California
Utilization Review Plan

Effective June 26, 2023

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Introduction and Overview

The following overview, description and policies and procedures constitutes Omaha National Underwriters, LLC (Omaha National) Utilization review plan. Omaha National has established and maintains this Utilization review plan and its Utilization Review Process in compliance with applicable law. Bolded terms used in the following Utilization Review plan have meanings further defined in the Definitions section of this plan.

The purpose of Omaha National's Utilization Review Process is to provide an assessment of clinical appropriateness and medical necessity of treatment requests and goods provided pursuant to Article 2 (commencing with LC § 4600) of Chapter 2 of Part 2 of Division 4 of the LC for accepted and delayed claims.

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

Approve or approval: Means a decision that the requested treatment or service is authorized or medically appropriate to cure or relieve the effects of a compensable industrial injury.

Authorization/Authorized/Certification: 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 § 4600, subject to provision of § 5402, based on either a completed "Request for Authorization" DWC Form RFA, as contained in the CCR, Title 8, § 9785.5 or a request

for authorization of medical treatment accepted as complete by the claims administrator under CCR § 9792.9.1(c) (2), that has been transmitted by the treating physician to the claims administrator.

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.

"CCR": Title 8 of the California Code of 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). Defined as 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). The Claims Administrator may utilize an entity contracted to conduct its utilization review responsibilities subject to § 4610.

"Complete", with respect to Request for Authorization: Request for authorization must identify both the employee and provider, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for requested treatment. The request for authorization must be signed by the treating physician and be mailed, faxed or emailed as designated by the claims administrator for this purpose.

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 "Doctor's First Report of Occupational Injury or Illness", Form DLSR 5021, found at CCR, Title 8, § 14006, or on the "Primary Treating Physician's Progress Report, DWC Form PR-2 as contained in CCR § 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.

Denial, Deny, or Non-Certify: 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 an occupational 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.

Drug Formulary: Drug List and the formulary rules set forth in CCR §§ 9792.27.1 to 9792.27.23.

Drug List: Drug list and related information set forth in CCR § 9792.27.15.

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.

Exempt and Exempt Drug: Drug on the drug list which is designated as being a drug that does not require authorization through prospective review or concurrent review prior to dispensing the drug, provided that the drug is prescribed in accordance with the Medical Treatment Utilization Schedule.

Expedited Review: 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: 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 LC §4616.

Immediately: Within one business day.

LC: California Labor Code

Material modification: When the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in CCR § 9792.7.

Medical Director: A physician and surgeon employed by or designated by Omaha National who is 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 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 LC § 5307.27:

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 LC § 5307.27 and set forth in Article 5.5.2 of this subchapter beginning with CCR § 9792.20.

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

Non-Exempt Drug: Meaning a drug on the drug list which is designated as requiring authorization through prospective review or concurrent review prior to dispensing the drug.

Perioperative Fill Drug: Non-exempt drug designated as a perioperative fill drug on the drug list.

Perioperative Period: Defined as the period 4 days prior to surgery to 4 days after surgery.

Pre-Designated Physician: A personal physician predesignated by the injured worker pursuant to LC § 4600 (d).

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.

Physician 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.

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. Unless accepted by a claims administrator under CCR § 9792.9.1 (c) (2), a request for authorization must be on a "Request for Authorization (DWC Form RFA)" completed by a treating physician, as contained in CCR, Title 8, § 9785.5.

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

Special Fill Drug: Non-Exempt Drug designated as a special fill drug on the drug list.

Utilization Review Decision: A decision pursuant to Labor Code §4610 to approve, modify, or deny—treatment recommendation(s) by a physician prior to, retrospectively, or concurrent with, the provision of medical treatment services pursuant to LC § 4600 or § 5402 (c). Utilization review decision may also mean a determination occurring on or after January 1, 2018, regarding medication prescribed pursuant to the Drug Formulary.

Utilization Review Process: The 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 LC § 4600. The utilization review process begins when the completed DWC Form RFA, or a request for authorization accepted as complete under CCR § 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 and Procedures

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.

Omaha National's utilization review decisions are made using the Medical Treatment Utilization Schedule (MTUS) including the MTUS Drug Formulary (collectively MTUS). Treatment will not be denied and authorization for treatment is not automatically precluded on the sole basis that MTUS does not include specific criteria for the requested treatment.

For all conditions or injuries not addressed by MTUS, or the MTUS presumption of correctness is being challenged, medical care shall be in accordance with other medical treatment guidelines or peer-reviewed studies found by applying the following medical evidence search sequence for the evaluation and treatment of injured workers pursuant to CCR §§ 9792.21.1 and 9792.25.1:

1) Search the most current version of ACOEM or Official Disability Guidelines (ODG)
2) Search the most current version of other evidence based medical treatment guidelines that are recognized by the national medical community and are scientifically based.
3) Search for current studies that are scientifically based, peer reviewed, and published in journals that are nationally recognized by the medical community.
4) Expert opinion

All criteria used in the utilization review process is consistent with the requirements of LC § 4604.5 and § 5307.27. At least annually, or as otherwise appropriate, the medical director evaluates all criteria, guidelines and protocols used in the utilization review decision making process to ensure these are consistent with the Medical Treatment Utilization Schedule and/or principles of evidence-based medicine. The medical director maintains current knowledge and familiarity with evidence-based peer-reviewed guidelines and updates the criteria as appropriate pursuant to CCR § 9792.7 (b)(1).

Personnel, Qualifications, and Scope

Omaha National shall ensure adequate staffing to implement and manage the utilization review process in a manner consistent with applicable Labor Code and regulatory requirements.

Medical Director

Qualifications: The designated medical director for Omaha National holds an unrestricted license to practice medicine in the State of California.

Scope: In compliance with LC § 4610 (g) (2) (A), Omaha National has designated a medical director to oversee the utilization review process. The medical director is responsible for all decisions made in the utilization review process and shall ensure that the processes by which Omaha National reviews and approves, modifies, or denies Requests for Authorization by physicians prior to, retrospectively, or concurrently with the provision of the medical services complies with the requirements of LC § 4610 and implementing regulations. The designated medical director's name, address, phone number and license number are set forth in attachment "A".

Physician Reviewers

Qualifications: Physician reviewers are medical doctors, doctors of osteopathy, psychologists, acupuncturists, optometrists, dentists, podiatrists, or chiropractic practitioners licensed in any state or the District of Columbia, are in active practice, and are Board Certified in their specialty, if applicable.

Scope: The physician reviewers may approve, modify, or deny authorization for medical treatment requests. A physician reviewer may request additional information that is necessary to render a decision. Only a physician reviewer who is 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, may modify, or deny, request for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury or due to incomplete or insufficient information.

Omaha National has designated a URAC-accredited third-party independent review organization to coordinate review of the requests of authorization by physician reviewers when internal staff are unable to approve a request for authorization. All physician reviewers are selected by the independent review organization. The independent review organization is required to comply with all state and federal statutory and regulatory requirements. The designated independent review organization's name, address and telephone number are set forth in Attachment "B".

Utilization Review Analysts

Qualifications: Omaha National's analysts will hold at least a high school diploma or equivalent and may be licensed professionals such as, registered nurses. They possess clinical experience and are knowledgeable in workers' compensation and medical management. They may hold additional certification, licensure or credentials corresponding to their responsibilities.

Scope: An analyst may approve requests for authorization of medical services. The analyst may discuss applicable criteria with the requesting physician should the treatment for which authorization is sought appears to be inconsistent with the criteria. In such an instance, the requesting physician may voluntarily withdraw a portion or all, of the treatment in question and submit an amended request for treatment authorization and the analyst may approve the amended treatment request. An analyst may also reasonably request appropriate additional information that is necessary to render a decision, in accordance with § 9792.9.1 (f). If an analyst cannot approve a request for authorization or if the requested information is not timely received, the analyst will refer the request for authorization to a physician reviewer. At no time shall an analyst modify or deny a request for authorization.

Utilization Review Specialists

Qualifications: Utilization review specialists are non-clinical support staff who hold at least a high school diploma or equivalent. Specialists may have some previous medical experience and/or undergo internal clinical medical training courses.

Scope: Specialists shall assist with telephone inquiries, obtain demographic information, facilitate workflow within the utilization review department and may be used to initially apply specified criteria to a request for authorization for medical services.

A specialist may approve requests for authorization for medical services. A specialist may discuss applicable criteria with the requesting physician should the treatment for which authorization is sought appears to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all, of the treatment in question and submit an amended request for treatment authorization and the specialist may approve the amended treatment request. A specialist may also reasonably request appropriate additional information that is necessary to render a decision, in accordance with § 9792.9.1 (f). If a specialist cannot approve a request for authorization or if the requested information is not timely received, the specialist reviewer will refer the request for authorization to an analyst. At no time shall a specialist modify or deny a request for authorization.

Utilization Review Supervisors

Qualifications: Supervisors will hold at least a high school diploma or equivalent, with at least 3 years of clinical experience and may hold professional licensure or advance degree.

Scope: Supervisors are responsible for day-to-day task management of the utilization review process, ensuring timely and quality reviews.

Supervisors may approve requests for authorization for medical services. Supervisors may discuss applicable criteria with the requesting physician should the treatment for which authorization is sought appears to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all, of the treatment in question and submit an amended request for treatment authorization and the Supervisor may approve the amended treatment request. A supervisor may also reasonably request appropriate additional information that is necessary to render a decision, in accordance with § 9792.9.1 (f). If a supervisor cannot approve a request for authorization, or if the requested information is not timely received, the supervisor will refer the request for authorization to a physician reviewer. At no time shall a supervisor modify or deny a request for authorization.

Utilization Review Manager/Medical Services Manager

Qualifications: Managers will hold at least a high school diploma or equivalent, with at least 3 years of clinical experience, and may hold professional licensure or advance degree.

Scope: Managers are responsible for the utilization review department staff, training, and education.

The managers may approve requests for authorization for medical services. Managers may discuss applicable criteria with the requesting physician should the treatment for which authorization is sought appears to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion, or all, of the treatment in question and submit an amended request for treatment authorization and managers may approve the amended treatment request. Managers may also reasonably request appropriate additional information that is necessary to render a decision, in accordance with § 9792.9.1 (f). If a manager cannot approve a request for authorization or if the requested information is not timely received, the manager will refer the request for authorization to a physician reviewer. At no time shall a manager modify or deny a request for authorization.

Disputed Liability for Injury/Recommended Treatment

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.

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 Complete 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 under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board
5) The written decision shall include the mandatory language set forth in CCR § 9792.9.1 (b) (1) (E):

   "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.

Requests for Authorization

The Utilization Review process begins when a complete request for authorization is received by Omaha National. Treatment Requests must be submitted in writing on a Request for Authorization DWC form RFA. The RFA form must be complete, submitted with documentation substantiating the medical necessity of the treatment, and signed by the treating physician. The request for authorization form may be sent via mail, facsimile or email to the addresses designated below:

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

Facsimile: 1.844.761.8400
This toll-free facsimile number is available 24 hours a day, including weekends and holidays.

Email: documents@omahanational.com

Omaha National will not accept or respond to requests for authorization submitted to any other mailing address, facsimile number, nor requests for authorization that are submitted via electronic billing systems. All requests for authorization must be submitted separately from bills for service.

Omaha National may, at its sole discretion, accept a misdirected RFA that is otherwise complete but is not required to do so, and acceptance will not be a waiver of the requirement to submit RFAs to the appropriate address or fax number.

Upon receipt of a request for authorization, the request will be reviewed by the claims adjuster and/or utilization review staff, to ensure all appropriate information has been submitted. If the request fails to include the demographics of the employee/provider, specific treatment being requested, supporting documentation for the treatment request or requesting physician signature, the request is deemed not complete. Omaha National may return it to the requesting physician marked "not complete", specifying the reason for the return of the RFA, no later than 5 business days from the receipt of the treatment request. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a complete request for authorization.

At Omaha National's discretion, a request for authorization not utilizing the DWC RFA form, may be accepted (but is not required to do so) provided (1) The first page of the document containing the Treatment Request clearly includes the words "Request for Authorization" at the top of the first page, (2) All requested medical services, goods or items are listed on the first page of the document and (3) the treatment request is accompanied by documentation substantiating the medical necessity of the requested treatment.

The DWC Form RFA shall be deemed to have been received by Omaha National 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: The date of receipt will be deemed to have been the date stamp, as received by Omaha National. 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 unless the request for authorization is sent via 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. 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.

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. 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.

Omaha National does not have prior authorization protocol. All non-emergency services require Prospective or Concurrent review, except as previously indicated.

Utilization Review

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 LC § 5307.27, by a member of the medical provider network or a health care organization, or by a physician predesignated pursuant to LC § 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. 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.

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.

Any medical treatment not addressed in the Medical Treatment Utilization Schedule is subject to prospective review or concurrent review, even if rendered in the first 30 days following the date of

injury. 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. 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.

Medical treatment rendered by a provider or physician that is not a member of the Omaha National medical provider network or predesignated Physician, is subject to prospective or concurrent review, regardless, if rendered within 30 days of the date of injury.

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.

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 complete 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 complete DWC Form RFA. These timeframes apply unless additional information is requested necessitating a timeframe extension, as described below.

Review Types

Standard Reviews – Prospective

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 and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of receipt of medical treatment recommendation from the physician.

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.

Concurrent Reviews

Except for treatment requests made pursuant to the formulary, 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 and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of receipt of medical treatment recommendation from the physician. Concurrent 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.

Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve the effects of the industrial injury. 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.

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).

Medication Requests

Medications prescribed or dispensed to treat work-related injury or illness are subject to the Medical Treatment Utilization Schedule, including the drug formulary. 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.

Exempt Drugs

Except as indicated below, an exempt drug may be dispensed to the injured worker without obtaining authorization through prospective review, concurrent Review or expedited Review, IF the drug treatment is in accordance with the Medical Treatment Utilization Schedule-Formulary.

Brand name Drugs

Prospective or concurrent review is required before an exempt brand name drug is dispensed when a less costly therapeutically equivalent generic drug exists.

Physician Dispensed Drugs

Exempt drugs dispensed by a physician must be authorized through prospective or concurrent review prior to being dispensed EXCEPT when allowed per special fill rules on the Medical Treatment Utilization Schedule-Formulary and in accordance with the Medical Treatment Utilization Schedule.

Compound Medications require authorization through prospective or concurrent review prior to dispensing.

Non-Exempt and Unlisted Drugs

Except as indicated on the Medical Treatment Utilization Schedule-Formulary with "special fill drugs" and "perioperative fill drugs", authorization through prospective Review or concurrent review must be obtained prior to a non-Exempt or a non-listed drug on the Medical Treatment Utilization Schedule-Formulary being dispensed.

If a medical provider prescribes a brand name drug when a less costly therapeutically equivalent generic drug exists and writes "Do Not Substitute" or "Dispense as Written" (DAW) on the prescription, the provider must document the medical necessity for prescribing the name brand in the patient's medical chart as well as in the submitted documentation on the Doctors' First Report of Occupational Injury or Illness or the Primary Treating Physicians Progress Report. The documentation must include patient specific factors that support the providers' determination that name brand is medically necessary.

Compounded Drugs

If the medical provider prescribes or dispenses a compounded drug instead of another drug, the medical provider must document the medical necessity in the patient's medical chart as well as in the submitted documentation on the Doctors' First Report of Occupational Injury or Illness or the Primary Treating Physicians Progress Report. The documentation must include patient specific factors that support the providers' determination that the compounded drug is medically necessary.

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, Omaha National may reasonably request additional information necessary to review the request for authorization as described in 8 CCR

§9792.9.1 (f)(1):
The timeframe for decisions specified in subdivision (c) may only be extended under one or more of the following circumstances:

> (A) The claims administrator or reviewer is not in receipt of all of the information reasonably necessary to make a determination

(B) The 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

(C) The reviewer needs a specialized consultation and review of medical information by an expert reviewer.

(2)(A) If the circumstance under subdivision (f)(1)(A) applies, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization.

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

(3)(A) If the information reasonably necessary to make a determination under subdivision (f)(1)(A) that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

(B) If the results of the additional examination or test required under subdivision (f)(1)(B), or the specialized consultation under subdivision (f)(1)(C), that is requested by the reviewer under this subdivision is not received within 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.

A physician reviewer, utilization review analyst, specialist, supervisor or manager shall submit a written request for information to the requesting provider within 5 business days from the date of receipt of the complete request for authorization.

Upon receipt of the information requested, for a prospective or concurrent review, the utilization review analyst/specialist/supervisor or manager shall make a decision to approve, or the physician reviewer shall make the decision to approve, modify or deny the request within 5 business days.

Upon receipt of the information requested, for an expedited review, the utilization review analyst/specialist/supervisor or manager shall make a decision to approve, or the physician reviewer shall make the decision to approve, modify or deny the request within 72 hours.

Upon receipt of the information requested, for a retrospective review, the utilization review analyst/specialist/supervisor or manager shall make a decision to approve, or the physician reviewer shall make the decision to approve, modify or deny the request within 30 days of the receipt of the request for authorization and medical information necessary to make a determination.

If the information requested by the physician reviewer, utilization review analyst/specialist/supervisor/manager, is not received within 14 (fourteen) days from the receipt of the completed request for authorization for prospective or concurrent review or within 30 (thirty) days of the request for the retrospective review, the reviewer shall deny the request with the stated

condition that the request will be reconsidered upon receipt of the information, specialized consultation or testing.

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 telephone, facsimile, mail, or e-mail.

Notification of Utilization Review Determination

Approvals

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

For prospective review, concurrent review, or expedited review, approvals shall be 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 business days for prospective review.

For retrospective review, 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.

Payment, or partial payment, of a medical bill for services requested on the request for authorization, within the 30-day timeframe for retrospective review, 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 employee who received the medical services, and his or her attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

Modifications and Denials

For prospective review, concurrent review, or expedited review, a decision to modify or deny shall be 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, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, within 24 hours of the decision for concurrent review and within 2 business days for prospective review and for expedited review within 72 hours of receipt of the complete request for authorization.

For retrospective review, a written decision to deny part or all, of 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 complete request for authorization and medical information that is reasonably necessary to make a determination.

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 an attorney, the injured worker's attorney. The written decision shall be signed by either Omaha National or the physician Reviewer, and shall contain the following information specific to the request:

1) The date on which the complete request for authorization was first received.
2) If applicable, the date on which information requested pursuant to CCR § 9792.9.1(f) was received.
3) The date on which the decision is made.
4) A description of the specific course of proposed medical treatment for which authorization was requested.
5) A list of all medical records reviewed.
6) A specific description of the medical treatment service approved, if any.
7) A clear, concise, and appropriate explanation of the reason for the Physician 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 CCR § 9792.8.
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, a specific description of the information that is needed, the date(s) and time(s) of attempts made to contact the physician to obtain the necessary information, and a description of the manner in which the request was communicated. The decision shall include the stated condition that the request for authorization will be reconsidered upon receipt of the information.
9) Enclose an application for Independent Medical Review (DWC Form IMR). All fields of the form, except the signature of the employee, must be completed by Omaha National. The written decision provided to the injured worker shall include an addressed envelope for mailing to the Administrative Director or his or her designee.
10) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of LC §§ 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 10 calendar days after the service of the utilization review decision to the employee for formulary disputes, and within 30 calendar days after service of the utilization review decision to the employee for all other medical treatment disputes.
11) Include the mandatory language set forth in CCR § 9792.9.1(e)(5)(I).

> "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."

12) The written decision modifying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the physician reviewer, and the telephone number in the United States of the physician reviewer. The written decision shall also disclose the hours of availability of either the physician reviewer or the medical director for the requesting physician to discuss the decision, which shall be, at a minimum, 4 hours per week during normal business hours, 9:00 AM to 5:30 PM, Pacific Time or an agreed upon scheduled time to discuss the decision with the requesting physician. In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer is who competent to evaluate the specific clinical issues involved in the medical treatment services.
13) If the injured worker's condition or injury is not addressed by the Medical Treatment Utilization Schedule or the Medical Treatment Utilization Schedule's presumption of correctness is being challenged, the physician reviewer shall provide in the written decision modifying or denying treatment authorization a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury. The citation provided by the physician reviewer shall be the primary source relied upon which he or she believes contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury. If the physician reviewer provides more than one citation, a narrative shall be included by the physician reviewer in the utilization review decision explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

Duration of Utilization Review Determination

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, in 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 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.

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.

Omaha National shall have no liability for medical treatment furnished without the authorization of Omaha National if the treatment is modified or denied by a utilization review decision unless the utilization review decision is overturned by an independent medical review or the Workers' Compensation Appeals Board.

There are two procedures available to resolve the dispute:

1) Omaha National voluntary internal utilization review appeal process
2) Independent Medical Review

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.

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

The physician 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.

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.

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 written utilization review determination issued by Omaha National to the injured worker.
2) For all other medical treatment disputes, thirty (30) calendar days after the service of the written utilization review determination issued by Omaha National to the injured worker.
3) If at the time of a utilization Review Decision, Omaha National is also disputing liability for the treatment besides medical necessity, the time for the employee to submit an application for independent medical review is extended to thirty (30) days after service of a notice to the employee showing that the dispute of liability has been resolved.

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.

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.

Omaha National shall provide the independent medical review organization the following documents within 15 days following the mailing of the notification from the independent medical review organization 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.
3) A copy of all information, including correspondence, provided to the injured worker by Omaha National 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 Omaha National in support of the request for the disputed medical treatment.

5) A copy of any other relevant documents or information used by the Omaha National in determining whether the disputed treatment should have been provided, and any statements by Omaha National explaining the reasons for the decision to deny or modify the recommended treatment based on medical necessity.
6) Omaha National's response to any additional issues raised in the injured worker's application for independent medical review.

Omaha National shall, concurrent with providing documents to the independent medical review organization, forward to the injured worker or the injured worker's representative a notification that lists all documents submitted to the independent medical review organization 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 § 123115(b).

Any newly developed or discovered relevant medical records in the possession of Omaha National after the listed documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. 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 independent medical review organization 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.

Termination of Independent Medical Review

Omaha National may terminate the independent medical review process at any time upon written notice to the independent medical review organization that the disputed medical treatment has been authorized, in the event that settlement or award resolves the disputed medical treatment or the physician withdraws the request for authorization while the Independent Medical Review is pending.

The final determination issued by the independent medical review organization 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 § 9792.10.7 (c) or liability for treatment is disputed as described in § 9792.10.7(a)(3). Implementation of the final determination shall be deferred until the liability dispute has been resolved.

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 § 4603.2 to 4603.6, inclusive.

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.

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 independent medical review by a different independent review organization, 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 independent review organization for review by a different reviewer in the organization.

Request for Utilization Review Plan

Omaha National's utilization review plan is available at www.omahanational.com. The plan is available upon request in hard copy, for a reasonable copying and postage fee that shall not exceed $0.25 per page plus actual postage costs.

Privacy

Omaha National does not disclose personal information, except as required or allowed by law. We authorize our workers, agents, outside vendors and others to access personal information only when they have a business reason to do so. We have physical, electronic, and procedural safeguards to protect personal information from unauthorized access.

Attachment A

Avrom Gart, MD
P&S Network, Inc.
8447 Wilshire Blvd. #202
Beverly Hills, CA 90211

Telephone: 323-556-0555
Fax: 323-556-0556

Board Certified Pain Medicine
Board Certified PM&R
Licensure: 59372, CO-0045996, CT-64820, KY-57093, LA-206746, MS-23829, NY-158934, OK-35596, TN-45545, TX-N0778

Attachment B

Physicians and Surgeons Network
(P&S Network, Inc.)
8447 Wilshire Blvd. #202
Beverly Hills, CA 90211

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