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Promesa Health, Inc. Utilization Review Plan

California Division of Workers' Compensation

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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, 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.
3. Claims Administrator-a self-administered workers' compensation insurer, subject to Labor code section 4610. The claims administrator may utilize an entity contracted to conduct its 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," Form DLSR 5021, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.
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 claims administrator that a factual, medical, or legal basis exists that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.
8. 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.
9. Expedited- means utilization 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.
10. Expert Reviewer- means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any

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

11. 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.
12. 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.
13. 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.
14. Medical Treatment Utilization Schedule- means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27; updated as of December 2017 (now referenced as CA MTUS)
15. Medical Treatment Utilization Schedule (MTUS) Drug Formulary- means the current version of the CA drug formulary adopted by the Administrative Director pursuant to Title 8 of the California Code of Regulations beginning with section 9797.27.1.
16. Modification-means a decision by a physician reviewer that part of the requested treatment or service is not medically necessary.
17. 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 Colombia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice.
18. Promesa Health- means Promesa Health, Inc.
19. Promesa Health UM- means Promesa Health Utilization Management.
20. 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.
21. Request for Authorization- means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) and 8 CCR §9792.6.1(t) or a written request for a specific course of proposed medical treatment.
22. Retrospective Review- means utilization review conducted after medical services have been provided and for which approval has not already been given.
23. 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. 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. The utilization review process begins when the completed DWC Form

RFA, or a request for authorization accepted as complete under section 9792.9.1(c)(2), is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

24. Written- includes a facsimile as well as communication in paper form.

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) providing services on behalf of all indirect insurer subsidiaries of AU Holding Company, Inc., to include 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 which include . 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.

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 functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians 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 our 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 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., which is a wholly-owned subsidiary of Bernard Acquisition Company, LLC. All indirect insurer subsidiaries of AU Holding Company, Inc. are wholly-owned subsidiaries of North American Casualty Co. 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. Promesa Health's Medical Director is Jeffrey Liva, M.D., California Medical License #G154330; 30 Bayberry Dr., Saddle River, New Jersey, 07458; 201-444-3060.

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(a)(3) 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).

Physician Reviewer

Review decisions to deny, or modify a request for medical treatment will be conducted by a physician reviewer in accordance with 8 CCR §9792.6.1(k), 9792.21 and 9792.23. The 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 the medical treatment services being requested. The medical treatment services being requested will be within the physician reviewers' scope of practice/medical expertise.

Promesa Health UM contracts with URAC accredited Independent Review Organizations (IRO). IRO's Genex formally d/b/a PRIUM and Care Review are utilized for peer review services to ensure availability of high quality specialty matched reviewers as

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required by 8CCR §9792.7(b)(2). 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 §9792.9.1.

Non-Physician Reviewer
Non-physician reviewers who consist of Registered Nurses will apply specified criteria to a particular request for medical treatment, may discuss criteria with the requesting physician, and may reasonably request necessary information to make a decision regarding the authorization request based on the information submitted and criteria utilized for the review. **Under no circumstances will a non-physician reviewer deny, or modify an authorization request for medical treatment/services.**

UM Personnel

Position Title	Job Duties
UM Medical Director	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.
Manager of UM	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 RN license with at least five (5) years of clinical experience.
UM Supervisor	Provides oversite 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.
UM Nurse Reviewer Team Leader	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. Qualifications: Requires a current RN license with at least three (3) years of clinical experience; five (5) years is preferred.
UM Nurse Reviewer	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 criteria related to the particular request, the request is referred to a contracted peer review vendor for assignment to a physician peer reviewer to address the medical necessity and appropriateness of the requested treatment/service/procedure. Qualifications: Requires a current RN license with at least three (3) years of clinical experience; five (5) years is preferred.
Physician Peer Reviewer	The contracted physician peer reviewer will review the available medical information to address the medical necessity and appropriateness of the level of care for the requested treatment, service or procedure. Peer review services are provided by a contracted URAC accredited Independent Review Organization which accepts responsibility for maintaining credentialing information and quality review monitoring for their peer reviewers. Qualifications: At least three (3) years of clinical experience; five (5) years is preferred. Only Physician Peer Reviewers can make modification or denial determinations.

UM Specialist Team Leader	Responsible for UM Specialist duties and ensures all processes are performed according 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. Qualifications: Requires a high school diploma or GED; Associates degree preferred.
UM Specialists	Receives the initial valid requests for authorization (RFA) from medical providers and/or claims adjuster and confirms claim information. Enters all data into software for continuation of the medical necessity review process. Qualifications-Requires a high school diploma or GED.

III. UM Process

Receipt of Request for Medical Treatment
The date of receipt of a valid DWC Form RFA is the date first received by the insurance company, employer, or the contracted Utilization Review Organization (URO).

Valid requests forwarded to Promesa Health UM are deemed received on the noted electronic date time stamp of the transmission. Facsimile requests received after 5:30 PM Pacific Time (7:30 PM Central Time) shall be deemed received the next business day.

Valid requests received by mail that have a valid post mark date will be deemed as received five (5) business days from the post mark date. In the absence of a valid postmark date, the request will be deemed as received based on the "received" date stamp by the entity receiving the Request for Authorization (RFA) first.

Where the valid DWC Form RFA is delivered via certified mail, with return receipt mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator on the receipt date entered on the return receipt.

Description of UM Process
The valid request for authorization for a medical treatment/service as defined in 8 CCR§ 9792.6.1(d) must be in written form set forth on the "Request for Authorization (DWC Form RFA)", as contained in California Code of Regulations, title 8 section 9785.5. Upon receipt of a DWC Form RFA found to not identify the employee or provider, not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity for the requested treatment/service, or is not signed by the requesting physician or non-physician as allowed in section 9792.7; the DWC Form RFA will be sent back to the requesting entity marked "incomplete" specifying the rationale for the "incomplete" finding, no later than five (5) business days from receipt. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of the completed valid DWC Form RFA.

Requests for authorization (RFA's) 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 or US Mail. The requests are validated at the time of receipt as to being in the proper written format as per California Code of Regulation 9792.9.1(a). This process begins with our UM Specialist, who validate that the RFA is signed by the requesting physician, that there is medical information attached addressing the request on the RFA, that the form is filled out fully and correctly, that the request is from an authorized treater, and that the request is for a compensable body part/condition to the claim. Once it has been determined the request is valid and for a compensable body part/condition for the claim 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 valid and compensable to the claim. If the request is

found to be valid and compensable to claim, the UM Nurse Reviewer will continue with the UM process.

The claims administrator may elect to defer the submitted request for authorization on a med-legal basis, at which point the UM process will be terminated. Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for an injury or treatment of the condition for which treatment is recommended pursuant to Labor Code §4062. If it is determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review shall begin on the date the determination of the employer's liability becomes final; the time to conduct prospective utilization review shall commence from the date of the receipt of newly submitted requests after the date of employers liability determination.

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.

Emergency Health Care Services per 8 CCR §9792.6.1(i) is "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 8 CCR §9792.9.1(e)(2) 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 claims administrator upon request.

CA Senate Bill 1160 updated parts of Labor Code 4610. Effective for all dates of injuries on or after January 1, 2018, 4610(b) states emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury shall be authorized without prospective utilization review, except as provided in subdivision (c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. 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. 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. Treatment 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.

UM Process for Requests that Lack Information

Prospective and retrospective requests for medical treatment with insufficient information available to make a medical necessity determination will be addressed in the following manner:

1. As soon as possible, but no later than the fifth business day of receipt of the request for prospective requests and 30 calendar days for retrospective requests, the UM staff will notify the requesting provider of the need for additional information to substantiate the request via written notice. The written notice will identify the information required to render the medical necessity determination.
2. Render a determination no later than the fourteenth calendar day of receipt of the original written request for prospective or concurrent reviews, or within 30 days of the request for retrospective reviews.
3. When there is insufficient information to render a medical necessity determination, the request will be forwarded to a physician peer reviewer to address. The physician peer reviewer may deny the request due to lack of medical information to substantiate the authorization request.

Once a final determination is made, no later than the fourteenth calendar day, final notification will be sent to the requesting medical provider, injured worker, the injured worker's attorney if applicable, and the rendering service provider, if known, indicating the final determination. If the final determination is a denial due to lack of information, then a statement is included indicating the request will be reconsidered upon receipt of the requested information. Efforts to obtain information will be documented before issuing a denial due to lack of information per 8 CCR §9792.9.1(g).

Time Extension Physician Peer Determination
The timeframe for decisions specified in subdivision (c) may only be extended under one or more of the following circumstances:

1. There is insufficient information to make the medical necessity determination;
2. An additional test or exam needs to be completed prior to being able to make a medical necessity decision, or;
3. A specialized consultation and review of medical information by an expert reviewer is required.

Process for Time Extension Notification
Per 8 CCR §9792.9.1(f)(2)(A), if the circumstances listed above apply, 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.

Per 8 CCR §9792.9.1(f)(2)(B), if any of the circumstances set forth in subdivisions (f)(1)(B) or (C) are deemed to apply following the receipt of a DWC Form RFA or accepted request for authorization, the reviewer shall within five (5) business days from the date of receipt of the request for authorization notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and the injured worker's attorney, if applicable, the anticipated date on which a decision will be rendered.

Per 8 CCR §9792.9.1(f)(3)(A), if the information reasonably necessary to make a determination under subdivision (f)(1)(A) that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed request or authorization for prospective or concurrent review, or within 30 days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information. Per 8 CCR §9792.1(f)(3)(B), if the results of the additional examination or test required under subdivision (f)(1)(B) or the specialized consultation under subdivision (f)(1)(C), that is requested by the reviewer under this subdivision is not received within 30 days from the date of the request for authorization, the reviewer shall deny the treating

physician's request with the stated condition that the request will be reconsidered upon receipt of the result of the additional examination, test, and/or specialized consultation.

IV. Types of Review

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.

Concurrent review determinations will be made as soon as possible based on the injured workers clinical situation, but in no case later than 72 hours from the date and time of the receipt of the complete written request.

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. 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 claims 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).

V. 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	CA MTUS is the first set of guidelines used for medical necessity as it is recognized as presumptively correct on the issue of extent and scope of medical treatment. Per Labor code section 5307.27(a) which addresses updates to the CA MTUS and includes the incorporation of parts of the ACOEM guidelines as well as the newly developed drug formulary (8 CCR §9792.20, 9792.22, 9792.23, 9792.24).
ACOEM	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	These guidelines are utilized for medical treatment not addressed by CA MTUS or ODG, as well as for appropriate levels of care. The criteria sets include: Adult Acute Medical Adult Inpatient Rehabilitation Adult Sub-acute; SNF Long Term Acute Care Care Management Criteria Durable Medical Equipment (DME)
Value Options	These guidelines will be used for medical treatment requests related to mental health issues not specifically addressed in CA MTUS or ODG. The criteria sets include: Inpatient Services for Adults Structured Day Treatment-Adult Outpatient Services-Adult

VI. Determination Notification Process

Notification of Authorization Determination Process
Notification of approval determinations will be communicated to the requesting physician initially by phone or facsimile 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 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 and followed up with a written notice within 24 hours of the decision. 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.
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.

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 10 days after the service of the utilization review decision to the employee for formulary disputes, and within 30 days after the service of the utilization review decision to the employee for all other medical treatment disputes.
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 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.
11. 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.
12. 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.

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.

VII. 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.

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.

VIII. 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.

IX. 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.