



Workers' Compensation
Utilization Management Plan

State of California

April 2026



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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 9792.9.5(e)(14) 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 contracted 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 §9792.9.4 for approvals (by non-physician and physician) and 9792.9.5 for modifications and denials (sent to 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.

- **§9792.6.1 (u), (1, 2, 3), Utilization Review Standards---Definitions**

(u) "Request for authorization" means a written request for a specific course of proposed medical treatment that meets all of the following criteria:

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

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

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

- Per 9792.9.1(b), upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a claims administrator, non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it “not complete” and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt. A request for authorization accepted as complete shall be subject to investigation under section 9792.11 and the assessment of administrative penalties under section 9792.12.
- **§9792.9.2. Utilization Review —Dispute of Liability; Deferral.**
 - (a)(1) Utilization review of a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.
 - (2)(A) A claims administrator who determines that Labor Code section 4610(k) precludes the need for utilization review must comply with the requirements under this section.
 - (B) A request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change. Such a request must be reviewed by a physician reviewer and any modification or denial of the request must comply with applicable requirements as set forth at section 9792.9.5.
- 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.

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

Section 9792.9.3 Utilization Review-Timeframes

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

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

(c) Prospective or concurrent decisions to approve, modify, or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under subdivision (b) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (b).

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

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

Section 9792.9.6, Utilization Review- Extension of Timeframes for Decision

(a)(1) The timeframes for decisions specified in section 9792.9.3 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.

(b)(1) If the circumstance under subdivision (a)(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.

(2) If any of the circumstances set forth in subdivisions (a) (1)(B) or (C) are deemed to apply following the receipt of a complete or accepted request for authorization, the physician 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 indicate that a consultation by an expert reviewer is needed, in which case, the specialty of the expert reviewer to be consulted must be identified.

(c)(1) If the information reasonably necessary to make a determination under subdivision (a) (1)(A) that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed or accepted request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, a physician reviewer shall deny the request in accordance with applicable rules in section 9792.9.5(e).

(d)(1) Upon receipt of the information requested pursuant to subdivisions (a)(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 in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5.

(2) Upon receipt of the information requested pursuant to subdivisions (a)(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 in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5.

Section 9792.9.7. Utilization Review – Medical Treatment – First 30 Days of the Date of Injury

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

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

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

(3) The initial treating physician timely submits the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, to the claims administrator as required by section 9785, subdivision (e), setting forth in detail the anticipated treatment plan for the injured worker.

- (4) All treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, are set forth in a request for authorization provided to the claims administrator in accordance with section 9785(h). The form shall be submitted to the claims administrator concurrent with the Doctor's First Report of Occupational Injury or Illness. Subsequent treating physicians during the 30-day period shall submit a request for authorization following their first visit with the injured worker indicating all treatment being rendered.
- (5) The treating physician's medical treatment bill for the non-emergency treatment rendered or services provided under this section is submitted to the claims administrator within thirty (30) days of the date the service was provided. Medical treatment bills for emergency treatment services shall be submitted within 180 days of the date that the treatment was provided.
- (b) The following medical treatment services, unless previously authorized by the claims administrator or rendered as emergency medical treatment, cannot be provided under subdivision (a) and shall require prospective utilization review under section 9792.9.1 or 9792.9.3:
- (1) Pharmaceuticals, to the extent they are not expressly exempt from prospective review under the MTUS Drug Formulary.
 - (2) Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician's office. This includes all necessary and routine pre-operative, intra-operative, and post-operative services performed for the purpose of surgery including, but not limited to, related diagnostic tests or procedures, rehabilitation services, durable medical equipment or supplies, and routine post-surgical pain management treatment or services. For the purpose of this section, "surgery" means: 1) any procedure set forth in the Surgery section of the American Medical Association's Current Procedural Terminology (CPT®) which is incorporated by reference at section 9789.31(h), and any updates pursuant to section 9789.36; or 2) any procedure code defined as "surgery" in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule found in the Healthcare Common Procedure Coding System (HCPCS), which is incorporated by reference at section 9789.31(i), and any updates pursuant to section 9789.36.
 - (3) Psychological or psychiatric treatment services, which includes diagnostic services, psychotherapy, and other services or procedures to an individual or group in all care settings provided by a physician or other qualified health care provider, and including psychiatric pharmaceuticals, to the extent they are not expressly exempt from prospective utilization review under the MTUS Drug Formulary.
 - (4) Home health care services, including health care and other medically necessary services provided to the injured worker in the residential setting.
 - (5) Imaging and radiology services, excluding X-rays.
 - (6) All durable medical equipment, prosthetics, orthotics, and supplies where the purchase or rental cost of the item with necessary supplies, if any, for the expected course of treatment is

greater than \$250.00 as determined by the DWC Official Medical Fee Schedule (OMFS), or, for an unlisted item, where the billed amount will be greater than \$250.00.

(7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies. For the purpose of the subdivision, electrodiagnostic medicine is a medical specialty where the physician uses neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic, neuromuscular, and/or muscular systems. This includes, but is not limited to, procedures set forth in the American Current Procedural Terminology (CPT®) Medicine section, under the subheading "Neurology and Neuromuscular Procedures," and any test that measures the speed and degree of electrical activity in the muscles and nerves in order to make a diagnosis.

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

(c)(1) If the claims administrator determines, after retrospective review, that a physician providing treatment under subdivision (a) of this section has a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, the claims administrator may:

(A) Remove the ability of the physician to render treatment exempt from prospective review to any injured worker whose claim is adjusted or administered by the claims administrator. The claims administrator must provide written notice to the physician that: (1) documents, based on retrospective review, the physician's pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary; (2) advises that based on the documented failure the physician can no longer render exempt treatment to any injured worker whose claims are adjusted or administered by the claims administrator; and (3) advises of the requirement of prospective utilization review for all subsequent medical treatment.

(B) Remove the physician as the injured worker's primary treating physician by filing a petition for change of primary treating physician under section 9786.

(C) Terminate the physician from the claims administrator's or employer's medical provider network or health care organization.

(2) For the purpose of this section, "pattern and practice" means when treatment has been rendered inconsistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, for twenty (20) separate and unrelated recommended medical services or goods with ten (10) or more injured workers over the course of three (3) months; or for eight (8) separate and unrelated medical services or goods with two (2) or less injured workers within a month.

(d) If a physician renders treatment under this section without timely submitting the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, to the claims administrator as required by section 9785(e), or without timely submitting a complete request for authorization as required by section 9792.6.1(u), the claims administrator may remove the physician's ability to provide further medical treatment that is exempt from prospective review to the employee

for the remainder of the thirty-day time period referenced at subdivision (a) by issuing written

notice to the physician. The written notice must identify that the physician either failed to timely submit the DIR Form 5021 or failed to timely submit a complete request for authorization, advise that the physician can no longer render exempt treatment to the injured worker for the remainder of the thirty days, and advise that any such treatment is subject to prospective utilization review.

- (e) Any dispute between the treating physician and the claims administrator regarding application of the provisions as allowed under subdivision (c) or (d) shall be resolved by the Workers' Compensation Appeals Board.

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 REVIEW

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.

9792.9.8. Utilization Review — MTUS Drug Formulary.

(a) This subdivision governs review of Exempt Drugs listed on the MTUS Drug List.

(1) Notwithstanding sections 9792.9.1 through 9792.9.7, the following drugs can be dispensed to an injured worker without obtaining authorization through prospective review:

(A) Drugs identified on the MTUS Drug List as exempt under section 9792.27.15;

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

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

(2) Exempt drugs identified in subsection (1) must still be set forth in a request for authorization as required under section 9792.6.1(u), or in a manner agreed upon by the treating physician and the claims administrator.

(b) This subdivision governs review of Non-Exempt Drugs that are listed on the MTUS Drug List. For a drug not covered under subdivision (a) of this section, regardless of whether a drug is prescribed and dispensed within 30 days from the date of injury, the treating physician must request authorization through prospective utilization review by submitting a request for authorization in the manner set forth in section 9792.6.1(u), or in a manner agreed upon by the treating physician and the claims administrator.

(1) Prospective decisions to approve, modify, or deny a request for authorization for a drug not covered under subdivision (a) of this section shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the request for treatment. The reviewer or non-physician reviewer may request the treating physician to

provide additional information reasonably necessary to make a determination as follows:

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

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

(2) The decision shall be communicated in the manner set forth in sections 9792.9.4 and 9792.9.5.

(3) The extension of time as set forth in section 9792.9.6 is not applicable to a request for authorization of a drug covered under this subdivision.

(c) This subdivision governs review of drugs that are not listed on the MTUS Drug List. A treating physician must request authorization through prospective review for a drug not listed on the MTUS Drug List by submitting a request for authorization in the manner set forth in section 9792.6.1(u) or in a manner agreed upon by the treating physician and the claims administrator, regardless of whether a drug is prescribed or dispensed within 30 days from the date of injury. Prospective decisions to approve, modify, deny a request for authorization of a drug not listed on the MTUS Drug List shall be made in a timely fashion in accordance with section 9792.9.3 and section 9792.9.6. The decision shall be communicated in the manner set forth in sections 9792.9.4 and 9792.9.5.

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

(e) Except for drugs that fall under 9792.9.7(a), a utilization review decision to deny a request for authorization of a drug which falls under subdivision (a) of this section based on the failure of the treating physician to prescribe or dispense the medication consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule, can be grounds for the denial of payment for the medication.

(f)(1) A decision to modify or deny a request for authorization under this section based on medical necessity shall be reviewed only through the claims administrator's voluntary internal utilization review appeals process, or the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

(2) A dispute regarding a decision to modify or deny a request for authorization under this section based on a reason other than medical necessity shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

(3) If a decision is made to modify or deny a request for authorization under this section based on both medical necessity and a reason other than medical necessity, the non-medical necessity dispute shall be resolved first.

(g) The following rules apply when a treating physician prescribes or dispenses a drug to treat an

injured worker under the provisions of section 9792.9.7(a).

(1) The injured worker's initial treating physician shall describe in the treatment plan on the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, all drugs that are being prescribed or dispensed to treat the injured worker, and list on the request for authorization required under section 9792.9.7(a)(4), all drugs that are being prescribed or dispensed. Subsequent primary treating physicians shall submit a request for authorization following their first visit with the injured worker indicating all drugs that are being prescribed or dispensed for treatment.

(2) The treating physician may prescribe or dispense a drug identified under subdivision (a) of this section without the need to obtain authorization through prospective utilization review.

(3) For a drug not covered under subdivision (a) of this section, the treating physician must request authorization through prospective utilization review by submitting a request for authorization in the manner set forth in section 9792.9.1, or in a manner agreed upon by the treating physician and the claims administrator.

(4) The claims administrator may conduct retrospective review of a drug prescribed or dispensed to the Injured worker under subdivision (a) of this section only for the purpose of determining whether the use of the drug is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director under Section 5307.27.

(A) Payment for an exempt drug dispensed under the provisions of section 9792.9.7(a) shall not be denied based on a determination that use of the drug was not consistent with the applicable guideline.

(B) Use of an exempt drug that is not consistent with the applicable guideline may be used as a basis to find that the physician, under section 9792.9.7(c), has a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule.

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.

Per 9792.9.4. Utilization Review — Decisions to Approve a Request for Authorization

(a) (1) All written decisions to approve a request for authorization shall specify the date the complete, or accepted as complete, request for authorization was first received, the medical treatment service requested, the specific medical treatment service approved, and the date of the decision. If applicable, the written decision shall also include the date the request for information, exam, or consultation under section 9792.9.6, subdivision (a)(1)(A), (B), or (C) was requested, and the date the information was received.

(2) For approvals of a request for authorization of a drug where the request for authorization did not indicate “Do Not Substitute” or “Dispense as Written,” the written decision approving the request in generic form shall indicate, “generic substitute authorized” or words to that effect and meaning.

(3) For approvals of a request for authorization of a drug that is exempt on the Drug Formulary, the written decision approving the request shall indicate, "Exempt per MTUS Drug Formulary" or words to that effect and meaning.

(4) For approvals of a request for authorization of non-drug treatment that are exempt under section 9792.9.7 (i.e., the 30-day exemption), the written decision approving the request shall identify the exempt treatment as, "30-day exemption" or words to that effect and meaning.

(b) For prospective, concurrent, or expedited review, a decision to approve a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. If the initial communication is by telephone, written communication shall issue to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.

(c)(1) For retrospective review, a written decision to approve shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.

(2) Payment, or partial payment, of a medical bill for services requested on a request for authorization shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete. A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured employee who received the medical services, and his or her attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

Per 9792.9.5. Utilization Review — Decisions to Modify or Deny a Request for Authorization.

(a) The review and decision to deny or modify a request for medical treatment must be conducted by a physician reviewer, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice.

(b) Failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.

(c) For prospective, concurrent, or expedited review, a decision to modify or deny a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. Written communication of the decision shall issue to the injured worker, and, if applicable, to the injured worker's representative within 24 hours of the decision for concurrent review, within two

(2) business days for prospective review, and, for expedited review, within 72 hours of receipt of the request. Written communication in accordance with this paragraph shall also issue to the requesting physician where the initial communication of the decision to the physician was by telephone.

(d) For retrospective review, a written decision to deny part or all of the requested medical treatment based on medical necessity 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 the receipt of the request for authorization and information that is sufficient for a reviewer to make a determination as to whether the treatment was medically necessary.

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

(1) The date on which the completed or accepted request for authorization was first received.

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

(3) The date on which the decision is made.

(4) A description of the specific course of medical treatment set forth on the request for authorization.

(5) A list of all medical records reviewed.

(6) A specific description of the medical treatment service approved, if any.

(7) (A) A clear, concise, and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity or; if applicable, that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation.

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

(8) For decisions based on medical necessity, a citation to and a description of the relevant medical criteria or guidelines used to reach the decision.

(9) Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.

(10) 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.

(11) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

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

"You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call 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."

(13) Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, including with respect to disputes over the necessity of or availability of the requested information, 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.

(14) The written decision modifying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or, if applicable, 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. In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

(f) The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment:

(1) 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.

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

Per 9792.10.1. Utilization Review--Dispute Resolution

(a)(1) A request for independent medical review of a utilization review decision that denies or modifies a medical treatment request must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days of service of the written utilization review determination issued by the claims administrator under section 9792.9.5(e).

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

(b) A request for independent medical review must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision denying or modifying the request for authorization of medical treatment. At the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision denying, or modifying the request for authorization of medical treatment, to the claims administrator.

CONFIDENTIALITY POLICY REFERENCES

Labor Code section 4603.4

- (a) The administrative director shall adopt rules and regulations to do all of the following:
- (1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms.
 - (2) Require acceptance by employers of electronic claims for payment of medical services.
 - (3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.
 - (4) Require the timely submission of paper or electronic bills in conformity with subparagraph (B) of paragraph (1) of subdivision (b) of Section 4603.2.
- (b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996.
- (c) Require all employers to accept electronic claims for payment of medical services.
- (d) Payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made with an explanation of review by the employer within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Section 5307.1. If the billing is contested, denied, or incomplete, payment shall be made with an explanation of review of any uncontested amounts within 15 working days after electronic receipt of the billing, and payment of the balance shall be made in accordance with Section 4603.2.

Labor Code section 4610.5

- (a) This section applies to the following disputes:
- (1) Any dispute over a utilization review decision regarding treatment for an injury occurring on or after January 1, 2013.
 - (2) Any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.
 - (3) Any dispute occurring on or after January 1, 2018, over medication prescribed pursuant to the formulary adopted pursuant to Section 5307.27.

(b) A dispute described in subdivision (a) shall be resolved only in accordance with this section.

(c) For purposes of this section and Section 4610.6, the following definitions apply:

(1) "Disputed medical treatment" means medical treatment that has been modified or denied by a utilization review decision on the basis of medical necessity.

(2) "Medically necessary" and "medical necessity" mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied as set forth in the medical treatment utilization schedule, including the drug formulary, adopted by the administrative director pursuant to Section 5307.27:

(A) The guidelines, including the drug formulary, adopted by the administrative director pursuant to Section 5307.27.

(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(3) "Utilization review decision" means a decision pursuant to Section 4610 to modify or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendation by a physician prior to, retrospectively, or concurrent with, the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402. "Utilization review decision" may also mean a determination, occurring on or after January 1, 2018, by a physician regarding the medical necessity of medication prescribed pursuant to the drug formulary adopted pursuant to Section 5307.27.

(4) Unless otherwise indicated by context, "employer" means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

(d) If a utilization review decision denies or modifies a treatment recommendation based on medical necessity, the employee may request an independent medical review as provided by this section.

(e) A utilization review decision may be reviewed or appealed only by independent medical review pursuant to this section. Neither the employee nor the employer shall have any liability for medical treatment furnished without the authorization of the employer if the treatment is modified or denied by a utilization review decision, unless the utilization review decision is overturned by independent

medical review in accordance with this section.

(f) As part of its notification to the employee regarding an initial utilization review decision based on medical necessity that denies or modifies a treatment recommendation, the employer shall provide the employee with a one-page form prescribed by the administrative director, and an addressed envelope, which the employee may return to the administrative director or the administrative director's designee to initiate an independent medical review. The employee may also request independent medical review electronically under rules adopted by the administrative director. The employer shall include on the form any information required by the administrative director to facilitate the completion of the independent medical review. The form shall also include all of the following:

(1) Notice that the utilization review decision is final unless the employee requests independent medical review.

(2) A statement indicating the employee's consent to obtain any necessary medical records from the employer or insurer and from any medical provider the employee may have consulted on the matter, to be signed by the employee.

(3) Notice of the employee's right to provide information or documentation, either directly or through the employee's physician, regarding the following:

(A) The treating physician's recommendation indicating that the disputed medical treatment is medically necessary for the employee's medical condition.

(B) Medical information or justification that a disputed medical treatment, on an urgent care or emergency basis, was medically necessary for the employee's medical condition.

(C) Reasonable information supporting the employee's position that the disputed medical treatment is or was medically necessary for the employee's medical condition, including all information provided to the employee by the employer or by the treating physician, still in the employee's possession, concerning the employer's or the physician's decision regarding the disputed medical treatment, as well as any additional material that the employee believes is relevant.

(g) The independent medical review process may be terminated at any time upon the employer's written authorization of the disputed medical treatment. Notice of the authorization, any settlement or award that may resolve the medical treatment dispute, or the requesting physician withdrawing the request for treatment, shall be communicated to the independent medical review organization by the employer within five days.

(h)(1) The employee may submit a request for independent medical review to the division. The request may be made electronically under rules adopted by the administrative director. The request shall be made no later than as follows:

(A) For formulary disputes, 10 days after the service of the utilization review decision to the employee.

(B) For all other medical treatment disputes, 30 days after the service of the utilization review decision to the employee.

(2) If at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit a request for independent medical review to the administrative director or administrative director's designee is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

(3) If the employer fails to comply with subdivision (f) at the time of notification of its utilization review decision, the time limitations for the employee to submit a request for independent medical review shall not begin to run until the employer provides the required notice to the employee.

(4) A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit a request for independent medical review on its own behalf. A request submitted by a provider pursuant to this paragraph shall be submitted to the administrative director or administrative director's designee within the time limitations applicable for an employee to submit a request for independent medical review.

(i) An employer shall not engage in any conduct that has the effect of delaying the independent review process. Engaging in that conduct or failure of the employer to promptly comply with this section is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars (\$5,000) for each day that proper notification to the employee is delayed. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(j) For purposes of this section, an employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf. A designation of an agent executed prior to the utilization review decision shall not be valid. The requesting physician may join with or otherwise assist the employee in seeking an independent medical review, and may advocate on behalf of the employee.

(k) The administrative director or his or her designee shall expeditiously review requests and immediately notify the employee and the employer in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons

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

(l) Upon notice from the administrative director that an independent review organization has been assigned, the employer shall electronically provide to the independent medical review organization under rules adopted by the administrative director a copy and list of all of the following documents within 10 days of notice of assignment:

(1) A copy of all of the employee's medical records in the possession of the employer or under the control of the employer relevant to each of the following:

(A) The employee's current medical condition.

(B) The medical treatment being provided by the employer.

(C) The request for authorization and utilization review decision.

(2) A copy of all information provided to the employee by the employer concerning employer and provider decisions regarding the disputed treatment.

(3) A copy of any materials the employee or the employee's provider submitted to the employer in support of the employee's request for the disputed treatment.

(4) A copy of any other relevant documents or information used by the employer or its utilization review organization in determining whether the disputed treatment should have been provided, and any statements by the employer or its utilization review organization explaining the reasons for the decision to deny or modify the recommended treatment on the basis of medical necessity. The employer shall concurrently provide a copy of the documents required by this paragraph to the employee and the requesting physician, except that documents previously provided to the employee or physician need not be provided again if a list of those documents is provided.

(m) Any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The employer shall concurrently provide a copy of medical records required by this subdivision to the employee or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

(n) If there is an imminent and serious threat to the health of the employee, as specified in subdivision (c) of Section 1374.33 of the Health and Safety Code, all necessary information and documents required by subdivision (l) shall be delivered to the independent medical review organization within 24 hours of approval of the request for review.

(o) The employer shall promptly issue a notification to the employee, after submitting all of the required material to the independent medical review organization, that lists documents submitted and includes copies of material not previously provided to the employee or the employee's designee.

(p) The claims administrator who issued the utilization review decision in dispute shall notify the independent medical review organization if there is a change in the claims administrator responsible for the claim. Notice shall be given to the independent medical review organization within five working days of the change in administrator taking effect.

Labor Code section 4610.6

(a) Upon receipt of a case pursuant to Section 4610.5, an independent medical review organization shall conduct the review in accordance with this article and any regulations or orders of the administrative director. The organization's review shall be limited to an examination of the medical necessity of the disputed medical treatment.

(b) Upon receipt of information and documents related to a case, the medical reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the employee, provider reports, and any other information submitted to the organization or requested from any of the parties to the dispute by the reviewers. If the reviewers request information from any of the parties, a copy of the request and the response shall be provided to of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (c).

(c) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the employee and the standards of medical necessity as defined in subdivision (c) of Section 4610.5.

(d)(1) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, and the determination shall be issued, as follows:

(A) For a dispute over medication prescribed pursuant to the drug formulary submitted under subdivision (h) of Section 4610.5, within five working days from the date of receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director.

(B) For all other medical treatment disputes submitted for review under subdivision (h) of Section 4610.5, within 30 days of receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director.

(C) If the disputed medical treatment has not been provided and the employee's provider or the administrative director certifies in writing that an imminent and serious threat to the health of the employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the employee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information.

(2) Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

(e) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the employee's medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (c) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(f) The independent medical review organization shall provide the administrative director, the employer, the employee, and the employee's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(g) The determination of the independent medical review organization shall be deemed to be the determination of the administrative director and shall be binding on all parties.

(h) A determination of the administrative director pursuant to this section may be reviewed only by a verified appeal from the medical review determination of the administrative director, filed with the appeals board for hearing pursuant to Chapter 3 (commencing with Section 5500) of Part 4 and served on all interested parties within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:

(1) The administrative director acted without or in excess of the administrative director's powers.

- (2) The determination of the administrative director was procured by fraud.
- (3) The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.
- (4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.
- (5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion.
- (i) If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent medical review by a different independent review organization. In the event that a different independent medical review organization is not available after remand, the administrative director shall submit the dispute to the original medical review organization for review by a different reviewer in the organization. In no event shall a workers' compensation administrative law judge, the appeals board, or any higher court make a determination of medical necessity contrary to the determination of the independent medical review organization.
- (j) Upon receiving the determination of the administrative director that a disputed health care service is medically necessary, the employer shall promptly implement the decision as provided by this section unless the employer has also disputed liability for any reason besides medical necessity. In the case of reimbursement for services already rendered, the employer shall reimburse the provider or employee, whichever applies, within 20 days, subject to resolution of any remaining issue of the amount of payment pursuant to Section 4603.2 to 4603.6, inclusive. In the case of services not yet rendered, the employer shall authorize the services within five working days of receipt of the written determination from the independent medical review organization, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the authorization.
- (k) Failure to pay for services already provided or to authorize services not yet rendered within the time prescribed by subdivision (l) is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars (\$5,000) for each day the decision is not implemented. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.
- (l) The costs of independent medical review and the administration of the independent medical review system shall be borne by employers through a fee system established by the administrative director. After considering any relevant information on program costs, the administrative director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent

medical review organization reviews and the cost of administering the independent medical review system, which may vary depending on the type of medical condition under review and on other relevant factors.

(m) The administrative director may publish the results of independent medical review determinations after removing individually identifiable information.

(n) If any provision of this section, or the application thereof to any person or circumstances, is held invalid, the remainder of the section, and the application of its provisions to other persons or circumstances, shall not be affected thereby.

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.

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). If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the internal utilization review appeal must be completed, and a determination issued, by the claims administrator within ten (10) days after receipt of the request under subdivision (f)(1). 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(f) states:

"(f)(1) Nothing in this section precludes the parties from participating in an internal utilization review deferral 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 timeframes in subdivision (a) in which to file an application for independent medical review. Any request by the injured worker or treating physician for an internal utilization review appeal process conducted under this subdivision must be submitted to the claims administrator within ten (10) days after the receipt of the utilization review decision."

"(2) A request for an internal utilization review appeal must be completed, and a determination issued, by the claims administrator within thirty (30) days after receipt of the request under subdivision (f)(1). If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the internal utilization review appeal must be completed, and a determination issued, by the claims administrator within ten (10) days after receipt of the request under subdivision (f)(1). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6(e) that determines the medical necessity of the disputed treatment."

(3) Any determination by the claims administrator following an internal utilization review appeal that results in a modification of the requested medical treatment shall be communicated to the requesting physician and the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney according to the requirements set forth in section 9792.9.5(e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.5(e)(7), must indicate that the decision is a modification after appeal

- 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 CareMC 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 CareMC 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)
- CMRS (Comprehensive Medical Review Services)

- Ethos

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
- CareMC 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

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: 714-385-8500
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:



Certificate Number: WUM010012-3



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



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Occupational and Environmental Medicine
Board Certified, ABPM
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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 Health 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 Schreiberstein
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

- A.W. Holdings DBA Benchmark
- Aaron Thomas Company
- Acadia
- Accelerated Claim Services
- A-D Comp
- Advance America, Cash Advance Centers, Inc.
- Advanced Services
- AGI Group Holdings
- Allergan
- Alliance Coal
- Alterra Mountain Company
- Aluminum Precision Products & Catalina Cylinders
- American Apparel
- Amy's Kitchen
- Anchor Glass
- Applied Materials, Inc.
- Aquamar Holdings
- Ardagh Glass Inc.
- Area USA, Inc.
- Arizona DOA /DOC
- Artisan Design Group
- Association of Universities for Research in Astronomy Inc (AURA)
- AVG Partners
- Avis Rent A Car System
- Avocado Green Brands
- BAE Systems, Inc
- Banner Health Systems
- Bass Pro Shops, LLC
- BBSI - Barrett Business Services Inc.
- BASF
- Bed Bath & Beyond
- Bedding Acquisitions
- Berger Transfer
- Big 5 Corp
- Big Brand Tire (MAJCO), LLC
- BITCO
- Block & Company Inc Realtors
- Bloomin Brands
- Boardriders, Inc.
- Boise Cascade Company
- Boot Barn
- Booz Allen Hamilton, Inc
- Brambles USA

- Briad Group
- Briad Hospitality Management
- Bridge Investment Group
- Bridgestone Americas, Inc
- Burberry
- Burke Williams
- Burrtec
- Caliber Holdings
- California Waste
- CalPortland
- Cambridge Healthcare Services
- Care West Insurance Company
- Carhartt
- Carlisle Companies
- Casitas Municipal Water District
- Castle and Cooke
- Cast and Crew
- CC-Development Group, Inc.
- Cedar Fair
- Central Garden & Pet
- Centurion
- Chaffey Jr Unified
- Champagne Resorts
- Chatham County Board of Commissioners
- Chico's FAS
- Choice Hotels
- Chubb & Son
- Chula Vista Elementary School District
- City of Beverly Hills
- City of Del Mar
- City of El Segundo
- City of Oxnard
- City of Salinas
- City of Solano Beach
- CKE Restaurants
- Clear Channel Outdoor Holdings
- CNH Industrial
- Coachella Valley Water District
- Columbia Sportswear
- Commercial Cleaning Systems
- Continuing Life LLC
- Copart, Inc
- CopperPoint Insurance
- Core Linen Services
- Core Civic
- County of Kern

- County of Santa Barbara EWC
- County of Tulare
- Coury Hospitality
- Crimson Renewable Energy
- Cross Country Healthcare
- Crown Equipment
- CSL Behring
- County of Los Angeles
- Dave and Buster's Management
- DBI Services
- Dell, Inc
- Delmar Throughbread
- Designer Brands (DSW)
- Discount Tire
- Driscoll's, Inc.
- Drybar - GC Program
- Drybar
- Eastman Kodak
- El Camino Hospital
- El Pollo Loco, Inc.
- Emanate Health
- Emeritus Senior Living/ Brookdale
- Encompass
- Encore Group
- Equipment Share
- Ergon
- Essendant
- Express
- ExxonMobil
- Falck Ambulance
- FAMSA, Inc.CSAC
- Federal Mogul
- FieldTrue
- First American Title Insurance Company
- Flagship Enterprises
- Floor and Décor
- Flower Foods, Inc.
- Foot Locker, Inc.
- Foundation Building Materials, LLC
- Fox Corp
- Franchise Group
- Friedken Companies
- Frontier Management
- Fullerton Unified School District
- Gainey Transportation

- GE Auto Insurance Program
- General Parts Intl.
- Geo Group, Inc
- Goodwill Industries of San Diego
- Green Diamond Resource Company
- GT's Living Foods
- GXO Logistics
- H&R Block
- Hayward Holdings, Inc.
- Helpside
- Hilmar Cheese
- HMS Host
- HMS Vineyards LLC/ Meadowoods Resort LLC
- HOAG Memorial Hospital Presbyterian
- Home Service Holdings, LP
- Hospital Housekeeping Systems (HHS)
- Hot Topic
- Husqvarna
- Icahn Automotive Group aka Pep Boys
- iHeart
- Ingram Micro Inc.
- Interinsurance Exchange of the Automobile Club CA
- Interstate Cleaning Corporation
- ISS Facility Services
- Jackson Family Wines, Inc.
- Jackson Food Stores
- JFC International
- Kellanova
- Kelley Amerit Holdings
- Keurig Dr. Pepper, Inc.
- Kikkoman
- Kings Hawaiian
- Kirkland's
- Kohler Co.
- Landry's
- Lane Bryant (Sycamore Partners)
- Larry Flynt Publications, Inc.
- Lennox Intl
- Leprino Foods
- Leslie's, Inc
- Life Care Services
- Lifetime Brands
- Lifetime, Inc.
- Lineage Logistics LLC
- LMH Resident Services LLC

- Los Angeles Community Development Authority
- Lowe Enterprises
- Luna Grill Restaurants
- Main Event Monte Claire
- Martin Marietta Materials, Inc
- Matheston Trucking, Inc.
- Maverik, Inc.
- McDermott International, Inc.
- Medline Industries
- MEMIC
- Mercury Insurance
- Meridian Management
- Merieux Nutrisciences Corporation
- Mettler – Toledo
- MHM Health Professionals
- Michael Kors
- Mister Car Wash
- Monroe Capital Holding
- MTS - San Diego Metropolitan Transit System
- National American Insurance Company
- National Veterinary Association (NVA)
- Nevada System of Higher Education
- Newport Diversified Staffing
- NextEra Energy
- Niagara Bottling LLC
- Nike, Inc.
- Norwalk La Mirada S.D.
- OI-Glass
- Ollie's Bargain Outlet
- Opendoor Labs
- Orange County Fire Authority
- O'Reilly Auto Parts
- OSI
- Pacific Dental Services
- Pacific Sunwear (PSEB)
- Park River Holdings, Inc
- Performance Contracting Group
- Performance Food Group/CoreMark
- Phoenix Retail, LLC.
- Polaris, Inc.
- POWDR
- Premium Brands
- Prosegur Services/Command Security Corporation / Aviation Safeguards
- Prospect Medical
- Providence Health & Services

- Pursuit Attractions and Hospitality Inc
- PVH Corp.
- R+L Carriers
- Ralph Lauren
- Rancho Santiago
- Recology
- Recreational Equipment, Inc
- Regions
- Reliance Steel & Aluminum
- Reser's Foods
- Resourcing Edge
- Restoration Hardware Holding
- Rite-Aid
- Robinson Helicopter Company
- Roseburg Forest Products
- RTI International
- SA Recycling
- Sacramento Municipal Utility District
- San Diego Community College District
- Satellite Healthcare, Inc.
- Savage Companies
- Save Mart Supermarkets
- Sensient Technologies
- Serta Simmons Bedding, LLC
- Service King
- Sharp Healthcare
- Sika Corporation
- Silverado Senior Living
- Sirius America-LPT
- Six Flags Entertainment
- Skechers
- SKF, USA
- Skinny Labs, Inc. dba SPIN
- Sonoco Products
- Southwest Gas Corporation
- Southwest Key
- SpaceX
- SPB Hospitality/ Craftworks
- Spruce Grove
- Staffing Partners
- Stanley Steemer
- Staples
- Stater Brothers
- Steel Partners Holdings
- Stella Jones

- StitchFix
- Summit Behavioral Health Care
- Sun Hill's Properties
- Sun Mar Healthcare
- Swift Transportation
- Syngenta Corporation
- Sysco Foods
- Takeda America Holdings
- Tawa Services/ 99 Ranch Market
- Texas Roadhouse
- The Cheesecake Factory
- The Gap, Inc.
- The Geo Group
- The Habit Burger Grill/Yum Brands
- The Hershey Company
- The Hiller Companies
- The Jones Financial Companies, LLLP
- The Marvin Company
- The One Group Hospitality
- The Vitamin Shoppe
- The Wonderful Company
- Thrive Market
- Tiffany & Co.
- Tilly's
- Today's Hotel Corporation
- Toll Brothers
- Toppan
- Tri City Healthcare District
- Trident Holdco
- Trillium Staffing Solutions
- True Value Company
- Truist
- Tuesday Mornings
- Tyson/Hillshire Brands
- U.S. Renal Care, Inc.
- U.S. Venture, Inc.
- UDR, Inc.
- Ultra Clean Technology
- UniFirst
- United Cerebral Palsy North Bay
- United Fire Group
- University of Southern California
- University Medical Center
- Urban Plates
- UTZ Quality Foods
- Vacasa

- Vallarta
- ValueHealth Intermediary/ Nueterra Metaholdings, Inc.
- Vincit
- Vistra Corp
- VVG Holdings/Velocity Vehicle Group
- W.L. Gore
- Water Holdings Acquisition / Inframark
- WayFair
- Wei-Chuan
- Wellpath Holdings, Inc.
- Wellpath Recovery Solutions, LLC.
- Wilks Brothers, LLC
- Wind Creek Bethlehem
- WKS
- Woodward Inc.
- World Market
- Worthington Industries
- Xylem, Inc
- YLG Holdings
- Zoe Holdings
- Zoetis
- Zurn Elkay Water Solutions Corp (aka Rexnord)

APPENDIX D: SAMPLE CORVEL LETTERS



Certification Recommendation

CLAIM #:	«claim1»	INSURED:	«empl»
DOI:	«claim3»	CARRIER/TPA:	«cust1» / «tpa1»
CLAIMANT:	«pt2» «pt1»	ADJUSTER:	«adj2» «adj1»
CORVEL #:	«claim2»- «claim30»«Service_Sequence Code»		

Determination Date:	«Date_Completed»
RFA First Received Date:	«Date_Customer_Received_Referral»
Info Request Date (If applicable otherwise N/A)	N/A
Info Received Date (If applicable otherwise N/A)	N/A
Information Requested:	N/A
Provider:	«phys2» «phys1»
Network:	«Network_Channeling»

CorVel Healthcare Corporation (Workers' Compensation Utilization Management URAC Accredited) 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 is summarized below:

SURGERY						
Determination	Type of Surgery	Body Part	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOK UP_BODY_DSCP»	«CO_SUR GEON»/« ASST_SUR GEON»	«LEN_OF _STAY»	«EFF_DATE»	«TERMINATION_D ATE»

MEDICATION						
Determination	Name of Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date
«UR_STATUS»	«MEDICATION_NAME» (dispense generic)	«DOSAGE»	«REFILL_N UM»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_D ATE»

THERAPY



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

TESTING							
Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date		
«UR_STATUS»	«TEST_TYPE»	«CONTRAST_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»		

INJECTION							
Determination	Type/Site of Injection	Name of Medication	Dosage	# of Injections	Body Part	Effective Date	Termination Date
«UR_STATUS»	«INJECTN_SITE»	«INJECTION_NAME»	«DOSAGE»	«INJECTN_NUM»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

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

CONTINUED STAY					
Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date
«UR_STATUS»	«PREVIOUSLY_CERTIFIED»	«NEW_REQUEST_OF_DAYS»	«TOTAL_LEN_OF_STAY»	«NEW_EFFECTIVE_DATE»	«NEW_TERMINATION_DATE»

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

OTHER			
Determination	Description	Effective Date	Termination Date
«UR_STATUS»	«Other_Treatment_Desc»	«notes»	«TERMINATION_DATE»

CorVel Healthcare Corporation hours of operation are from 9:00 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 9792.9.8

Sincerely,

«adv3» «adv4»

Utilization Management Department

**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.



Non-Certification Recommendation

CLAIM #:	«claim1»	INSURED:	«emp1» / «Ins1»
DOI:	«claim3»	CARRIER/TPA:	«cust1» / «tpa1»
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»
Info Requested Date via Phone, US Mail, and Fax:	N/A
Info Received Date:	N/A
Info Requested:	N/A
Requesting Provider:	«Phys2» «Phys1»
Network:	«Network_Channeling»

CorVel Healthcare Corporation (Workers' Compensation Utilization Management URAC Accredited) 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	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»

MEDICATION							
Determination	Type of Medication	Name of Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date
«UR_STATUS»	«Medication_Type»	«MEDICATION_NAME»	«DOSAGE»	«REFILL_NUMBER»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»

THERAPY



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

TESTING

Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date
«UR_STATUS»	«TEST_TYPE»	«CONTRAST_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

INJECTION

Determination	Type/Site of Injection	Name of Medication	Dosage	# of Injections	Body Part	Effective Date	Termination Date
«UR_STATUS»	«INJECTN_SITE»	«INJECTION_NAME»	«DOSAGE»	«INJECTION_NUM»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

DME

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

CONTINUED STAY

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

CONSULT

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

OTHER

Determination	Description	Effective Date	Termination Date	
«UR_STATUS»	«Other_Treatment_Desc»	«notes»	«EFF_DATE»	«TERMINATION_DATE»



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 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 9792.9.8.

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. This application was supplied with the original UR determination. An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.9.5(e)(13) that determines the medical necessity of the disputed treatment.

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 appeals process is on a voluntary basis and does not stop the time in which you have to file for Independent Medical Review (IMR), which runs concurrently with this internal, voluntary appeals process. Should the requesting medical provider wish to appeal the non-certification or modification decision via CorVel Healthcare Corporation's internal appeals process, and/or have additional pertinent medical information which has not previously been submitted for review. You may submit a request for appeal to CorVel Healthcare 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 Healthcare 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 ten (10) days after receipt of the request. Requests for appeal does not replace the IMR objection process noted above and are voluntary.

In accordance with regulation section 9792.9.5(e)(14), if the requesting physician wishes 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. 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.

Sincerely,

«adv3» «adv4»

Utilization Management Department

****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.



Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

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

Type of Utilization Review:

Regular D	Expedited D	Modification after Appeal D
Medication Only – MTUS	Retrospective for Exempt	Retrospective for Exempt
Formulary Drug List D	Treatment (Non-Drug) D	Treatment (Drug) D

Employee Information:

First Name: «pt2» Middle Initial: Last Name: «pt1»
Address: «pt4», «pt5» City: «pt6»
State: «PT7» Zip Code: «PT8» Telephone Number: «pt10»
Fax Number: Date of Injury: «claim3»
Insurance Claim Number: «claim1» EAMS Case Number:
WCIS Jurisdictional Claim Number (if assigned): «Jurisdiction_Claim_Number»
Employee Attorney (if known): «P_Atty2», «P_Atty1»
Address: «P_Atty4», «P_Atty5» City: «p_atty6»
State: «P_Atty7» Zip Code: «P_Atty8» Telephone Number: «P_Atty9»
Fax Number: «P_Atty10»

Requesting Physician Information:

Physician First Name: «Phys2» Middle Initial: Last Name: «Phys1»
Practice Name:
Address: «Phys4», «Phys5» City: «Phys6»
State: «Phys7» Zip Code: «Phys8» Telephone Number: «Phys9»
Fax Number: «Phys12» Specialty:

Claims Administrator Information:

Employer Name: «Cust1»
Name of Administrator: «TPA1» Contact Name: «Adj2» «Adj1»

Address: «Adj4», «Adj5»

City: «Adj6»

State: «Adj7»

Zip Code: «Adj8»


Telephone Number: «Adj9»

Fax Number: «Adj10»

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter: «peer_report_date»

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? Yes 

Reason: N/A

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

Request for Review and Consent to Obtain Medical Records

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

Employee Signature: _____

Date: _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical

Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

D30 days from the mailing date of the written determination letter.

D10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

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

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

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

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

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

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

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

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

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

**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):	
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I wish to designate

Name of Individual (Print):	
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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:
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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» / «tpa1»
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»
Info Requested Date via Phone, US Mail, and Fax:	N/A
Info Received Date:	N/A
Info Requested:	N/A
Requesting Provider:	«phys2» «phys1»
Network:	«Network_Channeling»

CorVel Healthcare Corporation (Workers' Compensation Utilization Management URAC Accredited) 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 modification decision was made on «Peer_Report_Date»

SURGERY						
Determination	Type of Surgery	Body Part	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOK UP_BODY_DSCP»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»

MEDICATION						
Determination	Name of Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date
«UR_STATUS»	«MEDICATION_NAME» (dispense generic)	«DOSAGE»	«REFILL_NUMBER»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»



THERAPY							
Determination	Type of Therapy	Total # Visits	Total Visits/Week	Total Weeks	Body Part	Effective Date	Termination Date
«UR_STATUS»	«THERAPY_REQ»	«RQST_TTL_VISITS»	«RQST_TTL_VISITS_WEEK»	«RQST_TTL_WK»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

TESTING					
Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date
«UR_STATUS»	«TEST_TYPE»	«CONTRAST_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

INJECTION							
Determination	Type/Site of Injection	Name of Medication	Dosage	# of Injections	Body Part	Effective Date	Termination Date
«UR_STATUS»	«INJECTN_SITE»	«INJECTION_NAME»	«DOSAGE»	«INJECTION_NUM»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

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

CONTINUED STAY					
Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date
«UR_STATUS»	«PREVIOUSLY_CERTIFIED»	«NEW_REQUEST_OF_DAYS»	«TOTAL_LEN_OF_STAY»	«NEW_EFFECTIVE_DATE»	«NEW_TERMINATION_DATE»

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

OTHER				
Determination	Description	Effective Date	Termination Date	
«UR_STATUS»	«Other_Treatment_Desc»	«notes»	«EFF_DATE»	«TERMINATION_DATE»

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 9792.9.8.

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. This application was supplied with the original UR determination. An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.9.5(e)(13) that determines the medical necessity of the disputed treatment.

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 appeals process is on a voluntary basis and does not stop the time in which you have to file for Independent Medical Review (IMR), which runs concurrently with this internal, voluntary appeals process. Should the requesting medical provider wish to appeal the non-certification or modification decision via CorVel Healthcare Corporation's internal appeals process, and/or have additional pertinent medical information which has not previously been submitted for review. You may submit a request for appeal to CorVel Healthcare 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 Healthcare 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 ten (10) days after receipt of the request. Requests for appeal does not replace the IMR objection process noted above and are voluntary.

In accordance with regulation section 9792.9.5(e)(14), if the requesting physician wishes 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. 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.

Sincerely,

«adv3» «adv4»

Utilization Management Department

****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.



Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

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

Type of Utilization Review:

Regular D	Expedited D	Modification after Appeal D
Medication Only – MTUS	Retrospective for Exempt	Retrospective for Exempt
Formulary Drug List D	Treatment (Non-Drug) D	Treatment (Drug) D

Employee Information:

First Name: «pt2» Middle Initial: Last Name: «pt1»
 Address: «pt4», «pt5» City: «pt6»
 State: «PT7» Zip Code: «PT8» Telephone Number: «pt10»
 Fax Number: Date of Injury: «claim3»
 Insurance Claim Number: «claim1» EAMS Case Number:
 WCIS Jurisdictional Claim Number (if assigned): «Jurisdiction_Claim_Number»
 Employee Attorney (if known): «P_Atty2», «P_Atty1»
 Address: «P_Atty4», «P_Atty5» City: «p_atty6»
 State: «P_Atty7» Zip Code: «P_Atty8» Telephone Number: «P_Atty9»
 Fax Number: «P_Atty10»

Requesting Physician Information:

Physician First Name: «Phys2» Middle Initial: Last Name: «Phys1»
 Practice Name:
 Address: «Phys4», «Phys5» City: «Phys6»
 State: «Phys7» Zip Code: «Phys8» Telephone Number: «Phys9»
 Fax Number: «Phys12» Specialty:

Claims Administrator Information:

Employer Name: «Cust1»
 Name of Administrator: «TPA1» Contact Name: «Adj2» «Adj1»

Address: «Adj4», «Adj5»

City: «Adj6»

State: «Adj7»

Zip Code: «Adj8»


Telephone Number: «Adj9»

Fax Number: «Adj10»

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter: «peer_report_date»

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? Yes 

Reason: N/A

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

Request for Review and Consent to Obtain Medical Records

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

Employee Signature: _____

Date: _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical

Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

D30 days from the mailing date of the written determination letter.

D10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

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

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

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

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

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

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

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

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

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

**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):	
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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:
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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:	«empl»
DOI:	«claim3»	CARRIER/TPA:	«cust1» / «tpa1»
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»
Info Requested Date via Phone, US Mail, and Fax:	N/A
Info Received Date:	N/A
Info Requested:	N/A
Requesting Provider:	«phys2» «phys1»
Network:	«Network_Channeling»

CorVel Healthcare Corporation (Workers' Compensation Utilization Management URAC Accredited) 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 has certified the requested treatment. The certification decision was made on «Peer_Report_Date» and is summarized below:

SURGERY						
Determination	Type of Surgery	Body Part	Surgeon (Co./Asst.)	Length of Stay	Effective Date	Termination Date
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOK_UP_BODY_DSCP»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»

MEDICATION						
Determination	Name of Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date
«UR_STATUS»	«MEDICATION_NAME» (dispense generic)	«DOSAGE»	«REFILL_NUM»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»

THERAPY							
Determination	Type of Therapy	Total # Visits	Total Visits/Week	Total Weeks	Body Part	Effective Date	Termination Date



«UR_STATUS»	«THERAPY_REQ»	«RQST_TTL_VISITS»	«RQST_TTL_VISITS_WK»	«RQST_TTL_WK»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»
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TESTING					
Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date
«UR_STATUS»	«TEST_TYPE»	«CONTRAST_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

INJECTION							
Determination	Type/Site of Injection	Name of Medication	Dosage	# of Injections	Body Part	Effective Date	Termination Date
«UR_STATUS»	«INJECTN_SITE»	«INJECTION_NAME»	«DOSAGE»	«INJECTION_NUM»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

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

CONTINUED STAY					
Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date
«UR_STATUS»	«PREVIOUSLY_CERTIFIED»	«NEW_REQUEST_OF_DAYS»	«TOTAL_LEN_OF_STAY»	«NEW_EFFECTIVE_DATE»	«NEW_TERMINATION_DATE»

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

OTHER				
Determination	Description	Effective Date	Termination Date	
«UR_STATUS»	«Other_Treatment_Desc»	«notes»	«EFF_DATE»	«TERMINATION_DATE»

CorVel Corporation hours of operation are from 9:00 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 9792.9.8.



Sincerely,

«adv3» «adv4»

Utilization Management Department

**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.



Appeal Determination Certification Recommendation

CLAIM #:	«claim1»	INSURED:	«empl»
DOI:	«claim3»	CARRIER/TPA:	«cust1» / «tpa1»
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»
Info Requested Date via Phone, US Mail, and Fax:	N/A
Info Received Date:	N/A
Info Requested:	N/A
Requesting Provider:	«phys2» «phys1»
Network:	«Network_Channeling»

CorVel Healthcare Corporation (Workers' Compensation Utilization Management URAC Accredited) has received a request for appeal of our non-certification determination. 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 is summarized below:

SURGERY						
Determination	Type of Surgery	Body Part	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOK UP_BODY_DSCP»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»

MEDICATION						
Determination	Name of Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date
«UR_STATUS»	«MEDICATION_NAME» (dispense generic)	«DOSAGE»	«REFILL_NUM»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»



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

TESTING					
Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date
«UR_STATUS»	«TEST_TYPE»	«CONTRAST_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

INJECTION							
Determination	Type/Site of Injection	Name of Medication	Dosage	# of Injections	Body Part	Effective Date	Termination Date
«UR_STATUS»	«INJECTN_SITE»	«INJECTION_NAME»	«DOSAGE»	«INJECTION_NUM»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

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

CONTINUED STAY					
Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date
«UR_STATUS»	«PREVIOUSLY_CERTIFIED»	«NEW_REQUEST_OF_DAYS»	«TOTAL_LEN_OF_STAY»	«NEW_EFFECTIVE_DATE»	«NEW_TERMINATION_DATE»

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

OTHER				
Determination	Description	Effective Date	Termination Date	
«UR_STATUS»	«Other_Treatment_Desc»	«notes»	«EFF_DATE»	«TERMINATION_DATE»



CorVel Healthcare Corporation hours of operation are from 9:00 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 9792.9.8.

Sincerely,

«adv3» «adv4»

Utilization Management Department

****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.



Appeal Determination Non-Certification Recommendation

CLAIM #:	«claim1»	INSURED:	«empl»
DOI:	«claim3»	CARRIER/TPA:	«cust1» / «tpa1»
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»
Info Requested Date via Phone, US Mail, and Fax:	N/A
Info Received Date:	N/A
Info Requested:	N/A
Requesting Provider:	«phys2» «phys1»
Network:	«Network_Channeling»

CorVel Healthcare Corporation (Workers' Compensation Utilization Management URAC Accredited) has received a request for appeal of our non-certification determination. The appeal has been reviewed by our physician advisor, «Peer_Reviewer_Name», «Peer_Reviewer_License_Number», who is board certified in «Peer_Reviewer_Specialty». After careful review of the submitted medical information, our Physician Advisor was unable to recommend the requested treatment. The appeal non-certification decision was made on «Peer_Report_Date»

SURGERY						
Determination	Type of Surgery	Body Part	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOK UP_BODY_DSCP»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»

MEDICATION						
Determination	Name of Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date
«UR_STATUS»	«MEDICATION_NAME» (dispense generic)	«DOSAGE»	«REFILL_NUM»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»



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

TESTING					
Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date
«UR_STATUS»	«TEST_TYPE»	«CONTRAST_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

INJECTION							
Determination	Type/Site of Injection	Name of Medication	Dosage	# of Injections	Body Part	Effective Date	Termination Date
«UR_STATUS»	«INJECTN_SITE»	«INJECTION_NAME»	«DOSAGE»	«INJECTN_NUM»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

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

CONTINUED STAY					
Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date
«UR_STATUS»	«PREVIOUSLY_CERTIFIED»	«NEW_REQUEST_OF_DAYS»	«TOTAL_LEN_OF_STAY»	«NEW_EFFECTIVE_DATE»	«NEW_TERMINATION_DATE»

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

OTHER				
Determination	Description	Effective Date	Termination Date	
«UR_STATUS»	«Other_Treatment_Desc»	«notes»	«EFF_DATE»	«TERMINATION_DATE»



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 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 9792.9.8.

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. This application was supplied with the original UR determination. An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.9.5(e)(13) that determines the medical necessity of the disputed treatment.

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.

In accordance with regulation section 9792.9.5(e)(14), if the requesting physician wishes 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. 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.

Sincerely,

«adv3» «adv4»

Utilization Management Department

****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.*



Appeal Determination Modification Recommendation

CLAIM #:	«claim1»	INSURED:	«emp1» / «Ins1»
DOI:	«claim3»	CARRIER/TPA:	«cust1» / «tpa1»
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»
Info Requested Date via Phone, US Mail, and Fax:	N/A
Info Received Date:	N/A
Info Requested:	N/A
Requesting Provider:	«Phys2» «Phys1»
Network:	«Network_Channeling»

CorVel Healthcare Corporation (Workers' Compensation Utilization Management URAC Accredited) has received a request for appeal of our non-certification determination. The appeal has been reviewed by our physician advisor, «Peer_Reviewer_Name», «Peer_Reviewer_License_Number», who is board certified in «Peer_Reviewer_Specialty». After careful review of the submitted medical information, our Physician Advisor was unable to recommend the requested treatment. The appeal modification decision was made on «Peer_Report_Date»

SURGERY						
Determination	Type of Surgery	Body Part	Surgeon (Co./ Asst.)	Length of Stay	Effective Date	Termination Date
«UR_STATUS»	«SURGERY_TYPE»	«BODY_PART_LOOK_UP_BODY_DSCP»	«CO_SURGEON»/«ASST_SURGEON»	«LEN_OF_STAY»	«EFF_DATE»	«TERMINATION_DATE»

MEDICATION							
Determination	Type of Medication	Name of Medication	Dosage	# of Refills	Brand Name	Effective Date	Termination Date
«UR_STATUS»	«Medication_Type»	«MEDICATION_NAME»	«DOSAGE»	«REFILL_NUMBER»	«BRAND_NAME»	«EFF_DATE»	«TERMINATION_DATE»



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

TESTING					
Determination	Type of Test	Type of Contrast	Body Part	Effective Date	Termination Date
«UR_STATUS»	«TEST_TYPE»	«CONTRAST_TYPE»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

INJECTION							
Determination	Type/Site of Injection	Name of Medication	Dosage	# of Injections	Body Part	Effective Date	Termination Date
«UR_STATUS»	«INJECTN_SITE»	«INJECTION_NAME»	«DOSAGE»	«INJECTION_NUM»	«BODY_PART_LOOKUP_BODY_DSCP»	«EFF_DATE»	«TERMINATION_DATE»

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

CONTINUED STAY					
Determination	Prev Certified # of Days	New Request # of Days	Total Length of Stay	New Effective Date	New Termination Date
«UR_STATUS»	«PREVIOUSLY_CERTIFIED»	«NEW_REQUEST_OF_DAYS»	«TOTAL_LEN_OF_STAY»	«NEW_EFFECTIVE_DATE»	«NEW_TERMINATION_DATE»

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

OTHER				
Determination	Description	Effective Date	Termination Date	
«UR_STATUS»	«Other_Treatment_Desc»	«EFF_DATE»	«TERMINATION_DATE»	«notes»



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 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 9792.9.8.

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. This application was supplied with the original UR determination. An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.9.5(e)(13) that determines the medical necessity of the disputed treatment.

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 appeals process is on a voluntary basis and does not stop the time in which you have to file for Independent Medical Review (IMR), which runs concurrently with this internal, voluntary appeals process. Should the requesting medical provider wish to appeal the non-certification or modification decision via CorVel Healthcare Corporation's internal appeals process, and/or have additional pertinent medical information which has not previously been submitted for review. You may submit a request for appeal to CorVel Healthcare 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 Healthcare 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 ten (10) days after receipt of the request. Requests for appeal does not replace the IMR objection process noted above and are voluntary.

In accordance with regulation section 9792.9.5(e)(14), if the requesting physician wishes 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. 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.

Sincerely,

«adv3» «adv4»
Utilization Management Department

****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.



Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

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

Type of Utilization Review:

Regular D	Expedited D	Modification after Appeal D
Medication Only – MTUS	Retrospective for Exempt	Retrospective for Exempt
Formulary Drug List D	Treatment (Non-Drug) D	Treatment (Drug) D

Employee Information:

First Name: «pt2» Middle Initial: Last Name: «pt1»
Address: «pt4», «pt5» City: «pt6»
State: «PT7» Zip Code: «PT8» Telephone Number: «pt10»
Fax Number: Date of Injury: «claim3»
Insurance Claim Number: «claim1» EAMS Case Number:
WCIS Jurisdictional Claim Number (if assigned): «Jurisdiction_Claim_Number»
Employee Attorney (if known): «P_Atty2», «P_Atty1»
Address: «P_Atty4», «P_Atty5» City: «p_atty6»
State: «P_Atty7» Zip Code: «P_Atty8» Telephone Number: «P_Atty9»
Fax Number: «P_Atty10»

Requesting Physician Information:

Physician First Name: «Phys2» Middle Initial: Last Name: «Phys1»
Practice Name:
Address: «Phys4», «Phys5» City: «Phys6»
State: «Phys7» Zip Code: «Phys8» Telephone Number: «Phys9»
Fax Number: «Phys12» Specialty:

Claims Administrator Information:

Employer Name: «Cust1»
Name of Administrator: «TPA1» Contact Name: «Adj2» «Adj1»

Address: «Adj4», «Adj5»

City: «Adj6»

State: «Adj7»

Zip Code: «Adj8»


Telephone Number: «Adj9»

Fax Number: «Adj10»

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter: «peer_report_date»

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? Yes 

Reason: N/A

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

Request for Review and Consent to Obtain Medical Records

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

Employee Signature: _____

Date: _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical

Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

D30 days from the mailing date of the written determination letter.

D10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

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

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

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

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

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

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

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

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

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

**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):	
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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:



«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»
DOI: «claim3»
CLAIMANT: «pt2» «pt1»
CORVEL #: «claim2»-
«claim30»«Service_Sequence_Code»

INSURED: «emp1» / «ins1»
CARRIER/TPA: «cust1» /
«tpa 1»
ADJUSTER: «adj2»«adj1»

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»

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



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.

Certification Recommendation

CLAIM #:		INSURED:	
DOI:		CARRIER/TPA:	
CLAIMANT:		ADJUSTER:	
CORVEL #:			

Determination Date:	
RFA First Received Date:	
Info Requested Date via Phone, US Mail, and Fax:	N/A
Info Received Date:	N/A
Info Requested:	N/A
Requesting Provider:	
Network:	

CorVel Healthcare Corporation (Workers' Compensation Utilization Management URAC Accredited) 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 is summarized below:

CONSULT			
Determination	Type of Consult	Effective Date	Termination Date
Requested	Cardiothoracic consult		
Certified	Cardiothoracic consult		

CorVel Healthcare Corporation hours of operation are from 9:00 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 9792.9.8

Sincerely,

Reviewer's Name
Utilization Management Department

****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.



Utilization Review Department

714.385.8500 / Fax 866.910.4423

URORANGE@CORVEL.COM

To: [REDACTED] **Date & Time:** 4/28/2026 11:51 PM
Company: **Fax Number:** [REDACTED]
From:
Subject: Confidential UR Determination Certify [REDACTED]

«Body»

This notification contains the following documents:
- 26118164808556pdf001

This notification has also been delivered to:

[REDACTED]



Utilization Review Department

714.385.8500 / Fax 866.910.4423

URORANGE@CORVEL.COM

To: [REDACTED] MD Date & Time: 4/28/2026 11:51 PM

Company: Fax Number: [REDACTED]

From:

Subject: Confidential [REDACTED]

«Body»

This notification contains the following documents:

- 26118164808556pdf001

This notification has also been delivered to:

- [REDACTED]
- ALAN [REDACTED] (90665 01 [REDACTED] 01 - Cost (011287)
- [REDACTED]
- 91364)
- [REDACTED]

«SpecialInstruction»



Division of Workers' Compensation

MAILING ADDRESS:

Medical Unit

Utilization Review Investigations

P.O. Box 71010

Oakland, CA 94612

Tel. (510) 286-3700

Via electronic e mail, sent on 5/7/2026 to:

audrey_klotz@corvel.com

May 7, 2026

Audrey Klotz

UR Review Manager So Cal

CorVel Corporation

1920 Main St, Ste 900

Irvine, CA 92614

RE: **UR PLAN APPROVAL**

URO #: **028**

URO: **CorVel Corporation**

Dear Audrey Klotz:

The Division of Workers' Compensation (DWC) has completed its review of **CorVel Corporation's** Utilization Review (UR) plan received on **03/27/2026**. Under California Labor Code section 4610(i) and California Code of Regulations, title 8, sections 9792.6.1 et seq., this UR plan has now been **approved**.

The approved UR plan has the following ongoing obligations:

- Ensure continued compliance with California Labor Code section 4610 and California Code of Regulations, title 8, sections 9792.6.1, et seq.
- File a material modification of its utilization review plan with the Administrative Director within 30 calendar days of the material modification as required under California Code of Regulations, title 8, section 9792.7.

DWC's approval of the UR plan identified herein is not intended to be an approval of policies and procedures that are contrary to law, and any such approval is unintended.

Additional information related to UR and UR regulations can be found on our website at https://www.dir.ca.gov/dwc/ur_main.htm.

Should you have any further questions, please contact us at DWCUR@dir.ca.gov.

Sincerely,

UR Workers' Compensation Consultant
DWC Medical Unit