

Zurich Services Corporation
ZSC URA #036
April 1, 2026

**California Utilization Review Plan
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Utilization Review Contacts

All questions or concerns regarding this plan should be directed to:

Primary Contact

Susan Bolster
Senior Compliance Advisor
Zurich North America
1299 Zurich Way
Schaumburg, IL 60196
Telephone: 847-413-5282
FAX: 224-539-9639
susan.bolster@zurichna.com

Backup Contact

Leah Montoya, MHA, BSN, RN
AVP – Pharmacy & Utilization Review
Zurich North America
1299 Zurich Way
Schaumburg, IL 60196
Telephone: 847-330-3127
leah.montoya@zurichna.com

Utilization Review Plan

Copy Request

Zurich Services Corporation shall make available the complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process to the public upon request.

If a member of the public requests a hard copy of the utilization review plan, Zurich Services Corporation may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed \$0.25 per page plus actual postage costs.

Material Modifications to the Utilization Review Plan

For purposes of this Utilization Review Plan, a “material modification” includes, but is not limited to, changes in the medical director, address, company name, corporate structure, or makes changes to the utilization review standards specified in 9792.7.

All material modifications shall be filed with the Administrative Director within thirty (30) calendar days of implementation and shall include certification that the Utilization Review Plan continues to meet all applicable statutory and regulatory requirements.

List of Insurers

Below is a list of the Insurers Zurich Services Corporation is contracted with:

American Guarantee & Liability Insurance Company
 American Zurich Insurance Company
 Zurich American Insurance Company
 Zurich American Insurance Company of Illinois
 Fidelity & Deposit Company of Maryland
 Universal Underwriters Insurance Company

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Zurich Services Corporation UTILIZATION REVIEW – OVERVIEW

(TO BE DISTRIBUTED TO EMPLOYERS/EMPLOYEES)



The Utilization Review Program within the Managed Care Department supports the goals through the prospective, concurrent and retrospective review of specified healthcare services. This process is carried out by Utilization Review Specialists who are licensed Registered Nurses (RN's).

The Utilization Review Unit has a California licensed, board-certified physician who is the medical director. The medical director is responsible for all decisions made in the Utilization Review Process and will oversee the operation of the program to include:

- Peer review of referred cases,
- Directing of alternative services,
- Non-certify the requests.

Communication between the Utilization Review Specialists, Claim Professional, Medical Case Managers and Quality Management Unit is critical in maximizing the appropriate utilization of healthcare services while managing medical costs.

Essential elements to achieving excellence in this program include:

- Expert clinical judgment, decision making and negotiation skills
- Strong written and verbal communication skills
- Consistent and prudent application of utilization protocols and nationally recognized medical criteria
- Knowledge of state regulations

Definitions:

- (a) **“Authorization”** means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed “Request for Authorization,” as defined in this section, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, sections 9792.9.1 through 9792.12.
- (b) **“Claims Administrator”** is a self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). “Claims Administrator” includes any utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.
- (c) **“Concurrent Review”** means utilization review conducted during an inpatient stay.
- (d) **“Course of Treatment”** means the course of medical treatment set forth in the treatment plan contained on the “Doctor's First Report of Occupational Injury or Illness,” DIR Form 5021, found at California Code of Regulations, title 8, section 14006.1, or on the applicable physician reporting forms authorized by section 9785.

(e) **Reserved**

- (f) **“Denial”** means a decision by a physician reviewer that the requested treatment or service is not authorized.
- (g) **“Dispute Liability”** means an assertion by the claims administrator that a factual, medical, or legal basis exists, other than medical necessity, that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.
- (h) **“Disputed Medical Treatment”** means medical treatment that has been modified or denied by a utilization review decision.
- (i) **“Emergency Health Care Services”** means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.
- (j) **“Expedited Review”** means utilization review or independent medical review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.
- (k) **“Expert Reviewer”** means 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, whose consultation for a specialized review has been requested by the claims administrator or utilization review organization, necessitating an extension of time, under section 9792.9.6, prior to the determination of medical necessity.
- (l) **“Health Care Provider”** means a provider of medical services, as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.
- (m) **“Immediately”** means within one business day.
- (n) **“Material Modification”** is when the claims administrator changes utilization review vendor(s); makes a change to the utilization review standards as specified in section 9792.7; or changes its medical director, address, company name or corporate structure.
- (o) **“Medical Director”** is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California. The medical director is responsible for all decisions made in the utilization review process.
- (p) **“Medical Services”** means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

- (q) **“Medical Treatment Utilization Schedule”** means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20.
- (r) **“Modification”** means a decision by a physician reviewer that part of the requested treatment or service is not medically necessary.
- (s) **“MTUS Drug Formulary”** means the drug formulary adopted by the Administrative Director under Labor Code section 5307.27 and defined in section 9792.27.1(m). The MTUS Drug Formulary contains the MTUS Drug List, which is set forth in section 9792.27.15.
- (t) **“Prospective Review”** means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services.
- (u) **“Request for Authorization”** means a written request for a specific course of proposed medical treatment that meets all of the following criteria:
- (1) Unless accepted by a claims administrator under section 9792.9.1(b), a request for authorization must be set forth on a “Request for Authorization (DWC Form RFA)” as contained in California Code of Regulations (CCR), title 8, section 9785.5, completed by a treating physician and as further outlined in this subdivision and in section 9785(h).
 - (2) “Completed,” for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization identifies both the employee and the requesting provider; identifies with specificity all the recommended treatments in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used; and is accompanied by documentation, issued or created no earlier than 30 days before the date of submission of the request for authorization, that substantiates the need for the requested treatment. A request for authorization shall be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.6.
 - (3) The request for authorization must be signed by the treating physician and may be mailed, faxed, or, if available, sent electronically through the use of an encrypted email system or via electronic data interchange (EDI) to the address, fax number, e-mail address, or clearinghouse designated by the claims administrator under section 9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.
- (v) **“Retrospective Review”** means utilization review conducted after medical services have been provided and for which approval has not already been given.
- (w)(1) **“Reviewer” or “Physician Reviewer”** means 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 or physician reviewer's practice.
- (2) **“Non-Physician Reviewer”** means an individual designated by the claims administrator or utilization review organization to assist in determining the medical necessity of the requested treatment. A non-physician reviewer may not modify or deny a treatment request.
- (x) **“URAC”** is the non-profit organization, located at 1220 L Street, NW, Suite 900, Washington, D.C., 20005, or as indicated online at www.urac.org, that provides accreditation for workers' compensation utilization review programs.
- (y) **“Utilization Review Decision”** means a decision pursuant to Labor Code section 4610 to approve, modify, or deny, a treatment recommendation or recommendations by a physician prior

to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code sections 4600 or 5402(c).

- (z) **“Utilization Review Plan”** means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.
- (aa) **“Utilization review process”** means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. The utilization review process begins when a completed request for authorization, or a request for authorization accepted as complete under section 9792.9.1(b), is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.
- (bb) **“Written”** includes a communication transmitted by facsimile or in paper form. Electronic mail or electronic data interchange (EDI) may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail or by EDI, unless sent through the use of an encrypted electronic mail or EDI system.
- (cc) **“Normal business day” or “business day”** does not include Saturday, Sunday, or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website.
- (dd) **“Working day”** as used in this article is the same as “business day” or “normal business day.”

Our Process:

The Utilization Review Unit has a California licensed, board-certified physician who is the medical director. The medical director is responsible for all decisions made in the Utilization Review Process and will oversee the operation of the program to include:

- Peer review of referred cases,
- Directing of alternative services,
- Non-certification of the requests.

Communication between the Utilization Review Specialists, Claim Professional, Medical Case Managers and Quality Management Unit is critical in maximizing the appropriate utilization of healthcare services while managing medical costs.

Essential elements to achieving excellence in this program include:

- Expert clinical judgment, decision making and negotiation skills
- Strong written and verbal communication skills
- Consistent and prudent application of utilization protocols and nationally recognized medical criteria
- knowledge of state regulations

Hours of Operation

The Utilization Review Unit will have representatives available to answer telephone calls and receive utilization requests Monday through Friday from 9 a.m. to 5:30 p.m. (PST) **(except holidays)** through a dedicated toll free 800 number. A voice mail system will be available during these hours as well as

after hours and on weekends; messages received will be returned within 24 hours or next business day.

Physician reviewers and advisors are available from 9:00 a.m. to 5:30 p.m. (PST) (except holidays).

Precertification Process

A treating physician may render medically necessary treatment or services to an injured worker without prospective utilization review during the first thirty (30) days after the date of injury, if all of the following conditions are met:

- The treatment or service is for a body part or condition accepted as compensable by the claims administrator;
- The treatment or service is consistent with the recommendations of the applicable Medical Treatment Utilization Schedule guideline;
- The initial treating physician timely submits the Doctor's First Report of Occupational Injury or Illness (DIR Form 5021), setting forth in detail the anticipated treatment plan;
- All treatment or services anticipated during the first 30 days, including exempt drugs under the MTUS Drug Formulary, are set forth in a Request for Authorization submitted concurrent with the Doctor's First Report;
- Subsequent treating physicians submit a Request for Authorization following their first visit with the injured worker;
- Medical treatment bills for non-emergency treatment are submitted within thirty (30) days of the date the service was provided, and emergency treatment bills are submitted within one hundred eighty (180) days.

Specific services are excluded from "30-day" exemption:

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

- Nonemergency surgery and surgical services
- Psychological/psychiatric treatment
- Physical therapy, occupational therapy, and chiropractic care exceeding the caps in Labor Code section 4604.5
- Home health care services
- Inpatient or outpatient hospitalization
- Electrodiagnostic medicine studies (e.g., EMG, nerve conduction studies)
- Durable medical equipment, prosthetics, orthotics and supplies where the purchase or rental cost of item with necessary supplies is greater than \$250
- Any treatment or service specifically listed as excluded under the Medical Treatment Utilization Schedule (MTUS) or applicable regulations
- Imaging and radiology services excluding x-rays
- Pharmaceuticals not expressly exempt from prospective review under MTUS Drug Formulary.
- Spinal injections including therapeutic medial branch nerve blocks, facet joint injections, intradiscal injections, epidural injections and sacroiliac joint injections.

Note: Always refer to the most current version of Title 8, CCR, section 9792.9.7 for a full and up-to-date list of excluded services.

Time frames and Definitions:

Types of Reviews	Short description	Timeline to complete the review
Prospective (Precertification) Review	A Utilization Review that occurs prior to receiving the requested treatment.	5 business days
Concurrent Review	A Utilization Review conducted during an inpatient stay.	5 business days
Retrospective Review	A Utilization Review conducted after medical services have been provided and for which approval has not already been given.	30 business days
Rush / Expedited Review	A Utilization Review that is completed on an expedited basis.	Not to exceed 72 hours after receipt of the written information reasonably necessary to make the determination, when the requesting physician certifies the need for expedited review.
Expedited appeal	An appeal that is completed on an expedited basis.	24 hours
Internal Appeal	A new review of a UR review that was previously non-certified.	10 working days

Emergency Care:

Emergency health care services do not require Utilization Review but may be reviewed retrospectively.

Reviewers:

Non-Physician Reviewers – means an individual designated by the claims administrator or utilization review organization to assist in determining the medical necessity of requested treatment. A non-physician reviewer **may not modify or deny** a Request for Authorization.

Physician Advisors - means a physician engaged by or on behalf of the claims administrator or utilization review organization to evaluate requests for authorization in accordance with applicable utilization review standards. Physician Advisors maintain a current license to practice medicine in at least one US State or the District of Columbia.

Fax Number:

This fax number can be used at any time 224-539-9639.

Notification through the 1-800 Utilization Review Unit number or through our fax number can be initiated by the Claim File Handler, the Medical Nurse Case Manager or the Treating Physician, hospital /

provider or the claimant any time an inpatient hospital stay, or outpatient services requires authorization.

Once the requested service is identified, a review is performed for both medical necessity and appropriateness of level of care. The Utilization Review Specialist gathers all pertinent clinical information from the treating physician's office. The clinical information is then compared with the CA adopted Medical Treatment Utilization Schedule.

Annual Review of Guidelines:

On an annual basis, the medical director reviews and approves both MTUS and Official Disability Guidelines for appropriateness. As part of the review process, the medical director obtains input from contracted Physician Advisors. Any changes to the guidelines will be communicated as needed.

Communication:

All decisions will be communicated immediately by fax or telephone followed by a written confirmation within one business day (or in accordance with the jurisdictional requirements).

Site Classification:

Zurich Services Corporation is a single-site organization that directly manages its UR functions from this one location:

Zurich Services Corporation
1299 Zurich Way
Schaumburg, IL 60196-1056

Disputes:

Any dispute will be resolved in accordance with the provision of Labor Code 4610.5 and 4610.6.

ZSC Precertification List – if not allowed by MTUS for the injury treated, the following requires Prospective Review

- Biofeedback
- Chiropractic Care
- Dental
- Discograms
- Durable Medical Equipment (DME) Guidelines
 - Any DME request that is documented a 'custom' (e.g. custom knee brace; custom wrist splint/brace; custom orthotic) must be opened by the intake coordinator
 - All DME, rental or purchase, should be opened by the intake coordinator with the following exceptions:
 - DME where it is clearly documented that the purchase (not rental) price is <\$250
 - Canes
 - Commode
 - Crutches
 - Dressing/Bandage Supplies

- Walker
- Wheelchair (non-electric)
- Wrist Splint
- Any DME request, opened by the intake coordinator, and for which the nurse reviewer determines the purchase price to be <\$250 may be withdrawn, or reviewed, at the nurse reviewer's discretion
- All DME rental requests must be reviewed by the nurse reviewer
- All DME purchase requests for which the nurse reviewer determines the purchase price to be >\$250 must be reviewed by the nurse
- Electrodiagnostic studies (EMG/NCV/NCS)
- Experimental Procedures (e.g. IDET, VAX-D, Artificial Disks, etc.)
- Functional Capacity Evaluation (FCE)
- Hearing Aid and Equipment if > \$250
- Home Health Care (HHC) (Nursing Services) (e.g. SNV, HHA, PT)
- Hospital / Inpatient Length of Stay (LOS)
- Imaging Studies (e.g. MRI, CT, etc.) (Does not include 'simple' x-rays)
- Injections (epidural, facet, medial branch, SI joint, intradiscal)
- Investigational Procedures (e.g., IDET, VAX-D, Artificial Disks, etc.)
- Laboratory Work:
- Lab Work – Chromatography and Genetic Predisposition DNA Testing
- Lab Work - Comprehensive Drug Testing and Quantitative Urine Drug Testing
- Non-exempt MTUS Drug Formulary medications
- Myelograms
- Occupational Therapy (OT)
- Pain Management Evaluation/Treatment
- Personal Care Services (custodial care)
- Physical Therapy (PT)
- Psychiatric/Psychological Evaluation/Testing/Treatment
- Computerized Range of Motion Testing
- Sleep Study
- Surface EMGs
- Surgery - Inpatient
- Surgery - Outpatient
- TENS Unit Purchase
- TENS Unit Rental
- TENS supplies
- Vision Care Services if > \$500
- Vocational Rehabilitation Services (VRS)
- Weight Loss Programs
- Work Conditioning
- Work Hardening

Medical Director Contact

Zurich Services Corporation is under the direction of a California licensed physician that performs in accordance with Labor Code 4610.

Gideon Letz, M.D. Medical Director
1299 Zurich Way
Schaumburg, IL 60196
Work #: (415) 699-3180
Specialty-Occupational Medicine, Preventive Medicine
License # G 35503
Expires:11/30/2027

Clinical Reviewer/Physician Advisor

POSITION DESCRIPTION

Title: Clinical Reviewer/Physician Advisor Reports to: medical director

General Summary: Clinical Reviewers/Physician Advisors are board certified physician advisors with clinical experience in their areas of expertise. Physician Advisors may be asked to review cases for medical necessity of requested medical or surgical procedures.

Key Initiatives:

- Review cases for medical necessity of requested medical or surgical procedures.
- Process inquiries from jurisdictional authorities on Utilization Review Services for claimant.
- Assist in prioritizing identified issues and present alternative solutions.
- Reports when required jurisdictional outcomes on Utilization Review Services.
- Participates in the Quality Improvement Team and holds quarterly meetings.
- Determine appropriateness for medical necessity, using clinical judgment.
- Provides in-services on new technology or procedures when available.
- All clinical reviewer/physician advisors are available to providers during normal business hours from 9:00 a.m. to 5:30 p.m. (PST) (**except holidays**).

Qualifications/Skills/Experience:

- A valid, current, unrestricted state (or District of Columbia) license to practice medicine.
- Evidence of medical school graduation and completion of residency.
- Evidence of Board Certification (current, if termed, i.e., not lifetime) in a Board recognized by the American Academy of Specialty Boards.
- Current unrestricted DEA certificate (MD/DO)
- Knowledge and applied practice utilizing clinical guidelines and their applications. A physician may only deny/modify treatment within their scope of practice and competency.

Policy: Confidentiality of Individually Identifiable Health Information	Effective Date: 7/30/1998
Last Revision Date: 2/3/2026	

Definition: The Confidentiality policy refers to the procedures utilized for maintaining the privacy of sensitive medical information regarding injured workers (IW). Covered in this policy will be components related to ensuring claimant/patient confidentiality when using a cellular phone for case management activities and the signing of a confidentiality statement by personnel and delegated contractors performing activities for Zurich Services Corporation.

Purpose: The purpose of the confidentiality policy is to document in a clear, concise manner the details of how confidentiality for the IW is maintained.

Objective:

1. To establish that Medical Management Services has processes in place protecting the confidentiality of IW-specific and provider-specific information collected during the Medical Management process.
2. To establish guidelines when utilizing a cellular phone that would protect non-public information and confidentiality of material disclosed concerning a claimant/patient.
3. To establish that all personnel providing Medical Management services for Zurich Services Corporation have been reviewed and signed the confidentiality statement prior to being assigned any cases.

Procedure: Medical management has established a policy concerning confidentiality of client specific information, IW records, and injury-related information. The information gathered is to be utilized for conducting case management and evaluation activities related to the claim incident only.

The following procedures are followed when Medical Management personnel or delegated contractors handle confidential medical information and/or respond to requests for confidential medical information.

Prior to being assigned any Case Management files, each staff member employed by Zurich Services Corporation or delegated contractor is required to understand the responsibility to preserve confidentiality and to sign a statement addressing confidentiality of client specific information. A copy of this signed statement is placed in each staff member's respective personnel file. Delegated contractors' agreements are kept with Business Product and Development.

1. All Medical Management personnel or delegated contractors are expected to:
 - Be familiar with all Medical Management policies and procedures.
 - Adhere to all Medical Management policies and procedures.
 - Comply with applicable professional standards and ethics in all aspects of their business relationship with Medical Management.
2. All Medical Management staff or delegated contractors understand that, according to state and federal laws and as a general principle of professional ethics, disclosure of personal and medical information is prohibited unless a written release has been executed by the claimant/patient or his/her legal representation. Consent for release or disclosure of confidential document information is valid only to the extent and purpose stated in such document. Accordingly, such information is not released nor shared with any individual or organization, unless the release is mandated by the state workers' compensation statute; or the claimant/patient has authorized the release and only to the extent authorized. Client information is used only for conducting Medical Management

including evaluation activities:

All information obtained during the Medical Management process including Utilization Review, Physician Review will be utilized solely for the purpose of quality assurance, discharge planning, and Medical Management activities.

3. The Medical Management personnel contacting a provider will identify him/herself as a Zurich Services Corporation Medical Management/Utilization Reviewer/Physician and provide appropriate licensure information, if requested.
4. Some staff members are issued analog and digital phones, which can increase the ability to intercept communication and decrease capability of maintaining confidentiality of non-public information. There should be no expectation of privacy with the use of a cellular phone. Caution is warranted when utilizing cell phones.
 - A cellular phone should be utilized for emergency communications only to limit the risk of intercepted communications.
 - The staff using cellular phones should find secure areas where conversations cannot be overheard.
 - When staff uses a cellular phone, they should disclose that they are utilizing a cellular phone and need to avoid disclosing non-public information. A claim number or other generic identifiers are recommended to avoid disclosing the claimant/patient by name, social security number, etc.
 - Lengthy conversations should be avoided when possible.
 - Utilization of a secured line with a stationary phone at an office is recommended, rather than using a cellular phone.
 - Cellular phone numbers should not be stored, but rather, deleted upon completion of the call.
5. All communications and records transmitted or stored including cellular phone, fax, or electronic systems shall be protected:
 - A fax cover sheet with an approved confidentiality statement shall be used when medical information is faxed to outside parties.
 - All medical records and IW documents shall be mailed to the Data Distribution Center for scanning into the electronic claim file or exported directly to the electronic claim file. The electronic claim file can only be accessed by a confidential password and user ID.
 - No IW information shall be stored on cellular phones.
 - All worksheets, medical records, review forms, data entry forms and similar documents shall be protected from intentional or inadvertent and/or publication.
 - All materials which contain the IW identifiable information must be stored in a secure place that is not routinely accessible to unauthorized individuals.
 - All Medical Management staff that handle or process IW records have the responsibility to protect against disclosure and to store confidential IW medical information in a secure environment (such as locked cabinets or password protected computer data entry systems).
 - Records and other documents or materials shall not be removed from the designated work areas without specific written permission of Medical Management staff.
 - All information obtained and generated by the Medical Management staff members related to any aspect of the Medical Management process, will remain a permanent part of the electronic claim file.
 - Any materials not pertinent to the claim file will be disposed of by shredding the material within the unit.
 - Access to the database containing IW-specific information shall be restricted to authorized personnel.

6. The IW will be identified by name or identification number to the following:
 - The IW's attending physician and other treating providers.
 - The medical director who periodically is engaged as a consultant for the IW's specific medical.
 - The Claims Handler.
 - The Utilization Review Specialist.
 - The employer, insurer or third-party administration payer.
 - The Team Manager for operational monitoring and reviewing purposes.
 - Other selected providers who deliver specialized health care services to the IW (ex. – vocational counselor, etc.).
 - The Quality Manager.
7. IW information shall never be discussed among staff who have no legitimate business needs in accessing the claimant/patient specific information, and/or - in the presence of non-authorized people, inside or outside the Medical Management office, or unauthorized outside individuals, entities, or organizations.
8. All medical reports, written evaluations, billing statements, data compilations and similar documents shall be issued through and discussed by Medical Management personnel only.
9. All IW inquiries from an external individual/entity shall be answered only if the inquiry is from a previously identified and designated employee of an organization or entity that is authorized to receive IW information. Any IW record requests that are not routinely related to medical care or bill payment shall be in writing and signed by the requesting party.
 - The IWs have the right to obtain recorded personal information about them by sending a written request to the Medical Management Department.
 - The Medical Management Department management may be called upon to release confidential material to individual jurisdictional commissioners in compliance with state mandates. This material is to be gathered by management and sent to the jurisdictional commissioner marked "personal and confidential material included".
10. At times, it may be necessary to communicate with the IW through a third person, such as a relative, friend, or interpreter. When such communication is necessary, the information communicated and/or requested from the IW through that third party shall be limited to the basic essential facts (i.e., injury, diagnosis, treatment plan, and recovery process). There should never be a discussion or disclosure beyond such basic essential facts.
11. All data collected from the Medical Management process identifying a physician or provider, including quality review studies or performance tracking data, may not be published without prior written notice to the provider.
12. Any questions regarding confidentiality should be directed to the Team Manager.

External Members of Committees/Boards:

All members of committees and boards that are associated with Zurich must sign a confidentiality agreement.

Supplier Vendor

As part of new employee onboarding with supplier vendor staff shall attend HIPAA training and complete subsequent training annually.

References:

- Personally Owned Mobile Device (POMD) Policy
- Data Protection and Privacy Standard
- Information and Communication Systems Policy
- Annual Data Protection and Security Acknowledgement
- Managed Care Confidentiality Policy

Internal Employees:

Employees are required to sign a confidentiality agreement on the 1st day of hire. All new employees are required to take training in confidentiality and privacy. All employees are required to take subsequent training yearly.

Policy: Staff Qualifications	Effective Date: 7/30/1998
Last Revision Date: 2/3/2026	

Definition:

The Utilization Review staff qualifications policy refers to the procedures utilized for the hiring and maintaining of qualified staff performing utilization review.

Purpose:

To document in a clear, concise manner the details of the staff qualifications policy.

Objective:

To ensure that Utilization Review has processes in place to maintain a professional unit.

Qualifications:

The professional staff must have:

1. A nursing degree
2. RN Licensure with prior clinical practice experience
3. Maintain a current, valid, unrestricted, US Registered Professional Nurse license as required jurisdictionally.



CERTIFICATE OF AWARD

in recognition of

**The Zurich Services Corporation
1299 Zurich Way
Schaumburg, Illinois 60196**

for compliance with

**Workers' Compensation Utilization Management 8.1
Accreditation Program**

is awarded

Full Accreditation

Effective from 09/01/2024 through 09/01/2027

Shawn Griffin, MD
President & Chief Executive Officer

Certificate Number: WUM010022



ACCREDITED

URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation. URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC, and shall be returned upon request.

Policy: MTUS Guidelines	Effective Date: 3/24/1998
Last Revision Date: February 2026	

Definition:

The State Guideline Policy refers to the procedure to review specific guidelines provided by individual states in regard to the requested medical service for the claimant/patient. The state guidelines will be reviewed along with specific Clinical Management Criteria to render a decision of the appropriateness of the requested medical service.

Purpose:

To ensure that the review process includes utilization of state specific guidelines where applicable and is done in a consistent manner.

Objective:

To allow for clear clinical decision making to enhance claimant/patient care quality and promote timely and responsible return to work.

Procedure:

Utilization Review staff will rely on the Medical Treatment Utilization Schedule (MTUS) regulations Title 8, California Code of Regulations Sections 9792.20 - 9792.27 and any additional adopted sections of this guideline. Utilization Review nurses are provided access to Reed Group's MD Guidelines.

Medical Treatment Utilization Schedule. MTUS will be used to evaluate the appropriateness of the medical services requested. The guidelines can also be used to help determine if over- utilization of medical services has occurred. If the requested service falls outside of the MTUS guidelines or is not part of the guidelines, then Official Disability Guidelines will be utilized.

CA MTUS Drug Formulary: Drugs exempt from prospective review under the MTUS Drug Formulary may be dispensed without prior authorization. Special Fill and Perioperative Fill drugs dispensed per sections 9792.27.12-9792.27.13 are exempt from prospective review.

Drugs not covered by exemption, regardless of whether prescribed within the first 30 days after the date of injury, require prospective utilization review. Prospective decisions to approve, modify or deny a Request for Authorization of a Non-Exempt Drug shall be made within five (5) business days from the date or receipt of the request for treatment. Additional information reasonably necessary to make a determination may be requested:

- Within four (4) business days from the date of receipt of the Request for Authorization
- If the information is not received within five (5) business days from the date of the Request for Authorization, a physician review may deny the request in accordance with 9792.9.5.

A request for independent medical review of a utilization review decision that denies or modifies **only a drug** listed on the MTUS Drug Formulary must be filed within **ten (10) days** of service of the written utilization review decision. All other treatment disputes must be filed within **thirty (30) days** of service of the written utilization review decision.

Policy: Accessibility Procedure	Effective Date: 9/1997
Last Revision Date: 6-24-2026	

Definition:

The Accessibility Policy refers to the procedures by which the Utilization Review Department allows accessibility to its business operations.

Purpose:

To define the timeframes in which the unit is operational.

Objectives:

Provide access to the review unit staff during the business day nationwide. Provide after-hours responses to calls.

Procedure:

All telephone calls are accessed through toll free lines where the department staff is available and accessible Monday through Friday from 9:00 a.m. to 5:30 p.m. (PST) **(except holidays)**. Clinical Reviewers are available throughout this time period.

Physician Reviewers and the medical director are available Monday – Friday from 9:00 a.m.– 5:30 p.m. (PST) **(except holidays)** for Peer-to-Peer discussions regarding Utilization Reviews.

All written notices of adverse determination shall contain the available hours that a physician reviewer is available to discuss the written decision.

The toll-free line is 800-451-8731 and a toll-free fax line is 866-743-1660.

Callers after hours will receive a recorded message that will allow them to leave a message.

Policy: Prospective, Extension, Concurrent, and Retrospective Review – Authorizations/Approvals	Effective Date: 10/1995
Last Revision Date: 8/13/2026	

Definition:

This policy refers to the procedure utilized to promote cost effective and efficient use of healthcare services and/or treatments. These services can be delivered in an Inpatient or Outpatient setting.

“Concurrent Review” Concurrent review is conducted during an inpatient stay. The timeframe to complete a concurrent review is five (5) business days. For prospective, concurrent, or expedited review, determinations to approve, modify, or deny a request for authorization shall be communicated to the requesting physician within 24 hours of the decision via telephone, facsimile, or electronic mail. Written notice shall follow within 24 hours of the decision for concurrent review and within two (2) business days for prospective review, in accordance with 8 CCR §§ 9792.9.4(b) and 9792.9.5(c). In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker.

“Extension Review” Extension review occurs when there is a request for ongoing treatment or services beyond those previously authorized. The timeframe to complete an extension review is five (5) business days. For extension review, determinations to approve, modify, or deny a request for authorization shall be communicated to the requesting physician within 24 hours of the decision via telephone, facsimile, or electronic mail. Written notice shall follow within 24 hours of the decision.

“Prospective Review” Prospective utilization review (precertification) is conducted prior to the claimant/patient receiving the requested medical treatment. The timeframe to complete a prospective review is five (5) business days. For prospective, concurrent, or expedited review, determinations to approve, modify, or deny a request for authorization shall be communicated to the requesting physician within 24 hours of the decision via telephone, facsimile, or electronic mail. Written notice shall follow within 24 hours of the decision for concurrent review and within two (2) business days for prospective review, in accordance with 9792.9.4(b) and 9792.9.5(c).

“Retrospective Review” Retrospective utilization review is conducted after medical services have been provided and for which authorization has not previously been provided. For retrospective review, written determinations approving, modifying, or denying a request for authorization shall be issued to the requesting physician who provided the medical services and to the injured worker and his or her attorney/designee, if applicable, within 30 days of receipt of the request for authorization and all information reasonably necessary to make the determination, in accordance with 8 CCR §§ 9792.9.4(c)(1) and 9792.9.5(d).

The Utilization Review (UR) nurse uses approved/appropriate criteria, along with clinical expertise, to review the requested services. The utilization review staff is provided with access to MD Guidelines and use the Medical Treatment Utilization Schedule (MTUS) regulations Title 8, California Code of Regulations Sections 9792.20 - 9792.27 and any additional adopted sections of this guideline.

Medical Treatment Utilization Schedule. MTUS guidelines will be used to evaluate the appropriateness of the medical services requested. The guidelines can also be used to help determine if over-utilization of medical services has occurred. If the requested service falls outside of the MTUS guidelines or is not part of the guidelines then Official Disability Guidelines will be utilized.

CA MTUS Drug Formulary: Pharmaceuticals will be processed and reviewed in accordance with the regulations governing Medical Treatment Utilization Schedule (MTUS) Drug Formulary treatment § 9792.27.1. thru § 9792.27.23.

Purpose:

To provide an evaluation and review of the utilization of healthcare services to identify unnecessary or inappropriate services before they are rendered. These reviews ensure our customers that mutual goals of quality claimant/patient care and reduction of medical costs are achieved.

Objectives:

1. Determination of the medical necessity and appropriateness of the proposed treatment plan.
2. Prompt communication of the determination to prevent delay in scheduling treatment.
3. Referring to contracted providers/facilities in accordance with state jurisdictional requirements and managed care arrangements.
4. Ensure quality by:
 - a. Promoting the efficient provision of services in the appropriate setting: i.e., inpatient, outpatient, home, skilled nursing facility, rehabilitation facility, etc.
 - b. Application of appropriate criteria, as a guideline, to promote consistent utilization of healthcare services.
 - c. Educating the insured and claimant/patient regarding physicians and appropriate services.

Authorization:

During the Utilization Review process, if a procedure is certified as medically necessary, it is considered authorized. "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed "Request for Authorization," , as defined in this section, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, sections 9792.9.1 through 9792.12.

Time Frames:

For prospective, concurrent, or expedited review, or expedited review, a decision to approve a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or if agreed to by the parties, encrypted electronic mail. If the initial communication is by telephone, written communication shall be issued to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review 9792.9.4(b).

(a)(1) All written decisions to approve a request for authorization shall specify the date the complete, or accepted as complete, request for authorization was first received, the medical treatment service requested, the specific medical treatment service approved, and the date of the decision. If applicable, the written decision shall also include the date the request for information, exam, or consultation under section 9792.9.6, subdivision (a)(1)(A), (B), or (C) was requested, and the date the information was received.

(2) For approvals of a request for authorization of a drug where the request for authorization did not indicate "Do Not Substitute" or "Dispense as Written," the written decision approving the request in generic form shall indicate, "generic substitute authorized" or words to that effect and meaning.

- (3) For approvals of a request for authorization of a drug that is exempt on the Drug Formulary, the written decision approving the request shall indicate, "Exempt per MTUS Drug Formulary" or words to that effect and meaning.
- (4) For approvals of a request for authorization of non-drug treatment that are exempt under section 9792.9.7 (i.e., the 30-day exemption), the written decision approving the request shall identify the exempt treatment as, "30-day exemption" or words to that effect and meaning.

Policy: Utilization Review (UR) Procedures	Effective Date: 10/1995
Last Revision Date: 8/13/2026	

Definition:

The process used to evaluate requested healthcare services for medical necessity, appropriateness, and efficiency, including prospective, concurrent and retrospective review, to prevent unnecessary or inappropriate care and promote cost-effective, quality outcomes.

Procedure:

1. Non-Emergency/ Non-Urgent/ Elective

- a. The Utilization Review (UR) timeframe begins upon receipt of a complete written request for authorization in accordance with 9792.9.1. A request for authorization may consist of a written request for medical treatment that is accepted as complete by the claims administrator in accordance with 9792.9.1(b). If a provider contacts the Managed Care Service Center (MCSC) UR department by phone or fax regarding a non-emergency medical service during normal business hours (Monday through Friday, 9:00 a.m. to 5:30 p.m. (PST) **(except holidays)** a written request for authorization is required to complete the submission. For operational purposes, the MCSC requires receipt of the written request within 72 hours; however, the UR timeframe is triggered based on regulatory receipt and acceptance standards under 9792.9.1.
- b. For purposes of calculating any utilization review timeframe under Title 8, California Code of Regulations, section 9792.9.3, the first day of the applicable timeframe is the first normal business day after receiving a completed Request for Authorization, or a request accepted as complete. A Request for Authorization transmitted by fax or electronically after 5:30 p.m. (PST) will be considered received on the following business day except in the case of expedited or concurrent review.
- c. Notification to the claim's administrator of a request for authorization for proposed medical services, in accordance with applicable state requirements, shall be made prior to services being rendered and may be initiated by any of the following:
 - Insured
 - Claimant / Patient
 - Adjuster / Claims File Handler
 - Case Manager
 - Physician / Provider
 - Hospital / Facility
 - Other Claimant Representative
 - State Regulator
- d. A UR nurse or an Intake Coordinator staff member is responsible for collecting the initial demographic information and entering this information into the UR database. The 'Data Entry – Creating a UR File Procedure' defines this process and will be followed to verify information and to set up the file
- e. Instructions about the UR process are given to all telephone callers who are calling in a request for utilization review. These instructions include the UR department's process and requirements.
- f. A non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. All UR requests will be reviewed by a UR nurse within two (2) business days of notification / received date. Retrospective reviews are completed within 30 days of receipt of Request for Authorization and medical information that is reasonably necessary to make a determination.
- g. At the time of receipt of the request, an email note notification of the request is sent to the

adjuster. If deemed appropriate, the UR nurse will contact the adjuster via phone or e-mail. If the adjuster is unavailable, a detailed voice message is left, explaining the request. If no response is received within four (4) hours, the UR nurse will proceed with the request. (Note: If the adjuster is unavailable due to vacation etc., the UR nurse will contact the claims assistant or team manager, as appropriate.) If the Claim Professional asks the UR staff member to withdraw (or close) the request because he or she is going to authorize the request, the UR staff members will document this reason in the UR system.

- h. If not received at the time of the initial contact, only clinical information that is necessary to make a review determination will be requested by the UR nurse from the requesting provider.
- i. Review decisions are made based on information available at the time of the review.
- j. The UR nurse will compare clinical information to state treatment applicable MTUS guidelines.
- k. Prospective or concurrent decisions to approve, modify, or deny a Request for Authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed Request for Authorization."
- l. If appropriate information which is necessary to render a decision is not provided with the original Request for Authorization, such information may be requested by a reviewer or non-physician reviewer within five (5) working days from the date of receipt of the written Request for Authorization to make the proper determination. In no event shall the determination be made more than 14 days from the date of receipt of the original Request for Authorization by the health care provider. If the reasonable information requested is not received within 14 days of the date of the original written request by the requesting physician, a physician reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.
- m. If the physician 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, or the physician reviewer needs a specialized consultation and review of medical information by an expert reviewer, then the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, will be notified that the decision cannot be made within the required timeframe, and specify the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. If it is not received within thirty (30) days from the date of the RFA, 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 exam, test or specialized consultation.

Notification of the Prospective Review and concurrent review certification decision, including a certification number if appropriate, is made by phone within twenty-four (24) hours of the determination. For prospective decisions, the written confirmation shall be sent within two business days after the verbal notification of the outcome. For concurrent reviews the written confirmation shall be sent to the physician requester within twenty- four (24) hours after verbal notification of the outcome. Written notification shall be sent to the following:

- Claimant / Patient
 - Requesting Provider
 - Primary Provider
 - Adjuster / Claims File Handler
 - Attorney (if required by state jurisdictional guidelines)
- n. Copies of all letters are attached to the appropriate request in the UR database.
 - o. Throughout the review process, the adjuster / claims file handler will be kept informed of the status of the review.

2. Requests for Urgent and Emergency Care

- a. Emergency health care services mean 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 claimant/patient's health in serious jeopardy. Emergency/urgent care service(s) may be followed concurrently, or reviewed retrospectively, as requested by any of the following:
 - Claimant/Patient
 - Adjuster / Claims File Handler
 - Case Manager
 - Requesting and/or Treating Provider
- b. "Failure to obtain prior authorization for 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." (Section 9792.9.5(b))
- c. Emergency health care services may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.
- d. Retrospective reviews will be performed with the clinical information that was available at the time the requested service was rendered.

3. Notice of Incomplete Request:

- A. "Request for authorization" means a written request for a specific course of proposed medical treatment.
 - 1) Unless accepted by a claims administrator under section 9792.9.1(b), a Request for Authorization must be set forth on a "Request for Authorization," completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5. Prior to March 1, 2014, any version of the Request for Authorization adopted by the Administrative Director under section 9785.5 may be used by the treating physician to request medical treatment.
 - 2) "Completed," for the purpose of this section and for purposes of investigations and penalties, means that the Request for Authorization must identify both the employee and the provider, identify with specificity a recommended treatment or treatments, be accompanied by documentation substantiating the need for the requested treatment, and have been created 30 days before the date of submission. A request for authorization shall be considered completed after receipt of information, tests results, or specialized consultation requested under section 9792.9.6.
 - 3) The Request for Authorization must be signed by the treating physician and may be mailed, faxed or e-mailed to, if designated, the address, fax number, or e-mail address designated by the claims administrator for this purpose. By agreement of the parties, the treating physician may submit the Request for Authorization with an electronic signature.
- B. If no written request is received and cannot be obtained from the requesting provider, after documented attempts within seventy-two (72) hours of receipt of request, provider is notified that the request will not be reviewed.
- C. Notification of an Incomplete Request will be made by phone and will be followed by written notification. The letter will include the principal reason(s) and the procedure to follow to re-open the request. Written notification will be sent to the Requesting Provider.

- D. Telephone Requests: If a telephone request for utilization review services is received, written follow-up from the provider must be received within 72 hours. A telephone or an oral Request for Authorization must be followed by a written confirmation of the request within seventy-two (72) hours in order for it to be considered as a valid Request for Authorization.
- E. If an UR decision is to non-certify due to lack of information, the requesting provider will be notified that the request will be reviewed once the requested additional information is received. Whenever a reviewer issues a decision to deny a Request for Authorization based on the lack of medical information necessary to make a determination, the claims administrator's file must document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail.

4. Physician Advisor (PA) Non- Certification:

- 1) If clinical information obtained by the UR nurse does not meet initial criteria and/or justify certification, or an alternative treatment is identified that is not agreed upon, the request will be referred by the UR nurse to be reviewed by a PA within twenty-four (24) hours, or the next business day, of receipt of request.
- 2) Physician Reviewers and the medical director are available Monday – Friday from 9:00 a.m. – 5:30 p.m. (PST) (**except holidays**) for Peer-to-Peer discussions regarding Utilization Reviews.
- 3) If the provider does not call the PA within the specified timeframe and the PA is unable to confirm medical necessity without speaking with the provider, the PA will document a non-certification decision. An appropriate UR Department staff member will contact the provider and notify him/her that the certification is not granted. The clinical rationale (as documented by the PA) will be given and the process for appeal will be explained followed by a written UR decision.
- 4) All conversations and pertinent information will be documented in the UR database.
- 5) If the PA and the requesting provider discuss the case and the request cannot be agreed upon, the PA will inform the requesting provider that certification is not granted, giving the clinical rationale for the decision and explaining the process for appeal. All conversations and pertinent information will be documented in the UR database.
- 6) Notification of the prospective review and concurrent review non - certification decision, including a certification number if appropriate, is made by phone upon within twenty-four (24) hours of the determination. The prospective review decision is followed by written confirmation that must be sent within two business days after verbal notification of the outcome. For concurrent reviews, notification of the utilization review decision, including a certification number, if appropriate, is made by phone to the physician requester upon determination within twenty-four (24) hours. For concurrent reviews a written confirmation must be sent to the physician requester within twenty-four (24) hours after verbal notification of the outcome. The letter will include the principal reason(s) for the determination, the clinical criteria utilized, and the procedure to initiate an appeal.

If the requesting provider disagrees with the initial determination, the next level is an appeal.

Written notification will be sent to the following:

- Requesting Provider
- Primary / Treating Provider
- Facility
- Adjuster / Claims File Handler
- Attorney (if required by state jurisdictional guidelines)

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

(a) The date on which the completed or accepted request for authorization was first received.

(b) If the timeframe for decision was extended under section 9792.9.6, a specific description of the information needed to make a medical necessity determination of the treatment request; the date(s) and time(s) the request(s) for information, exam, or consultation under subdivision (a)(1)(A), (B), or (C) of section 9792.9.6 were requested; the manner in which the requests were made; and the date the information was first received.

(c) The date on which the decision is made.

(d) A description of the specific course of medical treatment set forth on the request for authorization.

(e) A list of all medical records reviewed.

(f) A specific description of the medical treatment service approved, if any.

(g)(i) A clear, concise, and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity or; if applicable, that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation.

(ii) Where the requesting physician has expressly opined that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician shall provide an explanation for why the requesting physician's explanation is insufficient.

(h) For decisions based on medical necessity, a citation to and a description of the relevant medical criteria or guidelines used to reach the decision.

(i) Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.

(j) The Application for Independent Medical Review, DWC Form IMR (Rev. 04/01/2026), which is hereby incorporated by reference. All fields of the form, except for the signature of the employee, must be completed by the claims administrator. The written decision provided to the injured worker, shall include an addressed envelope, which may be

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postage-paid for mailing to the Administrative Director or his or her designee.

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

(l) Include the following mandatory language advising the injured employee:

"You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (insert claims adjusters 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."

(m) Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, including with respect to disputes over the necessity of or availability of the requested information, and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

(n) The written decision modifying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or, if applicable, expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the reviewer, the expert reviewer, or the medical director for the treating physician to discuss the decision, which shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time (**except holidays**). In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

5. Rush/Expedited Request

- A. A rush request is defined as a request for elective medical services when the provider, claim adjuster, claimant, or case manager, etc. requests an expedited review.
- B. When a rush request is received by the UR Department, the UR staff member documenting the request will flag the request as a Rush, as per the UR Department procedure for rush requests:
- 1) The UR staff member will notify the UR team leader that a rush request has been received and entered into the UR database.
 - 2) The request is system-assigned to the appropriate UR team.
 - 3) The UR team leader will identify a staff member who can handle the request on a priority basis.

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The UR nurse assigned to the rush request follows the steps outlined in Section I and completes the review as timely as possible. Prospective or concurrent decisions related to an expedited review shall be made in a timely fashion appropriate to 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.

6. Extension of Timeframe for Decision

A. The timeframes for decisions specified in Section 9792.9.3 may only be extended under one or more of the following:

- 1) The claims administrator is not in receipt of all the reasonably necessary information to make a determination.
 - a. The reviewer or non-physician reviewer shall request such information from the requesting or treating physician within five (5) business days of receipt of the Request for Authorization
 - b. If the information is not received within fourteen (14) days of completed or accepted Request for Authorization for prospective or concurrent review or within thirty (30) days of the request for retrospective review, a physician review shall deny the request in accordance with section 9792.9.5(e).
- 2) 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.
 - a. Physician reviewer will within five (5) business days notify the requesting physician, injured worker and injured worker's attorney that the reviewer cannot make a decision within the required timeframe and request additional examinations or tests required.
 - b. If the results from the additional exam or tests are not received within thirty (30) days from the date of the Request for Authorization, the reviewer shall deny the treating physicians request in accordance with section 9792.9.5(e).
- 3) The reviewer needs a specialized consultation and review of medical information by an expert reviewer. Physician reviewer will, within five (5) business days notify the requesting physician, injured worker and injured worker's attorney that the reviewer cannot make a decision within the required timeframe because a consultation by an expert reviewer is needed and identify the specialty of the expert reviewer to be consulted.

B. Upon receipt of the information requested, claims administrator or reviewer shall make a decision to approve, modify or deny the Request for Authorization

- 1) For prospective or concurrent review, within five (5) business days of receipt in accordance with 9792.9.4 and 9792.9.5
- 2) For prospective or concurrent decisions related to an expedited review, within 72 hours of receipt of the information in accordance with 9792.9.4 and 9792.9.5
- 3) For retrospective reviews, within thirty (30) calendar days of receipt of the information requested in accordance with 9792.9.4 and 9792.9.5.

Utilization Management Policy

Policy: WC 22 Non-Certification and Written Notice of Non-Certification – Non-certification/Modifications	Effective Date: 10/1995
Last Revision Date: 8/13/2026	

Definition:

This policy defines the procedures used for documentation and communication when a Non-certification/Modifications recommendation is rendered. The Utilization Review (UR) nurse uses approved/appropriate criteria, along with clinical expertise, to review the requested services. In California, the utilization review staff are provided access to Reed Group's MD Guidelines and use the Medical Treatment Utilization Schedule (MTUS) regulations Title 8, California Code of Regulations Sections 9792.20 - 9792.27 and any additional adopted sections of this guideline.

Medical Treatment Utilization Schedule. MTUS guidelines will be used to evaluate the appropriateness of the medical services requested. The guidelines can also be used to help determine if over-utilization of medical services has occurred. If the requested service falls outside of the MTUS guidelines or is not part of the guidelines then Official Disability Guidelines will be utilized.

Only the Physician Advisor may deny or modify treatment.

CA MTUS Drug Formulary: Pharmaceuticals will be processed and reviewed in accordance to the regulations governing Medical Treatment Utilization Schedule (MTUS) Drug Formulary treatment § 9792.27.1. thru § 9792.27.23.

Purpose:

To provide defined processes for evaluation and review of proposed medical services and, when indicated, render a Non-certification/Modifications recommendation for those services deemed to be unnecessary or inappropriate prior to implementation.

Objectives:

- 1) To ensure a Non-certification/Modifications of a requested service is rendered when medical necessity and appropriateness of the proposed treatment plan is reviewed by a Physician Advisor
- 2) To ensure that timely communication of the Non-certification/Modifications determination is made.

Non-certifications Based on Initial Screening

- 1) Utilization Review does not issue non-certification decisions based on initial screenings which include scripted clinical screening or structured clinical data collection.

Physician Advisor (PA) Non-certification (NC) procedure:

- 1) A request is referred to the Physician Advisor (PA) within 24 hours, or the next business day, when the clinical information reviewed by the UR nurse does not meet criteria and certification cannot be made during the initial review.
- 2) If the physician advisor is not able to certify the request based on the clinical information provided, a phone call is made to the requesting provider to initiate a peer-to-peer discussion and call back information will be provided to staff or voicemail if not able to connect with the provider. If no peer-to-peer discussion occurs, then the physician advisor will make a determination based on the clinical information available.

- 3) If the request is not certified on the initial review, the provider may request a voluntary appeal. Appeals must occur within 30 business days. All conversation and pertinent information related to the non-certification recommendation is documented in the claimant's record in the UR database.
- 4) If the PA and the treating/requesting provider discuss the case and the medical necessity of the proposed service(s) cannot be agreed upon, the PA will inform the treating/requesting provider that certification is not granted, and the appeal process will be explained. The peer-to-peer conversation and all pertinent information relating to the review is documented in the claimant record in the UR database.
- 5) If the PA is unable to discuss the decision with the requesting provider, then the decision will be made with the information received.
- 6) In addition to telephonic communication, written notification of the non-certification decision is provided. Written notification will be mailed to the following parties:
 - Claimant / Patient
 - Requesting Provider
 - Facility
 - Adjuster
 - Attorney (if required by state jurisdictional guidelines)
- 7) The written decision modifying or denying treatment authorization, shall be provided to the requesting physician, the injured worker, and, if applicable, the injured worker's representative and/or attorney. The written decision shall be signed by either the claims administrator or the physician reviewer, and shall only contain the following information specific to the request.
 - (a) The date on which the completed or accepted request for authorization was first received.
 - (b) If the timeframe for decision was extended under section 9792.9.6, a specific description of the information needed to make a medical necessity determination of the treatment request; the date(s) and time(s) the request(s) for information, exam, or consultation under subdivision (a)(1)(A), (B), or (C) of section 9792.9.6 were requested; the manner in which the requests were made; and the date the information was first received.
 - (c) The date on which the decision is made.
 - (d) A description of the specific course of medical treatment set forth on the request for authorization.
 - (e) A list of all medical records reviewed.
 - (f) A specific description of the medical treatment service approved, if any.
 - (g)(i) A clear, concise, and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity or; if applicable, that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation.
 - (ii) Where the requesting physician has expressly opined that prerequisite treatment or

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criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician shall provide an explanation for why the requesting physician's explanation is insufficient.

- (h) For decisions based on medical necessity, a citation to and a description of the relevant medical criteria or guidelines used to reach the decision.
- (i) Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.
- (j) The Application for Independent Medical Review, DWC Form IMR (Rev. 04/01/2026), which is hereby incorporated by reference. All fields of the form, except for the signature of the employee, must be completed by the claims administrator. The written decision provided to the injured worker, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.
- (k) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.
- (l) Include the following mandatory language advising the injured employee:
"You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (insert claims adjusters 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."

- (m) Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, including with respect to disputes over the necessity of or availability of the requested information, and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.
- (n) The written decision modifying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or, if applicable, expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the reviewer, the expert reviewer, or the medical director for the treating physician to discuss the decision, which shall be, at a minimum, four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM., Pacific Time (**except holidays**). In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Policy: Incomplete Request for Authorization	Effective Date: 11/6/2020
Last Revision Date: February 2026	

Definition:

Upon receipt of a Request for Authorization that does not meet the definition of a complete Request for Authorization, the claims administrator, non-physician reviewer as permitted, or physician reviewer shall either:

- 1) accept the request as a complete Request for Authorization and comply with all applicable utilization review requirements; or
- 2) return the request to the requesting physician marked “not complete,” specifying the reasons for the return, no later than five (5) business days from the date of receipt.

A Request for Authorization that is accepted as complete shall be subject to investigation and assessment of administrative penalties, notwithstanding any deficiencies in completeness.

Purpose:

A Request for Authorization that is missing pertinent information necessary to open a Utilization Review request will be returned to the submitting provider requesting they provide required information and resubmit the request to the Utilization Review department.

Objective:

To have a procedure by which the Utilization Review Intake department can terminate the request without determining the medical necessity when a requesting provider has not provided necessary information to identify the claim, claimant, treating provider or requested service(s) or treatment.

Procedure:

- 1) UR intake staff will review faxed documents for information required to open a UR request (claim number, claimant’s name, requesting provider with demographic information, requested service(s) or treatment).
- 2) Within 5 business days of the receipt of RFA that is missing pertinent information required to initiate a Request for Authorization intake staff will fax the RFA back to the requesting provider to request the necessary information be provided and the RFA resubmitted.
- 3) Intake staff will create a documentation note to document date, time and requesters name of RFA returned to requesting provider.
- 4) Upon return of the complete RFA the request for service(s) or treatment will be opened for review.
- 5) The timeframe for a decision on a returned Request for Authorization shall begin anew upon receipt of a completed Request for Authorization.

Policy: Deferral/Withdrawal	Effective Date: 3/20/1998
Last Revision Date: 8/13/2026	

Pursuant to 8 CCR § 9792.9.2(b), utilization review of a medical treatment request submitted on the Request for Authorization may be deferred when the claims administrator disputes liability for the claimed industrial injury or for the requested treatment on grounds other than medical necessity.

The Utilization Review Standards regulations in Chapter 4.5. Division of Workers' Compensation state that "A non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization." (Section 9792.7(b)(3)).

A Utilization Review "Withdrawal" is a Utilization Review decision that is neither a certification nor a non-certification for medical necessity.

The provider may choose to have the request withdrawn.

If it is determined that the treatment requested is for a denied claim or body part the UR nurse will contact the provider to advise request is deferred.

If the claims administrator disputes liability under this subdivision (a), it may, no later than five (5) business days from receipt of the Request for Authorization, issue a written decision deferring utilization review of the requested treatment unless the requesting physician has been previously notified under this subdivision of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.

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

- (1) The date on which the request for authorization 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 claims administrator's dispute of liability for either the injury, claimed body parts or parts, or the recommended treatment.
- (4) A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.
- (5) The following mandatory language advising the injured employee:

"You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (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.”

DECISIONS TO MODIFY OR DENY – 12-MONTH EFFECTIVE PERIOD

- A utilization review decision that modifies or denies a Request for Authorization on the basis of medical necessity shall remain effective for a period of twelve (12) months from the date of the decision without further action by the claim’s administrator with regard to any subsequent recommendation for the same treatment made by the same requesting physician or another physician within the same practice group.
- This provision shall not apply where a subsequent recommendation is supported by a documented change in facts material to the basis of the original utilization review decision.

Purpose:

To have a procedure by which the Utilization Review Nurse can defer the UR review of a RFA if liability for the occupational injury is disputed for either the injury or for the medical treatment itself on grounds other than medical necessity.

- A. The Utilization Review request is initiated and completed in the computer system per procedure.
- B. When a provider is contacted for clinical information and none is available i.e.: chart is in dictation, physician is not available, claims file handler does not have pertinent clinical, etc., explain to the provider that they may choose to withdraw the request.
- C. When a UR nurse cannot approve the request because the request does not meet MTUS guidelines, the request will be sent for physician review.

Procedure

- 1) In both the UR database and Claims notes; document date, time and requester’s name
- 2) Contact the caller who initiated the request if different from above
- 3) Notify Claims File Handler the provider has withdrawn the request
- 4) Utilization Review, on behalf of the Claim File Handler, will notify the provider of the rational of the withdrawal either by phone or fax
- 5) Request is closed and filed
- 6) If an amended request by the requesting provider received it will be processed according to the “Prospective, Extension, Concurrent, and Retrospective Review policy”.
- 7) Issue a letter within five (5) business days to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, if contact with the physician cannot be made to advise the request is deferred and request will be reviewed if the occupational claim is determined compensable.

Policy: Expedited Appeal	Effective Date: 1/1997
Last Revision Date: 6/24/2026	

Definition:

The Expedited Appeal Policy refers to the procedure of examining a non-certification decision when an immediate decision is necessary. The Expedited Appeals process is on a voluntary basis. If the claimant/patient disagrees with the non-authorization decision, they may dispute it. The claimant/patient must send written notice of their objection to the claims administrator or Utilization Review Agent within thirty (30) days of receipt of non-authorization decision or for a decision that denies a request for a drug listed on the MTUS Drug List, within ten (10) days of receipt of the written utilization review decision. The claimant/patient must meet the deadline even if they decide to participate in the claims administrator's internal voluntary review appeals process.

Purpose:

To provide the requestor an opportunity to have the requested service(s) reviewed by a specialty-matched provider and to expedite the maximum exchange of information by telephone or facsimile.

Objectives:

- Provide a course of action to the provider to request an immediate reassessment of the non-certification decision when there has been peer-to-peer contact.
- Ensure all state jurisdictional requirements are followed.
- Provide a fair and objective method of expeditiously reassessing the medical necessity of the requested service(s) after it has been determined to be not medically necessary at the initial review.
- Provide an immediate reassessment of the claimant's/patient's need for the requested service that was determined to be not medically necessary at the initial review.

Procedure:

- A. An expedited appeal request must be made within thirty (30) days of the initial non-certification, or as per state jurisdictional guidelines. An expedited appeal request is handled with urgency, as the medical service requested may be imminent or concurrent during treatment. This request will be completed as soon as possible and must be completed within 24 hours from the time the request was received, unless dictated otherwise by state jurisdictional guidelines.
- B. The request may be made by the provider, facility, adjuster, case manager, injured worker, or injured worker representative, to the Managed Care Service Center (MCSC) Utilization Review Department through toll free lines Monday through Friday from 6:00 a.m. to 7:30 p.m. (PST) (**except holidays**). Expedited appeal requests may also be in writing (via fax or mail), with clinical information and/or copies of the medical records.
- C. The Appeal Procedure is followed except for the following:
 - 1) The PA decision must be immediate or within 24 hours after receipt of information.
 - 2) For a non-certification decision, the letter will include the method to initiate the Appeal Process

- D. Fax or verbal notification of the outcome of the Expedited Appeal will be made to the requesting party within 1 (one) business day of the receipt of the request.
- E. Written notification of the Expedited Appeals outcome will be sent within 1(one) business day of the verbal notification of the outcome.
- F. Refer to Non-Certification Policy and Written Notice of Non-Certification for information contained in the written notification.

Policy: Voluntary Internal Appeal	Effective Date: 1/1997
Last Revision Date: 6/24/2026	

Definition:

The Voluntary Internal Appeal Policy refers to the procedure of reviewing a Utilization Review (UR) Department non-certification decision on a prospective, concurrent, and retrospective or bill review request.

Purpose:

To provide the requesting provider an opportunity to have the requested services reviewed by a specialty-matched provider.

Objectives:

Provide a course of action to the provider to request a reassessment of the non- certification decision when there has been peer-to-peer contact. Ensure that all state jurisdictional requirements are followed.

Provide a fair and objective method of reassessing the medical necessity of a request after it has been determined to be not medically necessary at the initial review.

Provide a reassessment of the claimant's/patient's need for the requested service(s) that were determined to be not medically necessary.

Procedure:

- A. An appeal request must be received by the UR Department within thirty (30) days from the date of the non-certification decision letter or as per state jurisdictional requirements.
- B. An appeal request may be made via phone and/or in writing by fax or mail for impending (non- emergency) clinical service(s) can be made to the Managed Care Service Center (MCSC) UR department via toll free lines Monday through Friday from 9:00 a.m. to 5:30 p.m. (PST) **(except holidays)**. Notification, in accordance with state jurisdictional requirements, should be prior to the service(s) being rendered and can be initiated by any of the following:
 - Insured
 - Claimant / Patient
 - Adjuster / Claims File Handler
 - Case Manager
 - Physician
 - Provider Hospital / Facility
 - Other Claimant Representative
 - State Regulator
- C. The Utilization Review Process is coordinated with the regulatory appeals process that may be available to the worker as part of the State appeals process.

Intake Coordinator

- A. The Intake Coordinator enters the request into the UR Database at the time of notification, as per UR Departmental procedure. If the appeal request is received via telephone, the Intake Coordinator notifies the requestor that a determination will be made within ten (10) business days, or as per state jurisdictional requirements.

Utilization Review Nurse

- A. The UR Nurse triages the case to verify that the request is an appeal.
- B. If the request is an appeal, the UR Nurse continues to review the file, identifying if additional clinical information has been received.
- C. If additional clinical information has not been received, the UR Nurse will contact the appropriate provider and request that clinical information be faxed to the toll-free dedicated fax number.
- D. The UR Nurse prepares the file for PA review as per UR Departmental policy. Marks all pertinent clinical information for PA review (in the UR Database). Creates the PA Referral event. If appropriate, requests a specific PA that did not perform the original utilization review to complete the review. PA Referral event is system-assigned to the Unassigned PA Referral queue.

Physician Advisor Coordinator (PAC) Supplier

- A. Monitors the Unassigned PA Referral queue.
- B. Opens the PA Referral event and reviews any documentation entered by the UR Nurse, as per UR Departmental procedure.
- C. Assigns the PA Referral to the appropriate PA or as requested by the UR Nurse. Appeal requests will be assigned based upon the following requirements:

The Physician Advisor:

- Is a clinical peer of the requesting provider.
- Holds an active, unrestricted license to practice medicine or a health profession.
- Is board certified by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists.
- Is in the same or similar specialty that typically manages the medical condition and treatment being requested.
- Is not the individual who made the original non-certification determination, nor the subordinate of such an individual.

Physician Advisor (PA)

- A. The PA is responsible to monitor his cases throughout the day to identify newly assigned PA Referrals.
- B. The PA reviews the appeal request file. Contacts the requesting provider to obtain or clarify clinical information received. All attempts to contact the requester must be documented and must include dates and times of each attempt, as well as outcome of each contact (e.g., s/w Mary Jo / Dr. Jones; lvmm (left voice mail message) on Dr. Jones line; etc.).
- C. If the PA is unable to contact the requesting provider after two (2) documented attempts within ten (10) business days following the receipt of the request for appeal, the non-certification determination will stand. The requesting provider will be notified by fax or telephonically of the determination within one (1) business day of the decision date. Written notification will be sent within one (1) business day following the fax or telephonic notification.

- D. If Specialty PA review determines that the requested service can be certified as medically necessary based upon the medical information provided and without peer-to-peer contact, the PA documents his decision and rationale in the UR Database as per UR Departmental procedure.
- E. The requesting provider is notified of the review decision, telephonically, by UR Department staff as per UR Departmental procedure for certification decisions.
- F. Written confirmation is generated within one (1) business day of the date of determination and is sent to the following as appropriate:
 - Claimant / Patient
 - Requesting Provider Primary Provider
 - Adjuster / Claims File Handler
 - Attorney (if required by state jurisdictional guidelines)
- G. Copies of all letters are attached to the appropriate request in the UR Database.
- H. If Specialty PA review determines that he/she is unable to determine the medical necessity of the requested service without peer-to-peer contact, the PA must make two (2) attempts to speak with the requesting provider, and these attempts must be documented as per above procedure. If peer-to-peer contact is made and the decision remains to non-certify the requested service(s), the PA informs the requesting provider of the dispute process outlined in the non-certification letter. The PA documents his decision and rationale in the UR Database as per procedure.
- I. The Request status is system-changed to PA Review Completed.

UR Assistant

- A. Monitors the queue and identifies requests with a status equal to PA Review Completed.
- B. Reviews the PA Response and completes the Request as per UR Departmental procedure.
- C. Within one (1) business day of the date of decision, faxes or telephonically contacts the requesting provider and facility with review decision and PA rationale. (Note: If contact person has any questions about the decision, the UR Assistant transfers the caller to the appropriate UR Nurse.)
- D. Within one (1) business day of the date of decision, sends an email note to the adjuster and case manager (if applicable) with review decision and PA rationale.
- E. Documents all contacts in the UR Database as per UR Departmental procedure.

Urgent Cases:

“Emergency health care services” means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the claimant/patient's health in serious jeopardy. 9792.6.1(i).

“Expedited review” means utilization review or independent medical review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function 9792.6.1(j).

Retrospective Reviews may be performed on Urgent and Emergency medical care. See Prospective, Extension, Concurrent, and Retrospective Review - Authorizations/Approvals Policy.

The UR team leader will receive this request via the UR system on a priority basis. The team leader will identify a staff member who can handle the request on a priority basis.

Policy: Peer Addendum	Effective Date: 5/3/2023
Last Revision Date: 2/3/2026	

Definition: Addendum workflow procedure outlines the process to re-open a completed UR review if the requesting provider and peer clinical reviewer were not able to connect for a peer-to-peer discussion prior to the non-certification or modified certification decision if requested by the requesting provider within fourteen (14) calendar days of the initial non-certification/modified decision.

Purpose: To allow for a peer-to-peer discussion by the requesting provider and peer clinical reviewer prior to the review going to the appeal level.

Objective: To facilitate a peer-to-peer discussion to provide the best review outcome for the injured worker.

Procedure:

If the request is already closed and the requesting provider calls back and requests a peer-to-peer discussion within fourteen (14) calendar days of the non-certification or modified certification, follow as outlined below.

- A. The UR nurse who completed the initial review will contact the requesting provider for their available date/time and phone number for peer-to-peer discussion. Add this information to the Client Instructions in the request.
- B. Once above information is received UR nurse will request the Physician Advisor Coordinator (PAC) contact the PA vendor to have the request re-opened for additional attempt at peer-to-peer discussion providing the requesting providers best availability date/time and contact number to the peer vendor.
- C. Original peer reviewer will attempt to contact the requesting provider within five (5) business days during provider's stated availability and document calls in UR database.
- D. If the determination remains a non-certification:
 - Peer Review vendor will notify PAC of addendum.
 - PAC will change status of request to Peer vendor assigned so the vendor can add the addendum information.
 - Peer review vendor will add the addendum to the peer review report and upload new report to UR database.
 - If the peer-to-peer is successful change the peer-to-peer in the PA response to yes.
 - If the peer-to-peer is unsuccessful the peer-to-peer will remain as no.
 - PAC will task the URA to create a new claim note in UR database with the addendum.
 - URA will review new information for accuracy and close the request per UR workflow so new letters and claim note that include the addendum are generated
- E. If the determination changes from non-certification to a Certified, Partial Certification or Negotiated change of treatment plan:
 - Peer review vendor will document peer review calls and update call information section and determination of the review.
 - Peer review vendor attaches the updated Peer Report with the addendum information to the review.
 - Peer review vendor will notify PAC of addendum and the change of determination from Non-Certified to Certified, Partial Certification or Negotiated in the Peer Report.

- PAC will have URA review new information and close the request with the updated determination so new letters and claim note are generated.

Policy: Financial Incentive Policy	Effective Date: 1/1/1997
Last Review Date: 2/3/2026	

Zurich Services Corporation does not provide financial incentives or consideration to Peer Review Physicians based on the number of modifications or denials made by the physician.

Attachment A

Template Letters and Forms

CERTIFICATION NOTICE

NON-CERTIFICATION NOTICE

NON-CERTIFICATION NOTICE (PEER TO PEER)

APPEAL NON-CERTIFICATION NOTICE

APPEAL MODIFIED NOTICE

EXTENSION CERTIFICATION NOTICE

MODIFIED EXTENSION NOTICE (WITH PEER TO PEER)

MODIFIED EXTENSION NOTICE (WITHOUT PEER TO PEER)

MODIFIED DECISION NOTICE (WITH PEER TO PEER)

MODIFIED DECISION LETTER (WITHOUT PEER TO PEER)

TIME EXTENSION NOTICE

CALIFORNIA WITHDRAWAL/DEFERRAL NOTICE

DENIAL FOR LACK OF MEDICAL INFORMATION NOTICE

SAMPLE NON-CERTIFICATION NOTICE

APPLICATION FOR INDEPENDENT MEDICAL REVIEW (FORM IMR)

Zurich Services Corporation

DISCLAIMER NOTE: CERTIFICATION OF THE TREATMENT REFERENCED BELOW IS NOT AN APPROVAL OF BENEFITS. ONLY A CLAIM ADJUSTER MAY MAKE GUARANTEE OF PAYMENT. ALL TREATMENT IS SUBJECT TO THE POLICY PROVISIONS AS WELL AS STATE REGULATIONS REGARDING ELIGIBILITY AND COMPENSABILITY

CONFIDENTIAL

[address block]

[decision date]

Claimant:

Primary MD:

Claim Number:

Tax ID:

Requesting MD:

Place of Service:

Tax ID:

Certification Notice

We have certified the treatment(s) listed below:

Date Additional Information requested: [If applicable]

Services Requested: [Request]

Request First Received Date: [date]

Services Certified: [treatment/services requested]

Drug requests that do not specify "Do Not Substitute" or "Dispense as Written" and are approved for generic equivalent when available are considered "Generic Substitute Authorized." Drug approvals that are exempt under the MTUS Drug Formulary are considered "Exempt per MTUS Drug Formulary." Approved non-drug treatment requests that qualify for an exemption under California Code of Regulations, section 9792.9.7, are considered "30-day exemption."

Outcome Decision Date: [date]

Certification Period: [certification date range] (# of Visits/days etc.)

Certification Number: [certification number]

If additional treatment and/or additional time is required, please contact us at (800) 451-8731. 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.

Zurich Services Corporation
MCSC - Utilization Review Unit

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:00 p.m. (PST) (except holidays)

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD (if applicable), Claims Professional, Nurse Case Manager (if applicable)

Zurich Services Corporation

<Decision Date>

<Address Block>

Zurich Services Corporation is URAC Accredited for Workers' Compensation Utilization Management.

Non-Certification Notice

Claimant:

Requesting MD:

Claim Number:

Tax ID:

Primary MD:

Tax ID:

Request First Received Date:

Place of Service:

Tax ID:

Date Additional Information requested: [If applicable]

This letter is in reference to the above claimant (Associated Claimant) and the request for (description of specific course of medical treatment requested).

This letter will serve as written notice to your office that we are unable to certify this request based on the clinical information provided.

We have been unable to speak with you and the clinical information available for our review does not meet preliminary guidelines.

Outcome Decision Date:

(PA Response Text, including clear and concise explanation of the reasons for the reviewer/reviewing physician's decision includes list of medical records reviewed)

APPEAL

The internal utilization review appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6 but may be pursued on an optional basis.

On a voluntary basis, if you would like to have this determination appealed, an appeal request will be accepted via telephone, in writing, or fax within 30 days from the receipt date of this letter to:

Utilization Review / MCSC

Zurich Services Corporation-MCSC Phone No: (800) 451-8731
 1299 Zurich Way Fax No: (866) 452-0254
 Schaumburg, IL 60196

If you would like to initiate a peer-to-peer discussion to have this determination re-reviewed, a request will be accepted via telephone, in writing or fax within 14 days from the date of this letter to the address and telephone number as above.

_____OR._____

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6 and that an objection to the utilization review decision must be completed 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 the timeframe indicated on the last page of the application. To request an Independent Medical Review sign the enclosed IMR form and forward in the enclosed addressed envelope to:

DWC-IMR
 c/o MAXIMUS Federal Services.
 Inc.
 P.O. Box 138009
 Sacramento.CA 95813-8009

You may also file this form by faxing the document to: (916) 605-4270

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (Adjuster Assignment) at (Claim Office Number). However, if you are represented by an attorney, please contact your attorney instead of me.

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

Decision PA.Name
 Board Certified, MD Specialty (signature on file)
 License Info

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:00 p.m. (PST) (except holidays).

cc: Injured Worker, Attorney (if represented) Requesting MD, Primary MD, Claims Adjuster, Nurse Case Manager (if applicable) IMR form

Zurich Services Corporation

<Decision Date>

<Address Block>

Zurich Services Corporation is URAC Accredited for Workers' Compensation Utilization Management.

Non Certification Notice (Peer to Peer)

Claimant:

Requesting MD:

Claim Number:

Tax ID:

Request First Received Date:

Primary MD:

Tax ID:

Place of Service:

Tax ID:

Date Additional Information requested: [If applicable]

This letter is in reference to the above claimant (Associated Claimant), and the request for (description of specific course of medical treatment requested).

This letter will serve as written notice to your office that we are unable to certify this request based on the clinical information provided.

I spoke with (Peer Contact Name) on (Peer Contact Date) and based on our discussion and the clinical information available for my review, the request does not meet preliminary guidelines and is not supported by medical necessity.

Outcome Decision Date

PA Response Text

APPEAL

The internal utilization review appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6 but may be pursued on an optional basis.

On a voluntary basis, if you would like to have this determination appealed, an appeal request will be accepted via telephone, in writing, or fax within 30 days from the receipt date of this letter to:

Utilization Review / MCSC

Zurich Services Corporation-MCSC

1299 Zurich Way

Schaumburg, IL 60196

Phone No: (800) 451-8731

Fax No: (866) 452-0254

----- OR-----

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6 and that an objection to the utilization review decision must be completed 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 the timeframe indicated on the last page of the application. To request an Independent Medical Review, sign the enclosed IMR form and forward in the enclosed addressed envelope to:

DWC-IMR
c/o MAXIMUS Federal Services, Inc.
P.O. Box 138009
Sacramento.CA 95813-8009

You may also file this form by faxing the document to: (916) 605-4270

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (Adjuster Assignment) at (Claim Office Number). However, if you are represented by an attorney, please contact your attorney instead of me.

For information about the workers' compensation claims process and your rights and obligations. Go to www.diwc.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.

(Decision PA)
Board Certified (MD Specialty) (signature on file)
License Info:

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:30 p.m. (PST) (except holidays).

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD, Claims Adjuster, Nurse Case Manager (if applicable), IMR Form

Zurich Services Corporation

<Decision Date>

<Address Block>

Zurich Services Corporation is URAC Accredited for Workers' Compensation Utilization Management.

Appeal Non-Certification Notice

Claimant: Primary MD:

Claim Number: Tax ID:

Date RFA first Received: Requesting MD:

Tax ID:

Place of Service:

Tax ID:

This letter is in reference to a request for (description of specific course of medical treatment requested) that we non-certified on (Decision Date). An appeal request was received on (Received Date).

I am unable to certify this appeal based on the clinical information available and/or our discussion.

Outcome Decision Date:

PA Response Text: (including clear and concise explanation of the reasons for the reviewer/reviewing physician's decision includes list of medical records reviewed)

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (Adjuster Assignment) at (Claim Office Number). However, if you are represented by an attorney, please contact your attorney instead of me.

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

("Decision PA")
Board Certified, MD Specialty
(Signature on file)
PA License Info

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 am - 5:00 pm (PST) (except holidays).

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD, Claims Adjuster, Nurse Case Manager (if applicable).

Zurich Services Corporation

DISCLAIMER NOTE: CERTIFICATION OF THE TREATMENT REFERENCED BELOW IS NOT AN APPROVAL OF BENEFITS. ONLY A CLAIM ADJUSTER MAY MAKE GUARANTEE OF PAYMENT. ALL TREATMENT IS SUBJECT TO THE POLICY PROVISIONS AS WELL AS STATE REGULATIONS REGARDING ELIGIBILITY AND COMPENSABILITY

Zurich Services Corporation is URAC Accredited for Workers' Compensation Utilization Management.

CONFIDENTIAL

[decision date]

[address block]

Appeal Modified Notice

Claimant:

Primary MD:

Claim Number:

Tax ID:

Requesting MD:

Place of Service:

Tax ID:

Tax ID:

Date RFA First Rec'd:

This letter is in reference to a request for (description of specific course of medical treatment requested) that we non certified on (date). An appeal request was received on (date). Based on review of the clinical information provided and/or our discussion the request has been modified.

Modified Services Certified: (treatment/services certified)

Drug requests that do not specify "Do Not Substitute" or "Dispense as Written" and are approved for a generic equivalent when available are considered "Generic Substitute Authorized." Drug approvals that are exempt under the MTUS Drug Formulary are considered "Exempt per MTUS Drug Formulary." Approved nondrug treatment requests that qualify for an exemption under California Code of Regulations, section 9792.9.7, are considered "30 day exemption."

Certification Period: (certification date range) (# of visits/days etc.)

Certification Number: (certification number)

I have modified this appeal based on the following:

Outcome Decision Date:

[Physician advisor's response including clear and concise explanation of the reasons for the reviewer/reviewing physicians decision and list of clinicals reviewed.]

If additional treatment and/or additional time is required, please contact us at (800) 451-8731

APPEAL

You may request an IMR for the portion of the request that was not certified.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6 and that an objection to the utilization review decision must be completed 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 the timeframe indicated on the last page of the application. To request an Independent Medical Review, sign the enclosed IMR form and forward in the enclosed addressed envelope to:

DWC-IMR
c/o MAXIMUS Federal Services, Inc.
P.O. Box 138009
Sacramento, CA 95813-8009

You may also file this form by faxing the document to: (916) 605-4270

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have a question about the information in this notice, please call me (Adjuster Assignment) at (Claim Office Number) . However, if you are represented by an attorney, please contact your attorney instead of me.

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

[signature]

PA Name

Board Certified, Pain Management

State License Info

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:00 p.m. (PST) (except holidays).

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD (if applicable), Claims Professional, Nurse Case Manager (if applicable), IMR Form

Zurich Services Corporation

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CONFIDENTIAL

(decision date)

(Address block)

Extension Certification Notice

Claimant:
Claim Number:
Requesting MD:

Tax ID:

Primary MD:
Tax ID:
Requesting MD:
Tax ID:
Place of Service:
Tax ID:

Date Additional Information requested: [If applicable]

We have certified the treatment(s) listed below:

Request First Received Date:
Additional Services Certified:

(date)
(Treatment/Services certified)

Drug requests that do not specify "Do Not Substitute" or "Dispense as Written" and are approved for a generic equivalent when available are considered "Generic Substitute Authorized." Drug approvals that are exempt under the MTUS Drug Formulary are considered "Exempt per MTUS Drug Formulary." Approved non-drug treatment requests that qualify for an exemption under California Code of Regulations, section 9792.9.7, are considered "30-day exemption."

Current Certification Period	(Approved Date Range)
Certification Number	(Certification Number)
New Total number of Services Certified	(total number to date)
Anticipated date of new review if more services are needed:	(Next Review Date)

If additional treatment and/or additional time is required, please contact us at (800) 451-8731.

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.

Zurich Services Corporation
MCSC - Utilization Review Unit

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:30 p.m. (PST) (except holidays).

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD (if applicable), Claims Professional,
Nurse Case Manager (if applicable)

Zurich Services Corporation

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Zurich Services Corporation is URAC Accredited for Workers' Compensation Utilization Management.

CONFIDENTIAL

[decision date]

[address block]

Modified Extension Notice (With Peer to Peer)

Claimant:

Primary MD:

Claim Number:

Tax ID:

Requesting MD:

Place of Service:

Tax ID:

Tax ID:

Date RFA First Rec'd:

Date Additional Information requested: [if applicable]

This letter is in reference to the above claimant, (claimant name), and the request for [description of specific course of medical treatment requested and # visits/days etc.].

This letter will serve as written notice to your office that we are unable to certify the complete request based on the clinical information provided.

We have modified the request to certify the treatment(s) listed below:

Request First Received Date:

(date)

Additional Services Certified:

**(Treatment/Services and # visits/days
certified)**

Drug requests that do not specify "Do Not Substitute" or "Dispense as Written" and are approved for a generic equivalent when available are considered "Generic Substitute Authorized." Drug approvals that are exempt under the MTUS Drug Formulary are considered "Exempt per MTUS Drug Formulary." Approved non-drug treatment requests that qualify for an exemption under California Code of Regulations, section 9792.9.7, are considered "30-day exemption".

Current Certification Period

(Approved Date Range)

Certification Number

(Certification Number)

New Total number of Services Certified

(total number of all visits/days certified to date)

Anticipated date of new review if more services

(Date) are needed:

I spoke with [contact name] and based on our discussion and the clinical information available for my review. The original request is modified to certify (certified portion of request with # visits/days etc.).

Outcome Decision Date: [date]

[Physician advisor's response including clear and concise explanation of the reasons for the reviewer/reviewing physician's decision and list of clinicals reviewed.]

You may appeal or request an IMR for the portion of the request that was not certified.
If additional treatment and/or additional time is required, please contact us at (800) 451-8731.

APPEAL

The internal utilization review appeals process is a voluntary process that neither triggers nor bars the use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6 but may be pursued on an optional basis. On a voluntary basis, if you would like to have this determination appealed, an appeal request will be accepted via telephone, in writing, or fax within 30 days from the date of this letter to:

Utilization Review / MCSC
Zurich Services Corporation-MCSC
1299 Zurich Way
Schaumburg, IL 60196

Phone No: (800) 451-8731
Fax No: (866) 452-0254

_____OR_____

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6 and that an objection to the utilization review decision must be completed 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 the timeframe indicated on the last page of the application. To request an Independent Medical Review, sign the enclosed IMR form and forward in the enclosed addressed envelope to:

DWC-IMR
c/o MAXIMUS Federal Services, Inc.
P.O. Box 138009
Sacramento, CA 95813-8009

You may also file this form by faxing the document to: (916) 605-4270

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (Adjuster Assignment) at (Claim Office Number) However, if you are represented by an attorney, please contact your attorney instead of me.

For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact 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.

(signature)
Decision PA Name
Board Certified, MD Specialty
License Info

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:00 p.m. (PST) (except holidays).

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD (if applicable), Claims Professional, Nurse Case Manager (if applicable) IMR Form

Zurich Services Corporation

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Zurich Services Corporation is URAC Accredited for Workers' Compensation Utilization Management.

CONFIDENTIAL

(decision date)

(address block)

Modified Extension Notice (Without Peer to Peer)

Claimant:

Primary MD:

Claim Number:

Tax ID:

Requesting MD:

Place of Service:

Tax ID:

Tax ID:

Date RFA First Rec'd:

Date Additional Information requested: [if applicable]

This letter is in reference to the above claimant (Claimant name) and the request for (requested treatment/services and # visits/days).

This letter will serve as written notice to your office that we are unable to certify the complete request based on the clinical information provided. We have been unable to speak with you and the clinical information available for our review does not meet preliminary guidelines.

We have modified the original request to certify (portion of requested treatment/services with # visits/days etc.). You may appeal or request an IMR for the portion of the request that was not certified.

Request First Received Date:

(date)

Additional Services Certified:

(Treatment/Services and # visits/days certified)

Drug requests that do not specify "Do Not Substitute" or "Dispense as Written" and are approved for a generic equivalent when available are considered "Generic Substitute Authorized." Drug approvals that are exempt under the MTUS Drug Formulary are considered "Exempt per MTUS Drug Formulary." Approved non-drug treatment requests that qualify for an exemption under California Code of Regulations, section 9792.9.7, are considered "30-day exemption".

**Current Certification Period
Certification Number**

**(Approved Date Range)
(Certification Number)**

New Total number of Services Certified

(total number of all visits/days certified to date)

*
**Anticipated date of new review if more services (Date)
are needed**

Outcome Decision Date: (date)

(Physician advisor's response including clear and concise explanation of the reasons for the reviewer/reviewing physician's decision and list of clinicals reviewed.)

APPEAL

The internal utilization review appeals process is a voluntary process that neither triggers nor bars the use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6 but may be pursued on an optional basis.

On a voluntary basis, if you would like to have this determination appealed, an appeal request will be accepted via telephone, in writing, or fax within 30 days from the date of this letter to:

Utilization Review / MCSC

Phone No: (800) 451-8731

Zurich Services Corporation-MCSC
1299 Zurich Way
Schaumburg, IL 60196

Fax No: (866) 452-0254

If you would like to initiate a peer to peer discussion to have this determination re-reviewed, a request will be accepted via telephone, in writing or fax within 14 days from the date of this letter to the address and telephone number as above.

----- OR -----

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6 and that an objection to the utilization review decision must be completed 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 the timeframe indicated on the last page of the application. To request an Independent Medical Review, sign the enclosed IMR form and forward in the enclosed addressed envelope to:

DWC-IMR
c/o MAXIMUS Federal Services, Inc.
P.O. Box 138009
Sacramento, CA 95813-8009

You may also file this form by faxing the document to: (916) 605-4270.

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (Adjuster Assignment) at (Claim Office Number). However, if you are represented by an attorney, please contact your attorney instead of me.

If additional treatment and/or additional time is required, please contact us at (800) 451-8731.

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.

Zurich Services Corporation
MCSC - Utilization Review Unit

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:00 p.m. (PST) (except holidays).

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD (if applicable), Claims Professional,
Nurse Case Manager (if applicable)

Zurich Services Corporation

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Zurich Services Corporation is URAC Accredited for Workers' Compensation Utilization Management.

CONFIDENTIAL

(Decision Date)

(Address Block)

Modified Decision Notice

Claimant:	Primary MD:
Claim Number:	Tax ID:
Requesting MD:	Place of Service:
Tax ID:	Tax ID:
Date RFA First Rec'd:	
Date Additional Information requested: [if applicable]	

This letter is in reference to the above claimant, [associated claimant], and the request for [description of specific course of medical treatment requested and # visits].

We have modified the request to certify the treatment(s) listed below:

Request Received Date: [date]

Services Certified: [treatment/services requested]

Drug requests that do not specify "Do Not Substitute" or "Dispense as Written" and are approved for a generic equivalent when available are considered "Generic Substitute Authorized." Drug approvals that are exempt under the MTUS Drug Formulary are considered "Exempt per MTUS Drug Formulary." Approved non-drug treatment requests that qualify for an exemption under California Code of Regulations, section 9792.9.7, are considered "30-day exemption".

Certification Period: [certification date range] and (# of Visits/days etc.)

Certification Number: [certification number]

Detailed Request: [System-generated field summarizing key utilization review details, including requested services and determination outcome.]

Outcome Decision Date: [date]

[Physician advisor's response including clear and concise explanation of the reasons for the reviewer/reviewing physician's decision and list of clinicals reviewed.]

APPEAL

You may appeal or request an IMR for the portion of the request that was not certified. The internal utilization review appeals process is a voluntary process that neither triggers nor bars the use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6 but may be pursued on an optional basis.

On a voluntary basis, if you would like to have this determination appealed, an appeal request will be accepted via telephone, in writing, or fax within 30 days from the date of this letter to:

Utilization Review / MCSC
Zurich Services Corporation-MCSC
1299 Zurich Way
Schaumburg, IL 60196

Phone No: (800) 451-8731
Fax No: (866) 452-0254

_____OR_____

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6 and that an objection to the utilization review decision must be completed 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 the timeframe indicated on the last page of the application. To request an Independent Medical Review, sign the enclosed IMR form and forward in the enclosed addressed envelope to:

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C/o MAXIMUS Federal Services, Inc.
P.O. Box 138009
Sacramento, CA 95813-8009

You may also file this form by faxing the document to: (916) 605-4270.

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (Adjuster Assignment) at (Claim Office Number). However, if you are represented by an attorney, please contact your attorney instead of me.

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

(signature)
Decision PA Name
Board Certified, MD Specialty
License Info

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:00 p.m.(PST) (except holidays).

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD (if applicable), Claims Professional, Nurse Case Manager (if applicable), IMR Form

Zurich Services Corporation

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Zurich Services Corporation is URAC Accredited for Workers' Compensation Utilization Management.

CONFIDENTIAL

(decision date)

(Address Block)

Modified Decision Notice

(without peer to peer)

Claimant:

Primary MD:

Claim Number:

Tax ID:

Requesting MD:

Place of Service:

Tax ID:

Tax ID:

Date RFA First Rec'd:

Date Additional Information requested: [if applicable]

This letter is in reference to the above claimant, (associated claimant), and the request for (description of specific course of medical treatment and # visits /days requested)

We have been unable to speak with you and the clinical information available for our review does not meet preliminary guidelines. Based upon review of the clinical information provided the request has been modified as medically necessary.

Request Received Date: (request received date)

Services Certified: (description of treatment/services certified)

Drug requests that do not specify "Do Not Substitute" or "Dispense as Written" and are approved for a generic equivalent when available are considered "Generic Substitute Authorized." Drug approvals that are exempt under the MTUS Drug Formulary are considered "Exempt per MTUS Drug Formulary." Approved non-drug treatment requests that qualify for an exemption under California Code of Regulations, section 9792.9.7, are considered "30-day exemption".

Certification Period: (certification date range) (# of visits/days etc.)

Certification Number: (certification number)

Outcome Decision Date: (date)

(Physician advisor's response including clear and concise explanation of the reasons for the reviewer/reviewing physicians decision and list of clinicals reviewed)

APPEAL

You may appeal or request an IMR for the portion of the request that was not certified.

The internal utilization review appeals process is a voluntary process that neither triggers nor bars the use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6 but may be pursued on an optional basis.

On a voluntary basis, if you would like to have this determination appealed, an appeal request will be accepted via telephone, in writing, or fax within 30 days from the date of this letter to:

Utilization Review / MCSC
Zurich Services Corporation-MCSC
1299 Zurich Way
Schaumburg, IL 60196 Phone
No: (800) 451-8731
Fax No: (866) 452-0254

If you would like to initiate a peer-to-peer discussion to have this determination re-reviewed, a request will be accepted via telephone, in writing or fax within 14 days from the date of this letter to the address and telephone number as above.

----- OR -----

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6 and that an objection to the utilization review decision must be completed 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 the timeframe indicated on the last page of the application.. To request an Independent Medical Review, sign the enclosed IMR form and forward in the enclosed addressed envelope to:

DWC-IMR
c/o MAXIMUS Federal Services, Inc.
P.O. Box 138009
Sacramento, CA 95813-8009

You may also file this form by faxing the document to: (916) 605-4270.

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (Adjuster Assignment) at (Claim Office Number). However, if you are represented by an attorney, please contact your attorney instead of me.

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

Decision PA Name
Board Certified, MD Specialty
(signature on file) License
Info

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:00 p.m. (PST) (except holidays)

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD (if applicable), Claims Professional, Nurse Case Manager (if applicable), IMR Form

Zurich Services Corporation

Decision Date
Address Block

Time Extension Notice

Claimant:

Requesting MD:

Claim Number:

Tax ID:

Birthdate:

Primary MD:

Date of Injury:

Tax ID:

Request First Received Date:

Place of Service:

Tax ID:

This letter is in reference to the above claimant, (claimant name), and the request for (description of specific course of medical treatment requested).

This request has been evaluated against MTUS or if the services fall outside of our request for additional information is based on Official Disability Guidelines. This letter will serve as written notice to your office that we are requesting additional information for this Request for Authorization due to one or more of the following reasons:

The following (test and/or examination) is needed to be performed on the injured worker which is reasonable and consistent with professionally recognized standards of medical practice.

A specialized consultation and review of medical information by an expert reviewer is needed. Per 8 CCR 9792.9.6(a)(1)(B)-(C) if the results of the additional examination or test required or the specialized consultation that is requested by the reviewer is not received within 30 days from the date of the request for authorization, the reviewer shall deny the treating physician's request with the stated condition the request will be reconsidered upon receipt of the results of the additional exam, test, or specialized consultation.

The determination will be made once the report from the additional test or examination and or the expert consultation is completed and reviewed. If applicable, please fax the report from the additional test or examination to the UR department at (888) 704-3153 as soon as possible.

Decision PA Name
Board Certified, MD Specialty
(Signature on file) License Info

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:00 p.m. (PST) (except holidays).

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD, Claims Adjuster, Nurse Case Manager (if applicable),

Zurich Services Corporation

«Addressee»
«Address1» «Address2»
«City», «State» «Zip»

«Current Date»

CONFIDENTIAL

Claimant:	«EmployeeNameInfo»	Primary MD:	«TrPhyNameInfo»
Claim Number:	«ClaimNumber»	Tax ID:	«TreatingTaxID»
Requesting MD:	«ReqPhyNameInfo»	Place of Service:	«FacilityName»
Tax ID:	«RequestingTaxID»	Tax ID:	«FacilityTaxID»

Date RFA First Received: «CarrierReceivedDate».

California Withdrawal/Deferral Notice

This letter is in reference to the above claimant, «EmployeeNameInfo», and the request for «Request».

This request has been withdrawn/deferred for the following reason:

- «Text7» (denied claim)

This letter serves as notification of this withdrawal/deferral.

If other treatment is required, please fax the required request for authorization with appropriate medical records to the Utilization Review Department.

Utilization Review / MCSC
Zurich Services Corporation-MCSC 1299 Zurich Way
Schaumburg, IL 60196

Phone No: (800) 451-8731

Fax No: (866) 743-1634

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.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call «AdjusterFirstName» «AdjusterLastName» at «AdjusterPhone»«AdjusterExt» at (800) 338-3160. However, if you are represented by an attorney, please contact your attorney instead of me.

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

Zurich Services Corporation / MCSC MCSC
- Utilization Review Unit – MCSC

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:00 p.m. (PST) (except holidays).

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD (if applicable), Claims Professional,
Nurse Case Manager (if applicable)

Zurich Services Corporation

Decision Date

«Addressee»

«Address1» «Address2»

«City», «State» «Zip»

Denial for Lack of Medical Information Notice

Claimant:

Requesting MD:

Claim

Tax ID:

Number:

Primary MD:

Birthdate:

Tax ID:

Date of Injury:

Request First Received Date:

Place of Service:

**Date Additional Information requested:
[if applicable]**

Tax ID:

This letter is in reference to the above claimant, (claimant name), and the request for (description of specific course of medical treatment requested).

The request is being denied for lack of information in compliance with California Regulations 9792.9.6(a)(1):

(A) If the information reasonably necessary to make a determination under subdivision 9792.9.6(c)(1) 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 9792.9.6(c)(2), or the specialized consultation under subdivision 9792.9.(c)(2), 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.

This request will be reconsidered upon receipt of the information.

The internal utilization review appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6 but may be pursued on an optional basis.

On a voluntary basis, if you would like to have this determination appealed, an appeal request will be accepted via telephone, in writing, or fax within 30 days from the receipt date of this letter to:

Utilization Review I MCSC Zurich Services Corporation-MCSC
1299 Zurich Way
Schaumburg, IL 60196

Phone No: (800) 451-8731

Fax No: (866) 452-0254

If you would like to initiate a peer-to-peer discussion to have this determination re-reviewed, a request will be accepted via telephone, in writing or fax within 14 days from the date of this letter to the address and telephone number as above.

*
____OR____

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6 and that an objection to the utilization review decision must be completed 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 the timeframe indicated on the last page of the application. To request an Independent Medical Review sign the enclosed IMR form and forward in the enclosed addressed envelope to:

DWC-IMR c/o MAXIMUS Federal Services. Inc.
P.O. Box 138009
Sacramento.CA 95813-8009

You may also file this form by faxing the document to: (916) 605-4270.

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (Adjuster Assignment) at (Claim Office Number). However, if you are represented by an attorney, please contact your attorney instead of me.

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

Decision PA Name:
Board Certified, MD Specialty
(Signature on file)
License Info:

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:00 p.m. (PST) (except holidays).

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD, Claims Adjuster, Nurse Case Manager (if applicable),

Zurich Services Corporation



CONFIDENTIAL

xx/xx/xxxx

Zurich Services Corporation is URAC Accredited for Workers' Compensation Utilization Management.

Claimant name
Claimant address
Claimant city, state,
zip

Non-Certification Notice

Claimant Name
Claim Number xxxxxxxxxxxxxx
Requesting MD Dr. MD
Tax ID
Request First Received Date xx/xx/xxxx

Primary MD:
Tax ID:
Place of Service
Tax ID

Date Additional Information requested: [If applicable]

This letter is in reference to the above claimant, Claimant name, and the request for Norco 5/325 mg # 20 .

This letter will serve as written notice to your office that we are unable to certify this request based on the clinical information provided.

We have been unable to speak with you and the clinical information available for our review does not meet preliminary guidelines.

Outcome Decision Date: xx/xx/xxxx

DATA REVIEWED AND CONTACT INFORMATION:

- " PA Referral Summary dated xx/xx/xxxx
- " PRS
- " Request for Authorization dated xx/xx/xxxx
- " Request for Authorization Invoice Bill
- " Supplemental Report with Request for Authorization for Additional Treatment by requesting provider dated xx/xx/xxxx

First and Last Name of Contact	Left Message	Date of Call	Time of Call
Call dropped No	xx/xx/xxxx	3:53 PM PT	
office staff Yes	xx/xx/xxxx	3:54 PM PT	

x/xx/xxxx 3:53 PM PT - Reached Call dropped - I called the office of the provider at (xxx-xxx-xxxx) and the call dropped.

x/xx/xxxx 3:54 PM PT - Reached office staff - I called the office of the provider at (xxx-xxx-xxxx) and I spoke with office staff, and she informed me that the request for Norco was for post-operative pain if claimant were to need it after his dental implant surgery. She stated that the surgery is not planned yet as the office is still awaiting authorization.

SUMMARY OF RECORDS:

SAMPLE

Claimant is a male claimant, date of birth is xx/xx/xxxx, with a date of injury of xx/xx/xxxx. The mechanism of injury was claimant sustained multiple injuries to the right wrist, lower back and right-side repetitive work while building a sewer system and heavy lifting in the course of his job. The diagnosis is bruxism/clenching and grinding of the teeth and bracing of the facial muscles, and osteoarthritis of the TMJ. This claimant was seen on xx/xx/xxxx by requesting provider for periodontal maintenance. This claimant reported to have heavy bleeding, moderate plaque, and light to moderate calculus. The exam shows tooth number 18 is missing in tooth number 15 as present. Plan is for dental implant surgery.

REVIEW QUESTION (S):

1. Based on review of the medical records provided, is the proposed treatment consisting of Norco 5/325 mg # 20 appropriate and medically necessary for this diagnosis and clinical findings? Yes or No. Please explain.

T Non-Certification

The proposed treatment consisting of Norco 5/325 mg # 20 is not medically necessary.

The request for Norco is for possible post-operative pain if the claimant were to require narcotics for pain control. However, per office staff, claimant's procedure has not yet been scheduled. Since claimant is not currently having pain that requires narcotics, this request is not appropriate or medically necessary per guidelines. Therefore, the proposed treatment consisting of Norco 5/325 mg # 20 is not medically necessary. Due to the nature of this drug, weaning is recommended.

GUIDELINE/REFERENCE

CA ACOEM Opioids for Treatment of Acute, Severe Pain
Recommended.

Opioids are recommended for treatment of acute, severe pain (e.g., crush injuries, large burns, severe fractures, injury with significant tissue damage) uncontrolled by other agents and/or with functional deficits caused by pain. They also may be indicated at the initial visit for a brief course for anticipated pain accompanying severe injuries (i.e., failure of other treatment is not mandatory). Tramadol* may be indicated if there is true allergy to nonsteroidal anti-inflammatory drugs (NSAIDs) and acetaminophen, other contraindication to an alternative medication, or insufficient pain relief with an alternative. A Schedule II opioid may be indicated for more severe pain. Recommend tapering off opioid use in 1 to 2 weeks.

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed. (CDC, 2016)
Strength of Evidence Recommended, Evidence (C)

Level of Confidence High

Indications: Patients should meet all the following:

Severe injury with a clear rationale for use (objective functional limitations due to pain resulting from the medical problem, e.g., extensive trauma such as forearm crush injury, large burns, severe radiculopathy). See examples of decision logic in Table 1. (Other indications beyond the scope of this guideline include acute myocardial infarction or agitation interfering with acute trauma management.)

Other more efficacious treatments should have been instituted, and either: documented to have failed and/or have reasonable expectations of the immediate need for an opioid to obtain sleep the evening after the injury

Prescription databases (usually referred to as Prescription Drug Monitoring Program (PDMP)) should be checked and not show evidence of concomitant prescriptions, conflicting opioid prescriptions from other providers or evidence of misreporting. Any of these are strong contraindications for a prescription, especially in the absence of severe objective injury. (Exceptions such as acute, severe trauma should be documented.) When the PDMP indicates other opioids medications have been recently used, yet there is need for a second prescription of opioids, a few days of prescription at a low dose (e.g., 20mg morphine equivalent dose (MED)) may be reasonable with close monitoring.

Non-opioid prescriptions (e.g., NSAIDs, acetaminophen) absent contraindication(s) should nearly always be the primary treatment and accompany an opioid prescription. Due to greater than 10-fold elevated risks of adverse effects and death, considerable caution is warranted among those using other sedating medications and substances, including benzodiazepines, anti-histamines (H1-blockers), and/or illicit substances.(105, 109, 167, 168) Patients should not receive opioids if they use illicit substances unless there is objective evidence of significant trauma or at least moderate to severe injuries.

The internal utilization review appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6 but may be pursued on an optional basis.

On a voluntary basis, if you would like to have this determination appealed, an appeal request will be accepted via telephone, in writing, or fax within 30 days from the receipt date of this letter to:

Utilization Review / MCSC
Zurich Services Corporation-MCSC
1299 Zurich Way
Schaumburg, IL 60196

Phone No: (800) 451-8731
Fax No: (866) 452-0254

If you would like to initiate a peer-to-peer discussion to have this determination reconsidered, a request will be accepted via telephone, in writing or fax within 14 days from the date of this letter to the address and telephone number as above.

_____OR_____

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6 and that an objection to the utilization review decision must be completed 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 the timeframe indicated on the last page of the IMR application. To request an Independent Medical Review, sign the enclosed IMR form and forward in the enclosed addressed envelope to:

DWC-IMR
c/o MAXIMUS Federal Services, Inc
P.O. Box 138009
Sacramento, CA 95813-8009

You may also file this form by faxing the document to: (916) 605-4270

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (Adjuster Assignment) at (Claim Office Number). However, if you are represented by an attorney, please contact your attorney instead of me.

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

[REDACTED]

Utilization Review and Physician Reviewer Department Hours of Operation: 9:00 a.m. - 5:00 p.m. (PST) (except holidays).

cc: Injured Worker, Attorney (if represented), Requesting MD, Primary MD (if applicable), Claims Professional, Nurse Case Manager (if applicable), IMR Form

Division of Workers' Compensation
Department of Industrial Relations
State of California

Form IMR



REQUEST INDEPENDENT MEDICAL REVIEW:

- Sign and date this application and consent to obtain medical records.
- Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to: **Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009**
FAX Number: (916) 606-4270
- Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator.
THE DEADLINE FOR FILING IS AT THE END OF THE FORM.

Type of Utilization Review:

Regular ☐	Expedited ☐	Modification after Appeal ☐
Medication Only – MTUS	Retrospective for Exempt	Retrospective for Exempt
Formulary Drug List ☐	Treatment (Non-Drug) ☐	Treatment (Drug) ☐

Employee Information:

First Name: «EmployeeFirstName» Middle Initial: «EmployeeMiddleName» Last Name: «EmployeeLastName»
Address: «EmployeeAddress1», «EmployeeCity» Number/Unit: «EmployeeAddress2»
State: «EmployeeState» Zip Code: «EmployeeZip» Telephone Number: «EmployeeCell»
«EmployeePatientPhone»

Fax Number: «EmployeeFax» Date of Injury: «EmployeeDOI»
Insurance Claim Number: «ClaimNumber» EAMS Case Number: «EAMS» WCIS
Jurisdictional Claim Number (if assigned): «JurisdictionClaimNumber»

Employee Attorney (if known): «AttorneyFName» «AttorneyLName»
Address: «AttorneyAddress1», «AttorneyCity» Number/Unit: «AttorneyAddress2»
State: «AttorneyState» Zip Code: «AttorneyZip» Telephone Number: «AttorneyPhone» «AttorneyExt»
Fax Number: «AttorneyFax»

Requesting Physician Information:

Physician First Name: «ReqPhyFirstName» Middle Initial: «ReqPhyMiddleName» Last Name: «ReqPhyLastName»
Practice Name: «ReqPhysClinic»
Address: «ReqPhyAddress1», «ReqPhyCity» Number/Unit: «ReqPhyAddress2»
State: «ReqPhyState» Zip Code: «ReqPhyZip» Telephone Number: «ReqPhyPhone» «ReqPhyExt» Fax
Number: «ReqPhyFax» Specialty: «ReqPhySpecialty»

Claims Administrator Information:

Employer Name: «Employer» «EmployerInsuredName»
Name of Administrator: Zurich North America Contact Name: «AdjusterFirstName» «AdjusterLastName»
Address: P.O. Box 968005, Schaumburg Number/Unit:
State: Illinois Zip Code: 60196 Telephone Number: «AdjusterPhone»«AdjusterExt»
Fax Number: 818- 227- 1740

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):
«Diagnosis»

* Mailing Date of the Utilization Review Determination Letter:
«CurrentDate»

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☐No

Reason:
«ClaimDispute»

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

- 1. Denied and Modified treatments

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of

California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

- ☐ 30 days from the mailing date of the written determination letter.
- ☐ 10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" determination letter) that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review ("IMR") of the medical treatment request by a physician who is not connected to your Claims Administrator. If the IMR is decided in your favor, your Claims Administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your Claims Administrator.

- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.
- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

**DWC-IMR, c/o Maximus Federal Services, Inc.
PO Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270**

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	
------------------------	--

I wish to designate

Name of Individual (Print):	
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to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:		Date:
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Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)			
Address:			
City:	State:	Zip Code:	
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:		Date:	