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Promesa Health, Inc. Utilization Review Plan

Arkansas Division of Workers' Compensation

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I. General Definitions

1. Board means the State Board of Health.

2. Certificate means a certificate of registration granted by the State Board of Health to a private review agent.

3. Director means the Director of the Arkansas Department of Health or his/her designee.

4. Hospital means any facility established for the purpose of providing inpatient diagnostic care and treatment for two or more unrelated persons for more than 24 hours may not be conducted or maintained in this State without being licensed.

5. Private Review Agent means a non-hospital affiliated entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of an Arkansas business entity or third party that provides or administers hospital and medical benefits to citizens of this State including a health maintenance organization or entity offering health insurance policies, contracts or benefits in this state including a health insurer, nonprofit health service plan, health insurance service organization, or preferred provider organization. Per Ark Code 20-9-903 has been granted this certificate by the State Board of Health which entitles this entity to approve or deny payment for hospital or medical services on a case by case basis based on medical necessity.

6. Utilization Review means a system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients. More specifically, utilization review refers to a preservice determination of the medical necessity or appropriateness of services to be rendered in a hospital setting either on an inpatient or outpatient basis, when such determination results in approval or denial of payment for the services. It includes prospective, concurrent or retrospective reviews.

7. Utilization Review Plan means a description of the standards governing utilization review activities performed by a private review agent.

8. Utilization Review Representative means the person(s) in a physician office or hospital designated by the physician or hospital to provide the necessary information to complete the review process.

9. Consulting Physician means a Medical Doctor, Doctor of Osteopathy, Dentist or Chiropractor who possess the degree of skill ordinarily possessed and used by members of his or her profession in good standing engaged in the same type of practice and specialty in the locality where the service under review occurred or in a similar locality.

10. Certified Private Review Agent means a private review agent who meets all the criteria for certification as set forth in these Rules and Regulations, has paid all current fees, and has been assigned a certification number.

11. 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 Ark. Code 20-9-901.

12. Concurrent Review- means utilization review conducted during an inpatient stay.

13. Course of Treatment- means the course of medical treatment set forth in the treatment plan contained on the physician's report/summary/plan of care

14. Denial- means a decision by a physician reviewer that the requested treatment or service is determined not authorized/medically necessary.

15. Expedited- means an utilization review is conducted in a time frame 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.

16. 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.

17. Medical Director- is the physician and/or surgeon who holds an unrestricted license to practice medicine in the state that he/she actively practice medicine in. The Medical Director is responsible for all decisions made in the utilization review process.

18. Modification-means a decision by a physician reviewer when part of the requested treatment or service is found to be not medically necessary.

19. 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.

20. Promesa Health- means Promesa Health, Inc.

21. Promesa Health UM- means Promesa Health Utilization Management.

22. 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.

23. Request for Authorization- means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant

24. Retrospective Review- means utilization review conducted after medical services have been provided and for which approval has not already been given.

25. 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 prior to, retrospectively, or concurrently per Ark Code 20-9-901 through 20-9-914. Utilization review does not include determinations of the work-relatedness of injury or disease. The utilization review process will begin upon the receipt of the request for authorization by either facsimile, secure email, adjuster, or mail.

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., Applied Risk Services (ARS), as well as any unaffiliated insurance carriers we have an agreement with to provide services. This filing will consist of a detailed description of the utilization review process utilized by Promesa Health UM. Promesa Health UM has established and maintains this Utilization Review Plan and its Utilization Review Process in compliance with Ark. Code 20-9-901 through 20-9-914 et seq and applicable regulations.

Promesa Health UM will make this Utilization Review Plan available to the public by posting it on https://promesa.auw.com; Promesa Health's Arkansas Utilization Review Plan may be available upon request 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;

1. Promote the delivery of quality health care in a cost-effective manner;
2. Foster greater coordination between payors and providers conducting utilization review activities;
3. Protect patients, business, and providers by ensuring that private agents are qualified to perform utilization activities and to make informed decisions on the appropriateness of medical care; and
4. Ensure that private review agents maintain the confidentiality of medical records per Ark Code 20-9-901.

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. Promesa Health, Inc. will only request information necessary to make a medical necessity determination for the requested service, procedure or hospitalization. This pertains to all levels of review (prospective, concurrent and retrospective). The length of certification and the frequency of continued reviews are based on the severity or complexity of the worker's condition, necessary treatment, discharge planning needs, and the professional judgment of the UM Nurse Reviewer. The Utilization Process does not include compensable/causally related determinations of the injury/disease process for the claim. Promesa Health UM determinations are communicated to the Promesa Health Bill Review department who ensure that medical treatment/services found medically necessary by the Promesa Health UM department are billed correctly by the requesting physician and/or rendering service provider, and that services found not medically necessary are not reimbursed or paid for. Physicians identified with overutilization or incorrect billing practice may be targeted for 100% concurrent review per ARK 20-9-901-20-9-914; they will be notified in a written format per the claim's adjuster. The claim's adjuster will be

notified of the concern by the bill review department upon discovery of the issue of concern.

Promesa Health UM performs functions directly related to workers compensation and injuries related to such; we do not provide UM services for disease management for an acute hospital/rehab/SNF type setting so we do not provide this service.

Promesa Health UM performs functions directly related to workers compensation and injuries related to such; we do not provide UM services for case management for an acute hospital/rehab/SNF type setting so we do not provide this service. We do not provide case management for workers compensation either, many states do not allow utilization review to be performed by the department/nurses who provide case management to the claimant as well therefore Promesa Health UM does not provide this service.

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.

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 MCO Medical Director. The evaluation of the Medical Director's performance is in no way tied to financial outcomes. We have provided utilization management services for ARS and their subsidiaries since 2007.

Medical Director

Promesa Health employs a Medical Director to oversee the Utilization Review Process. The Medical Director will hold an unrestricted license to practice in his state of residence and is responsible for all decisions made during the utilization management process. Promesa Health's Medical Director is Jeffrey Liva, M.D., New Jersey License #25MA04900900; Paramus, New Jersey, 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 the multiple specific state jurisdiction regulations.

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 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). Promesa Health UM does not record telephone conversations, so therefore cannot be provided upon request.

Physician Reviewer
Review decisions to deny, or modify a request for medical treatment will be conducted by a physician reviewer per URAC requirements. A physician reviewer is defined as 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, Care Review, and MLS Group of Companies, LLC are utilized for peer review services to ensure availability of high quality specialty matched reviewers as required by several specific state regulations.

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. 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 appeal process. As stated above the IRO's utilized by Promesa Health UM are URAC accredited and therefore all their Peer Reviewers utilized (first level and appeal level) for the state of Arkansas hold an active and unrestricted license in their respective states. Each IRO has their own policy in place to validate the licensure and credentialing of each of their peer reviewers.

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 URAC and state specific regulations requirements/standards. 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 URAC standards as well as state specific regulations.

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.

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 he/she resides. 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. ***any change in Medical Director will be reported to the Director within 30 days.**
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 authorization request will be the date first received by 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 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 authorization request 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 must be in a written format, dated and signed either by signature or electronic signature by the medical professional performing the exam and making the recommendation. **Please note that the state of Arkansas requires preauthorization for all nonemergency hospitalizations, transfers between facilities, and outpatient facilities, and outpatient services expected to exceed $1000.00 in billed charges for a single date of service by a provider.**

Requests for authorization (RFA's) of medical treatment/service are to be received by the claims administrator and forwarded to the Promesa UM department via secure scan. This process begins with our UM Specialist, who will validate that the request for authorization is signed by the requesting physician, that there is medical information attached addressing the request, 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 or condition 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; and continue with the UM process. Authorization requests associated with non-compensable conditions/claimants will be addressed by the claim's adjuster on an administrative med-legal basis within five (5) business days of receipt of a valid authorization request.

Emergency Health Care Services 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. 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.

Treatment provided 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 nationally recognized evidence-based guidelines utilized to address medical necessity/appropriateness of care along with appropriateness of level of care. Treatment outside of these specific guidelines will require prior authorization.

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 Ark. Code 20-9-901 through 20-9-914.

Note Rate Negotiation/Reduction Review* Promesa Health, Inc. UM Nurse Reviewer's will secure reimbursement rates when an authorization is issued to a non-network provider for medically necessary services that are not addressed in the individual state fee schedule or when requested by the adjuster. These entities include, but are not limited to home health care, home infusion therapy, and care provided in an extended care facility such as a skilled nursing facility (SNF) or acute rehabilitation facility. Refer to UM Policy 2-31.

As stated above, Promesa Health UM determinations are communicated to the Promesa Health Bill Review department who ensure that medical treatment/services found medically necessary by the Promesa Health UM department are billed correctly by the requesting physician and/or rendering service provider, and that services found not medically necessary are not reimbursed or paid for. A certified bill review coder will review the submitted bill/claim with the medical information submitted, the coder will make the appropriate changes if needed based on their review which in turn may affect the overall bill/claim submitted.

IV. Types of Review

Please note that the state of Arkansas requires preauthorization for all nonemergency hospitalizations, transfers between facilities, and outpatient facilities, and outpatient services expected to exceed $1000.00 in billed charges for a single date of service by a provider. A denial of these services must be made by an utilization review based on medical necessity by an Arkansas certified private review agent. Promesa Health UM determinations are communicated to the Promesa Health Bill Review department who ensure that medical treatment/services found medically necessary by the Promesa Health UM department are billed correctly by the requesting physician and/or rendering service provider, and that services found not medically necessary are not reimbursed or paid for.

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 a utilization review that is conducted during an acute inpatient hospital stay. 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 means utilization review is 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 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 retrospective 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).

Note * The claimant per Promesa Health, UM policy will be afforded **one** opportunity to obtain a second surgical opinion (SSOP) for a non-emergent/elective surgical procedure as required/allowed by jurisdiction specific legislation. The second opinion physician shall be within the Promesa Health, Inc. network or the specified provider network in the identified jurisdiction if applicable. Refer to Promesa Health UM Policy 2-23.

Determination letters are sent out on all review processes mentioned above to all appropriate. entities; the ordering physician, the claimant, the adjuster on file, the claimant attorney if applicable, the treating physician if other than the ordering physician, and 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. Adverse determination notification letters will contain the information the claimant, the claimant representative, and/or requesting physician require to request either a reconsideration and/or an appeal of said adverse determination. Copies of any adverse determinations shall be furnished at the request of the Director per 20-9-901. Promesa Health UM determinations are also communicated to the Promesa Health Bill Review department who ensure that medical treatment/services found medically necessary by the Promesa Health UM department are billed correctly by the requesting physician and/or rendering service provider, and that services found not medically necessary are not reimbursed or paid for.

Promesa Health, UM non-clinical staff may accept, process, and transfer clinical and non-clinical data as part of the UM process. However, at no time are they responsible for interpreting clinical information or performing medical necessity review activities. Under no circumstances will a Promesa Health UM Nurse Reviewer performing the initial clinical review render a non-certification, delay or modification determination (adverse determination).

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
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, by secure email, 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. It is Promesa Health, Inc.'s policy to provide all notifications (verbal and written) within twenty-four (24) hours of the decision. All written notification correspondence is mailed, sent by secure email, or faxed within twenty-four (24) hours of the UM decision. Information contained in the determination notifications include:

1. Date on which the request for authorization was first received.
2. Date decision was rendered.
3. Description of the specific course of proposed medical treatment for which authorization was requested and a specific description of medical treatment approved
4. Specific begin cert date and end cert date
5. Rendering Service Provider
6. Peer Reviewer Name and Specialty if applicable/vendor
7. Primary Treating Physician Information

Notification of Adverse Determination Process
Peer review decisions to modify, or deny medical treatment related to prospective, expedited, retrospective 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. 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). A copy of the adverse determination will be sent to the injured worker via US Mail. Information contained in the adverse determination notifications include:

8. Date on which the request for authorization was first received.
9. Date decision was rendered.
10. Description of the specific course of proposed medical treatment for which authorization was requested.
11. A list of all medical records reviewed.
12. A specific description of the medical treatment approved, if any.
13. 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.

14. A clear statement advising the injured worker that any dispute shall be resolved in accordance with
15. The name and specialty of the reviewer or expert reviewer, the telephone number of the peer reviewer or expert reviewer.
16. 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.

Reconsideration/Appeal Process

If you disagree with our decision, you have the option to request a reconsideration within 48 hours of receipt of this notification. If the medical provider associated with this determination did not speak directly with the peer reviewer associated directly the peer reviewer associated with the adverse determination, a reconsideration is available and a peer-to-peer may be requested. This is not considered an appeal but a reconsideration. Contact information as well as hours of operation are provided on the determination letter.

If a peer-to-peer did take place and you disagree with the decision, the option for an appeal is available; either at an expedited or standard timeframe but not both. Upon completion of either type of appeal, the appeal rights with Promesa Health, UM are exhausted unless otherwise permitted through Arkansas appeal process at the state level. A peer reviewer not involved in the initial review will address the appeal request based on information submitted initially along with any additional information submitted with the appeal request. An expedited appeal must be submitted within 1 business day of receipt of the adverse notification; the expedited appeal will be completed within 72 hours of receipt. Standard appeal must be submitted within 30 days of receipt of the adverse notification; and will be completed within within 30 calendar days of receipt. **All reconsideration/appeal requests can initially be received verbally but must be followed with a written request submitted either by facsimile, secure email, or mail.**

Promesa Health, Inc
Utilization Management Department
Attn: Appeals
10815 Old Mill RD
Omaha, NE 68154

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 claim's 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, sent by secure email, 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 Ark. 20-9-901 through 20-9-914 if applicable.

IX. Conclusion

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