Utilization Management Plan
and
Policies and Procedures

September 15, 2017

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Introduction and Overview

This document constitutes the Utilization Review (UR) Plan (Plan) and the Policies and Procedures of Omaha National Underwriters, LLC (Omaha National) established in compliance with the regulations contained in the California (CA) Labor Code (LC) and the California Code of Regulations (CCR) Administrative Rules for Utilization Review (UR) Standards, including the Medical Treatment Utilization Schedule (MTUS) and the MTUS Drug Formulary.

The UR process of Omaha National is structured to perform management functions prospectively, retrospectively, and concurrently to assess the medical necessity and conformity of physician treatment recommendations with evidence-based criteria, to cure or relieve the effects of the work-related injury.

The goal of the UR Program is to achieve improved health outcomes for injured workers who have experienced a work-related illness or injury. Omaha National's UR Program will use evidence-based guidelines to promote the efficient delivery of high quality, medically necessary care in a timely manner.

Utilization Review is limited to a review based on medical necessity. It does not include determinations of whether the illness or injury is work-related, nor does it include bill review determinations verifying whether the medical services were accurately billed.

Material modifications to the Omaha National's Utilization Review Plan will be filed with the Administrative Director within 30 calendar days after such material modifications are made to the Plan.

This Utilization Review Plan and the Policies and Procedures were written in conformance with California statutes and regulations in effect at the time of its adoption. Any definitions or other provisions of this Plan or Policies and Procedures that, at a future date, become inconsistent with California statutes and regulations should be read and interpreted in conformance with the statutory and regulatory provisions in effect.

Financial Incentives

Omaha National, or any entity conducting utilization review on its behalf, shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications or denials made by the physician.

Omaha National shall not refer utilization review services conducted on its behalf to an entity in which Omaha National has a financial interest as defined under Section 139.32.

Definitions

Authorization: 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 the California Labor Code and Regulations.

Claims Adjustor: Staff employed by Omaha National to investigate claims resulting from work-related injury or illness.

Claims Administrator: Omaha National Underwriters, LLC (Omaha National).

Concurrent Review: Utilization review conducted during an inpatient stay.

Course of Treatment: The course of medical treatment set forth in the treatment plan contained on the applicable forms in the CCR or in narrative form containing the same information required in the forms.

Criteria: The set of guidelines used to assess the medical necessity of treatment requests, as defined in this document.

Denial: Decision by a Physician Reviewer that the requested treatment or service is not authorized.

Dispute liability: 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 a work-related injury, a claimed injury to any part or parts of the body, or a requested medical treatment.

Disputed medical treatment: Medical treatment that has been modified or denied by a utilization review decision on the basis of medical necessity.

Emergency health care services: 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.

Evidence-Based Medicine (EBM): A systematic approach to making clinical decisions which allows the integration of the best available research evidence with clinical expertise and patient values.

Expedited Review: Utilization 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: A medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, who has been consulted by the Reviewer or the Utilization Review Medical Director to provide specialized review of medical information.

Health care provider: 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 the California Labor Code (LC).

Immediately: Within one business day.

Material modification: When the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in the California Code of Regulations.

Medical Director: 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, and who is responsible for all decisions made in the utilization review process.

Medical necessity or medically necessary: Medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied as set forth in the medical treatment utilization schedule, including the drug formulary, adopted by the administrative director pursuant to the California Labor Code:

1) The guidelines, including the drug formulary, adopted by the administrative director.
2) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
3) Nationally recognized professional standards.
4) Expert opinion.
5) Generally accepted standards of medical practice.
6) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

Medical services: Goods and services provided pursuant to Article 2 (commencing with LC § 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

Medical Treatment Utilization Schedule (MTUS): The standards of care adopted by the Administrative Director pursuant to regulations contained in the California (CA) Labor Code (LC) and the California Code of Regulations (CCR) Administrative Rules for Utilization Review Standards, including the Medical Treatment Utilization Schedule (MTUS) and the MTUS Drug Formulary. The MTUS and the MTUS Drug Formulary are based on the principles of Evidence Based Medicine (EBM), which is a systematic approach to making clinical decisions which allows the integration of the best available evidence with clinical expertise and patient values. It incorporates peer-reviewed, nationally recognized standards of care, addressing at a minimum, the frequency, duration, intensity, and appropriateness of treatment procedures and modalities commonly performed in workers' compensation cases.

Modification: A decision by a Physician Reviewer that part of the requested treatment or service is not medically necessary.

Peer Review Panel: Contracted panel of providers (Reviewers) who are responsible to conduct utilization management reviews that result in modifications or denials of treatment requests. Individual Reviewers from the Panel may hold the status of 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, where these services are within the scope of the Reviewer's practice.

Physician: Includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.

Prior Authorization: An arrangement written into the UR plan that describes the specific conditions or circumstances under which a treating physician will be assured of appropriate reimbursement for specific treatment, without submitting an RFA before, during, or after treatment. As long as the treatment fits the description of prior authorization in the UR plan, the treating physician may treat and then submit the bill for payment.

Prospective Review: Any utilization review conducted prior to the delivery of the requested medical services, except for review conducted during an inpatient (hospital) stay.

Request for authorization (RFA): A written request for a specific course of proposed medical treatment pursuant to the California Labor Code or a written request for a specific course of proposed medical treatment. An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours. Both the written confirmation of an oral request and the written request must be set forth on the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in California Code of Regulations, 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.

Retrospective Review: Utilization review conducted after medical services have been provided and for which approval has not already been given.

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

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

Utilization Review Decision: A decision pursuant to the California Labor Code § 4610 to approve, modify or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation(s) by a physician prior to, retrospectively, or concurrent with, the provision of medical treatment services pursuant to the Labor Code. It may also mean a determination, occurring on or after implementation of the drug

formulary, by a physician regarding the medical necessity of medication prescribed pursuant to the drug formulary adopted pursuant to the Labor Code.

Utilization Review Nurse: A Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) employed by Omaha National to conduct utilization review functions.

Utilization Review Plan: The written plan filed with the Administrative Director pursuant to Labor Code § 4610, setting forth the policies and procedures, and a description of the utilization review process.

Utilization Review Process: The utilization review and 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 § 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code § 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 Omaha National, or in the case of prior authorization, when the physician satisfies the conditions described in the utilization review plan for prior authorization.

Written: A communication transmitted by facsimile or in paper form. Electronic mail may be used by prior written agreement of the parties, although an injured worker's health records shall not be transmitted by electronic mail.

Utilization Review Policy

The Utilization Review Policy of Omaha National shall facilitate injured workers receiving appropriate and medically necessary care to cure or relieve the effects of the industrial illness or injury in a timely manner, based on evidence-based guidelines.

Utilization Review is limited to a review based on medical necessity. It does not include determinations of whether the illness or injury is work-related, nor does it include bill review determinations verifying whether the medical services were accurately billed.

Accessibility for Submission of Requests

Submission Methods

The mailing address for Omaha National is:

Omaha National Underwriters, LLC
P.O. Box 451139
Omaha, NE 68145

Omaha National shall maintain toll-free telephone access and have a representative personally available by telephone from the hours of 9:00 AM to 5:30 PM Pacific Time on business days for health care providers to request authorization for medical services.

Requests for Authorization may be submitted via toll-free facsimile to the following number: 844.761.8402. This facsimile number is available 24 hours a day, including weekends and holidays.

Additionally, accessibility after hours is available via the toll-free voice mail system, at 1.844.761.8400 or via email by submitting a message to documents@omahanational.com.

Replies to messages received by any of the previously described methods will be returned within the required timelines established based on the inquiry type, and described elsewhere in this document.

Business Days

Business days are defined in the Government Code of the State of California, the California Labor Code, and the California Civil Code. For the purposes of this policy, business days are defined as any day not defined as a holiday or an optional bank holiday within these codes.

Request for Authorization

The Request for Authorization (RFA) for a course of treatment must be in written form, as required by the California Code of Regulations.

Details of the RFA

The Request for Authorization for Medical Treatment (DWC Form RFA) is required for the injured worker's treating physician to initiate the utilization review process required by the Labor Code. A Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment must be attached.

The DWC Form RFA, DLSR Form 5021, and DWC Form PR-2 may be accessed at the following website URL: http://dir.ca.gov/dwc/forms.html#Medical.

RFA Signature Requirements

The treating physician signature is mandatory, and must be either an original handwritten signature or an electronic signature. A typed name without a signature or the use of a signature stamp will not be accepted.

Alternate Request for Authorization

Omaha National may accept a request for authorization for medical treatment that does not utilize the DWC Form RFA according to 8 CCR § 9792.9.1(c)(2)(B), if:

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.

Incomplete RFA

Upon receipt of a request for authorization as described above, or a DWC Form RFA, the request will be reviewed to ensure all necessary information has been submitted. If the request fails to include any of the following information, it will be returned to the requesting physician marked "not complete":

1) Identification of the employee or provider;
2) Identification of specific recommended treatment(s);
3) Accompanied by documentation substantiating the medical necessity for the requested treatment; and
4) Requesting physician signature.

Additionally, the request may be returned as "not complete" if the request was not submitted on the current version of the DWC Form RFA and fails to include the required information in the format listed above.

The returned authorization marked "not complete" will specify the reasons for the return of the request and will be completed no later than five (5) business days from receipt. This response may be completed by the claims adjuster or nurse, and does not require the involvement of the Reviewer.

The timeframe for a decision on a return request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

Emergency Health Care Services

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

Disputed Liability for Injury / Disputed Liability of Recommended Treatment for Reasons Other Than Medical Necessity

In certain circumstances, Omaha National may dispute liability for either the injury for which the treatment is recommended, claimed body part or parts, or liability for the recommended treatment itself for reasons other than medical necessity. This type of deferral or postponement does not require the involvement of a Reviewer, and the decision can be made by the claims adjuster or the nurse.

When this occurs, no later than five (5) business days from receipt of the DWC Form RFA, Omaha National shall issue a written decision deferring utilization review of the requested treatment unless the requesting physician has been previously notified of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment.

The written deferral decision shall contain the following information specific to the request:

1) The date on which the DWC Form RFA was first received;
2) A description of the specific course of proposed medical treatment for which authorization was requested;
3) A clear, concise, and appropriate explanation of the reason for the dispute of liability for either the injury, claimed body part or parts, or the recommended treatment;
4) A plain language statement advising the injured worker that any dispute shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board; and
5) The written decision shall include the following mandatory language advising the injured worker:

   "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 (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."

The written decision shall be sent to the requesting physician, the injured worker, and if the injured worked is represented by counsel, the injury worker's attorney.

Resolution of Disputed Liability for Injury / Disputed Liability of Recommended Treatment for Reasons Other Than Medical Necessity

Resolution of disputed liability may be determined by an agreement of the parties or by a decision of the Workers' Compensation Appeals Board. If Omaha National is determined to be liable for the condition for which treatment is recommended, the time to conduct retrospective UR shall begin on the date the determination of the liability becomes final. The time to conduct prospective UR shall commence from the date of the claims administrator's receipt of a DWC Form RFA after the final determination of liability.

Unless additional information is requested necessitating an extension under "Timeframe Requirements" subsection "Timeframe Extensions" within this Plan, the UR process following a liability determination shall meet the timeframe requirements described below, based on the type of review being conducted.

The timeframe for a decision on a return request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

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

Prospective or concurrent decisions to approve, modify, or deny a request for an authorization related to an expedited review shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed 72 hours after receipt of the written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for standard utilization review would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe of five (5) business days from receipt of the completed DWC Form RFA.

Retrospective decisions to approve, modify, or deny a request for authorization shall be made within 30 calendar days of receipt of the request for authorization and medical information that is reasonably necessary to render a determination.

Utilization Review Process

The purpose of the UR Process is to perform management functions prospectively, retrospectively, or concurrently to assess the medical necessity and conformity of physician treatment recommendations with evidence-based criteria, to cure or relieve the effects of the work-related injury.

The goal of the UR Program is to facilitate improved health outcomes for injured workers who have experienced a work-related illness or injury.

The UR Process will be conducted in the following manner:

1. The request for authorization of medical services submitted by the treating physician is received by Omaha National. The request is processed via the intake process.
2. The non-clinical specialist performing intake, claims adjuster, nurse, or Reviewer reviews the medical information submitted with the DWC Form RFA or other acceptable request for authorization. A determination is made as to whether the request is complete and contains all information necessary to render a determination. The claims adjuster, nurse, or Reviewer may determine an inability to render a determination due to any of the following:
    a. The request for authorization does not include all information reasonably necessary to render a determination.
    b. The Reviewer asks for an additional examination or test to be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.
    c. The Reviewer asks for a specialized consultation and review of medical information by an expert reviewer.

If this occurs, the nurse will notify the requesting physician and conduct follow up based on the details described in the policy on Timeframe Requirements, Timeframe Extensions.

3. If the content of the request is complete, the nurse will compare the requested treatment plan submitted by the requesting physician to the Treatment Guidelines referenced in the applicable policy.
    a. If additional medical information is necessary, the nurse may contact the treating physician and request reasonable additional medical information necessary to render a decision or refer the request to the Reviewer for a determination.

b. If the requested treatment plan is consistent with the MTUS or other applicable criteria and is medically necessary, the nurse may issue approval of the requested authorization.
    i. The requesting physician shall be notified of the approval within 24 hours of making the decision. The notification shall be by telephone, facsimile, or electronic mail.
    ii. The written decision shall be issued according to the details in the Determination Letters subsection of the Communication of Determinations policy.
c. If 3.a. and 3.b. do not apply, the nurse may contact the requesting physician to discuss the RFA and the corresponding criteria.
    i. The treating physician may voluntarily withdraw all or a portion of the treatment initially in question. An amended written request for treatment authorization must be submitted by the treating physician. The nurse may approve the amended request for treatment authorization.
    ii. If the treating physician does not agree to alter the request, the nurse will refer the request to the Reviewer for a determination.
d. If appropriate, the UR Nurse will refer the request to the Reviewer for a determination.

No person other than a 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.

i. The nurse completes the referral to the Reviewer and will monitor the case for completion by the Reviewer within the required timeframe.
ii. The nurse may discuss the case with the Reviewer, as indicated by the circumstances of the case.
iii. The Reviewer may contact the requesting provider to discuss the case prior to rendering a determination.
iv. The Reviewer will complete the preliminary determination and communicate it to the nurse.
v. The nurse will conduct a final assessment of the determination for completeness, content, clarity, and conformance with applicable statutes and regulations.
vi. If additional clarification is needed from the Reviewer, the nurse will obtain it prior to finalization.
vii. Timeframes for communication of the determination begin upon finalization of the determination.
viii. The review results will be communicated to the requesting provider by Omaha National based on the required timeframes and methods detailed in the Communication of Determinations Policy.
    1. The requesting physician shall be notified of the approval within 24 hours of making the decision. The notification shall be by telephone, facsimile, or electronic mail.

2. The written decision shall be issued according to the details in the Determination Letters subsection of the Communication of Determinations policy.

The UR Process will be documented in the case file, including date(s), party(ies) contacted, documentation exchanged, and oral discussions.

Whenever a decision to deny a request for authorization based on the lack of medical information necessary to render a determination is issued, Omaha National's file shall document the attempt to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail.

Utilization Review Effective January 1, 2018

For dates of injury occurring on or after January 1, 2018, or such date as regulatory provisions become effective, policies and procedures within this Plan will operate in conformance with newly effective legal requirements. These include the following:

Emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable and is addressed by the medical treatment utilization schedule adopted pursuant to Labor Code § 5307.27, by a member of the medical provider network or a health care organization, or by a physician predesignated pursuant to Labor Code § 4600(d), within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided below in the section "Services Subject to Prospective Utilization Review Effective January 1, 2018".

A complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.

Services Subject to Prospective Utilization Review Effective January 1, 2018

Unless authorized by Omaha National 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 MPN, 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:

1) Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to the Labor Code.
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.

Omaha National will conduct retrospective utilization review for any treatment provided pursuant to the exception for prospective utilization review. The retrospective review will be for the purpose of determining if the physician is prescribing treatment consistent with the MTUS and drug formulary adopted pursuant to the Labor Code.

Removal of Physician or Provider's Ability to Render Care Exempt from Prospective Utilization Review

Should the physician fail to submit the required report and request for authorization, Omaha National may remove the physician's ability to provider further medical treatment to the injured worker that is exempt from prospective utilization review.

Upon retrospective review, if Omaha National identifies that there is a pattern and practice of the physician or provider failing to render treatment consistent with the MTUS, including the drug formulary, Omaha National may remove the ability of the physician or provider to provide further medical treatment to any employee that is exempt from prospective utilization review.

Omaha National will notify the physician or provider in writing of the results of the retrospective utilization review and the requirement for prospective utilization review for all subsequent medical treatment.

Receipt Date

The DWC Form RFA shall be deemed to have been received as follows, based on the method of communication of the request:

1) Facsimile or email: the receipt date is the date the form was received, based on the electronic date stamp of the transmission where 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. A DWC Form RFA transmitted after 5:30 PM Pacific Time shall be deemed to have been received on the following business day, except in the case of an expedited or concurrent review. The requesting physician must indicate if there is the need for an expedited review on the DWC Form RFA.
2) Mail:
    a. The date of receipt will be deemed to have been the date stamped as received by Omaha National.
    b. Absent documentation of receipt, the receipt date shall be deemed to have been received five (5) business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.
    c. If by Certified Mail, with return receipt: absent documentation of receipt, the form shall be deemed to have been received on the receipt date entered on the return receipt.
    d. 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 five days after the latest date the sender wrote on the document.

Timeframe Requirements

Omaha National will monitor the timeframes for reviews to ensure that reviews are completed within the regulatory timeframes in compliance with the California Code of Regulations, based on the following:

1) Type of review (i.e., prospective, concurrent, retrospective);
2) Date of receipt of the request;
3) Date of receipt of all necessary information reasonably required to render a determination; and,
4) Presence or absence of an extension of the due date.

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. These timeframes apply unless additional information is requested necessitating a Timeframe Extension, as described below.

Review Types

Standard Reviews – Prospective or Concurrent

Non-Formulary Requests

Except for treatment requests made pursuant to the formulary, prospective or concurrent decisions to approve, modify, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of the receipt of the completed DWC Form RFA or other acceptable request for authorization.

Formulary Requests

Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of receipt of the medical treatment request.

Expedited Reviews

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

Retrospective Reviews

Retrospective decisions to approve, modify, or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to render a determination.

Timeframe Extensions

Except for treatment requests made pursuant to the formulary, the timeframe for decisions may be extended under one or more of the following circumstances:

- Incomplete submission of information reasonably necessary to render a determination, as described in 8 CCR § 9792.9.1(f)(1)(A)
    - Within five (5) business days from the date of the receipt of the request for authorization, Omaha National shall request the information from the treating physician.
    - The requested information must be received based on the following:
        - Prospective or concurrent reviews: requested information must be received within 14 days from the receipt of the completed request for authorization for prospective or concurrent review.

- Retrospective reviews: requested information must be received within 30 days of the request for retrospective review.

If the information is not received within the timeframes specified above, the request shall be denied, stating the request will be reconsidered upon receipt of the requested information.

Whenever a decision to deny a request for authorization based on the lack of medical information necessary to render a determination is issued, Omaha National's file will document the attempt(s) to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail.

- Reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice, as described in 8 CCR § 9792.9.1(f)(1)(B).
    - Within five (5) business days from the date of the receipt of the request for authorization, Omaha National shall notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot render a decision within the required timeframe, and request, as applicable, the additional examination or test required, and provide the anticipated date on which a decision will be rendered.

If the additional examination or test required that is requested by the Reviewer is not received within 30 days from the date of the request for authorization, the Reviewer shall deny the treating physician's request with the stated condition that the request will be reconsidered upon receipt of the results of the additional examination or test.

Whenever a decision to deny a request for authorization based on the lack of the additional examination or test is issued, Omaha National's file will document the attempt(s) to obtain the necessary examination or test from the physician either by facsimile, mail, or e-mail.

- Reviewer needs a specialized consultation and review of medical information by an expert reviewer, as described in 8 CCR § 9792.9.1(f)(1)(C)
    - Within five (5) business days from the date of the receipt of the request for authorization, Omaha National shall notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot render a decision within the required timeframe, and request, as applicable, the specialty of the expert reviewer to be consulted, and provide the anticipated date on which a decision will be rendered.

If the additional specialized consultation required that is requested by the Reviewer is not received within 30 days from the date of the request for authorization, the Reviewer shall deny the treating physician's request with the stated condition that the request will be reconsidered upon receipt of the results of the specialized consultation.

Whenever a decision to deny a request for authorization based on the lack of specialized consultation and review of medical information by an expert reviewer that is necessary to render a determination, Omaha National's file will document the attempt(s) to obtain the specialized consultation.

Communication of Determinations

Omaha National will communicate the results of UR determinations to the injured worker and the injured worker's attorney/designee pursuant to the timeframe, procedure, and notice requirement of the California Code of Regulations.

For all review types, a determination or decision is considered finalized and ready to disseminate to the treating physician, injured worker, injured worker's designee, and if represented, the injured worker's attorney once it has undergone finalization by the nurse. This finalization process includes a review for completeness, content, clarity, and conformance with applicable statutes and regulations. Once deemed finalized, the results will be communicated to the applicable parties in accordance with legal requirements.

Initial Communication of Determinations

Approvals

Prospective, concurrent, or expedited reviews: approvals shall be communicated to the requesting physician within 24 hours of the finalized decision, 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 two (2) business days for prospective review.

Retrospective reviews: a written decision to approve shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable. However, payment or partial payment, consistent with the provisions of the California Code of Regulations, of a medical bill for services requested on the DWC Form RFA or other acceptable authorization request, within the 30-day timeframe set forth in the CCR, shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete. A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured worker who received the medical services, and his or her attorney/designee, if applicable, in lieu of communication expressly acknowledging the retrospective approval.

Modifications or Denials

Prospective, concurrent, or expedited reviews: a decision to modify or deny shall be communicated to the requesting physician within 24 hours of the finalized decision, 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 the injured worker is represented by counsel, the injured worker's attorney within:

1) 24 hours of the decision for concurrent review;
2) two (2) business days for prospective review; and,
3) 72 hours of the receipt of the request for expedited review.

Responses Following Timeframe Extensions for Submission of Requested Additional Medical Information, Additional Examination or Test, or Following Specialized Consultation

Timely responses received following timeframe extensions will be answered as detailed below:

1) Submission of requested additional medical information:

   Upon receipt of the requested information, the decision to approve, modify, or deny the request for authorization for:

   - Standard prospective or standard concurrent reviews: a decision shall be made within five (5) business days of the receipt of the information. The requesting physician shall be notified by telephone, facsimile, or electronic mail within 24 hours of the decision.

- Expedited prospective or expedited concurrent reviews: a decision shall be made within 72 hours of the receipt of the information. The requesting physician shall be notified by telephone, facsimile, or electronic mail within 24 hours of the decision.
- Retrospective reviews: a decision shall be made within 30 calendar days of receipt of the requested information.

When additional information is required and requested, the decision is made within 14 days of the receipt of the initial request for authorization.

2) Submission of additional examination or test requested by the Reviewer:

   Upon receipt of the results of the requested additional examination or test performed upon the injured worker, the decision to approve, modify, or deny the request for the authorization for:

   - Standard prospective or standard concurrent reviews: a decision shall be made within five (5) business days of the receipt of the results of the examination or test. The requesting physician shall be notified by telephone, facsimile, or electronic mail within 24 hours of the decision.
   - Expedited prospective or expedited concurrent reviews: a decision shall be made within 72 hours of the receipt of the results of the examination or test. The requesting physician shall be notified by telephone, facsimile, or electronic mail within 24 hours of the decision.
   - Retrospective reviews: a decision shall be made within 30 calendar days of receipt of the requested information.

3) Submission of the results of a Reviewer-requested specialized consultation and review of medical information by an expert reviewer:

   Upon receipt of the consultation report from the expert reviewer, the decision to approve, modify, or deny the request for authorization for:

   - Standard prospective or standard concurrent reviews: a decision shall be made within five (5) business days of the receipt of the consultation report from the expert reviewer. The requesting physician shall be notified by telephone, facsimile, or electronic mail within 24 hours of the decision
   - Expedited prospective or expedited concurrent reviews: a decision shall be made within 72 hours of the receipt of the consultation report from the expert reviewer. The requesting physician shall be notified by telephone, facsimile, or electronic mail within 24 hours of the decision.
   - Retrospective reviews: a decision shall be made within 30 calendar days of receipt of the consultation report from the expert reviewer.

Determination Letters

Determination letters shall be issued at the conclusion of the review, unless otherwise specified. This includes determination letters following timeframe extensions due to requests for additional medical information, additional examination or testing, or following specialized consultation. The exception is in the case of a retrospective review, when the document indicating that a payment has been made for the requested services, such as an explanation of review, is provided to the injured worker who

received the medical services, and his or her attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

Approvals

Approval of a request for authorization shall specify the following:

1) The date the complete request for authorization was received.
2) The medical treatment service requested.
3) The specific medical treatment service approved.
4) The date of the decision.

Authorization may be provided by utilizing the indicated response section of the "Request for Authorization," DWC Form RFA if the treating physician initially submitted that form.

Modifications or Denials

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 injury worker's attorney.

Retrospective reviews: a written decision to deny part or all the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to render a determination.

The written decision modifying or denying treatment authorization shall be signed by either the claims administrator or the Reviewer, and shall only contain the following information specific to the request:

1) The date on which the DWC Form RFA was first received.
2) The date on which the decision is made.
3) A description of the specific course of proposed medical treatment for which authorization was requested.
4) A list of all medical records reviewed.
5) A specific description of the medical treatment service approved, if any.
6) A clear, concise, and appropriate explanation of the reasons for the Reviewer'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 the California Code of Regulations § 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.
7) The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the "Employee Signature", 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.
8) A clear statement advising the injured worker that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code § 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.

9) Include the following mandatory language advising the injured worker:

   "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 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."

10) Details about the Omaha National internal utilization review appeals process for the requesting physician, 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 the Labor Code § 4610.5 and § 4610.6, but may be pursued on an optional basis.
11) 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 a minimum, four (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.

Denials Due to Incomplete or Insufficient Information

If Omaha National is unable to make a decision within the applicable timeframes specified by the Labor Code or the California Code of Regulations because Omaha National is not in receipt of, or in possession of, all of the information reasonably necessary to make a determination, Omaha National shall immediately notify the physician and the employee, in writing, that a decision cannot be made within the required timeframe, and specify the information that must be provided by the physician for a determination to be made.

If a UR decision to deny a medical service is due to incomplete or insufficient information, the decision shall specify all of the following:

1) The reason for the decision.
2) A specific description of the information that is needed.
3) The date(s) and time(s) of attempts made to contact the physician to obtain the necessary information.
4) A description of the manner in which the request was communicated.

When a denial is made due to a lack of information, test, examination, or specialty consultation, the denial will state that the request will be reconsidered upon receipt of the requested information or the results of the requested test, examination, or specialty consultation, pursuant to 8 CCR § 9792.9.1(f)(3)(A) and 8 CCR § 9792.9.1(f)(3)(B).

Whenever Omaha National issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the file must document the attempt by

Omaha National or the Reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or email.

Special Concurrent Review Requirements

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

1) Medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker.
2) Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve from the effects of the work-related injury.

Determination Results

The review and decision to approve a request for medical treatment may be conducted by a nurse or a Reviewer, utilizing the treatment guidelines and criteria detailed within this Plan.

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

A 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 Omaha National with regard to a further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Treatment Guidelines

Omaha National will use the latest version of the Medical Treatment Utilization Schedule (MTUS) adopted by the Administrative Director pursuant to California Labor Code as the primary source of guidance for treating physicians and physician Reviewers for the evaluation and treatment of medical care in accordance with the Labor Code for all injured workers diagnosed with work-related conditions, except in specific circumstances addressed herein.

The MTUS is based on the principals of Evidence Based Medicine (EBM), which is a systematic approach to making clinical decisions to allow the integration of the best available evidence with clinical expertise and patient values. It incorporates peer-reviewed, nationally recognized standards of care, addressing at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases. The recommended guidelines set forth in the MTUS are presumptively correct on the issue of extent and scope of medical treatment. However, treatment shall not be denied on the sole basis that the condition or injury is not addressed by the MTUS.

If the condition or injury is not addressed in the MTUS, medical care shall be in accordance with other nationally-accepted evidence based medical treatment guidelines, peer-review studies, or other state-adopted guidance. The treating physician who seeks treatment outside of the MTUS bears the burden of rebutting the presumption of correctness of the MTUS by a preponderance of scientific medical evidence that establishes that a variance from the schedule is reasonably required to cure or relieve the injured worker from the effects of his or her injury.

Omaha National will annually conduct a review and update of policies and procedures and treatment guidelines in consultation with its Medical Director and other appropriate medical management staff.

Personnel, Qualifications, and Scope

Omaha National shall ensure the availability of qualified staffing to implement and manage the Utilization Review Plan in a manner consistent with applicable Labor Code and regulatory requirements. Staffing shall be through direct or contracted arrangements. Licensed staff and Reviewers are required to maintain active and unrestricted licensure and necessary certifications throughout their relationship with Omaha National. Licenses and credentials will be verified by Omaha National upon direct employment, or validated and monitored by the contracting entity. All licensed staff is required to notify Omaha National or the contracting entity if any action is taken on their licensure or other credentials while a direct employee or while providing contracted services. The scope of responsibilities for each level of staffing is detailed below.

Medical Director

Qualifications: The designated Medical Director for Omaha National holds an unrestricted license to practice medicine in the state of California.

Scope of Responsibilities: The Medical Director is responsible for all decisions made in the UR Process, and assists in ensuring that the processes comply with the Labor Code and corresponding regulations. Additionally, the Medical Director is available during specified time periods during which decisions modifying or denying treatment authorization may be discussed with the treating physician, if requested.

At least annually, Omaha National will conduct a review and update of policies and procedures and treatment guidelines in consultation with its Medical Director and other appropriate medical management staff. However, updates to these documents may be made prior to the annual review, if indicated.

The Medical Director for Omaha National is:

Stanley G. Katz, M.D.
1717 E. Lincoln Avenue
Anaheim, CA 92805

Phone: 714-635-2642
Fax: 714-635-8547

California License: G49280
Nevada License: 6675

Reviewers

Qualifications: The Reviewers for Omaha National hold current, unrestricted professional licenses in any state or the District of Columbia, are in active practice, and are Board Certified in their specialty, if applicable.

Scope: The Reviewers are responsible for the final review decisions to modify or deny authorization for medical treatment requests for reasons of medical necessity to cure and relieve. The Reviewer conducting the review will be competent to evaluate the specific clinical issues involved in the medical treatment services, and where the services are within the scope of the Reviewer's practice. The Reviewer shall be available during specified hours during which decisions modifying or denying treatment authorization may be discussed with the treating physician, if requested.

Omaha National contracts with PRIUM for peer review services. PRIUM maintains URAC Accreditation for Workers' Compensation Utilization Management.

Nurses

Qualifications: Omaha National's nurses are licensed professionals. They possess clinical nursing experience and are knowledgeable in workers' compensation and medical management. They may also possess additional certification or credentials corresponding to their responsibilities.

Scope: The nurse may initially apply the MTUS and other specified criteria to requests for authorization of medical services. The nurse may approve requests for authorization of medical services which correspond to the criteria. The nurse may: 1) discuss applicable criteria with the requesting physician, to seek clarification when the treatment for which authorization is sought appears to be inconsistent with the criteria, which may result in an amendment to the request by the treating physician; 2) reasonably request appropriate additional information that is necessary to render a decision; 3) refer cases to the Reviewer when the requesting physician is seeking authorization of medical services which appear inconsistent with the criteria; and/or, 4) refer cases to the Reviewer when additional information has been requested but has not been received within 14 days of the initial request for authorization.

PRIUM nurses may occasionally provide services to supplement the existing Omaha National UR nursing staff. When this occurs, there will be no change in the method of submitting requests for treatment, nor in the final determination notification process and no externally visible difference in the process.

Non-Clinical Staff

Qualifications: Omaha National employees or contracted consultants who do not perform clinical assessments or provide callers with clinical advice.

Scope: Non-clinical staff will assist with the management of written or telephone inquiries to the UR Department. They are permitted to perform the following:

1) Obtain demographic information;
2) Obtain employer name and information;
3) Obtain information regarding the dates of planned procedures, surgeries, or other services;
4) Obtain provider or facility name and corresponding contact information;
5) Provide benefit information;
6) Redirect and route callers;
7) Identify if a Request for Authorization includes basic information necessary for the UR nurse to conduct a review. These elements include:

    a) Identification of the employee and provider.

    b) Identification of specific recommended treatment(s).

    c) Documentation substantiating the medical necessity for the requested treatment.

    d) Requesting physician or provider signature.

Requests for Authorization may be reviewed by non-clinical staff in the following circumstances:

1) The compensability of the claim for worker's compensation has been denied. Therefore, the denial is based on a lack of compensability, and is outside the scope of a utilization review determination.
2) The compensability has been denied for a certain body part or other medical condition because it is not related to the accepted compensable claim, and the request is for the denied body part or medical condition.
3) The information submitted does not meet the underlying definition of a request for authorization. For example, the request is seeking benefit information, rather than authorization for treatment.
4) Non-clinical staff are not permitted to respond to inquiries that involve clinical decision making or medical necessity determinations.
5) Non-clinical staff are not permitted to interpret medical record documentation or provide clinical decision making of any type.
6) Non-clinical staff will have access to the Utilization Review nurses while performing initial screening activities. Questions may be directed to UR nurses as needed.

UR Nurses will assist non-clinical staff to redirect inquiries, if needed, for clinical and medical necessity questions or issues.

Dispute Resolution

If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute related to the unapproved medical treatment shall be resolved in accordance with Labor Code § 4610.5 and § 4610.6.

There are two procedures available to resolve the dispute: 1) Independent Medical Review, and 2) Omaha National Internal Utilization Review Appeal Process.

Nothing in the section describing the Independent Medical Review precludes the parties from participating in an Omaha National Internal Utilization Review Appeal Process on a voluntary basis, provided the injured worker and, if the injured worker is represented by counsel, the injured worker's attorney, have been notified of the time limit to file an objection to the utilization review decision in accordance with the Labor Code. A request for an Omaha National Internal Utilization Review Appeal must be submitted to Omaha National within ten (10) days after the receipt of the utilization review decision.

Independent Medical Review (IMR)

A request for independent medical review must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee. The request shall be made no later than as follows:

1) For formulary disputes, ten (10) days after the service of the utilization review determination issued by Omaha National to the injured worker.
2) For all other medical treatment disputes, 30 calendar days after the service of the written utilization review determination issued by Omaha National to the injured worker.

The request must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision denying or modifying the request for authorization of medical treatment. At the time of filing, the injured worker shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision denying or modifying the request for authorization of medical treatment, to Omaha National.

Parties eligible to file a request for IMR include:

1) The injured worker, or if the injured worker is represented, the injured worker's attorney. If the injured worker's attorney files the DWC Form IMR, the form must be accompanied by a notice of representation or other document or written designation confirming representation.
2) An unrepresented injured worker may designate a parent, guardian, conservator, relative, or other designee of the injured worker as an agent to act on his or her behalf in filing an application for IMR. A designation of an agent executed prior to the UR decision shall not be valid.
3) The physician whose request for authorization of medical treatment was denied or modified may join with or otherwise assist the injured worker in seeking an IMR. The physician may submit documents on the injured worker's behalf and may respond to any inquiry by the independent review organization.
4) A provider of emergency medical treatment when the injured worker faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit an application for independent medical review on its own behalf within 30 days after the service of the UR decision that either denies or modifies the provider's retrospective request for authorization of the emergency medical treatment.

If expedited review is requested for a utilization review decision eligible for independent medical review, the Application for Independent Medical Review, DWC Form IMR, shall include, unless the initial utilization review decision was made on an expedited basis, written certification from the injured worker's treating physician with documentation confirming that the injured worker faces an imminent and serious threat to his or her health as described in the California Code of Regulations.

If, at the time of a UR decision, Omaha National is also disputing liability for the treatment for any reason besides medical necessity, the time for the injured worker to submit an application for independent medical review is extended to 30 days after service of a notice to the injured worker showing that the other dispute of liability has been resolved.

Omaha National shall provide the Independent Review Organization (IRO) the following documents within 15 days following the mailing of the notification from the IRO that the disputed medical treatment has been assigned for IMR, or within 12 days if the notification was sent electronically, or for expedited review within 24 hours following receipt of notification:

1) A copy of all reports of the physician relevant to the injured worker's current medical condition produced within six months prior to the date of the request for authorization, including those that are specifically identified in the request for authorization or in the utilization review determination. If the requesting physician has treated the employee for less than six months prior to the date of the request for authorization, the claims administrator shall provide a copy of all reports relevant to the employee's current medical condition produced within the described six-month period by any prior treating physician or referring physician.
2) A copy of the written Application for Independent Medical Review, DWC Form IMR, that was included with the written determination, issued under the California Code of Regulations, which notified the employee that the disputed medical treatment was denied or modified. Neither the written determination nor the application's instructions should be included.
3) Other than the written determination by the claims administrator issued under the California Code of Regulations, a copy of all information, including correspondence, provided to the injured worker by the claims administrator concerning the utilization review decision regarding the disputed treatment.
4) A copy of any materials the injured worker or the injured worker's provider submitted to the claims administrator in support of the request for the disputed medical treatment.
5) A copy of any other relevant documents or information used by the claims administrator in determining whether the disputed treatment should have been provided, and any statements by the claims administrator explaining the reasons for the decision to deny or modify the recommended treatment based on medical necessity.
6) The claims administrator's response to any additional issues raised in the injured worker's application for independent medical review.

Omaha National shall forward to the injured worker or the injured worker's representative a notification that lists all documents submitted to the IRO as stated above. With the notification, Omaha National shall provide a copy of all documents that were not previously provided to the injured worker or the injured worker's representative excluding mental health records withheld from the injured worker pursuant to Health and Safety Code section 123115(b).

Any newly developed or discovered relevant medical records in the possession of Omaha National after the listed documents are provided to the IRO shall be forwarded immediately to the IRO. Omaha National shall concurrently provide a copy of medical records required by this subdivision to the injured worker, or the injured worker's representative, or the injured worker's treating physician, unless the offer of medical records is declined or otherwise prohibited by law.

At any time following the submission of documents described above, the IRO may reasonably request appropriate additional documentation or information necessary to render a determination that the disputed medical treatment is medically necessary. Additional documentation or other information requested under this section shall be sent by the party to whom the request was made, with a copy forwarded to all other parties, within five (5) business days after the request is received in routine cases or one (1) calendar day after the request is received in expedited cases.

The confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

The final determination issued by the IRO shall be deemed to be the determination of the Administrative Director and shall be binding on all parties.

Upon receiving the final determination of the Administrative Director that a disputed medical treatment is medically necessary, Omaha National shall promptly implement the determination, unless an appeal is filed under subdivision 9792.10.7(c) or liability for treatment is disputed as described in subdivision 9792.10.7(a)(3), promptly implement the determination.

In the case of reimbursement for services already rendered, Omaha National shall reimburse the provider or injured worker, whichever applies, within twenty (20) days after receipt of the final determination, subject to resolution of any remaining issue of the amount of payment pursuant to the Labor Code.

In the case of services not yet rendered, Omaha National shall authorize the services within five (5) business days of receipt of the final determination, or sooner if appropriate for the nature of the injured worker's medical condition, and shall inform the injured worker and provider of the authorization.

If, at the time of receiving the final determination, Omaha National is disputing liability for the medical treatment on grounds other than medical necessity, implementation of the final determination shall be deferred until the liability dispute has been resolved.

The parties may appeal a final determination of the Administrative Director by filing a petition with the Workers' Compensation Appeals Board.

If the final determination of the Administrative Director is reversed by the Workers' Compensation Appeals Board, the dispute shall be remanded to the Administrative Director. The Administrative Director shall:

1) Submit the dispute to IMR by an IRO, if available;
2) If a different independent medical review organization is not available after remand, the Administrative Director shall submit the dispute to the original IRO for review by a different reviewer in the organization.

Omaha National Internal Utilization Review Appeal Process

Omaha National has established an Internal Utilization Review Appeal Process as a voluntary option for eligible parties to resolve disputes related to unapproved medical treatment requests for authorization. Participation is voluntary, and participation in this process does not trigger nor bar the use of the dispute resolution described in Labor Code § 4610.5 and § 4610.6.

Parties eligible to request an Internal Utilization Review Appeal are the same parties outlined in the above section describing Independent Medical Review.

The request for the Internal Utilization Review Appeal must be submitted in writing to Omaha National. It must be clearly marked as a “Request for Internal Utilization Review Appeal.” The request must be

submitted within ten (10) days after the receipt of the decision. The treating physician may provide supplemental medical record documentation of additional findings or evidence-based guidance for consideration by the Reviewer as rebuttal of the original determination when the request is submitted. The supplemental information must be submitted with the request for the internal utilization review appeal for its consideration in the appeal. If there is no supplemental information provided, then the Internal Utilization Review Appeal determination will be unchanged from the original determination.

If the Reviewer deems it necessary, Omaha National will establish an appointment date and time that is mutually agreed upon between the Reviewer and the treating physician for case discussion. The Reviewer will initiate the contact to the treating physician at the appointed time using the contact information provided by the treating physician.

The Reviewer will render an appeal determination on the original decision. This appeal determination will be based on the original documentation and any supplemental documentation provided by the treating physician.

The Reviewer will document the case file and inform the nurse of the appeal determination. The nurse will complete the finalization process as described in the Communication of Determinations section previously detailed in this document.

A determination must be issued by Omaha National within 30 days after receipt of the request. However, if the treating physician provides written certification with supporting documentation verifying 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, the review will be conducted on an expedited basis. Omaha National will complete the review and issue a determination within three (3) days of receipt of the request for an expedited Internal Utilization Review Appeal.

Any determination by the claims administrator following an Internal Utilization Review Appeal that results in a modification of the requested medical treatment shall be communicated to the requesting physician, the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney. The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under the California Code of Regulations must indicate that the decision is a modification after appeal.

If the final determination on the Internal Utilization Review Appeal upholds the original modification or denial, and the treating physician continues to disagree with the decision, the case remains eligible to proceed to request IMR, as previously described.

Request for Utilization Review Plan

Upon request by the public, Omaha National's complete Utilization Review Plan, consisting of the policies and procedures, and a description of the Utilization Review Process, will be made available. The Plan may be distributed via electronic method or in hard copy, for a reasonable copying and postage fee that shall not exceed $0.25 per page plus actual postage costs.