



Utilization Management Department  
P.O. Box 3247 Omaha, NE 68103-0247  
Phone: 800-615-4320 • Fax: 877-853-6853

**Promesa Health, Inc. Utilization Review Plan**  
**California Division of Workers' Compensation**

**March 24, 2026**



**Table of Contents**

Table of Contents

- Table of Contents..... 2
- I. General Definitions ..... 4
- II. Promesa Health, Inc. Utilization Review Plan Overview ..... 9
  - Introduction ..... 9
  - Executive Summary..... 10
  - Medical Director ..... 10
  - Program ..... 10
  - Hours of Operation ..... 11
  - Physician Reviewer ..... 11
  - Non-Physician Reviewer ..... 12
  - UM Personnel ..... 12
- III. UM Process ..... 14
  - Receipt of Request for Medical Treatment -Review Timeframes ..... 14
  - Not Complete Request..... 15
  - Requests Addressed via Deferral ..... 15
  - Valid -Complete Requests ..... 16
- IV. Types of Review ..... 17
  - Prospective Review Process ..... 17
  - Concurrent Review Process..... 17
  - Expedited Review Process..... 17
  - Retrospective Review Process..... 17
  - Extension of Timeframe for Decision ..... ,18
- V. Exempt Treatment..... 19
  - First 30 Days following Date of Injury Medical Treatment ..... 19
  - MTUS Drug Formulary ..... 20
  - Promesa Health Direct Contract/MPN Providers ..... 21

Determination Letters .....	22
Certifications .....	22
Adverse Determinations.....	23
VI. Treatment Guidelines .....	25
Clinical Decision Support Tools .....	25
VII. Determination Notification Process.....	26
Notification of Authorization Determination Process.....	26
Notification of Adverse Determination Process.....	27
Optional Internal Appeal Process .....	28
Adverse Determination Timeframe Duration.....	29
VIII. Confidentiality Policy .....	29
IX. Electronic Reporting to State .....	31
X. Conclusion.....	31

## **I. General Definitions**

- 1) ACOEM Practice Guidelines- the American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines, Second Edition.
- 2) Authorization- means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to Section 4600 of the Labor Code, subject to the provisions of Section 5402 of the Labor Code, set forth on a completed “Request for Authorization,” as defined in this section, that has been transmitted by the treating physician to the claim’s administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, sections 9792.9.1 through 9792.12.
- 3) Claims Administrator-a self-administered workers’ compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor code section 4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). “Claims Administrator” includes any utilization review organization under contract to provide or conduct the claims administrator’s utilization review responsibilities.
- 4) Concurrent Review- means utilization review conducted during an inpatient stay.
- 5) Course of Treatment- means the course of medical treatment set forth in the treatment plan contained on the, “Doctor’s First Report of Occupational Injury or Illness”, DIR Form 5021, found at California Code of Regulations, title 8, section 14006.1, or on the applicable physician reporting forms authorized by section 9785.
- 6) Denial- means a decision by a physician reviewer that the requested treatment or service is not authorized.
- 7) Dispute Liability- means an assertion by the claim’s administrator that a factual, medical, or legal basis exists other than medical necessity, that precludes compensability on the part of the claim’s administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.
- 8) Disputed Medical Treatment-means medical treatment that has been modified, or denied by a utilization review decision.
- 9) Emergency Health Care Services- means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient’s health in serious jeopardy.

- 10) Exempt (First 30 Days of the Date of Injury)- a treating physician may render medically necessary treatment or services to an injured worker without prospective utilization review provided that;
- a. Treatment or service is for a body part or condition that has been accepted as compensable by the claims adjuster
  - b. 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
  - c. 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, sub division (e), setting forth in detail the anticipated treatment plan for the injured worker (Services not covered under the exempt would be DME >\$250, diagnostics outside of plain xrays, surgical procedures, home services, hospital admissions, outpatient hospital procedures, ASC procedures, rehab services, etc.
- 11) Expedited Review- means utilization review or independent medical review conducted when the injured worker’s condition is such that the injured worker faces an imminent and serious threat to his/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.
- 12) Expert Reviewer- means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual’s scope of practice, whose consultation for a specialized review has been requested by the claims administrator or utilization review organization, necessitating an extension of time, under section 9792.9.6, prior to the determination of medical necessity.
- 13) Health Care Provider- means a provider of medical services, as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.
- 14) Immediately-means within one business day.
- 15) Material Modification-is when the claims administrator changes utilization review vendor(s), makes a change to the utilization review standards as specified in section 9792.7, or changes its medical director, address, company name or corporate structure.

- 16) Medical Director- is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California. The Medical Director is responsible for all decisions made in the utilization review process.
- 17) Medical Services- means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 Part 2 of Division 4 of the Labor Code.
- 18) Medical Treatment Utilization Schedule- means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20.
- 19) Medical Treatment Utilization Schedule (MTUS) Drug Formulary- means the CA drug formulary adopted by the Administrative Director under Labor Code section 5307.27 and defined in section 9792.27.1(m). The MTUS Drug Formulary contains the MTUS Drug List, which is set forth in section 9792.27.15.
- 20) Modification-means a decision by a physician reviewer that part of the requested treatment or service is not medically necessary.
- 21) Peer Reviewer- means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice.
- 22) Promesa Health- means Promesa Health, Inc.
- 23) Promesa Health UM- means Promesa Health Utilization Management.
- 24) Prospective Review- means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services.
- 25) Request for Authorization- means a written request for a specific course of proposed medical treatment that meets all of the following criteria:
  - a. 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).

- b. “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 under section 9792.9.6.
- c. 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.
- 26) Retrospective Review- means utilization review conducted after medical services have been provided and for which approval has not already been given.
- 27) Reviewer or Physician Reviewer- means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer’s or physician reviewer’s practice.
- 28) Non-Physician Reviewer-means an individual designated by the claim’s administrator or utilization review organization to assist in determining the medical necessity of the requested treatment. A non-physician reviewer may not modify or deny a treatment request.
- 29) URAC- is a non-profit organization, located at 1220 L Street, NW, Suite 900, Washington, DC., 20005, or as indicated online at [www.urac.org](http://www.urac.org), that provide accreditation for workers’ compensation utilization review programs.
- 30) Utilization Review Decision- means a decision pursuant to Labor Code section 4610 to approve, modify, or deny, a treatment recommendation by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code sections 4600 or 5402(c).

- 31) Utilization Review Plan-means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.
- 32) Utilization Review Process- means utilization management (UM) functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. The utilization review process begins when a completed request for authorization, or a request for authorization accepted as complete under section 9792.9.1(b) is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization. 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 accurately billed.
- 33) Written- includes a communication transmitted by facsimile or in paper form. Electronic mail or electronic data interchange (EDI) may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail or by EDI, unless sent through the use of an encrypted electronic mail or EDI system.
33. Normal Business Day or Business Day-does not include Saturday, Sunday or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website.
34. Working Day- used in this article is the same as "business day" or "normal business day"

## **II. Promesa Health, Inc. Utilization Review Plan Overview**

### **Introduction**

This document will serve as a filing of the utilization review plan of Promesa Health, the Utilization Review Organization (URO) a wholly owned subsidiary of Applied Underwriters providing services to California Insurance Company, Continental Indemnity Company, Texas Insurance Company, Illinois Insurance Company, Pennsylvania Insurance Company, Oklahoma Property & Casualty Insurance Co.; Applied Risk Services (ARS), as well as any unaffiliated insurance carriers we have an agreement with to provide services for. This filing will consist of a detailed description of the utilization review process utilized by Promesa Health UM. To comply with 8 CCR §9792.7(d), the complete utilization review plan consisting of the policies and procedures and a description of the utilization review process will be available to the public upon request. As a California Claims Administrator, Promesa Health UM has established and maintains this Utilization Review Plan and its Utilization Review Process in compliance with Labor Code §4610 et seq and applicable regulations. This plan is filed as a material modification in response to the recently updated CA UR regulations and the addition of a peer review vendor, Promesa Health, Inc. certifies that we remain compliant with the rules governing utilization review at sections 9792.6.1 et seq.

Promesa Health UM makes this Utilization Review Plan available to the public by posting it on <https://promesa.auw.com> Promesa Health's Utilization Review Plan may be available through electronic means or hard copy for a reasonable copy and postage fee that shall not exceed \$0.25 per page plus actual postage costs.

The purpose of the Promesa Health UM Process is to provide an assessment of clinical appropriateness and medical necessity of treatment requests and services provided pursuant to Article 2 commencing with Labor Code §4600 of Chapter 2 of Part 2 of Division 4 of the Labor Code for accepted and delayed claims. The Promesa Health UM department will perform review functions prospectively, retrospectively, or concurrently to either approve, modify, or deny based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physician's prior to, retrospectively, or concurrent with the provision of medical treatment services. The Utilization Process does not include compensable/causally related determinations of the injury/disease process for the claim; nor does it address billing issues for the claim.

Promesa Health UM maintains an accreditation by the Utilization Review Accreditation Committee (URAC) to perform utilization reviews for workers' compensation claims. Promesa Health UM functions are governed by written policies and procedures which correspond to URAC standard and requirements as well as the applicable California regulations and Medical Treatment Guidelines per Labor Code §5307.27.

### **Executive Summary**

Promesa Health, Inc. and ARS are wholly-owned subsidiaries of Applied Underwriters, Inc. All medical determinations are made based solely on medical necessity using approved, nationally-recognized standards of care along with state specific guidelines where appropriate. The entire process is outlined in this submission. All medical operations report to the HCO Medical Director. The evaluation of the Medical Director's performance is in no way tied to financial outcomes.

### **Medical Director**

Pursuant to Labor Code §4610(g) and per 8 CCR §9792.7(a)(1), Promesa Health employs a Medical Director to oversee the Utilization Review Process. The Medical Director will hold an unrestricted license to practice in the State of California and is responsible for all decisions made during the utilization management process, and ensures that the processes comply with Labor Code section 4610 and the implementing regulations associated with such. Promesa Health's Medical Director is Jeffrey Liva, M.D.

### **Contact:**

Jeffrey Liva, MD  
30 Bayberry Dr.  
Saddle River, New Jersey, 07458  
201-444-3060  
California Medical License #G154330

### **Program**

The Medical Director is actively involved in the oversight of the utilization management, pharmacy, and medical networks departments of Promesa Health.

1. The Medical Director receives input and consultation from network physicians and other health care professionals through their participation in the Quality Management Committee, the Credentialing Committee, and meetings with the Promesa Health UM department.
2. The Medical Director annually reviews and approves the current Utilization Management policies and procedures ensuring that requests for authorization of medical treatment received from medical providers are in compliance with Labor Code §4610.

## **Hours of Operation**

Promesa Health's UM department maintains the office hours of 8:00 AM to 7:30 PM Central Time, which include business hours of 9:00 AM to 5:30 PM Pacific Time in accordance with 8 CCR §9792.9.1 on normal business days to afford health care providers the ability to request authorization of medical services for injured workers. In addition, medical providers can reach the Promesa Health UM department after hours via secure confidential facsimile (866-234-4416) or voice mail (800-615-4320) to enable the requesting physicians to submit additional information/submit questions/requests for authorization, the claimants to submit questions/concerns, vendors to submit questions/concerns, etc. Note- the same numbers are utilized during normal working hours.

## **Physician Reviewer**

Review decisions to deny, or modify a request for medical treatment will have been conducted by a physician reviewer in accordance with the medically based criteria per 8 CCR §9792.8, 9792.25.1 and Labor Code section 5307.27, including the methodology for evaluating medical evidence under section 9792.25.1. Please note that these specific CA state regulations do not preclude authorization of medical treatment beyond what is covered in the medical treatment utilization schedule or supported by the best available medical evidence in order to account for medical circumstances warranting an exception in accordance with section 9792.8(a)(1). A physician reviewer would be a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia; competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the reviewer's or physician reviewers practice who may certify/modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury. Promesa Health Medical Director will ensure that this process which involves modifying/denying requests for medical service authorizations comply with Labor Code section 4610 and these implementing regulations.

Promesa Health UM contracts with URAC accredited Worker Compensation UM Review Organizations and Independent Review Organizations (IRO). IRO's Care Review, MLS Group of Companies, LLC, and CMRS, LLC are utilized for view services to ensure availability of high-quality specialty matched reviewers as required by 8CCR §9792.7(b)(2), the Workers' Compensation URAC accredited Utilization Review company Enlyte/formally dba Genex/formally dba PRIUM is also utilized for peer review services when the need arises. URAC standards assure that accredited organizations performing peer review services are free from conflicts of interest and establish qualifications for physician reviewers; a policy is in place which prevents and financial incentives to doctors and other providers based on utilization review determinations (per 4610(g)(4)). These standards include verification of state licensure, credentialing of reviewers, address medical necessity and experimental treatment issues, have established reasonable time periods for standard and expedited reviews, and supports the use of an appeals process.

Promesa Health's Medical Director is involved in the monitoring and oversight of the aforementioned peer review organizations. Promesa Health's Medical Director randomly reviews peer review reports for appropriateness and completeness ensuring compliance with Labor Code section §4610. When issues are identified, these are discussed with the contracted IRO. Administrative action is taken on an as needed basis in regard to those identified concerns to maintain compliance with Labor Code §4610 to include the timeliness standards set forth in 8 CCR §9792.9.1.

Peer Review physicians are available at a minimum of four (4) hours per week during normal business hours of 9:00 AM to 5:30 PM Pacific Time to discuss the decision with the requesting physician per 8 CCR §9792.9.5(e)(14).

**Non-Physician Reviewer**

Non-physician reviewers who consist of Registered Nurses will apply specified criteria to requests for medical treatment. The UM Nurse Reviewer may discuss applicable review criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the UM Nurse Reviewer may approve the amended request for treatment authorization. Additionally, the UN Nurse Reviewer may request appropriate additional information that is necessary to render a decision but in no event shall this exceed the time limitations imposed in section 9792.9.3 and 9792.9.4. Any time beyond the time specified in these sections is subject to the provisions of section 9792.9.6. **Under no circumstances will a non-physician reviewer deny, or modify an authorization request for medical treatment/services.**

**UM Personnel**

Position Title	Job Duties
<p><b>UM Medical Director</b></p>	<p>Provides oversight and guidance to Promesa Health including the department of Utilization Management, Quality Management Committee, Provider Network Development, Medical Bill Review, and Promesa Health Pharmacy.            Qualifications: Shall be a board-certified physician who will maintain at all times an unrestricted medical license in the state of California. He/she will be in active medical practice at least eight (8) hours per week or be an otherwise qualified licensed physician with administrative experience in utilization review oversight or quality assessment. He will ensure that the process by which authorization requests area reviewed and approved, modified, denied by physicians prior to, retrospectively, or concurrently with the provision of medical services, comply with Labor Code section 4610 and these implementing regulations.</p>
<p><b>Manager of UM</b></p>	<p>Responsible for keeping up-to-date information on individual state regulations pertaining to UM services in the jurisdictions that Promesa Health conducts UM review activity. The UM Manager monitors quality data presented by the Promesa Health Data Specialist to the Promesa Health Quality Management Committee (QMC) and is an active member of this committee. The manager is also involved in development and monitoring of quality improvement projects presented to the QMC on an annual basis.             Qualifications: Requires a current unrestricted RN license with at least five (5) years of clinical experience.</p>

<b>UM Supervisor</b>	<p>Provides oversight of the UM processes that encompasses both the UM Specialist duties and the UM Nurse Reviewer duties. Oversight of the UM processes also involves administering and monitoring the quality review outcomes of both the UM Specialists and UM Nurse Reviewers to include the inter-rater reliability reviews for UM. The supervisor is responsible for monitoring the training of new UM employees and also assists with updating UM processes, policies, and procedures for the UM team. Qualifications: Requires a current RN license with at least three (3) years of clinical experience; five (5) years is preferred.</p>
<b>UM Nurse Reviewer Team Leader</b>	<p>Responsible for nurse reviewer duties and assigning cases requiring medical necessity review determinations to available nurse reviewers. Assignments are based on knowledge of the nurse reviewer’s clinical experience, current workload and, whenever possible, assigning the same nurse reviewer throughout the continuum of the life of the claim.</p> <p>Qualifications: Requires a current RN license with at least three (3) years of clinical experience; five (5) years is preferred</p>
<b>UM Nurse Reviewer</b>	<p>Reviews and processes requests for authorization of treatment/services and procedures related to inpatient and outpatient care based on medical necessity and appropriateness of the level of care. If the Nurse reviewer is unable to validate applicable criteria related to the particular request, the request is referred to a contracted peer review vendor for assignment for a physician peer reviewer to address the medical necessity and appropriateness of the requested treatment/service/procedure. A no time will a UM Nurse Reviewer issue an adverse determination without physician peer review input.</p> <p>Qualification: Requires a current RN license with a least three (3) years of clinical experience; five (5) years is preferred.</p>
<b>Physician Peer Reviewer</b>	<p>The contracted physician peer reviewer will review the available medical information, the Reviewer is to address the medical necessity and appropriateness of the level of care for requested treatment/service or procedure. Peer review services are provided by a contracted URAC accredited Independent Review Organization or URAC Workers’ Compensation accredited entity which accepts responsibility for maintaining credentialing information and quality review monitoring for their peer reviewers.</p> <p>Qualifications: At least three (3) years of clinical experience; five (5) years is preferred. Physician Peer Reviewers will be board certified and have the knowledge/experience to comment on the authorization request they are commenting on when making a determination.</p>

<b>UM Specialist Team Leader</b>	<p>Responsible for UM duties and ensures all processes are performed according to Promesa Health UM policies and procedures. Trains and monitors newly hired UM Specialists. Maintains responsibility for administering and monitoring quality reviews, and inter-rater reliability reviews of the UM Specialists.</p> <p>Qualifications; Requires a high school diploma or GED, Associates degree preferred.</p>
<b>UM Specialist</b>	<p>Receives the initial request for authorization (RFA) from medical providers and/or claims adjuster and confirms claim information. Enters all data into software once request has been confirmed “complete” (valid/compensable), for continuation of the medical necessity review process.</p> <p>Qualification; Requires a high school diploma or GED, Associates degree preferred.</p>

### **III. UM Process**

#### **Receipt of Request for Medical Treatment -Review Timeframes**

Per Article 5.5.1 of subchapter 1 of chapter 4.5 of title 8 of the California Code of Regulations, a written request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, must be made in a request for authorization in accordance with the report in subdivision (f) as applicable and as set forth in section 9792.6.1(u). A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment. A request for authorization can be made by the primary treating physician or a secondary physician. Promesa Health UM requests that all authorization requests be submitted in written format, preferably the CA DWC Form RFA with documentation attached substantiating the need for the requested treatment.

Per 9792.9.1 the date of receipt of a valid request for authorization shall be deemed to have been received by the claim’s administrator or Promesa UM by facsimile, electronic mail, or by electronic data interchange on the date the form was received if the receiving facsimile, electronic mail address, or clearing house electronically stamped date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claim’s administrator or the Promesa UM. A request for authorization transmitted by facsimile, electronic mail, or electronic data interchange after 5:30 PM Pacific Time shall be deemed to have been received by the claim’s administrator on the following business day, except in the case of an expedited or concurrent review. The requesting physician must indicate on the request for authorization if there is a need for an expedited review, bear a notation of the date, time, and place of

transmission telephone facsimile number request was sent to. Where the request for authorization is sent by mail, the form absent documentation of receipt shall be deemed to have been received by the claims administrator five (5) business days after deposit in the mail at a facility regularly maintained by the United States Postal Service. Requests received via certified mail will be deemed received the dated of receipt. In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the request for authorization shall be deemed to have been received by the claims administrator five (5) days after the latest date the sender wrote on the document.

Prospective or concurrent decisions to approve, modify, or deny a request for authorization shall be made by Promesa UM in a timely fashion appropriate for the nature of the injured worker's condition, but not to exceed (5) business days from the receipt of the complete request for authorization.

Valid requests forwarded to Promesa Health UM are deemed received on the noted electronic date time stamp of the transmission, inpatient concurrent and expedited request are measured in hours and the time begins upon receipt and is limited to 72 hours to complete upon receipt. 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, would be determinantal to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in title 8 9792.9.3(b).

Retrospective decisions to approve, modify, or deny a request for authorization will be made within 30 days of receipt of a complete 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.

Please note 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 timeline is measured in hours. Whenever timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the request for authorization per 9792.9.3(a).

The calculation of review time above outlined in this section applies to all Promesa UM determinations as they do not violate the timeframes relating to MTUS formulary disputes, which are subject to the requirements of section 9792.9.8.

### **Not Complete Requests**

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, or Promesa UM as allowed by section 9792.7 will mark the request as "not complete" and return it to the requesting physician specifying the reasons for the return of the request on the form no later than five (5) business days from receipt.

### **Requests Addressed via Deferral**

Per 9792.9.2 a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity. If the claims administrator

disputes liability he/she will issue a written decision deferring utilization review of the requested treatment no later than five (5) business days from receipt of the request for authorization with an explanation for the deferral of the utilization review for the specific course of treatment. This written decision is sent to the requesting physician, the injured worker, and the injured workers representative if applicable. This process is addressed by the claims administrator.

If utilization review is deferred pursuant to 9792.2, and finally determined liable for treatment of the condition for which treatment is recommended by the claims department per agreement by both parties or on a medical basis, the time allowed to conduct **retrospective** review on deferred authorization requests shall begin on the date the determination of the claims administrator's liability becomes final. The time for the claims administrator to conduct **prospective** utilization review shall commence from the date of the administrator's receipt of a request for authorization after the final determination of liability.

### **Valid – Complete Requests**

Requests for authorization of medical treatment/service can be received by the claims administrator and forwarded to the UM department, or the medical provider may send it directly to Promesa Health UM via facsimile, electronic mail, electronic data interchange, or US Mail. The requests are validated for “completeness” at the time of receipt. This process begins with our UM Specialist, who will validate the “completeness” by ensuring that there is medical information attached to the authorization request addressing the request for authorization, that the request is from an authorized treater, and that the request is for a compensable body part/condition corresponding to the specified claim. Once it has been determined the request is valid/complete and for a compensable body part/condition for the specified claim associated with the date of injury listed on the request for authorization and corresponding supporting medical documentation, the request is set up and forwarded onto the UM Nurse Reviewer who will also review the submitted information and confirm that the request is complete and compensable to the date of injury/corresponding claim listed in our system. If the request is found to be complete and compensable to claim, the UM Nurse Reviewer will continue with the UM process addressing medical necessity by applying the appropriate MTUS guidelines pursuant to the appropriate section 9792.4, 9792.9.5, 9792.6 9792.9.7, or 9792.9.8. If upon review the Promesa UM Nurse Reviewer is unable to meet the appropriate CA MTUS guidelines or other evidence based utilized guidelines the request is then referred onto a physician peer reviewer to address medical necessity. This entire process is addressed within the timeframe associated with the specific referral request i.e., prospective, expedited, concurrent, retrospective, time begins when the “complete” valid request has been received. Determination letters are either right faxed or mailed with proof of service to all parties (requesting physician, PTP (if different than ordering), Applicant and Defense Attorney, Adjuster, rendering service provider) except for the claimant who is mailed a copy of the determination letter within 24 hours of the determination except for expedited requests which are sent the same day as the due date of the request.

## **IV. Types of Reviews**

### **Prospective Review Process**

Prospective/non-urgent review determinations will be made as soon as possible based on the injured workers clinical situation, but in no case later than five (5) business days from the date of the receipt of the complete written request (if no additional information is requested/needed).

### **Concurrent Review Process**

Concurrent review means utilization review that is conducted during an acute inpatient hospital stay. In this instance, medical care shall not be discontinued until the requesting physician has been notified of the adverse determination and the requesting medical provider has agreed upon a care plan that is appropriate for the medical needs of the injured worker. In addition, the non-physician provider of goods or services identified in the request for authorization shall be notified in writing of the adverse decision modifying, or denying a request for authorization. Medical care provided during a concurrent review shall be medical treatment that is reasonably required to cure or relieve the claimant from the effects of the industrial injury.

### **Expedited Review Process**

Expedited review per 8 CCR §9792.6.1 (j) means utilization review or independent medical review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other major bodily function or 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. 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 9792.9.3 would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (b). Prospective or concurrent requests for medical treatment necessitating an expedited review will be completed as soon as reasonably necessary but not more than 72 hours from date and time of receipt of the request.

### **Retrospective Review Process**

Requests for medical treatment received by the claim's administrator or Promesa Health UM after services have been provided are deemed to be a retrospective authorization request. The requests which contain all the medical information to render a medical necessity determination will be delivered and communicated telephonically, then followed by written notification within 30 calendar days of receipt of the

authorization request. The written notification will be sent to the requesting medical provider, injured worker, claimant attorney, if applicable, as well as the non-physician provider of goods/services (if known).

### **Extension of Timeframe for Decision**

Per 9792.9.6 Promesa Health UM may extend the timeframe for a determination decision specified in section 9792.9.3 under one or more of the following conditions:

- The claims administrator or reviewer is not in receipt of all of the information reasonably necessary to make a determination.
- The reviewer has requested that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.
- The reviewer requires a specialized consultation and review of medical information by an expert reviewer.

If the above circumstances apply, the reviewer or UM Nurse reviewer will request the required information from the treating physician within five (5) business days from the receipt of the request for authorization. This request is then sent in written format to the requesting physician, injured worker, injured worker's counsel/attorney if applicable, defense attorney if applicable, adjuster, PTP if different than the ordering physician, and adjuster specifying the information needed and timeframe it is needed by; within 14 days of accepted prospective or concurrent authorization request or 30 days of retrospective request. If the specialized consultation or test per 9792.9.6(c)(2) requested by the expert physician reviewer is not received with thirty (30) days from the date of the request for authorization, the reviewer shall deny the treating physician's request in accordance with the applicable requirements under section 9792.9.5(e). The authorization request will be reconsidered upon receipt of a new request for authorization containing the requested additional information, exam/consultation or test per 9792.9.5(7)(A); or upon receipt of the requesting physician's opinion that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or are irrelevant to the requested treatment per 9792.9.5(7)(B).

Upon receipt of the requested information pursuant to provisions of sections 9792.9.4 and 9792.9.5 Promesa UM will make their decision to approve, modify, or deny the request for authorization based on the type of authorization request submitted; i.e. prospective, concurrent, expedited, retrospective.

If the requested information is not received within the requested timeframe, or the requested exam/test/or consult has not been completed by the requested timeframe the physician reviewer will deny the request in accordance with applicable rules per section 9792.9.5(e). An adverse determination letter will be sent to all parties stating such. Refer to adverse determination letter section.

## **V. Exempt Treatment**

### **First 30 Days Following the Date of Injury-Exempt Medical Treatment**

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:

- The treatment or service is for a body part or condition that has been accepted as compensable by the claims administrator.
- The treatment or service is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director under Section 5307.27.
- The initial treating physician timely submits the “Doctor’s First Report of Occupational Injury or Illness,” DIR Form 5021, to the claim administrator as required by section 9785, subdivision (e), setting forth in detail the anticipated treatment plan for the injured worker.
- All treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, are set forth in a request for authorization provided to the claims administrator in accordance with section 9785(h). The form shall be submitted to the claims administrator concurrent with the Doctor’s First Report of 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. If a physician renders treatment 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 injured worker for the remainder of the thirty-day(30) period. A written notice must be sent to the physician by the claims administrator with the appropriate information. The following medical treatment services unless authorized by the claims administrator or rendered as emergency medical treatment require prospective utilization review under section 9792.9.1 or 9792.9.3;
- Pharmaceuticals not expressly on the exempt MTUS Drug Formulary list require prospective review
- Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician’s office; including all necessary pre-operative/intra-operative/post-operative services performed for the purpose of surgery including but not limited to diagnostic test/procedures/rehabilitation services/durable medical equipment and supplies/post op pain management treatment or services require prospective review
- Psychological or psychiatric treatment services, which include diagnostic services, psychotherapy, and other services or procedures to an individual or group in all care settings provided by a physician or other qualified health care provider, and including psychiatric pharmaceuticals, to the extent they are not expressly exempt from prospective utilization review under the MTUS Drug Formulary.

- Home health care services, including health care and other medically necessary services provided to the injured worker in the residential setting.
- Imaging and radiology services, excluding X-ray.
- All durable medical equipment, prosthetics, orthotics, and supplies where the purchase or rental cost of the item with necessary supplies, if any, for the expected course of treatment is greater than \$250.00 as determined by the DWC Official Medical Fee Schedule (OMFS), or for an unlisted item, where the billed amount will be greater than \$250.00.
- Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies. Where the physician uses neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic neuromuscular, and/or muscular systems.
- Spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections.

### **MTUS Drug Formulary**

Pursuant 9792.9.8 any request for a Non-Exempt Drug or Drug not listed on the MTUS Drug Formulary regardless of whether it is prescribed and dispensed within 30 days from the date of injury, the treating physician must request prospective utilization review by submitting a request for authorization in the manner set forth in section 9792.6.1(u). Prospective decisions to approve, modify, or deny a request for authorization for a drug not on the Exempt List will 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 receipt of the request for treatment. The reviewer or UM Nurse reviewer may request the requesting treating physician to provide additional information reasonably necessary to make a determination as follows:

- Reviewer or UM Nurse Reviewer will request the information from treating physician within four (4) business days from the date of receipt of the request for authorization.
- If the information is not received within five (5) business days from the date of the request for authorization of treatment, a physician reviewer may deny the request in accordance with section 9792.9.5, subdivision (e). The time extension set forth in section 9792.9.6 is NOT applicable to a request for authorization of a drug covered under the MTUS Formulary.

Pursuant 9792.9.8, 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;

- Drugs identified on the MTUS Drug List as exempt under section 9792.27.15
  - Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Special Fill policy under section 9792.27.12.
  - Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Perioperative Fill policy under section 9792.27.13.
- Exempt drugs identified in subsection (1) must still be set forth in a request for authorization as required under section 9792.6.1(u) by the treating physician.

Determination letters are addressed below.

## Promesa Health Direct Contracts/MPN Providers

Medical providers that possess a direct contract with Promesa Health Networks department may be given the opportunity to refer claimants for limited services without obtaining prior approval from Promesa Health UM. The prior authorization process, discussed by the Manager of Medical Networks at the time of contract signing, requires the direct contract provider to only complete a Notification of Services form and fax it to Promesa Health. These services are documented in the claim notes and a copy is placed in the claim file to ensure proper reimbursement. Promesa Health, Inc. does have direct contracts in California but the only medical clinic with permission to provide specific specified services without prior authorization is Kaiser Clinic. The list of services Kaiser is allowed to provide/order for compensable conditions/body parts of the associated claim without prior authorization have been reviewed and approved by the Promesa Health Medical Director, they are;

1. Initial 6 sessions of Physical Therapy.
2. Initial x-rays when clinically indicated.
3. Initial CT scan when clinically indicated.
4. DME priced at under \$200.00, that is clinically indicated.
5. MRI Scan when clinically indicated.

Individual Medical providers that possess a direct contract with Promesa Health Networks department may be given the opportunity to refer claimants for limited services pertaining to compensable body parts/conditions associated with the corresponding claim without obtaining prior approval from Promesa Health UM. Again, these services are approved by the Promesa Health Medical Director and the details surrounding which providers possess direct individual contracts and allowed to utilize these services is considered proprietary to the Networks Department. The prior authorization process, discussed by the Manager of Medical Networks and the Promesa Health Medical Director, at the time of contract signing, requires the direct contract provider to only complete a Notification of Services form and fax it to Promesa Health. These services are documented in the claim notes and a copy is placed in the claim file to ensure proper reimbursement.

Emergency Health Care Services per 8 CCR §9792.6.1(i) are “health care services for a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to place the patient’s health in serious jeopardy”. In accordance with 9792.9.5(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 subject to retrospective review. Documentation for emergency health care services shall be made available to the claim’s administrator upon request. For treatment rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer–selected physician, the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five (5) days following the employee’s initial visit and evaluation on the “Doctor’s First Report of Occupational Injury or Illness,” DIR Form 5021 as required by section 9785, subdivision (e). California Insurance Company, Continental Indemnity Company, Texas Insurance Company, Illinois Insurance Company, Pennsylvania Insurance Company,

Oklahoma Property & Casualty Insurance Co., Applied Risk Services and any unaffiliated carriers which have an agreement for us to provide services for will provide medical treatment for their covered injured employees via medical providers in their Promesa Health Medical Provider Network (MPN) or Promesa Health, Inc. Health Care Organization (HCO). Under updated Labor Code 4610 (c), unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services rendered within the 30 days following the initial date of injury shall be subject to prospective utilization review:

1. Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27
2. Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.
3. Psychological treatment services.
4. Home health care services.
5. Imaging and radiology services, excluding x-rays.
6. All durable medical equipment, whose combined total value exceeds \$250.00, as determined by the official medical fee schedule.
7. Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
8. Any other service designated and defined through rules adopted by the administrator director.

Treatment provided within the first 30 days from the initial date of injury to a compensable body part/condition by an in network medical provider, predesignated physician, or arranged by the employer is subject to the CA MTUS guidelines section 9792.9.7. When written requests are received for authorization of a non-drug treatment that is exempt under section 9792.9.7 (30-day exemption) the written decision approving the request shall identify the exempt treatment as, “30-day exemption”. Treatment/services outside of these specific guidelines will require that a prospective request for authorization be submitted even if being provided within the initial 30 days from the date of injury.

## **Determination Letters**

### **Certifications**

Per 9792.9.4 all Promesa Health UM Determination Letters shall contain the date the complete authorization request was received, the date the medical treatment service was requested, the specific medical treatment service approved, the date of the decision; and 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.

Determination letters for authorization of medication requests that did not indicate “Do Not Substitute” or Dispense as Written,” the written decision approving the request in generic form shall indicate all of the above as well as “generic substitute authorized” or words to that effect and meaning.

Determination letters for authorization of medication requests addressing drugs which are listed exempt on the Drug Formulary, the determination letter will indicate “exempt per MTUS Drug Formulary” or words to that effect and meaning along with the additional information listed above.

Determination letters for authorization of non-drug treatment that are exempt under section 9792.9.7 (i.e., the 30-day exemption), will contain the information mentioned above as well as identifying the request as exempt treatment under the, “30-day exemption” rule or words to that effect or meaning.

Certification decisions are communicated to the requesting physician within 24 hours of the decision by telephone followed by a written determination letter sent via facsimile or agreed upon encrypted electronic mail within 24 hours of the decision of concurrent review and per Promesa Health UM Policy within two (2) business days for prospective review, and retrospective reviews. A copy of the determination letter is also sent to the rendering service provider, PTP if different than the requesting physician, claimant representative if applicable, defense attorney if applicable, claims adjuster, and mailed directly to the claimant.

#### Adverse Determinations

Per 9792.9.5 any decision to deny, or modify a request for medical treatment must be conducted by a physician reviewer, 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. Promesa Health UM utilizes only URAC accredited IRO’s and Workers’ Comp UR entities to perform their physician reviews. This is closely monitored by our Medical Director, Jeffrey Liva, MD.

Per 9792.9.5(c) 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 determination by telephone, facsimile, or, if agreed by the parties, encrypted electronic mail. Written determination letters will be issued to the injured worker, and, if applicable, to the injured worker’s representative, defense attorney if applicable, adjuster, rendering service provider if applicable, requesting physician, and PTP if applicable within 24 hours of the determination for concurrent review, within two (2) business days for prospective review, and, for expedited review within 72 hours of receipt of the request. Note modification letters will include the information of which part of the request has been approved and what rendering service provider is to provide the services and for what certification timeframe. Reviews will be completed within the appropriate timeframes associated with the corresponding reviews. The adverse determination letters will contain the following information:  
-The date on which the completed request for authorization was first received.

- Per 9792.9.6 if the review time was extended and a letter was sent requesting additional information to assist in making a medical decision regarding a medical treatment request. Per 9792.9.6 the letter will provide a specific description of the information required to make the medical necessity determination for 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) as well as the date the information was first received.
- The date on which the decision is made.
- A description of the specific course of medical treatment set forth on the request for authorization.
- A list of all medical records reviewed.
- A specific description of the medical treatment service approved, if any.
- A clear, concise, and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity 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.
- 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.
- For decisions based on medical necessity, a citation to and a description of the relevant medical criteria or guidelines used to reach the decision.
- 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.
- 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'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.
- “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 your claims adjuster at 877-234-4420 option 1. However, if you are represented by an attorney, please contact your attorney instead.
- “For information about the workers' compensation claims process and your rights and obligations, go to [www.dwc.ca.gov](http://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.”
- A clear statement that the Promesa Health Internal Appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.
- The name and specialty of the physician reviewer issuing the adverse determination, as well as the contact information to request an appeal if applicable.

## VI. Treatment Guidelines

### Clinical Decision Support Tools

The Promesa Health UM program utilizes nationally recognized review criteria and evidence-based medicine guidelines as decision support tools to assist in medical necessity review determinations. The Promesa Health Medical Director, the Manager of UM and the Quality Management Committee review the guidelines and criteria when the guidelines/criteria are updated or revised, but no less than annually.

Criteria Set	Description
CA MTUS/MD Guidelines/ACOEM	The criteria available for a physician reviewer to utilize to determine the medical necessity of requested treatment shall be consistent with the medical treatment utilization schedule adopted pursuant to Labor Code section 5307.27, including the methodology for evaluating medical evidence under section 9792.25.1. Note nothing in the CA Labor Code precludes authorization of medical treatment beyond what is covered in the medical treatment utilization schedule or supported by the best available medical evidence in order to account for medical circumstances warranting an exception in accordance with section 9792.21.1(e) American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines, when the request is not covered in the updated CA MTUS guidelines.
Official Disability Guidelines (ODG)	When requests for medical treatment are not addressed by CA MTUS, Promesa Health UM staff has the ability to use these guidelines for authorization of treatment being reviewed.

Inter-Qual Criteria	<p>These guidelines are utilized for medical treatment not addressed by CA MTUS or ODG, i.e acute inpatient levels of care for hospital and acute rehab/SNF level of care admissions vs outpatient admissions.</p> <p>The criteria set include:</p> <p>Adult Acute Medical</p> <p>Adult Inpatient Rehabilitation Adult Sub-acute; SNF</p> <p>Long Term Acute Care Management Criteria</p> <p>Durable Medical Equipment (DME)</p>
Value Options	<p>These guidelines will be used for medical treatment requests related to mental health issues not specifically addressed in CA MTUS or ODG. The criteria set include:</p> <p>Inpatient Services for Adults</p> <p>Structured Day Treatment-Adult.</p> <p>Outpatient Services-Adult</p>

## **VII. Determination Notification Process**

### **Notification of Authorization Determination Process**

Notification of approval determinations will be communicated to the requesting physician initially by phone or facsimile within 24 hours of the decision and followed up with the corresponding written notification. The written notice of the determination will include the date the request was received, medical treatment requested, specific medical treatment that has been approved, rendering service provider (if appropriate), and the date of the decision. Copies of the authorization letter will be sent by facsimile when the number is available, or by US Mail with proof of service to the requesting physician, the primary treating physician, injured worker’s attorney (if applicable), the claims adjuster, defense attorney (if applicable), and the rendering provider of services. A copy is sent to the injured worker via US Mail with proof of service. It is Promesa Health, Inc.’s policy to provide all notifications (verbal and written) within twenty-four (24) hours of the decision despite the regulation which allows the written determination to be sent within 2 business days for prospective reviews. All written notification correspondence is mailed or faxed within twenty-four (24) hours of the UM decision.

Notification of medication approvals where the request for authorization did not indicate “Do Not Substitute” or “Dispense as Written”, the determination letter will indicate “Generic Substitute Authorized” per 9792.9.4.

Notification of medication approvals where the authorization request was for a drug on the exempt list of the CA Drug Formulary the determination letter will indicate that the medication requested is “Exempt per MTUS Drug Formulary”.

### **Notification of Adverse Determination Process**

Peer review decisions to modify, or deny medical treatment related to prospective, expedited or concurrent review requests will be communicated to the requesting physician by phone or facsimile within 24 hours of the decision then followed up with a written notice. It is Promesa Health, Inc.’s policy to provide all notifications (verbal and written) within twenty-four (24) hours of the decision despite the regulation which allows the written determination to be sent within 2 business days for prospective reviews. Written correspondence will be sent to the injured worker, the injured worker’s attorney (if applicable), the requesting physician, the primary treating physician, defense attorney (if applicable), claims adjuster, and the rendering service provider (if known). The notification sent to the rendering service provider will NOT contain the medical rationale, criteria/guidelines used in reaching the adverse determination. A copy of the adverse determination will be sent to the injured worker via US Mail with proof of service. Information contained in the adverse determination notifications include:

1. Date on which the DWC Form RFA was first received.
2. Date decision was rendered.
3. Description of the specific course of proposed medical treatment for which authorization was requested.  
  
-If the timeframe for decision was extended under section 9792.9.6, a description of the specific information needed to make a medical necessity determination is included as well as the date(s) and time(s) the request(s) for information, exam, or consultation under subdivision (a)(1)(A), (B) or (C) of section 99792.9.6 were requested; the manner in which the requests were made; and the date the information was first received.
4. A list of all medical records reviewed.
5. A specific description of the medical treatment approved, if any.
6. A clear, concise, and appropriate explanation of the reasons for the reviewing physician’s decision, including the clinical reasons regarding medical necessity and a description to modify, or deny a medical service due to incomplete or insufficient information. The decision shall specify the reason for the decision and specify the information that is needed. A description of clinical guidelines or medical criteria used in the decision process will be listed. 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 per 9792.9.5(7)(B). The documentation will

include a citation to and a description of the relevant medical criteria or guidelines used to reach the determination utilized by the reviewer per 9792.9.5(8). The documentation will also identify the URAC accredited entity, approved DWC liable for the utilization review determination per 9792.9.5(9).

7. The application for Independent Medical Review, DWC Form IMR, accompanied by an envelope addressed to the Administrative Director to submit the IMR. All fields on the form, except for the signature of the employee, must be completed by the claims' administrator.
8. A clear statement advising the injured worker 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 any 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.
9. The following language, "You have the right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your claims adjuster (name of adjuster), at (adjuster phone contact). However, if an attorney represents you, please contact your attorney instead," and "For information about workers' compensation claims process and your rights and obligations, go to [www.dwc.ca.gov](http://www.dwc.ca.gov) or contact an information and assistance (I&A) office of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll free 1-800-736-7401".
10. The name and specialty of the reviewer or expert reviewer, the telephone number of the peer reviewer or expert reviewer. Hours of availability for the reviewer or the medical director for the treating physician to discuss the decision which shall be, at a minimum, 4 hours per week during normal business hours, 9:00 AM to 5:30 PM Pacific Time, or an agreed upon scheduled time to discuss the decision with the requesting physician. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.
11. Initial adverse determinations will also contain Promesa Health UM's internal appeal process information.

### **Optional Internal Appeals Process**

Optional Internal Appeals Process language: If you disagree with our decision, you have the option to request an internal appeal directly from Promesa Health, Inc. To participate in the internal appeal process, you must request the internal appeal in writing within ten (10) calendar days from the decision date of the modification or denial. Fax your request, clearly marking it as an appeal, with any additional available medical information, to 1-877-853-6853. You may also submit your internal appeal request via US Mail to Promesa Health, Inc., ATTN: Appeals. The internal appeal will be processed and a decision rendered no later than 30 calendar days from the initial decision date.

Participation in the Promesa Health 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. Participation in this voluntary appeal process neither tolls nor extends the timeframe limits to submit a request for IMR through the California DWC dispute resolution process per provisions of Labor Code section 4610.5 and 4610.6 as noted above.

A peer reviewer not involved in the initial medical necessity review, will review the appeal request based on additional information submitted to Promesa Health, or if no additional information is available the peer reviewer will make the medical necessity decision based on information currently available. Upon completion of Promesa Health's internal appeal process, be advised that your appeal rights are exhausted unless otherwise permitted through the DWC State Independent Medical Review process. Please refer to the attached DWC Form IMR for further instructions.

If the adverse determination only addresses a medication and the injured worker requests an internal appeal the internal appeal will be completed within ten (10) days after receipt of the request under 9792.10 (2)(f)(1)., all other internal appeal requests not dealing with a medication request are addressed within a 30-day timeframe. The determination of the Promesa Health Internal Appeal process will be communicated to all parties, requesting physician, injured worker, injured worker representative if applicable, defense attorney if applicable, adjuster, PTP if different than requesting physician, etc., along with the appropriate IMR form/addressed envelope.

### **Adverse Determination Timeframe Duration**

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

## **VIII. Confidentiality and Security**

### **Confidentiality Policy**

Promesa Health will protect the confidentiality of all individually identifiable health information (IIHI) obtained during the UM process. It is the responsibility of Promesa Health employees, committee members and board members to preserve the confidentiality of IIHI.

IIHI obtained by Promesa Health staff members about an injured worker is to be used solely for identification purposes during the determination process for medical necessity of a particular request for medical treatment. This information will not be shared with anyone not directly involved in this process unless written permission is obtained from the injured worker.

Members of Promesa Health Client Services, Bill Intake, Medical Bill Review, Promesa Health Pharmacy, Medical Networks, UM, and the Medical Director will have access to IIHI only to the extent necessary to perform their specific job duties. The IT department is responsible for loading the software onto staff member's computers. The Internal Auditor is responsible for granting access to software in accordance with guidelines set by each staff member's supervisor/manager. Access to the Claims Management System is secured by password access.

Information containing IIHI may be received by Promesa Health staff by:

1. Orally via the telephone or from the claims adjuster
2. Written form via secure toll-free facsimile
3. Written form via the US mail
4. Written form via our IRO vendor's secure FTP/website.
- 5.

The following information containing IIHI may be distributed by Promesa Health staff, by any of the above-mentioned routes:

1. Medical necessity determination letters containing IIHI will be faxed or mailed to only those parties that require notification of the determination.
2. IIHI transferred electronically to a contracted Peer Review Organization will include only that information necessary for the peer reviewer to make a medical necessity determination.

All Promesa Health staff members, including both committee members as well as board members, are responsible for preserving the confidentiality of the claimant's IIHI by utilizing the information only for the purpose of completing their assigned job duties. They are required to sign a confidentiality agreement upon hire or at the time of policy implementation stating that they understand their responsibility to preserve confidentiality. This form is signed by both clinical and non-clinical staff members, and the UM staff update this document annually.

## **IX. Electronic Reporting to State**

Promesa Health shall provide electronic documents for every utilization review performed by Promesa Health UM as required under Labor Code §4610(o) in the format prescribed by the CA DWC.

## **X. Conclusion**

This concludes Promesa Health's filing of its utilization review plan as an external utilization review organization. This filing consists of a detailed description of the Utilization Review process used by Promesa Health effective upon filing.