COMPWEST INSURANCE COMPANY
UTILIZATION PLAN

REVISED 05/19/20

MEDICAL DIRECTOR
LESTER SACKS, MD, PhD

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Introduction

Purpose:
The Utilization Review Program of CompWest Insurance Company is predicated on the need for appropriate medical care for the injured worker based on realistic evidence-based criteria, which is reasonably medically necessary to cure or relieve the effects of that injury or illness. It is the goal of CompWest Insurance Company to enhance communication between the necessary parties to support the medical standards and guidelines used in the decision.

Document Scope:
The following document will provide a description of the Utilization Review Program and the processes necessary to fulfill the intent of the program including:

1. Utilization review criteria documentation
2. The medical team participating in the decisions
3. The communication management guidelines
4. The timeframes and processes followed to manage compliance with the regulations

Utilization Review Definitions:

ACOEM Practice Guidelines means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition.

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.

Claims Administrator is 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.

Concurrent review means utilization review conducted during the hospital stay.

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, found at California Code of Regulations, title 8, section 14006, 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.

Denial means a decision by a physician reviewer that the requested treatment or service is not authorized.

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Dispute liability means an assertion by the claims administrator that a factual, medical or legal basis exists, other than medical necessity, 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.

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.

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 or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

Expert reviewer means a medical doctor, a doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner, licensed in any state or 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 qualifications, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.

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.

Immediately means within one business day.

IMR REGULATIONS: If the employee objects to a decision made pursuant to Labor Code section 4610 to modify, or deny a treatment recommendation, the dispute shall be resolved by independent medical review pursuant to Labor Code section 4610.5, if applicable, or otherwise pursuant to Labor Code section 4062. 4610(g)(3)(A) [LC 4610]: If an RFA is not approved in full, "disputes shall be resolved in accordance with Section 4610.5 [IMR], if applicable, or otherwise in accordance with Section 4062." 4610(g)(4) [LC 4610] states in part that: "If a [UR] decision to deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed."

4610(k)(6) [LC 4610]: "A [UR] decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer regarding any further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the [UR] decision."

Material modification is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

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.

Medical services are those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

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.

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Modification is a decision by a physician reviewer that part of the requested treatment or service is not medically necessary.

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.

Request for authorization is a written request for a specific course of proposed medical treatment.

Retrospective review is a utilization review conducted after medical services have been provided and for which approval has not already been given.

Reviewer means a medical doctor, doctor of osteopathy, psychologist, acupuncturists, optometrist, dentist, podiatrist or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate specific clinical issues involved in the medical treatment services, where these services are within the scope of the reviewer's practice.

Utilization review process means utilization management functions that prospectively, retrospectively or concurrently review and approve, modify or deny, based in whole or in part on medical necessity to cure or relieve treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. 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.

Written includes a communication transmitted by facsimile or in paper form. Electronic mail may be used by agreement of the parties although an employee’s health records shall not be transmitted via electronic mail.

§9792.9.1 Utilization Review Standards

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Timeframe, Procedures and Notice

This section applies to any request for authorization of medical treatment, submitted under Article 5.5.1 of this Subchapter, for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the decision on the request is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.
(a) The request for authorization for a course of treatment as defined in section 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.

(1) For purposes of this section, the DWC Form RFA shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail on the date the form was received if the receiving facsimile or electronic mail address electronically 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 claims administrator or the claims administrator's utilization review organization. A DWC Form RFA transmitted by facsimile after 5:30 p.m. Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review. The copy of the DWC Form RFA or the cover sheet accompanying the form transmitted by a facsimile transmission or by electronic mail shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall display the facsimile telephone number to which the form was transmitted. The requesting physician must indicate if there is the need for an expedited review on the DWC Form RFA.

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(2)(A) Where the DWC Form RFA 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 the deposit in the mail at a facility regularly maintained by the United States Postal Service.
(B) Where the 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.
(C) In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the DWC Form RFA shall be deemed to have been received by the claims administrator five days after the latest date the sender wrote on the document.

(3) (A) Every claims administrator shall maintain telephone access and have a representative personally available by telephone from 9:00 a.m. to 5:30 p.m. Pacific Time, on business days for health care providers to request authorization for medical services. Every claims administrator shall have a facsimile number available for physicians to request authorization for medical services. Every claims administrator shall maintain a process to receive communications from health care providers requesting authorization for medical services after business hours. For purposes of this section the requirement that the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by maintaining a voice mail system or a facsimile number or a designated email address for after business hours requests.

(b) Utilization review of a medical treatment request made on the DWC Form RFA 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.
(1) If the claims administrator disputes liability under this subdivision, it may, no later than five (5) business days from receipt of the DWC Form RFA, issue a written decision deferring utilization review of the requested treatment unless the requesting physician has been previously notified under this subdivision of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall contain the following information specific to the request:
(A) The date on which the DWC Form RFA was first received.
(B) A description of the specific course of proposed medical treatment for which authorization was requested.
(C) A clear, concise and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts or the recommended treatment.
(D) A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.
(E) The following mandatory language advising the injured employee:

“You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (714-641-9500). However, if you are represented by an attorney, please contact your attorney instead of me.”

and

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

(2) If utilization review is deferred pursuant to this subdivision, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, the time for the claims administrator to conduct retrospective utilization review in accordance with this section shall begin on the date the determination of the claims administrator's liability becomes final. The time for the claims administrator to

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conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a DWC Form RFA after the final determination of liability.

Pursuant to §9792.9.1(c), unless additional information is requested necessitating an extension under subdivision (f), the utilization review process shall meet the following timeframe requirements:

(1) The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA.

(2)(A) Upon receipt of a request for authorization as described in subdivision (c)(2)(B), or a DWC Form RFA that does not identify the employee or provider, does not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity for the requested treatment, or is not signed by the requesting physician, a non-physician reviewer as allowed by section 9792.7 or reviewer must either regard the request as a complete DWC Form RFA and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete," specifying the reasons for the return of the request 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 a completed DWC Form RFA.
(B) The claims administrator may accept a request for authorization for medical treatment that does not utilize the DWC Form RFA, provided that: (1) "Request for Authorization" is clearly written at the top of the first page of the document; (2) all requested medical services, goods, or items are listed on the first page; and (3) the request is accompanied by documentation substantiating the medical necessity for the requested treatment.

Pursuant to §9792.9.1(f)(3)(B-C), If the results of the additional examination or test required under subdivision (f)(1)(B), or the specialized consultation under (f)(1)(C), that is requested by the reviewer under this subdivision is not received within thirty (30) days from the date of the request for authorization, the reviewer shall deny the treating physician's request with the stated condition that the request will be reconsidered upon receipt of the results of the additional examination or test or the specialized consultation.

Pursuant to §9792.9.1(g), Whenever a reviewer issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the claims administrator's file must document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or email.

Pursuant to §9792.9.1(h), a utilization review decision to modify, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Utilization Review Policy and Procedure
Prospective, Concurrent and Retrospective Review

Pursuant to Labor Code Section 4610, CompWest Insurance Company will conduct Utilization Review consistent with the regulations contained in Labor Code Section 4610 and Title 8. Industrial Relations, Division 1. Department of Industrial Relations, Chapter 4.5 Division of Workers' Compensation, Subchapter 1. Administrative Director – Administrative Rules, Article 5.5.1 Utilization Review Standards and 8 CCR Section 9792.6.1 et seq (incorporated herein in its entirety by this reference).

This Utilization Review Process will be coordinated through the services of utilization review nurses, physician advisors, medical advisors and/or the medical director. The MTUS (Medical Treatment Utilization Guidelines), since its adoption as of April 15, 2007, and the guidelines adopted into the MTUS, are considered presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her

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injury. For all conditions or injuries not addressed by MTUS, authorized treatment shall be in accordance with other established evidence-based medical treatment guidelines, including but not limited to the ACOEM Practice Guidelines, the medical disability advisor (Presley-Reed, M.D.), the Official Disability Guidelines (O.D.G.) or Interquel. Any of these guidelines should be applied to cases where the MTUS does not cover the specific injury sustained by the injured employee. Subscriptions to each of the guidelines indicated above have been secured which provide updates as developed. These updates are incorporated into the review process as they are issued. Review criteria shall be updated automatically to include any and all changes in said guidelines upon notification of any such published changes. CompWest Insurance shall contact each of the above-named publishers a minimum of every six months to determine if any changes have occurred and obtain said information immediately. These guidelines and procedures will be in accordance with all the rules, regulations, laws and guidelines of the State of California, as adopted by the California governing bodies.

For all dates of injury occurring on or after January 1, 2018, 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. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. 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 days following the employee's initial visit and evaluation.

Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:
(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 two hundred fifty dollars ($250), 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 administrative director

A utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review services, by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical material used in issuing a utilization review decision, peer-to-peer consultation, internal appeal procedure, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The administrative director shall adopt rules to implement the selection of an independent, nonprofit organization for those accreditation purposes. Until those rules are adopted, the administrative director shall designate URAC as the accrediting organization. The administrative director may adopt rules to do any of the following:

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(A) Require additional specific criteria for measuring the quality of a utilization review process for purposes of accreditation.
(B) Exempt nonprofit, public sector internal utilization review programs from the accreditation requirement pursuant to this section, if the administrative director has adopted minimum standards applicable to nonprofit, public sector internal utilization review programs that meet or exceed the accreditation standards developed pursuant to this section.

The following Medical Treatment Utilization Schedule (MTUS) has been included in the Utilization Review Plan Effective June 1, 2007 as amended:

Workers' Compensation Final Regulations
Medical Treatment Utilization Schedule Regulations
Title 8, California Code of Regulations
Sections 9792.20 - 9792.26

Additional regulations have been filed with secretary of state June 18, 2009
Effective July 18, 2009

Article 5.5.2 Medical Treatment Utilization Schedule, inclusive of all Sections:

Section 9792.20 – Medical Treatment Utilization Schedule – Definitions
(a) – (l) – inclusive of all subsections
Section 9792.21 – Medical Treatment Utilization Schedule
(a) – (c) – inclusive of all subsections
Section 9792.22 – General Approaches
Section 9792.23 – Clinical Topics
(a) – (b) – inclusive of all subsections

Regulations Effective May 2007

The following Medical Treatment Utilization Schedule (MTUS) has been included in the Utilization Review Plan Effective July 18, 2007 as amended:

Article 5.5.2 Medical Treatment Utilization Schedule, inclusive of all Sections:

Section 9792.24 – Special Topics – Inclusive of all subsections
Section 9792.24.1 – Acupuncture Medical Treatment Guidelines
(a) – (e) – inclusive of all subsections
Section 9792.24.2 – Chronic Pain Medical Treatment Guidelines
(a) – (e) – inclusive of all subsections

Regulations Effective July 18, 2009, in addition as other guidelines are adopted by MTUS, these will also be considered as primary, as well.

1. Upon receipt of the request for Utilization Review, the Utilization Review Process is initiated within one (1) business day. Where the request is submitted by the patient, attending provider, or facility rendering service the process is initiated within one (1) business day of receipt.

   A. When the UR Nurse receives a telephone call or written correspondence from the treating physician, requesting authorization for a proposed treatment the UR nurse, the medical director, or other medical advisor, shall obtain the medical information necessary to make a determination to certify, modify or deny a request for services. However, only a licensed physician can make the decision to modify or deny decisions.

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Section 9792.6.1—treatment recommendations must be from physicians, as defined in Labor Code section 3209.3. The written request must be set forth on the “Doctor’s First Report of Occupational Injury or Illness,” Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization. The physician’s request often is sent in by the claims adjuster, but the request is made by the treating physician.

B. Authorization of requested service means the assurance that the 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.

C. In the event there is a requirement for emergency health care services, defined as 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, the Utilization Review Process shall be initiated within one (1) business day after notification of such an event. Documentation for emergency health care services shall be made available.

2. Information collected will include:

Patient name, address, phone number, date of birth, insurance ID number; employee name, social security number, address, phone number, employer group; treating physician, address, phone number and tax ID number; facility name, address phone number and tax ID number; and diagnosis, proposed treatment plan and medical information to support the treatment plan. Data is entered into a secure computer application and information is shared with all disciplines within the UR department that have a need to know to complete the review process.

A. When conducting prospective review, concurrent review or retrospective review, the UR nurse:

(1) Will collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services;

(2) Will request from hospitals, physicians, and other providers the numerical code of the diagnosis (ICD-9) or procedure (CPT code) to be considered for certification;

(3) May request appropriate information which is necessary to render a decision that was not provided with the original request for authorization;

(4) Requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; and

B. In situations where there is insufficient information to conduct the review, the UR Nurse will make at least two (2) attempts to notify attending provider, provider or facility rendering service (as applicable) within the UR process timeframes required by law, of the need for additional information, the information needed, and the method by which to submit it. One attempt must be by fax or mail, as well as by phone. The provider (physician) has 14 calendar days from the receipt of the original notice (RFA) to respond with the requested information. The specific timeframes required are as follows: Reviews must be completed within five business days following the receipt of the request. If the request cannot be completed due to lack of information stated above, the timeframe specifically for completion shall be 14 calendar days at which time, the review may be deemed non-certified.

C. If attending provider, provider or facility rendering service does not give medical information for pre-certification determination, when such information is requested within the first five days of receipt of

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the RFA, and not received within the first 14 days of receipt of the original RFA, then the case is referred to our medical advisor or medical director for a non-certification due to lack of information, with the stated condition that the request will be reconsidered upon receipt of the information requested.

Our non-certification correspondence indicates reason for non-certification and is accompanied with our appeals process and forwarded to the patient, attending provider, provider or facility rendering service within one (1) business day of the determination. If the treatment plan is non-certified for lack of information and the patient, attending provider, provider or facility rendering service subsequently provides complete clinical information within the allowable timeframe, the UR nurse can certify the treatment plan. If the UR nurse is unable to certify the treatment plan, the original medical advisor or medical director who denied the treatment plan for lack of information can re-review the treatment plan to make a determination.

3. The Initial clinical review is conducted by a UR Nurse who reviews the proposed treatment plan for medical appropriateness and necessity using **MTUS** and/or other medically recognized criteria when an MTUS guideline does not address the condition or requested treatment**. MTUS must be used first, then if the treatment or condition is not addressed in MTUS, the other evidence based criteria may be used** If the treatment plan is not supported by the initial clinical information provided, or if the provider is unable to be contacted. Then the case will be referred for physician peer clinical review within 24 hours. No person other than a California licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve ("reasonably medically necessary").

   A. Peer clinical reviews are only performed by individuals who:

      (1) Are licensed physicians qualified, as determined by the medical director or clinical director, to render a clinical opinion about the medical condition, procedures, and treatment under review;

      (2) Reside in California and hold a current and valid license to practice medicine in the State of California in the same license category as the ordering provider; some of the peer reviewers also hold licenses in other states; and

      (3) Meet all applicable State Utilization Review requirements.

   B. Health professionals conducting peer clinical reviews will be available, by telephone, or in person, to discuss review determinations with attending physicians or other ordering providers.

4. UR process timeframes are inclusive of the entire UR process from receipt of the request for a UR decision to the issuance of the decision. Issuance of review determinations are made in accordance with the following timeframes:

   A. For prospective review, CompWest Insurance will issue a determination:

      (1) Within 24 hours of the request for a utilization management determination, if it is a case involving urgent care, or;

      (2) Within five business days of the request for a utilization management determination, if it is a non-urgent case. However, if appropriate information which is necessary to render a decision is not provided with the original request, such information may be requested within the first five days of receipt of the RFA to make the proper determination, but in no event shall the determination be made more than fourteen (14) calendar days from the date of the original request by the provider. The request must be addressed within the initial five business day rule or sooner, if possible. If the utilization Review determination is a denial based upon the lack of receipt of the requested appropriate information within fourteen (14) days to make the proper

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determination, upon receipt of such reasonable information all requests will be reconsidered and the normal time frames for a prospective review shall be applied.

(3) Within 72 hours for an expedited review after the receipt of the written information reasonably necessary to make the determination.

B. For concurrent review, defined as utilization review conducted during an inpatient stay, CompWest Insurance will issue a determination:

(1) Within 24 hours of the request for a utilization management determination, if it is a case involving urgent care; or

(2) Within five working days of the request for a utilization management determination, if it is a non-urgent case. However, if appropriate information which is necessary to render a decision is not provided with the original request, such information may be requested within the first five business days of receipt of the RFA to make the proper determination, but in no event shall the determination be made more than 14 calendar days from the date of the original request by the provider. If the utilization review determination is a denial based upon the lack of receipt of the requested appropriate information within fourteen (14) calendar days to make the proper determination, upon receipt of such reasonable information all requests will be reconsidered and the normal time frames for a concurrent review shall be applied. If a denial due to lack of information has been sent and then requested information is received after 14 days, the request will be considered and a decision rendered within five working days from the date of receipt of the requested necessary information.

In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision. In accordance with 9792.1 payment for goods or services will follow the regulatory billing requirements including the DRG fees for facilities' and the inpatient composite factors, as well as, implantable hardware.

(3) Within 72 hours for an expedited review after the receipt of the written information reasonably necessary to make the determination.

(4) In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker.

C. For retrospective review, CompWest Insurance will issue a determination:

(1) Within 30 calendar days of the request for a utilization review determination. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

5. Decisions to approve, modify or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to injured workers, shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in approval, modifications or denial of all or part of the requested health care services shall be communicated to physicians initially by telephone or facsimile, and to the physician, injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in

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writing of the decision modifying or denying a request for authorization that shall **not** include the rationale, criteria or guidelines used for the decision. CompWest will only notify the provider of the goods or facility, the decision rendered.

A. The UR nurse will recommend certification of the proposed treatment plan that appear medically appropriate, according to medical criteria.

(1) Notification of Certification decision is communicated to the requesting physician within 24 hours of the decision and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within 2 (two) business days for prospective review. (Section 9792.9.1(d)(2).

(2) Confirmation of certification for continued hospitalization or services includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

(3) All decisions to approve a request for authorization shall specify the specific date the complete request for authorization was received, medical treatment service requested, the specific medical service approved and the date of the decision.

B. In Non-Certification decisions, notification is provided to the attending physician or other ordering provider rendering service through a method that will be received within 24 hours of the non-certification decision and will be communicated to the requesting physician initially by telephone, facsimile or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within 2 (two) business days for prospective review and for expedited review within 72 hours of the receipt of the request. (section 9792.9.1(e)(3)

(1) In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

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

A) The date on which the DWC Form RFA was first received

B) The date on which the decision is made

C) A description of the specific course of proposed medical treatment for which authorization was requested

D) A list of all medical records provided

E) A specific description of the medical treatment service approved, if any

F) A clear, concise and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section 9792.8. If a utilization review decision to modify or deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

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G) The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee, must be completed by the claims administrator. The written decision provided to the injured worker shall include an addressed envelope, which may be postage paid for mailing to the administrative director or his or her designee. Prior to March 1, 2014, any version of the DWC Form IMR adopted by the administrative director under section 9792.10.2 may be used by the claims administrator in a written decision modifying or denying treatment authorization.

H) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days after service of the decision.

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

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

K) The written decision modifying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the reviewer, the expert reviewer or the medical director for the treating physician to discuss the decision, which shall be, at minimum, four (4) hours per week during normal business hours, 9 a.m. to 5:30 p.m. Pacific Time, or an agreed-upon scheduled time to discuss the decision with the requesting physician. In the event the reviewer in 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.

C. When a determination is made to issue a non-certification and no peer-to-peer conversation has occurred, CompWest Insurance will provide, within one (1) business day of a request by the attending physician or ordering provider, the opportunity to discuss the non-certification decision with the clinical peer advisor making the initial determination, or, with a different clinical peer if the original clinical peer advisor cannot be available within one (1) business day.

6. Prospective and concurrent review determinations are solely based on the information obtained by the UR Nurse or Peer Reviewer at the time of the review determination; for retrospective review, the determinations are solely based on medical information available to the attending or ordering provider at the time medical care was provided. A reverse of certification can only occur when there is receipt of additional medical information that is materially different from that which was reasonably available at the

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time of the original determination. Based on Labor Code 4610.3 which states an employer that authorizes medical treatment shall not rescind or modify that authorization after the medical treatment has been provided based on that authorization for any reason, including but not limited to, the employer's subsequent determination that the physician treating the employee was not eligible to treat that injured employee. If there is a series of treatments, only those treatments not completed may be rescinded or modified.

7. The frequency of reviews for the extension of initial determinations is based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

8. Upon request by the public, CompWest Insurance shall make available the complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process.

A. CompWest Insurance may make available the complete Utilization Review Plan, consisting of the policies and procedures and a description of the utilization review process through electronic means. If a member of the public requests a hard copy of the utilization review plan, CompWest my charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed $.25 per page plus actual postage costs.

All utilization review procedures will be in accordance with any applicable rules, regulations, guidelines or laws in the state of California.

TELEPHONE # 1 888-266-7937
FACSIMILE # 1 877-607-7419

Appeals Procedure

The Appeals process letter will advise 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 (as stated previously) and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative or injured worker's attorney on behalf of the injured worker on the enclosed Application of Independent Review (IMR) DWC Form.

[LC4610.5(h)(1)(A-B)] The employee may submit a request for independent medical review to the division. The request may be made electronically under rules adopted by the administrative director. The request shall be made no later than as follows:

A) For formulary disputes, 10 days after the service of the utilization review decision to the employee
B) For all other medical treatment disputes, 30 days after the service of the utilization review decision to the employee

It must be clearly stated that CompWest's internal appeal process is strictly voluntary for the requesting physician and that neither triggers nor bars use of the dispute resolution procedures of Labor Code Sections 4610.5 and 4610.6, but may be pursued on an optional basis. Only the requesting physician may appeal a utilization review decision. The appeal must be in writing and must be received within twenty (20) days of the UR decision. Reconsideration applies only to a decision when there has been a denial due to lack of information. **Reconsideration is not an appeal.**

1. In the event that an attending physician, ordering provider, injured worker, facility, patient, patient representative or other health care provider has additional medical information that may impact an initial non-certification/denial or modification recommendation, he/she may submit a written request to CompWest Insurance within twenty (20) days of receipt of any such determination, unless timeframes otherwise mandated by state statutes, to have the additional medical information reviewed via an expedited or standard appeals process by a medical/clinical peer who did not make the original determination not to certify or to modify.

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(a) Copies of the medical record documentation supporting the additional medical information must be included with the request for the standard appeal. UR vendor will take into account all documents, records, or other information submitted by the patient, provider, or facility rendering service relating to the case, without regard to whether such information was submitted or considered in the initial consideration of the case.

(b) Appeals consideration is conducted by a board-certified (if applicable) clinical peer holding an active, unrestricted license to practice medicine in the State of California in the same profession, similar specialty as typically manages the medical condition, procedure or treatment as mutually deemed appropriate, AND is neither the individual who made the original non-certification decision, nor the subordinate of such an individual.

2. Appeal timeframes are inclusive of the entire appeals process from receipt of the request to issuance of a written determination. All requests for appeal are completed and issuance of the appeal decision in accordance with the following timeframes:

(a) Expedited appeals are completed as soon as possible, and no later than 72 hours after the initiation of the appeals process;

(b) Standard appeals are completed within 30 calendar days of the initiation of the appeal process.

(c) All appeal procedures will be in compliance with state statutes. All negative decisions for appeals may be addressed through the IMR process by the injured worker, representative, attorney of record and submitted for the Independent Medical Review under sections 4610.5 (e).

(d) Any decision made by the initial utilization reviewer after the appeal with a denial will remain in force for one year following the decision unless overturned by the IMR review board of Maximus. Additionally, no further action is done unless there is a documented change in the facts material to the basis of the utilization review decision.

3. CompWest Insurance will notify the Attending Physician or other Ordering Provider rendering service of the appeals determination through a method that will be received within 24 hours of the appeals determination (types of notification include verbal, voicemail, email, fax or letter); and issues written notification within one (1) business day of the appeals determination to the patient and attending physician or other ordering provider and facility rendering service (if applicable). If the patient is a child under the age of 18, the notification will go to the insured. (children may work in entertainment industry)

   (a) Written notification of adverse appeals determinations includes the principal reasons for the determination to uphold the non-certification; a statement that the clinical rationale used in making the appeal decision will be provided, in writing, upon request (exception--the written notification shall not include the rationale, criteria or guidelines used for the decision for any non-physician provider of goods or services); and in the case of expedited appeals, the method to initiate the standard appeal process.

   (b) Upon request, CompWest Insurance will provide the attending physician or other ordering provider and patient who has been unsuccessful in an attempt to reverse a determination not to certify, the clinical rationale for that determination in writing.

4. The medical advisor, medical director or clinical peer will be available within one business day to discuss by telephone the determination with the attending physician and/or other ordering provider.

5. Records will be kept for each appeal that include:

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(a) Name of the patient, provider, and/or facility rendering service;

(b) Copies of all correspondence from the patient, provider, or facility rendering service and UR vendor regarding the appeal;

(c) Dates of appeal reviews, documentation of actions taken, and final resolution; and

(d) Minutes or transcripts of appeal proceedings (if any)

6. It is the policy of CompWest Insurance Company that a maximum of two (2) appeals can be submitted with new information, which might impact the reviewers' decision. Once the review has been performed for the second time and there is still a non-certification (denial) or modification, further reviews will not be undertaken. There will be a letter of notice to all parties as required by the current law.

Requests for Reconsideration

1. Any time an initial determination not to certify treatment is made and no contact has occurred with the attending physician or ordering provider, the attending physician or ordering provider can request reconsideration by the clinical peer that made the initial determination. Reconsideration can occur when the initial denial is a result of the lack of information only.

A. The UR Nurse or a Peer Reviewer informs the attending physician or ordering provider that within one (1) business day the original Peer Reviewer or designated physician (if the original is not available) will contact them.

B. The UR Nurse will inform their supervisor and Peer Reviewer of the attending physician or ordering provider's reconsideration request.

C. The UR nurse will maintain documentation of the attending physician or ordering provider's reconsideration request, including date and time.

D. The Medical Director or Peer Reviewer will be notified and given all case information.

E. If the Peer Reviewer or Medical Director and the attending physician/ordering provider are not in agreement, the attending physician/ordering provider will be notified immediately of their right to initiate an expedited or standard appeal.

F. All results of the reconsideration will be maintained by CompWest Insurance.

G. The attending physician/provider, claimant and/or patient can request the disclosure of information.

H. The attending physician/provider, claimant and/or patient can request the disclosure of criteria used to render non-certification.

I. The name of the criteria, edition and diagnosis of the criteria will be supplied in writing upon request within one (1) business day.

J. Only a UR Nurse or Peer Reviewermedical advisor or medical director can release this information.

K. The disclosure of criteria used to render non-certification will be in compliance with the laws of California.

Utilization Review Miscellaneous Policies and Procedures

CompWest Insurance will maintain a toll-free number that the review staff can be accessed from between 9 a.m. to 5:30 p.m. Pacific Time of each standard business day (Monday through Friday) in the provider's local time zone. The dedicated fax number is 877 607-7419.

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1. The Medical Director shall bear the responsibility of oversight of the Utilization Review Program and all processes including compliance with all California Regulations detailed in Title 8, California Code of Regulations, and Sections 9792.6.1 et seq.

2. The Medical Director shall be responsible for all decisions made in the utilization review process. The medical director is responsible for all decisions as stated in section 9792.6.1. The medical director shall routinely audit a minimum of 1 of every 25 determinations, or an amount equal to any regulatory requirement should they be enacted, on a random basis and/or upon request of claims administrator.

2.a The Medical Director for CompWest Insurance is:
Lester L. Sacks, M.D. PhD
3 Hutton Place, Ste. 550
Santa Ana, CA 92707
Phone: 1-888-266-7937 ext. 9590
California License #A28341

The Medical Director of CompWest Insurance is responsible for the oversight of all utilization activities, ensures that the utilization review process is in accordance with this document, consistent with the applicable labor codes of the state of California. The medical director is responsible for all decisions made in the utilization review process. The medical director is a board-certified occupational physician with an unrestricted license to practice in California. A staff of licensed RNs support the program under the management of Paul Kauffman, Director of Medical Management.

The CompWest Insurance Co. Medical Director is responsible for:

- Developing and disseminating the overall policy and philosophy of the UR program
- Responsible for the quality assurance program governing the UR decisions
- Responsible for all decisions made in the utilization review process
- Provides periodic review of the UR database including identifying the educational opportunities for the staff
- Oversees the clinical guidelines used in the decision making for the utilization team and conducts the management of the State specific guidelines, such as the MTUS and ACOEM
- Evaluating the performance of both the internal utilization team and the contracted providers associated with the functions of utilization

3. Requests for utilization reviews must be made via mail to:

CompWest Insurance Company
PO BOX 40790
Lansing, MI 48901-7990

OR

Requests for utilization reviews may be made via fax to:

CompWest Insurance Company
877-607-7419

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Telephone access will be made available by CompWest Insurance 9 a.m. to 5:30 p.m. Pacific Time on normal business days. For requests made at times other than these, CompWest Insurance shall maintain a voice mail system to handle all incoming requests and/or messages.

4. All outgoing communications related to utilization management will be conducted during providers' reasonable and normal business hours, unless otherwise mutually agreed.

5. The review staff will identify themselves when calling by name, title and name of organization when contacting attending physician/provider, enrollee/patient/injured worker, facility, claims payor or patient representative.

6. There will be access to the 888-266-7937 line after hours with the capability to leave a message on a recorder.

7. If CompWest Insurance is closed due to unforeseen emergencies, such as inclement weather or catastrophes, a detailed message will be left on the recorder, providing the caller with applicable directions for medical care or treatment or methods to obtain authorization for care.

8. All calls that are received during business hours from providers and patients/injured workers will be returned within one business day.

9. Upon request, utilization review staff member(s) orally inform patients, injured workers, designated facility personnel, the attending physician and other ordering providers of specific utilization review requirements; and patient, injured workers, hospitals, physicians and other health professionals of CompWest Insurance review procedures.

10. The preauthorization protocol in the automated software, DecisionUR, follows the initial allowance recommended in the MTUS directive of allowances suggested in the current treatment programs for the first 30 days of treatment following the initial injury. For treatments provided per Labor Code Section 4610(b), we forward the doctor's first report of injury to Decision UR to log any treatments provided by a MPN doctor within the first 30 days. Any treatment provided outside of the guidelines will be referrred for a retro UR. All claim handlers are allowed to certify any treatment requests without sending to UR, however, it is a recommendation that a RFA be submitted for any treatment requests and forward to UR.

11. The quality assurance program practiced by CompWest Insurance follows the recommendation of the URAC accreditation policy and procedures. The URAC accreditation is filed with California and is posted to the CompWest website.

UR Dispute Resolution

All disputes are addressed by LC section 4610.5 and LC 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 form/Application for Independent Review, DWC Form IMR within 10 days after the service of the utilization review decision for formulary requests and within 30 calendar days after the service of the utilization review decision for all other medical treatment disputes.

Notice to Injured Worker

All utilization disputes will be resolved in accordance with 4610.5, 4610.6 (b) If the employee objects to a decision made pursuant to Section 4610 to modify or deny a request for authorization of a medical treatment recommendation made by a treating physician, the objection shall be resolved only in

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accordance with the independent medical review process established in Section 4610.5. The DWC form IMR will be attached to all non-certification/modified letters to be completed by the injured worker, representative or designee including the following mandatory language advising the injured employee:

> You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name in parentheses) at (714-641-9500). However, if you are represented by an attorney, please contact your attorney instead of me.
>
> For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

Medical Provider Network

If the employee is subject to the rules governing the Medical Provider Network (MPN) and he/ she disputes the diagnosis or treatment of the primary treating physician, the employee may seek the opinion of another physician in accordance with Labor Code 4616.3. These disputes are not considered utilization review disputes.

Confidentiality Procedures

All patient information obtained during the utilization review process is considered part of the CompWest Insurance business record. All medical information is subject to state and federal regulations protecting confidentiality of medical information, and is subject to release only within strict guidelines of confidentiality. Medical information is released only within the requirements of such regulations and in accordance with strict corporate guidelines. Listed below are the procedures in place to protect the confidentiality of the patient's medical information.

1. Employees are required to review our confidentiality and non-disclosure agreement upon employment. This agreement is to be signed by the new employee and yearly thereafter, and is kept in the employee's personnel file.

2. Upon request, there is a patient confidentiality of medical information form that is forwarded to the patient describing how the medical information will be kept confidential while utilization review is being completed.

3. Detailed patient-identified information is released only with the patient's authorization or, where applicable, state laws, rules and regulations provide authorization. This includes all communications and records transmitted or stored, including cellular phones, fax or electronic systems.

4. All medical information will be maintained in a secure environment, which has a sophisticated security system. Only authorized personnel can access the system with appropriate password codes.

5. Each state and federal statute regarding confidentiality and non-disclosure is adhered to and updated when applicable.

6. Provider-specific data obtained during the review process is not publicly released. It can be shared only with those agencies that have the legal and contractual authority to receive such information. This includes all communications and records transmitted or stored, including cellular phones, fax or electronic systems.

   A. Special care is taken when faxing information that includes patient specific medical and identifying information. All fax correspondence cover pages will contain a confidentiality clause statement.

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B. All email transmissions will contain a confidentiality clause statement. Utilization review letters and activity notes may only be emailed to authorized parties.

7. Medical information collected is used solely for the purpose of utilization review, quality assurance, discharge planning and catastrophic case management.

8. UR patient information includes any information captured within the utilization review process such as demographics, medical treatment requests/approvals, provider and case activities/results. Worker-specific information includes injury cause, job type and any return-to-work information. Provider-specific information is any clinical, treatment outcomes or provider specific information capture through the utilization process for a specific patient.

9. Review notifications containing information that might suggest a diagnosis such as non-certification rationale, are sent only to the patient, physician, facility or other health care provider. Review notifications to employers do not contain medical information.

Statement of Regulatory Compliance

As noted, this Utilization Review plan has been developed in accordance with Labor Code Section 4610, 4604.5 and any or all other duly enacted Labor Code Sections, or DWC regulation that may apply currently. If any changes to the Labor Code, Department of Workers' Compensation Administrative Rules or current regulations that govern any part of this Utilization Review plan are enacted, they are hereby incorporated herein and take precedence over any provision of this Utilization Review plan that is in conflict with these enacted regulations. If during the course of time any term, provision, covenant or condition of this Utilization Review plan is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remainder of the provisions herein shall remain in full force and effect and shall in no way be affected, impaired or invalidated as a result of such decision. Utilization Review and Independent Medical Review Regulations 8 C.C.R. Labor Code Sections 9785, 9785.1,9792.6-9792.10.5 (approved 02/12/2014)

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