery, large steel finishing mill, nationwide consumer products manufacturer, construction materials manufacturer, biotechnology reagent manufacturer, and the U.S. Mint, to assure appropriate control of injury and disability management, union interactions, and OSHA log as well as ADA / FMLA / FEHA issues.

- Designed, implemented, revamped and supervised medical surveillance programs to comply with mandated and optional standards and with good medical practice.

Pharmaceutical:

- Worked with several large biotech firms to reorganize and improve occupational medicine services at multiple locations
- Led complete restructuring of existing Medical Unit of a facility with over 1500 employees, to create and improve ongoing programs
- On-site evaluation and treatment of occupational injury claims
- Medical / toxicological surveillance programs for compliance with NIOSH/ OSHA as well as FDA, European Union, and NAFTA GMP requirements
- Continuous surveillance of employee disability eligibility and Return-to-Work/ Modified duty programs
- Close interaction with Human Resources to evaluate ADA, FEHA and CFRA issues, as well as recommendations for accommodation, both pre-placement and for existing employees
- Close interaction with Engineering and Safety to evaluate and recommend changes to improve ergonomics and hazardous materials handling, preventing injuries
- Supervision and consultation for quality assurance monitoring and case management by on-site nursing with regular guidance to insurers for Workers' Compensation and STD/ LTD
- Devised and supervise animal care worker safety programs for pre-placement and surveillance
- Advised and consulted regarding medical protection and reproductive hazard issues for employees working with novel technologies and substances.
- Medical/ toxicological surveillance programs for compliance with NIOSH/ OSHA as well as FDA, European Union, and NAFTA GMP requirements
- Determination of recommended exposure limits to novel and potent compounds in research and manufacturing processes
- Advise and consult regarding medical protection, medical surveillance and reproductive hazard issues for employees working with novel technologies (such as recombinant DNA) and substances (dangerous chemicals), as well as exotic and dangerous pathogens (e.g. prions/ "Mad Cow disease", botulinum toxin (Botox), "simian B virus" from exposure to nonhuman primates, meningococcus (a cause of meningitis), retroviruses, hepatitis viruses, etc.)

Construction Industry:

- Provide medical staffing and systems implementation for 24-7 on-call availability to large construction companies and manufacturers nationwide
- Designed, staffed and supervised on-site medical facility at a very large multi-year construction site for an industrial manufacturing facility with nurses, paramedics, and physician coverage
- Developed a post-offer, pre-placement job applicant medical evaluation procedure for a nationwide general contractor in industrial construction
- Devised and implemented a post-incident medical surveillance program in cooperation with labor and management to rapidly respond to urgent health concerns and keep jobsite open

► OTHER EXPERIENCE

- Western Occupational and Environmental Medicine Association:
    - Chairman of the Board, 2018
    - President, 2017
    - Board of Directors, 2011-2018
    - Legislative Committee 2010- present
    - Committee member, Outcomes Based Collaboration in Workers Compensation 2012-2014
    - Advisory Group to Cal. Dept of Public Health Occupational Lead Poisoning Prevention Program (CDPH-OLPPP) for "Medical Guidelines for the Lead-Exposed Worker"
- Member, Scientific Advisory Group, International Carbon Black Association, 2015 – present
- Fellow, American College of Occupational and Environmental Medicine:
    - Co-Chair/ member, Council on OEM Practice, 2015 - 2023
    - House of Delegates, 2013, 2015, 2017, 2018, 2019
    - Member, Task Force on E&M Coding in Workers' Compensation, 2012-present
    - Member, ACOEM working group on Preventing Needless Work Disability by Helping People Stay Employed, current
- Northern California Summit for Promoting Stay at Work/ Return to Work, 2007
- Medical Review Officer (MRO), 1992 -
- Potent Compound Safety Training for the Environmental Health and Safety Professional (SafeBridge), 2004
- Automated External Defibrillator (AED) Supervising Physician, 2001- current
- Medical Consultant, Metropolitan Transportation Commission, Oakland and Bay Area, CA 1992 (Americans with Disabilities Act Protocols)
- Advanced Cardiac Life Support Instructor, Stanford University Medical Center, 1984-1985

► PUBLICATIONS:

Safely Returning America to Work Part I: General Guidance for Employers. Taylor, Tanisha MD; Das, Rupali MD; Mueller, Kathryn MD; Pransky, Glenn MD; Christian, Jennifer MD; Orford, Robert MD; Blink, Robert MD. (2020). Journal of Occupational & Environmental Medicine. Publish Ahead of Print. 10.1097/JOM.0000000000001984.

Utilization Review in Workers' Compensation: Current Status and Opportunities for Improvement
Glass, Lee S. MD, JD; Blink, Robert C. MD, MPH; Bean, Melissa DO, MPH; Erdil, Michael MD; Rosenthal, Jill A. MD, MPH; Taylor, Tanisha MD, MPH, ACOEM Utilization Review Task Force, Journal of Occupational & Environmental Medicine 2017 Oct; 59 (10):1024-1026

Defining Documentation Requirements for Coding Quality Care in Workers' Compensation
Cloeren, Marianne MD; Adamo, Philip MD; Blink, Robert MD et al
Journal of Occupational & Environmental Medicine
December 2016 - Volume 58 - Issue 12, pp. 1270–1275

Fitness-for-Duty Evaluation: Walking the Medical-Legal Tightrope
Robert C. Blink, Jerome Schreibstein
Journal of Chemical Health and Safety
Volume 14, Issue 2, March–April 2007, pp. 9–13

► AFFILIATIONS

- Fellow, American College of Occupational and Environmental Medicine
- Western Occupational and Environmental Medicine Association
- Hospital Staff Membership:
    California Pacific Medical Center, San Francisco, CA

References available on request.

APPENDIX C: CLIENT LIST

- ACTS Retirement Life Communities
- A-D Comp
- Advance America, Cash Advance Centers, Inc.
- Advanced Services
- AG Facilities Operations, LLC
- AGL Resources
- Alaska National Insurance Company
- Allergan
- Alliance Coal
- Alliant Energy
- Allied/Nationwide Insurance
- Aluminum Precision Products
- American Apparel
- American Casino
- AmTrust North America
- Antelope Valley Union High School District
- Applied Materials, Inc.
- Arch Insurance Company / Performance Contracting, Inc.
- Ardagh Glass Inc.
- Area USA, Inc.
- Arizona DOA /DOC
- Athens
- Iveanna Healthcare
- Banner Health Systems
- Baptist Healthcare Systems
- Bashas
- Bass Pro Group, LLC
- BB&T Corporation
- BBSI - Barrett Business Services Inc.
- Beall's
- Bed Bath & Beyond
- Belk, Inc.
- Big 5
- BITCO – Detroit
- BREC
- Braid Restaurant Group, LLC
- Briggs and Stratton
- Burberry ltd.
- Caliber Collision (Holdings)
- California Fair Service Authority – CFSA
- CalPortland Company
- Cambridge Healthcare Services
- Capistrano Unified School District
- Capitol Insurance Companies
- Casitas Municipal Water District
- Catalina Cylinders
- Catholic Mutual / Windhaven Health Center
- CC-Development Group, Inc.
- Central Garden & Pet
- Chaffey Joint Union High School
- Chaffey Joint Union HS
- Cheesecake Factory
- Cherokee Insurance
- Chico's FAS
- Chubb
- Chubb & Son (WC) - Dallas, TX
- Citrus Valley Health Partners
- City of New Orleans
- City of Omaha
- City of Redding
- City of Salinas
- City of San Diego
- City of Seattle
- Coachella Valley Water District
- Command Security Corporation
- Community Development Commission
- Community Medical Centers
- Contra Costa County Transit Authority
- Core Civic
- Corizon Health
- Corrections Corporation of America (CCA)
- County of DuPage
- County of Humboldt
- County of Los Angeles
- County of Santa Barbara
- Crawford & Company
- Creative Risk Solutions
- Crescent Facilities Operations
- Crum & Forster Case Management Program
- CSAC

- Dart Container Corporation
- Del Taco, LLC
- Dell
- Department of Public Instruction / Brunswick Co Schools
- Drummond Company Inc.
- DSW Inc.
- Eastman Kodak Company
- EBMUD East Bay Municipal Util. Dist. (Athens)
- El Pollo Loco
- Emeritus
- Ergon, Inc.
- Ericsson Inc.
- ESD113
- Express
- Extra Storage Space
- ExxonMobil
- FAMSA, Inc.
- Farmer Johns / Clougherty Packing LLC
- Federal Mogul
- FedEx
- Footlocker
- Ford Kentucky Truck Plant
- Ford Motors
- Foremost Insurance
- Fox Entertainment
- Fredkin Industries
- Gallagher Bassett Employers
- Gap
- GE Auto Insurance Program / Hazelrigg
- General Parts International
- Geo Group
- George's Inc.
- GMA -Georgia Municipal Assoc
- Goodwill Industries of San Diego Co
- Government Employees Health Association
- Grange Insurance Co
- Green Diamond Resource Company
- Guide One Insurance
- Gulf/St Paul Travelers
- H & R Block
- Habit Restaurants LLC
- Hartford Insurance Company of the Midwest
- Heartland Express
- Help at Home Holdings (XL specialty)
- HHS (Hospital Housekeeping Systems)
- Highpoint Administrative Services / Risk Enterprise Management (REM)
- Hillshire Brands
- Hilmar Cheese Company
- Hilton Worldwide, LLC
- Homeport Insurance
- IASIS Healthcare
- Icahn Automotive Group, LLC (Pep Boys and Auto Plus)
- iHeart Media, Inc.
- Interinsurance Exchange of Automobile Club
- ISS Facility Services
- Kellogg Companies
- Kerry Holding Co.
- Kirkland's, Inc.
- Landry's
- Larry Flynt Productions
- Les Schwab - OR/WA only
- Lineage Logistics Holdings
- Matheson Trucking
- May Trucking Company
- MEMIC (The MEMIC Group)
- Mens Wearhouse
- Mercury Insurance Services, LLC
- Meridian Management Services, LLC
- Metro Risk Management / SSA Marine
- Mettler-Toledo
- Michael Kors
- Mitsui Sumitomo
- Morongo Basin Transit Authority
- MTS
- MultiCare
- National American Ins Co / SCA Construction
- National American Insurance Company (NAICO)
- National Interstate
- Nationwide Insurance
- Niagara Water
- Nike, Inc.
- North Dakota / Workforce Safety and Insurance (WSI)

- Northrop Grumann Corporation
- Norwalk La Mirada Unified School District
- Archer Daniels Midland Company (ADM)
- Orange County Fire Authority (OCFA)
- O'Reilly Auto Parts
- OSI Group, LLC
- Pacesetters Adjustment Company
- Pacific Coast Building Products
- Pacific Compensation Insurance Company
- Pacific Sun wear
- Performance Contracting
- Performance Food Group, Inc.
- PERMA
- Port of Oakland
- Prospect Medical Holdings, Inc.
- Protective Insurance – IW
- PSA Healthcare
- PSWCT
- Puget Sound Workers Compensation Trust
- PVH Corp
- QBE / General Casualty
- R&L Carriers / CCMSI
- Raley's Family of Fine Foods
- Ralph Lauren
- Rancho Santiago Community College District
- Recology
- Redwood Empire Schools Ins. Group - RESIG
- Rexnord Corporation
- SA RECYCLING
- San Diego Community College District
- Savage
- Save Mart Supermarkets
- Sedgwick/Chubb Group
- Select Staffing (NEW KOOSHAREMCORP)
- Shamrock Foods Company
- Shippers Employers – Employee Benefit Services – Group Health
- SIKA Corporation
- Sharp Healthcare
- Silverado
- SpaceX
- Spruce Grove Inc.
- SRS / Stericycle
- SSA Marine, Inc.
- Stanley Steamer
- Stater Brothers
- Sumner County Government
- SanMar Healthcare
- Swift Transportation Company
- Syngenta
- Takeda America Holdings
- Tawa Services, Inc.
- TBC - Tire Kingdom (GB)
- The Jones Financial Companies, LLLP
- The Standard Fire Insurance Company / Shamrock Foods Company
- The Vitamin Shoppe
- ThyssenKrupp Elevator
- Tiffany & Company
- Tilly's
- Timberland
- Toll Brothers
- Town of Colma (CSAC)
- Tri City
- Tribal First (WA)
- Trillium Staffing
- Tristar / REM (Risk Enterprise Management)
- Tyson/Hillshire Brands
- UDR, Inc.
- United Cerebral Palsy
- US Bank
- Vallarta Supermarkets
- Vanliner Insurance
- Velocity Vehicle Group
- Viad Corp
- Vistra Corp
- Wagamama USA
- Washington Hospital
- Wei-Chuang USA, Inc.
- Wellpath Holdings
- Western National
- Zoetis, Inc.

APPENDIX D: SAMPLE LETTERS

Appeal Determination Certification Recommendation

CLAIM #:	«claim1»	**INSURED:**	«emp1» / «ins1»
DOI:	«claim3»	**CARRIER/TPA:**	«cust1» / «tpa 1»
CLAIMANT:	**«pt2» «pt1»**	**ADJUSTER:**	«adj2»«adj1»
CORVEL #:	«claim2»-«claim30»«Service_Sequenc encoded»		

Determination Date: «Date Completed»

RFA First received Date: «Date_Customer_Received_Referral»

Review Type: «REQ_TYPE»

Provider: «phys2»«phys1»

Pre-cert #: «claim2»-«claim30»«Service_Sequence_Code»

Network: «Network Channeling»

Treatment being appealed:

CorVel Corporation has received a request for appeal of our non-certification determination on «Date_Customer_Received_Referral». After careful review of the submitted medical information, our Physician Advisor, «Peer_Reviewer_Name», «Peer_Reviewer_License_Number», who is board certified in «Peer_Reviewer_Specialty», has certified the requested treatment. The certification decision was made on «Date_Completed» and is summarized below:

SURGERY

Determination	Type of Surgery	Body Part	CPT	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

MEDICATION

Determination	Type of Medication	Nameof Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Medication_Type»	«MEDICATION_NAME»	«DOSAGE»	«REFILL_NUM»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

THERAPY

CorVel Corporation | PO Box 3529 | Costa Mesa, CA 92628 | *p* 714-385-8500 | *f* 866-910-4423
CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

Determination	Type of Therapy	Total # Visits	Total Visits/ Week	Total Weeks	Body Part	CPT	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«THERAPY_REQ»	«RQS T_TTL _VISI TS»	«RQS T_TTL _VISIT S_WK »	«RQS T_TTL _WK»	«BODY_PART_L OOKUP_BODY_ DSCP»	«CPT»	«EFF_DATE »	«TERMINA TION_DATE »	«HOSP_NAM E»	«DR_NAME»

TESTING

Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date	CPT	Facility	Provider
«UR_STATUS»	«TEST_TYPE»	«CONTRAS T_TYPE»	«BODY_PART_LO OKUP_BODY_DS CP»	«EFF_DATE »	«TERMINA TION_DATE »	«CPT»	«HOSP_NAME»	«DR_NAME»

INJECTION

Determination	Type/Site of Injection	Nameof Medication	Dosage	# of Injections	Body Part	Effective Date	Termination Date	CPT	Facility	Provider
«UR_STATUS»	«INJECTN_SITE»	«INJECTIO N_NAME»	«DOSA GE»	«INJECT N_NUM »	«BODY_PART_ LOOKUP_BOD Y_DSCP»	«EFF_DATE »	«TERMINA TION_DATE »	«CPT»	«HOSP_NAM E»	«DR_NAME»

DME

Determination	Type of Equipment	Rental / Purchase	If Rental, Duration	Body Part	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«EQPMT_TYPE»	«SALE_T YPE»	«DURATIO N»	«BODY_PART_LO OKUP_BODY_DS CP»	«EFF_DATE»	«TERMINATIO N_DATE»	«HOSP_NAME»	«DR_NAME»

CONTINUED STAY

Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date	Facility	Provider
«UR_STATUS»	«PREVIOUSLY _CERTIFIED»	«NEW_REQU EST_OF_DAY S»	«TOTAL_LEN _OF_STAY»	«NEW_EFFECTIVE_D ATE»	«NEW_TERMINATION _DATE»	«HOSP_NAME»	«DR_NAME»

«DR_N
AME»

Provider

ATE»

OTHER

Determination	Description	Effective Date	Termination Date	Facility	Provider

CorVel Corporation | PO Box 3529 | Costa Mesa, CA 92628 | *p* 714-385-8500 | *f* 866-910-4423
CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

«UR_STATUS» «Other_Treatment_Desc» «notes» «EFF_DATE» «TERMINATION_DATE» «HOSP_NAME» «DR_NAME»

To obtain a review for continued treatment after the above noted certification period, please call CorVel Corporation at (916) 605-3800. Our hours of operation are from 8:30 a.m. to 5:30 p.m. PST, Monday through Friday.

Please note this review has been done in accordance with California Labor Code Section 4610 and the California Medical Treatment Utilization Schedule has been utilized in the determination process as required in Title 8, California Code of Regulation 9792.8.

**For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

****NOTE****
Please attach a copy of this recommendation letter with your bill; otherwise, payment may be delayed.

Utilization review does not include determinations of employer liability of the work injury, or of bill review for the purpose of determining whether the medical services were accurately billed.

Sincerely,

«adv3» «adv4»
Utilization Management Department

cc: Office Copy

«adj2» «adj1»

«pt2» «pt1»

«fac1»

«p_atty2» «p_atty1»

«d_atty2» «d_atty1»

«CM_Name»

«Outside_nurse_CM_Name»

CorVel Corporation | PO Box 3529 | Costa Mesa, CA 92628 | *p* 714-385-8500 | *f* 866-910-4423
CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

Appeal Determination Non-Certification Recommendation

CLAIM #:	«claim1»	**INSURED:**	«emp1» / «ins1»
DOI:	«claim3»	**CARRIER/TPA:**	«cust1» / «tpa 1»
CLAIMANT:	**«pt2» «pt1»**	**ADJUSTER:**	«adj2»«adj1»
CORVEL #:	«claim2»-«claim30»«Service_Sequence_Code»		

Determination Date:	«Peer_Report_Date»
RFA FirstReceived Date:	«Date_Customer_Received_Referral»
Review Type:	«REQ_TYPE»
Provider:	«phys2»«phys1»
Pre-Cert #:	«claim2»-«claim30»«Service_Sequence_Code»
Network:	«Network_Channeling»
TreatmentRequested:	
Treatment Denied:	

CorVel Corporation has received a request for appeal of our non-certification determination on «Date_Customer_Received_Referral». The appeal has been reviewed by our Physician Advisor, «Peer_Reviewer_Name», «Peer_Reviewer_License_Number», «Peer_Reviewer_Specialty». After careful review of the submitted medical information, our physician advisor was unable to recommend the requested treatment. The non- certification decision was made on «Peer_Report_Date».

SURGERY

Determination	Type of Surgery	Body Part	CPT	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

MEDICATION

Determination	Type of Medication	Nameof Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Medication_Type»	«MEDICATION_NAME»	«DOSAGE»	«REFILL_NUM»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

Determination	Type of Therapy	Total # Visits	Total Visits/ Week	Total Weeks	Body Part	CPT	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«THERAPY_REQ»	«RQST_TTL_VISITS»	«RQST_TTL_VISITS_WK»	«RQST_TTL_WK»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

TESTING

Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date	CPT	Facility	Provider
«UR_STATUS»	«TEST_TYPE»	«CONTRAST_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«CPT»	«HOSP_NAME»	«DR_NAME»

INJECTION

Determination	Type/Site of Injection	Nameof Medication	Dosage	# of Injections	Body Part	Effective Date	Termination Date	CPT	Facility	Provider
«UR_STATUS»	«INJECTN_SITE »	«INJECTION_NAME»	«DOSAGE»	«INJECTN_NUM»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«CPT»	«HOSP_NAME»	«DR_NAME»

DME

Determination	Type of Equipment	Rental / Purchase	IfRental, Duration	Body Part	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«EQPMT_TYPE»	«SALE_TYPE»	«DURATION»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

CONTINUED STAY

Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date	Facility	Provider
«UR_STATUS»	«PREVIOUSLY_CERTIFIED»	«NEW_REQUEST_DAYS»	«TOTAL_LENGTH_OF_STAY»	«EFFECTIVE_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

«NEW_EFFECTIVE_D ATE»	«NEW_TERMI NATION _DATE»	«HOSP_ NAME» «DR_NA ME»

		Provider

CorVel Corporation | PO Box 3529 | Costa Mesa, CA 92628 | *p* 714-385-8500 | *f* 866-910-4423

CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 *f* 866-449-0449

CONSULT

Determination	Type of Consult	Effective Date	Termination Date	Facility
«UR_STATUS»	«TYPE_OF_CONSULT»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»

«DR_
NAME
»

CorVel Corporation | PO Box 3529 | Costa Mesa, CA 92628 | *p* 714-385-8500 | *f* 866-910-4423

CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 *f* 866-449-0449

OTHER

Determination	Description		Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Other_Treatment_Desc»	«notes»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

Guidelines used in the determination process: «Peer_Review_Guidelines_Used»

The clinical reasons regarding medical necessity, or lack of medical necessity, for non-certification are attached.

Please note the utilization review process is mandatory and has been done in accordance with California Labor Code §4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.8.

You have the right to disagree with the decision affecting your claim. If you have any questions about the information in this notice, please call your adjuster, «adj2» «adj1», at «adj9». However if you are represented by an attorney, please contact your attorney instead of your adjuster.

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

In accordance with regulation section 9792.9.1(e)(5)(K), if the requesting physician wishes to speak to the reviewing physician regarding this determination, you can call (916) 605 -3800 to arrange an agreed upon scheduled time between the hours of 8:30a.m. to 5:30p.m. Monday through Friday (PST). Should the reviewing physician be unable to speak with you, another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services will be made available.

**For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

****NOTE****

Please attach a copy of this recommendation letter with your bill; otherwise, payment may be delayed.

Utilization review does not include determination of employer liability of the work injury, or of bill review for the purpose of determining whether the medical services were accurately billed.

Sincerely,

«adv3» «adv4»
Utilization Management Department

cc: Office Copy
Peer Review's Report

«adj2» «adj1»

«pt2» «pt1»

«fac1»

«p_atty2» «p_atty1»

«d_atty2» «d_atty1»

«CM_Name»

«Outside_nurse_CM_Name»

**

Appeal Determination Modification Recommendation

CLAIM #:	«claim1»	**INSURED:**	«emp1» / «ins1»
DOI:	«claim3»	**CARRIER/TPA:**	«cust1» / «tpa 1»
CLAIMANT:	**«pt2» «pt1»**	**ADJUSTER:**	«adj2»«adj1»
CORVEL #:	«claim2»-«claim30»«Service_Sequence_Code»		

Determination Date: «Peer_Report_Date»

RFA First Received Date: «Date_Customer_Received_Referral»

Review Type: «REQ_TYPE»

Provider: «phys2»«phys1»

Pre-Cert #: «claim2»-«claim30»«Service_Sequence_Code»

Network: «Network_Channeling»

Treatment Requested:

Treatment Approved:

Treatment Denied:

CorVel Corporation has been asked to review the below noted treatment requested for medical necessity and appropriateness on «Date_Customer_Received_Referral». After careful review of the submitted medical information, our Physician Advisor, «Peer_Reviewer_Name», «Peer_Reviewer_License_Number who is board certified in «Peer_Reviewer_Specialty», was able to modify the requested treatment. The medication decision was made on «Peer_Report_Date».

SURGERY

Determination	Type of Surgery	Body Part	CPT	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

MEDICATION

Determination	Type of Medication	Nameof Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Medication_Type»	«MEDICATION_NAME»	«DOSAGE»	«REFILL_NUM»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

**

THERAPY

Determination	Type of Therapy	Total # Visits	Total Visits/ Week	Total Weeks	Body Part	CPT	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«THERAPY_REQ»	«RQST_TTL_VISITS»	«RQST_TTL_VISITS_WK»	«RQST_TTL_WK»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

TESTING

Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date	CPT	Facility	Provider
«UR_STATUS»	«TEST_TYPE»	«CONTRAST_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«CPT»	«HOSP_NAME»	«DR_NAME»

INJECTION

Determination	Type/Site of Injection	Nameof Medication	Dosage	# of Injections	Body Part	Effective Date	TDeaRteDmination	CPT	Facility	Provider
«UR_STATUS»	«INJECTN_SITE»	«INJECTION_NAME»	«DOSAGE»	«INJECTN_NUM»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«CPT»	«HOSP_NAME»	«DR_NAME»

DME

Determination	Type of Equipment	Rental/ Purchase	IfRental, Duration	Body Part	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«EQPMT_TYPE»	«SALE_TYPE»	«DURATION»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

CONTINUED STAY

Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date	Facility	Provider
«UR_STATUS»	«PREVIOUSLY	_CERTIFIED»	«NEW_REQU	EST_OF_DAY S»	«TOTAL_LEN	_OF_STAY»	

«NEW_EFFECTIVE_DATE»	«NEW_TERMINATION_DATE»	«HOSP_NAME» «DR_NAME»	**

CONSULT

Determination	Type of Consult	Effective Date	Termination Date	Facility	Provider

**

«UR_STATUS»	«TYPE_OF_CONSULT»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

OTHER

Determination	Description		Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Other_Treatment_Desc»	«notes»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

Guidelines used in the determination process: «Peer_Review_Guidelines_Used»

The clinical reasons regarding medical necessity, or lack of medical necessity, for non-certification are attached.

Please note the utilization review process is mandatory and has been done in accordance with California Labor Code §4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.8.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured workers representative, or the injured workers attorney on behalf of the injured worker on the Application for Independent Medical Review, DWC Form IMR, within 10 calendar days after the service of utilization review decision to the employee for formulary disputes, and within 30 calendar days after the service of the utilization review decision to the employee for all other medical treatment disputes.

You have the right to disagree with the decision affecting your claim. If you have any questions about the information in this notice, please call your adjuster, «adj2» «adj1», at «adj9». However if you are represented by an attorney, please contact your attorney instead of your adjuster.

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

In accordance with regulationsection 9792.9.1(e)(5)(K), if therequestingphysicianwishes to speak to the reviewingphysicianregardingthis determination, you can call (916) 605-3800 to arrange an agreed upon scheduled time between the hours of 8:30 a.m. to 5:30 p.m. Monday through Friday (PST). Should the reviewing physician be unable to speak with you, another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services will be made available.

**For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

****NOTE****

Please attach a copy of this recommendation letter with your bill; otherwise, payment may be delayed.

Utilization review does not include determination of employer liability of the work injury, or of bill review for the purpose of determining whether the medical services were accurately billed.

Sincerely,

«adv3» «adv4»
Utilization Management Department

cc: Office Copy

Peer Reviewer's Report

IMR form

«adj2» «adj1»

«pt2» «pt1»

«fac1»

«p_atty2» «p_atty1»

«d_atty2» «d_atty1»

«CM_Name»

«Outside_nurse_CM_Name»

State of California, Division of Workers' Compensation

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

DWC Form IMR

TO REQUEST INDEPENDENT MEDICAL REVIEW:

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

Type of Utilization Review: ☐ Regular ☐ Expedited	Modification after appeal ☒
Employee Name (First, MI, Last): «pt2» «pt1»	
Address: «pt4» «pt5» «pt6», «pt7» «pt8»	
Phone Number: «pt10»	Employer: «emp1»
Claim Number: «claim1»	Date of Injury (MM/DD/YYYY): «claim3»
WCIS Jurisdictional Claim Number (if assigned): «JurisdictionClaimNumber»	EAMS Case Number (if applicable) :
Employee Attorney (if known): «p_atty2» «p_atty1»	
Address: «p_atty4» «p_atty5» «p_atty6», «p_atty7» «p_atty8»	
Phone Number: «p_atty9»	Fax Number: «p_atty10»
Requesting Physician Name (First, MI, Last): «phys2» «phys1»	
Practice Name:	Specialty:
Address: «phys4» «phys5» «phys6», «phys7» «phys8»	
Phone Number: «phys9»	Fax Number: «phys12»
Claims Administrator Name: «cust1» / «tpa1»	
Adjuster/Contact Name: «adj2» «adj1»	
Address: «adj4» «adj5» «adj6», «adj7» «adj8»	
Phone Number: «adj9»	Fax Number: «adj10»
Disputed Medical Treatment (Complete below section)	
Primary Diagnosis (Use ICD Code where Practical): «trmnt1»	
Date of Utilization Review Determination Letter: «Peer_Report_Date»	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☐ No Reason:	
List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.	
1. «Treatments_Requested»	
2. «Treatments_Requested»	
3. «Treatments_Requested»	
4. «Treatments_Requested»	

Request for Review and Consent to Obtain Medical Records

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

Employee Signature:	Date:

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

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

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

You can request independent medical review by signing and submitting this form with a copy of the written determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your claims administrator.

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

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

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

Your Right to Provide Information

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

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

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling g toll-free I -800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.DWC Form IMR (Effective 2/2014)

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee s behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)			
Address:			
City:	State:		Zip Code:
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:			Date:

Certification Recommendation

CLAIM #:	«claim1»	**INSURED:**	«emp1» /«ins1»
DOI:	«claim3»	**CARRIER/TPA:**	«cust1» / «tpa 1»
CLAIMANT:	**«pt2» «pt1»**	**ADJUSTER:**	«adj2»«adj1»
CORVEL #:	«claim2»-«claim30»«Service_Sequence_Code»		

Determination Date: «Date_Completed»

RFA First Received Date: «Date_Customer_Received_Referral»

Review Type: «REQ_TYPE»

Provider: «phys2»«phys1»

Pre-cert #: «claim2»-«claim30»«Service_Sequence_Code»

Network: «Network_Channeling»

Treatment Requested:

Treatment Approved:

CorVel Corporation has been asked to review the below noted treatment request for medical necessity and appropriateness. After careful review of the submitted medical information, the requested treatment has been certified. The certification decision was made on «Date_Completed» and is summarized below:

SURGERY

Determination	Type of Surgery	Body Part	CPT	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

MEDICATION

Determination	Type of Medication	Nameof Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Medication_Type»	«MEDICATION_NAME»	«DOSAGE»	«REFILL_NUM»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

CorVel Corporation | PO Box 3529 | Costa Mesa, CA 92628 | *p* 714-385-8500 | *f* 866-910-4423

CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

Determination	Type of Therapy	Total # Visits	Total Visits/ Week	Total Weeks	Body Part	CPT	Effective Date	Termination Date	Facility	Provider

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CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

«UR_STATUS»	«THERAPY_REQ»	«RQST_TTL_VISITS»	«RQST_TTL_VISITS_WK»	«RQST_TTL_WK»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

TESTING

Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date	CPT	Facility	Provider
«UR_STATUS»	«TEST_TYPE»	«CONTRAST_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«CPT»	«HOSP_NAME»	«DR_NAME»

INJECTION

Determination	Type/Site of Injection	Nameof Medication	Dosage	# of Injections	Body Part	Effective Date	Termination Date	CPT	Facility	Provider
«UR_STATUS»	«INJECTN_SITE »	«INJECTION_NAME»	«DOSAGE»	«INJECTN_NUM»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«CPT»	«HOSP_NAME»	«DR_NAME»

DME

Determination	Type of Equipment	Rental/ Purchase	IfRental, Duration	Body Part	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«EQPMT_TYPE»	«SALE_TYPE»	«DURATION»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

CONTINUED STAY

Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date	Facility	Provider
«UR_STATUS»	«PREVIOUSLY_CERTIFIED»	«NEW_REQUEST_OF_DAYS»	«TOTAL_LEN_OF_STAY»	«NEW_EFFECTIVE_DATE»	«NEW_TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

CONSULT

Determination	Type of Consult	Effective Date	Termination Date	Facility
«UR_STATUS»	«TYPE_OF_CONSULT»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»

	Provider

«DR_
NAME
»

OTHER

Determination	Description		Effective Date	Termination Date	Facility	Provider
«UR STATUS»	«Other Treatment Desc»	«notes»	«EFF DATE»	«TERMINATION		DATE»

«HOSP_NAME» «DR_NAME»

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CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

To obtain a review for continued treatment after the above noted certification period, please call CorVel Corporation at (916) 605-3800. Our hours of operation are from 8:30 a.m. to 5:30 p.m. PST, Monday through Friday.

Please note this review has been done in accordance with California Labor Code Section 4610 and the California Medical Treatment Utilization Schedule has been utilized in the determination process as required in Title 8, California Code of Regulation 9792.8.

**For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

****NOTE****
Please attach a copy of this recommendation letter with your bill; otherwise, payment may be delayed.

Utilization review does not include determination of employer liability of the work injury, or of bill review for the purpose of determining whether the medical services were accurately billed.

Sincerely,

«adv3» «adv4»
Utilization Management Department

cc: Office Copy

«adj2» «adj1»

«pt2» «pt1»

«fac1»

«p_atty2» «p_atty1»

«d_atty2» «d_atty1»

«CM_Name»

«Outside_nurse_CM_Name»

**

Non-Certification Recommendation

CLAIM #:	«claim1»	**INSURED:**	«emp1» / «ins1»
DOI:	«claim3»	**CARRIER/TPA:**	«cust1» / «tpa 1»
CLAIMANT:	**«pt2» «pt1»**	**ADJUSTER:**	«adj2»«adj1»
CORVEL #:	«claim2»-«claim30»«Service_Sequence_Code»		

Determination Date:	«Peer_Report_Date»
RFA First Received Date:	«Date_Customer_Received_Referral»
Review Type:	«REQ_TYPE»
Provider:	«phys2»«phys1»
Pre-Cert #:	«claim2»-«claim30»«Service_Sequence_Code»
Network:	«Network_Channeling»
Treatment Requested:	
Treatment Denied:	

CorVel Corporation has been asked to review the below noted treatment request for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor, «Peer_Reviewer_Name», «Peer_Reviewer_License_Number», who is board certified in «Peer_Reviewer_Specialty», was unable to recommend the requested treatment. The non-certification decision was made on «Peer_Report_Date».

SURGERY

Determination	Type of Surgery	Body Part	CPT	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

MEDICATION

Determination	Type of Medication	Nameof Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Medication_Type»	«MEDICATION_NAME»	«DOSAGE»	«REFILL_NUM»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

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CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

**

THERAPY

Determination	Type of Therapy	Total # Visits	Total Visits/ Week	Total Weeks	Body Part	CPT	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«THERAPY_REQ»	«RQS T_TTL _VISI TS»	«RQS T_TTL _VISIT S_WK »	«RQS T_TTL _WK»	«BODY_PART_L OOKUP_BODY_ DSCP»	«CPT»	«EFF_DATE »	«TERMINA TION_DATE »	«HOSP_NAM E»	«DR_NAME»

TESTING

Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date	CPT	Facility	Provider
«UR_STATUS»	«TEST_TYPE»	«CONTRAS T_TYPE»	«BODY_PART_LO OKUP_BODY_DS CP»	«EFF_DATE »	«TERMINA TION_DATE »	«CPT»	«HOSP_NAME»	«DR_NAME»

INJECTION

Determination	Type/Site of Injection	Nameof Medication	Dosage	# of Injections	Body Part	Effective Date	Termination Date	CPT	Facility	Provider
«UR_STATUS»	«INJECTN_SITE »	«INJECTIO N_NAME»	«DOSA GE»	«INJECT N_NUM »	«BODY_PART_ LOOKUP_BOD Y_DSCP»	«EFF_DATE »	«TERMINA TION_DATE »	«CPT»	«HOSP_NAM E»	«DR_NAME»

DME

Determination	Type of Equipment	Rental / Purchase	IfRental, Duration	Body Part	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«EQPMT_TYPE»	«SALE_T YPE»	«DURATIO N»	«BODY_PART_LO OKUP_BODY_DS CP»	«EFF_DATE»	«TERMINATIO N_DATE»	«HOSP_NAME»	«DR_NAME»

CONTINUED STAY

Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date	Facility	Provider
«UR_STATUS»	«PREVIOUSLY_CERTIFIED»	«NEW_REQUEST_OF_DAYS»	«TOTAL_LEN_OF_STAY»	«NEW_EFFECTIVE_DATE»	«NEW_TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

CONSULT

Determination	Type of Consult	Effective Date	Termination Date	Facility	Provider

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CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

**

«UR_STATUS»	«TYPE_OF_CONSULT»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

OTHER

Determination	Description		Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Other_Treatment_Desc»	«notes»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

Guidelines used in the determination process: «Peer_Review_Guidelines_Used»

The clinical reasons regarding medical necessity, or lack of medical necessity, for non-certification are attached.

Please note the utilization review process is mandatory and has been done in accordance with California Labor Code §4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.8.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured workers representative, or the injured workers attorney on behalf of the injured worker on the Application for Independent Medical Review, DWC Form IMR, within 10 calendar days after the service of utilization review decision to the employee for formulary disputes, and within 30 calendar days after the service of the utilization review decision to the employee for all other medical treatment disputes.

You have the right to disagree with the decision affecting your claim. If you have any questions about the information in this notice, please call your adjuster, «adj2» «adj1», at «adj9». However if you are represented by an attorney, please contact your attorney instead of your adjuster.

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

The internal appeals process is on a voluntary basis. It 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. Should the requesting medical provider wish to appeal the non-certification or modification decision, and/or have additional pertinent clinical information, which has not previously been submitted for review, you may submit a request for appeal to CorVel Corporation or the claims administrator. You may include any additional clinical information if you have any. This

will be reviewed by a different reviewing physician. **Requests for appeal need to be sent to CorVel Corporation or the claims administrator within ten (10) days after the receipt of the utilization review decision.** A response to your appeal will be rendered within thirty (30) days after receipt of the request. Requests for appeal do not replace the objection process noted above and are voluntary.

In accordance with regulationsection 9792.9.1(e)(5)(K), if the requesting physician wishes to speak to the reviewing physician regarding this determination, you can call (916) 605-3800 to arrange an agreed upon scheduled time between the hours of 8:30 a.m. to 5:30 p.m. Monday through Friday (PST). Should the reviewing physician be unable to speak with you, another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services will be made available.

**For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

****NOTE****
Please attach a copy of this recommendation letter with your bill; otherwise, payment may be delayed.

Utilization review does not include determinations of employer liability of the work injury, or of bill review for the purpose of determining whether the medical services were accurately billed.

Sincerely,

«adv3» «adv4»
Utilization Management Department

cc: Office Copy

Peer Reviewer's Report

IMR form

«adj2» «adj1»

«pt2» «pt1»

«fac1»

«p_atty2» «p_atty1»

«d_atty2» «d_atty1»

«CM_Name»

«Outside_nurse_CM_Name»

CorVel Corporation | PO Box 3529 | Costa Mesa, CA 92628 | *p* 714-385-8500 | *f* 866-910-4423
CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

State of California, Division of Workers' Compensation

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

DWC Form IMR

TO REQUEST INDEPENDENT MEDICAL REVIEW:

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

Type of Utilization Review: ☐ Regular ☐ Expedited	Modification after appeal ☐
Employee Name (First, MI, Last): «pt2» «pt1»	
Address: «pt4» «pt5» «pt6», «pt7» «pt8»	
Phone Number: «pt10»	Employer: «emp1»
Claim Number: «claim1»	Date of Injury (MM/DD/YYYY): «claim3»
WCIS Jurisdictional Claim Number (if assigned): «JurisdictionClaimNumber»	EAMS Case Number (if applicable) :
Employee Attorney (if known): «p_atty2» «p_atty1»	
Address: «p_atty4» «p_atty5» «p_atty6», «p_atty7» «p_atty8»	
Phone Number: «p_atty9»	Fax Number: «p_atty10»
Requesting Physician Name (First, MI, Last): «phys2» «phys1»	
Practice Name:	Specialty:
Address: «phys4» «phys5» «phys6», «phys7» «phys8»	
Phone Number: «phys9»	Fax Number: «phys12»
Claims Administrator Name: «cust1» / «tpa1»	
Adjuster/Contact Name: «adj2» «adj1»	
Address: «adj4» «adj5» «adj6», «adj7» «adj8»	
Phone Number: «adj9»	Fax Number: «adj10»
Disputed Medical Treatment (Complete below section)	
Primary Diagnosis (Use ICD Code where Practical): «trmnt1»	
Date of Utilization Review Determination Letter: «Peer_Report_Date»	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☐ No Reason:	
List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.	
1. «Treatments_Requested»	
2. «Treatments_Requested»	
3. «Treatments_Requested»	
4. «Treatments_Requested»	

Request for Review and Consent to Obtain Medical Records

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

Employee Signature:	Date:

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

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

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

You can request independent medical review by signing and submitting this form with a copy of the written determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your claims administrator.

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

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

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

Your Right to Provide Information

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

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

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling g toll-free I -800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.DWC Form IMR (Effective 2/2014)

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee s behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)			
Address:			
City:	State:		Zip Code:
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:			Date:

**

Non-Certification Recommendation Lack of Information

CLAIM #:	«claim1»	**INSURED:**	«emp1» / «ins1»
DOI:	«claim3»	**CARRIER/TPA:**	«cust1» / «tpa 1»
CLAIMANT:	**«pt2» «pt1»**	**ADJUSTER:**	«adj2»«adj1»
CORVEL #:	«claim2»-«claim30»«Service_Sequence_Code»		

Determination Date:	«Peer_Report_Date»
RFA First Received Date:	«Date_Customer_Received_Referral»
Review Type:	«REQ_TYPE»
Provider:	«phys2»«phys1»
Pre-Cert #:	«claim2»-«claim30»«Service_Sequence_Code»
Network:	«Network_Channeling»
Treatment Requested:	

CorVel Corporation has been asked to review the below noted treatment request for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor, «Peer_Reviewer_Name», «Peer_Reviewer_License_Number», who is board certified in «Peer_Reviewer_Specialty», was unable to recommend the requested treatment. The non-certification decision was made on «Peer_Report_Date».

SURGERY

Determination	Type of Surgery	Body Part	CPT	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

MEDICATION

Determination	Type of Medication	Nameof Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Medication_Type»	«MEDICATION_NAME»	«DOSAGE»	«REFILL_NUM»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

**

CORVEL

THERAPY

Determination	Type of Therapy	Total # Visits	Total Visits/ Week	Total Weeks	Body Part	CPT	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«THERAPY_REQ»	«RQS T_TTL _VISI TS»	«RQS T_TTL _VISIT S_WK »	«RQS T_TTL _WK»	«BODY_PART_L OOKUP_BODY_ DSCP»	«CPT»	«EFF_DATE »	«TERMINA TION_DATE »	«HOSP_NAM E»	«DR_NAME»

TESTING

Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date	CPT	Facility	Provider
«UR_STATUS»	«TEST_TYPE»	«CONTRAS T_TYPE»	«BODY_PART_LO OKUP_BODY_DS CP»	«EFF_DATE »	«TERMINA TION_DATE »	«CPT»	«HOSP_NAME»	«DR_NAME»

INJECTION

Determination	Type/Site of Injection	Nameof Medication	Dosage	# of Injections	Body Part	Effective Date	Termination Date	CPT	Facility	Provider
«UR_STATUS»	«INJECTN_SITE »	«INJECTIO N_NAME»	«DOSA GE»	«INJECT N_NUM »	«BODY_PART_ LOOKUP_BOD Y_DSCP»	«EFF_DATE »	«TERMINA TION_DATE »	«CPT»	«HOSP_NAM E»	«DR_NAME»

DME

Determination	Type of Equipment	Rental / Purchase	IfRental, Duration	Body Part	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«EQPMT_TYPE»	«SALE_T YPE»	«DURATIO N»	«BODY_PART_LO OKUP_BODY_DS CP»	«EFF_DATE»	«TERMINATIO N_DATE»	«HOSP_NAME»	«DR_NAME»

CONTINUED STAY

**

Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date	Facility	Provider
«UR_STATUS»	«PREVIOUSLY_CERTIFIED»	«NEW_REQUEST_OF_DAY	S»	«TOTAL_LEN_OF_STAY»	«NEW_EFFECTIVE_DATE»	«NEW_TERMINATION_DATE»	

«HOSP_NAME» «DR_NAME»

**

CorVel Corporation | PO Box 3529 | Costa Mesa, CA 92628 | *p* 714-385-8500 | *f* 866-910-4423

CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

**

	Provider

CONSULT

Determination	Type of Consult	Effective Date	Termination Date	Facility	
«UR_STATUS»	«TYPE_OF_CONSULT»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

**

OTHER

Determination	Description		Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Other_Treatment_Desc»	«notes»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

Guidelines used in the determination process: «Peer_Review_Guidelines_Used»

The clinical reasons regarding medical necessity, or lack of medical necessity, for non-certification are attached.

The clinical reason for non-certification was due to lack of medical information. **Telephonic requests for medical information were made on** «First_follow_up_call_Date» **and on** «Second_follow_up_call_Date»**. A faxed request for medical information was made on** «Del~~ay –~~Info_Request_Date»**.** The decision will be reconsidered once the requested information is received.

Please note the utilization review process is mandatory and has been done in accordance with California Labor Code §4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.8.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured 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 this decision.

You have the right to disagree with the decision affecting your claim. If you have questions about the information in this notice, please call your adjuster, «adj2» «adj1», at «adj9». However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

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

The internal appeals process is on a voluntary basis. It 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. Should the requesting medical provider wish to appeal the non-certification or modification decision, and/or have additional pertinent clinical information, which has not previously been submitted for review, you may submit a request for appeal to CorVel Corporation or the claims administrator. You may include any additional clinical information if you have any. This will be reviewed by a different reviewing physician. **Requests for appeal need to be sent to CorVel Corporation or the claims administrator within ten (10) days after the receipt of the utilization review decision.** A response to your appeal will be rendered within thirty (30) days after receipt of the request. Requests for appeal do not replace the objection process noted above and are voluntary.

In accordance with regulationsection 9792.9.1(e)(5)(K), if therequestingphysicianwishes to speak to the reviewingphysicianregardingthis determination, you can call (916) 605-3800 to arrange an agreed upon scheduled time between the hours of 8:30 a.m. to 5:30 p.m. Monday through Friday (PST). Should the reviewing physician be unable to speak with you, another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services will be made available.

**For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

****NOTE****

Please attach a copy of this recommendation letter with your bill; otherwise, payment may be delayed.

Utilization review does not include determinations of employer liability of the work injury, or of bill review for the purpose of determining whether the medical services were accurately billed.

Sincerely,

«adv3» «adv4»
Utilization Management Department

cc: Office Copy

Peer Reviewer's Report

IMR

«adj2» «adj1»

«pt2» «pt1»

«fac1»

**

«p_atty2» «p_atty1»

«d_atty2» «d_atty1»

«CM_Name»

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**

«Outside_nurse_CM_Name»

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State of California, Division of Workers' Compensation

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

DWC Form IMR

TO REQUEST INDEPENDENT MEDICAL REVIEW:

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

Type of Utilization Review: ☐ Regular ☐ Expedited	Modification after appeal ☐
Employee Name (First, MI, Last): «pt2» «pt1»	
Address: «pt4» «pt5» «pt6», «pt7» «pt8»	
Phone Number: «pt10»	Employer: «emp1»
Claim Number: «claim1»	Date of Injury (MM/DD/YYYY): «claim3»
WCIS Jurisdictional Claim Number (if assigned): «JurisdictionClaimNumber»	EAMS Case Number (if applicable) :
Employee Attorney (if known): «p_atty2» «p_atty1»	
Address: «p_atty4» «p_atty5» «p_atty6», «p_atty7» «p_atty8»	
Phone Number: «p_atty9»	Fax Number: «p_atty10»
Requesting Physician Name (First, MI, Last): «phys2» «phys1»	
Practice Name:	Specialty:
Address: «phys4» «phys5» «phys6», «phys7» «phys8»	
Phone Number: «phys9»	Fax Number: «phys12»
Claims Administrator Name: «cust1» / «tpa1»	
Adjuster/Contact Name: «adj2» «adj1»	
Address: «adj4» «adj5» «adj6», «adj7» «adj8»	
Phone Number: «adj9»	Fax Number: «adj10»
Disputed Medical Treatment (Complete below section)	
Primary Diagnosis (Use ICD Code where Practical): «trmnt1»	
Date of Utilization Review Determination Letter: «Peer_Report_Date»	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☐ No Reason:	
List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.	
1. «Treatments_Requested»	
2. «Treatments_Requested»	
3. «Treatments_Requested»	
4. «Treatments_Requested»	

Request for Review and Consent to Obtain Medical Records

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

Employee Signature:	Date:

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

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

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

You can request independent medical review by signing and submitting this form with a copy of the written determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your claims administrator.

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

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

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

Your Right to Provide Information

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

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

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling g toll-free I -800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.DWC Form IMR (Effective 2/2014)

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee s behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)			
Address:			
City:	State:		Zip Code:
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:			Date:

**

Modification Recommendation

CLAIM #:	«claim1»	**INSURED:**	«emp1» / «ins1»
DOI:	«claim3»	**CARRIER/TPA:**	«cust1» / «tpa 1»
CLAIMANT:	**«pt2» «pt1»**	**ADJUSTER:**	«adj2»«adj1»
CORVEL #:	«claim2»-«claim30»«Service_Sequence_Code»		

Determination Date:	«Peer_Report_Date»
RFA FirstReceived Date:	«Date_Customer_Received_Referral»
Review Type:	«REQ_TYPE»
Provider:	«phys2»«phys1»
Pre-Cert #:	«claim2»-«claim30»«Service_Sequence_Code»
Network:	«Network_Channeling»
Treatment Requested:	
Treatment Approved:	
Treatment Denied:	

CorVel Corporation has been asked to review the below noted treatment request for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor, «Peer_Reviewer_Name», «Peer_Reviewer_License_Number», who is board certified in «Peer_Reviewer_Specialty», was unable to recommend the full requested treatment. The modification decision was made on «Peer_Report_Date».

SURGERY

Determination	Type of Surgery	Body Part	CPT	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

MEDICATION

Determination	Type of Medication	Nameof Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Medication_Type»	«MEDICATION_NAME»	«DOSAGE»	«REFILL_NUM»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

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**

THERAPY

Determination	Type of Therapy	Total # Visits	Total Visits/ Week	Total Weeks	Body Part	CPT	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«THERAPY_REQ»	«RQST_TTL_VISITS»	«RQST_TTL_VISITS_WK»	«RQST_TTL_WK»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

TESTING

Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date	CPT	Facility	Provid r
«UR_STATUS»	«TEST_TYPE»	«CONTRAST_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«CPT»	«HOSP_NAME»	«DR_NAME»

INJECTION

Determination	Type/Site of Injection	Nameof Medication	Dosage	# of Injections	Body Part	Effective Date	TDeaterte mination	CPT	Facility	Provider
«UR_STATUS»	«INJECTN_SITE»	«INJECTION_NAME»	«DOSAGE»	«INJECTN_NUM»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«CPT»	«HOSP_NAME»	«DR_NAME»

DME

Determination	Type of Equipment	Rental / Purchase	IfRental, Duration	Body Part	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«EQPMT_TYPE»	«SALE_TYPE»	«DURATION»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

CONTINUED STAY

Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date	Facility	Provider
«UR_STATUS»	«PREVIOUSLY_CERTIFIED»	«NEW_REQU		EST_OF_DAYS»		«TOTAL_LEN	

_OF_STAY»	«NEW_EFFECTIVE_DATE»	«NEW_TERMINATION_DATE»	«HOSP_NAME» «DR_NAME»

CONSULT

Determination	Type of Consult	Effective Date	Termination Date	Facility	Provider

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CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

**

«UR_STATUS»	«TYPE_OF_CONSULT»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

OTHER

Determination	Description		Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Other_Treatment_Desc»	«notes»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

Guidelines used in the determination process: «Peer_Review_Guidelines_Used»

The clinical reasons regarding medical necessity, or lack of medical necessity, for non-certification are attached.

Please note the utilization review process is mandatory and has been done in accordance with California Labor Code §4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.8.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured workers representative, or the injured workers attorney on behalf of the injured worker on the Application for Independent Medical Review, DWC Form IMR, within 10 calendar days after the service of utilization review decision to the employee for formulary disputes, and within 30 calendar days after the service of the utilization review decision to the employee for all other medical treatment disputes.

You have the right to disagree with the decision affecting your claim. If you have any questions about the information in this notice, please call your adjuster, «adj2» «adj1», at «adj9». However if you are represented by an attorney, please contact your attorney instead of your adjuster.

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

The internal appeals process is on a voluntary basis. It 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. Should the requesting medical provider wish to appeal the non-certification or modification decision, and/or have additional pertinent clinical information, which has not previously been submitted for review, you may submit a request for appeal to CorVel Corporation or the claims administrator. You may include any additional clinical information if you have any. This will be reviewed by a different reviewing physician. **Requests for appeal need to be sent to CorVel**

CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

Corporation or the claims administrator within ten (10) days after the receipt of the utilization review decision. A response to your appeal will be rendered within thirty (30) days after receipt of the request. Requests for appeal do not replace the objection process noted above and are voluntary.

In accordance with regulationsection 9792.9.1(e)(5)(K), if therequestingphysicianwishes to speak to the reviewingphysicianregardingthis determination, you can call (916) 605-3800 to arrange an agreed upon scheduled time between the hours of 8:30 a.m. to 5:30 p.m. Monday through Friday (PST). Should the reviewing physician be unable to speak with you, another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services will be made available.

**For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

****NOTE****
Please attach a copy of this recommendation letter with your bill; otherwise, payment may be delayed.

Utilization review does not include determinations of employer liability of the work injury, or of bill review for the purpose of determining whether the medical services were accurately billed.

Sincerely,

«adv3» «adv4»
Utilization Management Department

cc: Office Copy

Peer Reviewer's Report

«adj2» «adj1»

«pt2» «pt1»

«fac1»

«p_atty2» «p_atty1»

«d_atty2» «d_atty1»

«CM_Name»

**

«Outside_nurse_CM_Name»

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State of California, Division of Workers' Compensation

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

DWC Form IMR

TO REQUEST INDEPENDENT MEDICAL REVIEW:

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

Type of Utilization Review: ☐ Regular ☐ Expedited	Modification after appeal ☒
Employee Name (First, MI, Last): «pt2» «pt1»	
Address: «pt4» «pt5» «pt6», «pt7» «pt8»	
Phone Number: «pt10»	Employer: «emp1»
Claim Number: «claim1»	Date of Injury (MM/DD/YYYY): «claim3»
WCIS Jurisdictional Claim Number (if assigned): «JurisdictionClaimNumber»	EAMS Case Number (if applicable) :
Employee Attorney (if known): «p_atty2» «p_atty1»	
Address: «p_atty4» «p_atty5» «p_atty6», «p_atty7» «p_atty8»	
Phone Number: «p_atty9»	Fax Number: «p_atty10»
Requesting Physician Name (First, MI, Last): «phys2» «phys1»	
Practice Name:	Specialty:
Address: «phys4» «phys5» «phys6», «phys7» «phys8»	
Phone Number: «phys9»	Fax Number: «phys12»
Claims Administrator Name: «cust1» / «tpa1»	
Adjuster/Contact Name: «adj2» «adj1»	
Address: «adj4» «adj5» «adj6», «adj7» «adj8»	
Phone Number: «adj9»	Fax Number: «adj10»
Disputed Medical Treatment (Complete below section)	
Primary Diagnosis (Use ICD Code where Practical): «trmnt1»	
Date of Utilization Review Determination Letter: «Peer_Report_Date»	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☐ No Reason:	
List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.	
1. «Treatments_Requested»	
2. «Treatments_Requested»	
3. «Treatments_Requested»	
4. «Treatments_Requested»	

Request for Review and Consent to Obtain Medical Records

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

Employee Signature:	Date:

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

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

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

You can request independent medical review by signing and submitting this form with a copy of the written determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your claims administrator.

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

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

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

Your Right to Provide Information

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

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

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling g toll-free I -800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.DWC Form IMR (Effective 2/2014)

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee s behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)			
Address:			
City:	State:		Zip Code:
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:			Date:

Certification Physician Advisor Recommendation

CLAIM #:	«claim1»	**INSURED:**	«emp1» / «ins1»
DOI:	«claim3»	**CARRIER/TPA:**	«cust1» / «tpa 1»
CLAIMANT:	**«pt2» «pt1»**	**ADJUSTER:**	«adj2»«adj1»
CORVEL #:	«claim2»-«claim30»«Service_Sequence_Code»		

Determination Date: «Date_Completed»

RFA First Received Date: «Date_Customer_Received_Referral»

Review Type: «REQ_TYPE»

Provider: «phys2»«phys1»

Pre-cert #: «claim2»-«claim30»«Service_Sequence_Code»

Network: «Network_Channeling»

Treatment Requested:

Treatment Approved:

CorVel Corporation has been asked to review the below noted treatment request for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor, «Peer_Reviewer_Name», «Peer_Reviewer_License_Number», who is board certified in «Peer_Reviewer_Specialty», has certified the requested treatment. The certification decision was made on «Date_Completed» and is summarized below:

SURGERY

Determination	Type of Surgery	Body Part	CPT	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

MEDICATION

Determination	Type of Medication	Nameof Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Medication_Type»	«MEDICATION_NAME»	«DOSAGE»	«REFILL_NUM»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

CorVel Corporation | PO Box 3529 | Costa Mesa, CA 92628 | *p* 714-385-8500 | *f* 866-910-4423

CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

Determination	Type of Therapy	Total # Visits	Total Visits/ Week	Total Weeks	Body Part	CPT	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«THERAPY_REQ»	«RQS T_TTL _VISITS»	«RQS T_TTL _VISITS_WK»	«RQS T_TTL _WK»	«BODY_PART_LOOKUP_BODY_DSCP»	«CPT»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

TESTING

Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date	CPT	Facility	Provid r
«UR_STATUS»	«TEST_TYPE»	«CONTRAST_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«CPT»	«HOSP_NAME»	«DR_NAME»

INJECTION

Determination	Type/Site of Injection	Nameof Medication	Dosage	# of Injections	Body Part	Effective Date	TDeatermination	CPT	Facility	Provider
«UR_STATUS»	«INJECTN_SITE»	«INJECTION_NAME»	«DOSAGE»	«INJECTN_NUM»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«CPT»	«HOSP_NAME»	«DR_NAME»

DME

Determination	Type of Equipment	Rental / Purchase	If Rental, Duration	Body Part	Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«EQPMT_TYPE»	«SALE_TYPE»	«DURATION»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

CONTINUED STAY

Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date	Facility	Provider
«UR_STATUS»	«PREVIOUSLY_CERTIFIED»	«NEW_REQUEST_OF_DAY	«TOTAL_LEN_OF_STAY»	«NEW_EFFECTIVE_DATE»	«NEW_TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

CONSULT S»

Determination	Type of Consult	Effective Date	Termination Date	Facility
«UR_STATUS»	«TYPE_OF_CONSULT»	«EFF_DATE»	«TERMINATION_D	«HOSP_NAME»

«DR_
NAME
»

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CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

OTHER

Determination	Description		Effective Date	Termination Date	Facility	Provider
«UR_STATUS»	«Other_Treatment_Desc»	«notes»	«EFF_DATE»	«TERMINATION_DATE»	«HOSP_NAME»	«DR_NAME»

To obtain a review for continued treatment after the above noted certification period, please call CorVel Corporation at (916) 605-3800. Our hours of operation are from 8:30 a.m. to 5:30 p.m. PST, Monday through Friday.

Please note this review has been done in accordance with California Labor Code Section 4610 and the California Medical Treatment Utilization Schedule has been utilized in the determination process as required in Title 8, California Code of Regulation 9792.8.

**For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

****NOTE****
Please attach a copy of this recommendation letter with your bill; otherwise, payment may be delayed.

Utilization review does not include determinations of employer liability of the work injury, or of bill review for the purpose of determining whether the medical services were accurately billed.

Sincerely,

«adv3» «adv4»
Utilization Management Department

cc: Office Copy

«adj2» «adj1»

«pt2» «pt1»

CorVel Corporation | PO Box 3529 | Costa Mesa, CA 92628 | *p* 714-385-8500 | *f* 866-910-4423

CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

«fac1»

«p_atty2» «p_atty1»

«d_atty2» «d_atty1»

«CM_Name»

«Outside_nurse_CM_Name»

«phys4»
«phys6», «phys7» «phys8»
Fax: «phys12»

So we may expedite your UR request, please attach copy of this letter with your documentation & return within 48hours. Your prompt response is appreciated.

CLAIM #:	«claim1»	**INSURED:**	«emp1» / «ins1»
DOI:	«claim3»	**CARRIER/TPA:**	«cust1» / «tpa 1»
CLAIMANT:	**«pt2» «pt1»**	**ADJUSTER:**	«adj2»«adj1»
CORVEL #:	«claim2»-«claim30»«Service_Sequence_Code»		

Information Request Date:	«Delay_Info_Request_Date»
RFA FirstReceived Date:	«Date_Customer_Received_Referral»
Review Type:	«REQ_TYPE»
Provider:	«phys2»«phys1»
Pre-cert #:	«claim2»-«claim30»«Service_Sequence_Code»
Network:	«Network_Channeling»

We have been asked to provide utilization review of your recent request for certification of «Treatments_Requested». Additional information is necessary to reach a determination of the medical necessity of your request. Please submit reasonably necessary medical information as follows **within 48 hours**:

☐ The request for review was initiated without the Request for Authorization or Medical Reports required to process review of non-exempt medications in the pharmacy formulary. Please submit these documents immediately to avoid delays in addressing the plan of care.

☐ Provide Laboratory/Drug Screening results from most recent test.

☐ Per a previous peer to peer agreement, the request for «Treatments_Requested» was agreed to be discontinued and appears to have been re-requested. Please provide the medical necessity for this medication and a rational for the change from the previous review of this medication.

☐ Provide documentation of pain/medication contract with patient.

☐ Please document plan to address violations in pain/medication contract

☐ Our records currently show that «Treatments_Requested» was prescribed by [PHYSICIAN NAME] on [DATE]. Is your intent to replace this prior prescribing physician?

☐ Is there a plan to change prescription management between approved providers?

☐ Please state the medical necessity for physician dispensed medications.

This notification is in compliance with Labor Code section 4610. Should the request be non-certified due to lack of information, the case will be reopened and the request will be reconsidered upon receipt of the requested medical information. If you have any questions or if we may be of further assistance, please contact CorVel at the number below. You can discuss this case with CorVel by contacting us at (916) 605-3800. Our hours of operation are from 8:30 a.m. to 5:30 p.m. PST, Monday through Friday.

**For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Sincerely,

«adv3» «adv4»
Utilization Management Department
Telephone: «UR_CM_Phone»
Fax: «UR_CM_FAX»

cc: Office Copy

«adj2» «adj1»

«pt2» «pt1»

«fac1»

«p_atty2» «p_atty1»

«d_atty2» «d_atty1»

«CM_Name»

«Outside_nurse_CM_Name»

«Delay_Info_Request_Date»

«phys2» «phys1»
«phys12»

So we may expedite your UR request, please attach copy of this letter with your documentation& return within 48hours. Your prompt response is appreciated.

CLAIM #:	«claim1»	**INSURED:**	«emp1» /«ins1»
DOI:	«claim3»	**CARRIER/TPA:**	«cust1» / «tpa 1»
CLAIMANT:	**«pt2» «pt1»**	**ADJUSTER:**	«adj2» «adj1»
CORVEL #:	«claim2»- «claim30»«Service_Sequence_Code»	**RFA FIRST RECEIVED DATE:**	«Date_Customer_Received_Referral»

We have been asked to provide utilization review of your recent request for certification of «Treatments_Requested». Additional information is necessary to reach a determination of the medical necessity of your request. Please submit reasonably necessary medical information as follows **within 48 hours**:

«	Most current PR2
«	History & physical
«	Prior treatment/response
«	Operative/procedure report(s)
«	Laboratory results
«	Any available diagnostic studies
«	Initial evaluation/Progress reports

	CPT and ICD9 codes
	Current treatment plan
	Plans for discharge
	Number of visits to date
«	Start of care date
«	
«	
«	
«	

If we do not obtain the necessary information within three attempts; one being written, this request will be non-certified by a physician reviewer within the 14 day time frame due to lack of information. To expedite the review, you may fax directly to CorVel at «UR_CM_FAX».

This notification is in compliance with Labor Code section 4610. Should the request be non-certified due to lack of information, the case will be reopened and the request will be reconsidered upon receipt of the requested medical information. If you have any questions or if we may be of further assistance, please contact CorVel at the number below.

**For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state

prison.

Sincerely,

«adv3» «adv4»
Utilization Management Department

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CorVel Corporation | PO Box 279350 | Sacramento, CA 95827 | *p* 916-605-3800 | *f* 866-449-0449

cc: Office Copy

«adj2» «adj1»

«pt2» «pt1»

«fac1»

«p_atty2» «p_atty1»

«d_atty2» «d_atty1»

«CM_Name»

«Outside_nurse_CM_Name»

APPENDIX E: SAMPLE PEER REPORT

Network Medical Review Co. Ltd.

"An ExamWorks Company"

FILE TYPE:
REFERRED BY:
ADDRESS:
NAME:
CASE #:
EMPLOYER:
DOI:
REVIEW TYPE:
NMR #:
STATE JURISDICTION: CA
DATE:

TELECONFERENCE #1:
1) **TP NAME:**
2) **PHONE NUMBER:**
3) **DATE:**
4) **TIME:**
5) **PERSON SPOKEN WITH:**
6) **POSITION OF PERSON SPOKEN WITH:**

SUMMARY OF CONVERSATION:

TELECONFERENCE #2:
1) **TP NAME:**
2) **PHONE NUMBER:**
3) **DATE:**
4) **TIME:**
5) **PERSON SPOKEN WITH:**
6) **POSITION OF PERSON SPOKEN WITH:**

SUMMARY OF CONVERSATION:

TELECONFERENCE #3:
1) **TP NAME:**
2) **PHONE NUMBER:**
3) **DATE:**
4) **TIME:**
5) **PERSON SPOKEN WITH:**
6) **POSITION OF PERSON SPOKEN WITH:**

SUMMARY OF CONVERSATION:

MEDICAL RECORDS REVIEWED:

PROGRESS NOTES	John Smith, M.D.	06/21/18
MISC		06/21/18 - 07/17/18

DIAGNOSIS:

CLINICAL SUMMARY:

List Medicals reviewed:

Requested Treatment:	**Determination:**
	Not Certified
	Not Certified

IN ANSWER TO YOUR SPECIFIC QUESTIONS:

ASSESSMENT: Not Certified

EXPLANATION FOR ASSESSMENT:

NATIONAL CRITERIA/LITERATURE: California MTUS Chronic Pain Medical Treatment

Conflict of Interest Attestation:
I certify that I do not accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review. I do not have a material professional, familial, or financial conflict of interest (financial conflict of interest is defined as ownership interest of greater than 5%) regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of the principle drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the review.

This attestation certifies that the peer reviewer named below has the appropriate scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review and has current, relevant experience and/or knowledge to render a determination for the case under review.

PHYSICIAN ADVISOR:

Khiem D. Dao, M.D.
Board Certified Orthopedic Surgery
Board Certified Surgery of the Hand
Licensed in the State of CA #G 83781

NMR Conflict of Interest Attestation:

NMR attests to the fact that there is no conflict of interest with this review for referring entity, benefit plan, enrollee/consumer, attending provider, facility, drug, device or procedure. NMR attests that its compensation is not dependent on the specific outcome of this review or has had any involvement with this case prior to this referral.

To discuss the contents or decisions of this report, an appointment can be scheduled upon a treating physician's request. To schedule an appointment during the available hours of 8:00 a.m. to 2:30 p.m. Pacific Time please contact Network Medical Review at 815-964-2752. An appointment will be scheduled with either the reviewer, physician representative, or medical director.