Illinois
Utilization Review Plan

(Effective 6/26/2023)

PO Box 451139

Omaha, NE 68145

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 820 ILCS 305/8.7.

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 Illinois 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 Illinois 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.

Definitions

"ACOEM": American College of Occupational and Environmental Medicine's Occupational Medicine Guidelines, most current edition.

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 or illness.

Business Days: For the purposes of this policy, business days are defined as any day not defined as a holiday or an optional bank holiday within this State.

Claims Adjustor: Staff employed by Omaha National to investigate claims resulting from work-related injury or illness. Claims adjustors may review treatment request to render coverage determinations. Claims adjustors may not make medical necessity determinations for treatment requests and at no time shall deny or modify a treatment request.

Claims Administrator: Omaha National Underwriters, LLC (Omaha National). The Claims Administrator may utilize an entity contracted to conduct its utilization review responsibilities.

Concurrent Review: Utilization review conducted during an inpatient stay.

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.

Emergency Health Care Services: Healthcare services for a medical condition of sufficient severity that without immediate medical attention could 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. Criteria utilized to evaluate treatment requests (includes ODG-Official Disability Guidelines) for medical necessity.

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. Omaha National utilizes a third-party vendor for these types of requests.

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.

Immediately: Within 24 hours of receipt.

Medical Director: A physician and surgeon employed by or designated by Omaha National who holds an unrestricted license to practice medicine. 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.

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

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.

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

Retrospective Review: Utilization review conducted after medical services have been provided and for which approval has not already been given. When making retrospective determinations, the review shall base the review solely on medical information available to the attending physician or ordering provider at the time the health care services were provided.

Treatment request: A written request for a specific course of proposed medical treatment. Oral request for treatment must be followed by written confirmation of the request within seventy-two (72) hours. "Request for Authorization" is synonymous with "Treatment request".

Utilization Review: The evaluation of proposed or provided health care services to determine the appropriateness of both the level of health care services medically necessary and the quality of health care services provided to a patient, including evaluation of their efficiency, efficacy, and appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. The evaluation must be accomplished by means of a system that identifies the utilization of health care services based on standards of care of nationally recognized peer review guidelines as well as nationally recognized treatment guidelines and evidence-based medicine based upon standards as provided in this Act. Utilization techniques may include prospective review, second opinions, concurrent review, discharge planning, peer review, independent medical examinations, and retrospective review (for purposes of this sentence, retrospective review shall be applicable to services rendered on or after July 20, 2005). Nothing in this Section applies to prospective review of necessary first aid or emergency treatment.

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, prior to, retrospectively, or concurrent with the provision of medical treatment services.

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 ACOEM, ODG or other evidence-based medicine guidelines. Treatment requests will be assessed by the Claims Adjuster to determine coverage but will not make medical necessity determinations. Claims Adjusters may certify treatment requests based on previous determinations or when a medical necessity review is not required. If a medical necessity determination is necessary and is subject to Omaha National's Utilization Review Process, the Claims Adjuster will refer the treatment request to the Utilization Review process and issue a written notice to the requesting provider that Utilization Review is being invoked. The requesting provider must then comply with the Utilization Review Process.

Once determined that a medical necessity review is necessary, the treatment request will be referred to Utilization Review. If Utilization review staff are unable to determine the medical necessity of the request, the request is sent to a Peer Reviewer or Expert Peer Reviewer.

Personnel, Qualifications, and Scope

Omaha National shall ensure adequate staffing to implement and manage the Utilization Review Process in a manner consistent with applicable regulatory requirements.

Medical Director

Qualifications: The designated Medical Director for Omaha National holds an unrestricted license to practice medicine.

Scope: 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 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. 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. 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.

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. 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. 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.

Treatment requests/Requests for Authorization

The Utilization Review process begins when a Request for Authorization is referred into the Utilization review process. Treatment Requests must be submitted in writing with proper demographic information, clearly defining the requested treatment, submitted with documentation substantiating the medical necessity of the treatment, and signed by the treating physician. The treatment requests/request for authorization 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: 1.844.761.8402
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 treatment request that is otherwise complete, but is not required to do so, and acceptance will not be a waiver of the requirement to submit requests for authorization to the appropriate address or fax number.

Upon receipt of a Request for Authorization, the request will be reviewed by the Claims adjustor to determine coverage and given the scope of decision-making authority of the Claims adjustor. If the Claims adjustor determines coverage is available and a determination of medical necessity is needed, the treatment request will be forwarded to utilization review to begin the utilization review process. Omaha National will notify the provider that utilization review is being invoked.

Upon receipt of written notice that the employer or the employer's agent or insurer wishes to invoke the utilization review process, the provider of medical, surgical, or hospital services shall submit to the utilization review, following accredited procedural guidelines. The provider shall make reasonable efforts to provide timely and complete reports of clinical information needed to support a request for treatment. If the provider fails to make such reasonable efforts, the charges for the treatment or service may not be compensable nor collectible by the provider or claimant from the employer, the employer's agent, or the employee. Written notice of utilization review decisions, including the clinical rationale for certification or non-certification and references to applicable standards of care or evidence-based medical guidelines, shall be furnished to the provider and employee.

Receipt date

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 request for authorization transmitted after 5:30 PM Central Standard 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 submitted request.
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 request for authorization shall be deemed to have been received five days after the latest date the sender wrote on the document.

Mail, facsimile, or emails received after 5:30pm CST are considered received the following business day.

Omaha National shall maintain toll-free telephone access and have a representative personally available by telephone from the hours of 8:00 AM to 6:00 PM Central Standard Time (CST) 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.

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.

Review Types

Omaha National conducts Expedited, Prospective, Concurrent and Retrospective reviews according to the Utilization review process. Decisions for Prospective and Concurrent review requests 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 treatment request and supporting information reasonably necessary to make the determination.

Expedited Reviews

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).

Prospective and Concurrent Reviews

A request for authorization related to a prospective or concurrent review, 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 after the receipt of the written request.

For Concurrent reviews, medical care shall not be discontinued or denied until the requesting physician and the provider of goods or services, identified in the treatment request, have been notified of the decision and a plan has been agreed upon by the requesting physician. The agreed plan must be appropriate for the medical needs of the injured employee and consistent with evidence-based medicine guidelines, that may include ACOEM.

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. Retrospective review may be invoked with by the Claims adjustor or medical bill review. If a retrospective review for medical necessity is requested, the provider will be notified that the utilization process has been invoked.

Timeframe Extensions

If Omaha National is not in receipt of the information reasonably necessary to make the determination, then the Utilization review staff will attempt to obtain the necessary information via telephone and/or a request for information letter issued to the requesting provider. 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, within 24 hours of the decision and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail.

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 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.
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) 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. 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.

Treatment Guidelines

Omaha National will use the latest version of ACOEM as well as ODG (Official Disability Guidelines), as the primary sources of guidance for treating physicians and physician Reviewers for the evaluation and treatment of medical care for all injured workers diagnosed with work-related conditions, except in specific circumstances addressed herein.

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

There are two procedures available to resolve the dispute:

1) Omaha National Voluntary Internal Utilization Review Appeal Process
2) 820 ILCS 305

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.

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.

Use of the voluntary internal appeals process does not preclude the ability for dispute resolution for unapproved medical treatment within 820 ILCS 305.

820 ILCS 305/8.7 (i)(4)

When payment for medical services has been denied or not authorized by an employer or when authorization for medical services is denied pursuant to utilization review, the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standards of care used by the person or entity performing the utilization review pursuant to subsection (a) is reasonably required to cure or relieve the effects of his or her injury.

Testimony of reviewer

The medical professional responsible for review in the final stage of utilization review or any appeal must be available in this State for interview or deposition; or must be available for deposition by telephone, video conference or other remote electronic means. A medical professional who works or works or resides in this State or outside of this State my comply with this requirement by making himself or herself available for an interview or deposition in person or by making himself or herself available by telephone, video conference or other remote electronic means.

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.

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.

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

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