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**WORKERS' COMPENSATION MANAGED**  
**POLICIES, PROCESS AND PROCEDURE**

**POLICY/PROCESS/PROCEDURE:** UTILIZATION REVIEW PLAN FOR CALIFORNIA  
**ISSUING DEPARTMENT:** WORKERS' COMPENSATION MANAGED CARE  
DIVISION UTILIZATION REVIEW DEPARTMENT

**WESTERN INTEGRATED CARE  
WORKERS' COMPENSATION MANAGED CARE DIVISION  
UTILIZATION REVIEW (UR) DEPARTMENT  
UTILIZATION PLAN FOR THE STATE OF CALIFORNIA**

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## **I. INTRODUCTION**

- A. This Utilization Review Plan is filed on behalf of WESTERN INTEGRATED CARE (WIC). WIC has established and maintains this Utilization Review Plan and its Utilization Review Process in compliance with Labor Code §4610 and 8 CCR 9792 et seq. WIC will file a modified utilization review plan with the Administrative Director within 30 calendar days after any material modification to the plan.
- B. The purpose of the WIC Utilization Review Process is to provide an assessment of the clinical appropriateness and medical necessity of Treatment Requests and Medical Services provided for compensable claims. The Utilization Review Process does not include decisions of the compensability of the injury or disease or bill review for the purpose of determining whether the Medical Services were accurately billed.
- C. This Utilization Review Plan summarizes the policies, procedures, processes and standards that govern WIC'S Workers' Compensation Utilization Review Process. Upon request by the public, WIC will make available the complete Utilization Review Plan, consisting of the policies and procedures, and a description of the Utilization Review Process by sending a written request by mail to WESTERN INTEGRATED CARE at no cost to the requestor.
- D. Capitalized terms used in this Utilization Review Plan are defined by 8 CCR 9792.6.1 and/or are included in Appendix A.

## **II. UTILIZATION REVIEW PROGRAM STRUCTURE AND OVERSIGHT**

- A. The Medical Director oversees and evaluates the processes by which WIC reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of Medical Services, complies with Labor Code section §4610(d) and the 8 CCR 9792 et seq. The Medical Director is responsible for all decisions made in the Utilization Review Process. The Medical Director holds an unrestricted license to practice medicine in the State of California, issued pursuant to section 2450 of the Business and Professional Code.
- B. Administrative/Clerical staff perform intake and administrative tasks only, they do not make any Utilization Review Decisions. Administrative tasks include but are not limited to printing, collating, mailing, faxing, and e-mailing of letters, requests, and documents.
- C. Review Coordinators/First Level Reviewers and Claim Professionals are Non-Physician Reviewers who are trained in the application of the Medical Treatment Utilization Schedule (MTUS) and other evidence-based treatment guidelines utilized for the assessment of the medical appropriateness of the requested treatments and/or services. Non-Physician Reviewers that are Review Coordinators/First Level Reviewers are healthcare professionals and may include RN, LVN/LPN, DC, PA, PT, and OT. Non-Physician Reviewers can issue Authorizations of medical treatment requests that comply with MTUS, but they cannot issue Modifications or Denials. Our initial screening will be done by administrative staff.
- D. Peer Reviewers/Physician Reviewers are licensed medical doctors, doctors of osteopathy, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners

- licensed by any state or the District of Columbia, who are competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the Reviewer's scope of practice. Physician Reviewers may approve, modify, or deny requests for authorization of medical treatment for reasons of medical necessity. Physician Reviewers are available a minimum of four (4) hours per week during normal business hours, 9:00 a.m. to 5:30 p.m. Pacific Time, to discuss decisions with requesting providers.
- E. Expert Reviewer: Board Certified specialists who may consult with the Physician Reviewers or the Medical Director to provide specialized review services where required.
  - F. WIC contracts with The P&S Network, Inc., 8447 Wilshire Blvd., 202, Beverly Hills, CA 90211, phone: (323) 556-0555 to provide Physician Review and Expert Review services.
    - 1. P&S currently holds a URAC Certificate of accreditation in Workers Compensation Utilization Management (WCUM) effective 11/1/24 through 11/1/27.
    - 2. Neither WIC nor the Claims Administrator have financial interest, as defined under Labor Code Section 139.32, in the physician review organization, its Physician Reviewers, or its Expert Reviewers.
  - G. No Physician Reviewer, Expert Reviewer, or Medical Director conducting utilization review are offered nor provided any financial incentive or consideration based on the number of Modifications or Denials made by the Physician/Expert Reviewer/s and/or Medical Director.

### **III. MEDICAL BASED CRITERIA**

- A. The criteria or guidelines used in WIC'S UTILIZATION REVIEW PLAN will be consistent with 8 CCR 9792.20-26, or other sections as added, to the Medical Treatment Utilization Review Schedule (MTUS).
- B. For all injuries or illnesses not addressed by MTUS, authorized treatment will be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based. Treatment will not be denied on the sole basis that the treatment is not addressed in 8 CCR 9792.20-26, et al.
- C. WIC selects and applies treatment guidelines according to this hierarchy:
  - 1. Medical Treatment Utilization Schedule (MTUS) including the Drug Formulary which is considered presumptively correct.
  - 2. American College Occupational & Environment Medicine (ACOEM) Practice Guidelines, most recent on-line edition.
  - 3. Official Disability Guidelines Treatment in Workers Compensation (ODG-TWC), Work Loss Data Institute, most recent on-line edition.
- D. If no applicable guideline is found in WIC's hierarchy of medical guidelines, or if the Reviewing Physician believes there is another recommendation supported by a higher quality and strength of evidence, then the Reviewing Physician shall search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's injury or illness and choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1.

- E. WIC utilizes consistent documentation of selected guidelines as follows:
1. When citing the MTUS, the citation shall include:
    - a) The term “MTUS” or “Medical Treatment Utilization Schedule”.
    - b) The effective year of the guideline.
    - c) The title of the chapter referenced (e.g., Low Back Complaints).
    - d) The section referenced within the chapter (e.g., Surgical Considerations).
  2. When citing other medical treatment guidelines, the citation shall include:
    - a) The name or abbreviated name of the guidelines being cited (e.g., Official Disability Guidelines; ODG).
    - b) The name of the organization publishing the guidelines (e.g., Work Loss Data Institute).
    - c) The year of publication.
    - d) The title of the chapter.
    - e) The section referenced within the chapter (if applicable).
  3. When citing a peer-reviewed study, the citation shall include:
    - a) The last name and first initial of the first author listed in the study.
    - b) The published article’s title.
    - c) Journal title (standard abbreviations may be used).
    - d) Volume number.
    - e) Year published.
    - f) Page numbers.
- F. All guidelines used in the UR process to determine whether to authorize, modify, or deny medical treatment services are developed with involvement from actively practicing physicians. These guidelines must be consistent with the MTUS, including the drug formulary adopted pursuant to Cal. Lab. Code § 5307.27. All guidelines used are proprietary and reviewed for updates no less than annually.
- G. The relevant portion of the criteria or guidelines used will be included in the Written UR decision letter if used as a basis of a decision to modify or deny services in the specific case under review. There will be no charge to an injured worker, the injured worker’s attorney, or the Requesting physician for a copy of the relevant portion of the criteria or guidelines used to modify or deny the treatment request.

#### **IV. REQUEST FOR AUTHORIZATION**

- A. The Request for Authorization is defined in 9792.6.1(u) as a request for a specific course of proposed medical treatment.
- B. A Request for Authorization must be set forth on a “Request for Authorization (RFA),” completed by a Requesting physician, as contained in California Code of Regulations, title 8, section 9785.5. This form and its instructions can be found on the DWC Web Site: <http://www.dir.ca.gov/dwc/forms.html>. A request for authorization that is not set forth on a DWC form RFA must include all required information pursuant to 8 CCR § 9792.6.1 (u) (1-3) to be accepted.
- C. For WIC to deem an RFA complete, the RFA must:

1. Identify both the injured worker and the provider.
  2. Identify with specificity a recommended treatment or treatments.
  3. Be accompanied by documentation substantiating the need for the requested treatment.
  4. Be signed by the Requesting physician (electronic signature acceptable).
  5. Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Requesting physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment issued or created no earlier than 30 days before the date of submission of the request for authorization.
  6. Contain all the information needed to substantiate the Request for Authorization. If the request is to continue a treatment plan or therapy, attached documentation indicating progress should be submitted, if applicable.
- D. Complete RFAs will be reviewed in accordance with the Medical Treatment Utilization Schedule (MTUS) for the accepted injury or illness.
- E. Incomplete RFA's will be returned to the requesting provider within five (5) business days from receipt of the incomplete RFA which will be marked "Not Complete". The specific reason/s for the return of the request will also be included.
- F. The Utilization Review Process begins when the completed RFA is first received by WIC or in the case of prior authorization, when the Requesting physician satisfies the conditions described in the Utilization Review Plan for prior authorization.
- G. WIC determines the received date of the RFA as described in section 9792.9.1(a)(1-2).

Additionally:

1. An RFA is deemed to have been received by facsimile or by electronic mail on the date the form was received if the receiving facsimile or electronic mail electronically date stamps the transmission when received.
2. If there is no electronically stamped date recorded, then the date the RFA was transmitted shall be the date the form was received. An RFA transmitted by facsimile after 5:30 PM Pacific Time will be deemed to have been received on the following business day, except in the case of an Expedited or Concurrent Review.
3. The copy of the RFA or fax cover sheet, received by a facsimile transmission or by electronic mail shall demonstrate a notation of the date, time and place of transmission and the facsimile telephone number or electronic mail address to which the request was transmitted, or be accompanied by an unsigned copy of the affidavit, or certificate of transmission, or a fax transmission report. The Requesting physician must indicate the need for an Expedited Review on the RFA form.
4. Where the Request for Authorization is made by mail, and a proof of service by mail exists, the request will be deemed to have been received five (5) days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.
5. Where the Request for Authorization is delivered via certified mail, return receipt mail, the request will be deemed to have been received on the receipt date entered on the return receipt.
6. In the absence of documentation of receipt, evidence of mailing, or dated return receipt, the RFA form shall be deemed to have been received five (5) days after the latest date the sender wrote on the document.

- H. The timeframe for a decision on a returned Request for Authorization shall begin anew upon receipt of a Retrospective Review RFA.
- I. Failure to obtain authorization prior to providing Emergency Health Care Services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for Emergency Health Care Services. Emergency Health Care Services may be subject to Retrospective Review.
  - 1. “Emergency Health Care Services” means health care services for an injury or illness 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. Cases involving “urgent care” also follow the same definition.

## **V. ADMINISTRATIVE AUTHORIZATIONS & PROSPECTIVE REVIEW**

- A. Claims Professional acknowledges that the MTUS (Medical Treatment Utilization Schedule) Guidelines are the presumptively correct guidelines for California. Claims Professionals may only approve treatment requests under the WIC UR plan; a Claims Professional may not modify or deny a request for medical treatment based on medical necessity or lack of information.
- B. Claims Professional may choose to administratively approve requests for authorization.
- C. If the Claims Professional cannot approve the medical treatment request for a compensable injury/body part, the Claims Professional will forward the RFA for UR.
- D. The following list of treatments or procedures has been approved by the Medical Director and may be approved by the Claims Professional:
  - 1. Routine Care for common injuries within 30 days of date of injury.
  - 2. Medical Consults, Transfer of Care and Referral Appointments.
  - 3. Routine Pre-Operative Medical Clearance, Testing (CBC, UA, Chemistry Panel, CXR, EKG and Treadmill Testing) and Labs (PT/PTT INR).
  - 4. Standard DME orders such as: Crutches, Braces, Splints, Walkers, Basic Wheelchair Rental (x1 month), Grabbers, Toilet Seats and Canes with cost between \$201-\$500.
  - 5. Initial Physical, Acupuncture, Occupational and Chiropractic Therapy up to 24 sessions each.
  - 6. Initial Massage Therapy x6 sessions.
  - 7. Initial Imaging: MRI.
  - 8. Initial Cortisone Injection.
  - 9. Initial Trigger Point Injection.
- E. For all dates of injury, the treatments or procedures listed below fall under the prior authorization process and do not require Prospective Review. Such Services can be provided to the injured worker by the Requesting physician, without obtaining verbal or written authorization.
  - 1. DME less than \$200.
  - 2. Routine physician follow-ups.
  - 3. Initial plain film x-rays.
  - 4. Casting or splinting orthopedic injuries.

5. Exempt Prescription medication(s) prescribed for a specific accepted injury.
- F. For all dates of injury occurring on or after January 1, 2018, Emergency Health Care Services and medical treatment rendered for a body part, injury or illness that is accepted as compensable by the employer and is addressed by the Medical Treatment Utilization Schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized without Prospective utilization review, except for those treatment services listed in Section 9792.9.7 (a) (1-8).
  - G. In the event that the injured worker is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the injured worker shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a medical provider network physician or facility selected by the employer.
  - H. Following the injured worker's initial treatment rendered by a Requesting physician including a medical provider network physician, health care organization physician, a physician predesignated, or an employer selected physician, the Requesting physician shall provide a report as required under Labor Code Section 6409 and a complete Request for Authorization within five days the initial treatment.
  - I. The following medical treatment provided within 30 days of the date of injury is subject to Prospective utilization review.
    1. Pharmaceuticals, to the extent they are neither expressly exempted from Prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.
    2. Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.
    3. Psychological treatment services.
    4. Home health care services.
    5. Imaging and radiology services, excluding x-rays.
    6. All durable medical equipment, which's combined total value, exceeds two hundred fifty dollars (\$250), as determined by the official medical fee schedule.
    7. Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
    8. Spinal injections.
    9. Any other service designated and defined through rules adopted by the administrative director.
  - J. The services under this section shall be consistent with the most current MTUS, MTUS Drug Formulary and applicable WIC requirements. WIC may request Retrospective Review of the treatment for the purpose of determining compliance with MTUS. If Retrospective Review shows that treatment was not within MTUS guidelines, including the MTUS Drug Formulary, WIC may:
    1. Upon notice to the Requesting physician, require the provider to obtain Prospective Review for all treatment if there is a pattern and practice of failing to treat consistently within MTUS guidelines, including the MTUS Drug Formulary.

2. Petition for a change of physician or provider pursuant to Labor Code 4603; and/or remove the provider from the WIC MPN for failure to comply with WIC MPN requirements and per Labor Code 4610(f) (2) and Section 9792.9.7 (c) (A-C).
- K. Any request for payment for treatment provided under section VII. A – B shall comply with Labor Code Section 4603.2 and be submitted to the employer or its insurer or Claims Administrator within 30 days of the date the service was provided. If a physician fails to submit the report required under Section 6409 and a complete Request for Authorization, an employer may remove the physician’s ability under this subdivision to provide further medical treatment to the injured worker that is exempt from Prospective utilization review.

## **VI. DISPUTED LIABILITY**

- A. WIC will defer Utilization Review of a medical request received on a RFA form if the Claims Professional Disputes Liability for either the occupational injury and/or body part for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.
- B. The Claims Administrator shall issue a Written decision deferring utilization review of the requested treatment within five (5) business days from receipt of the RFA. The Written decision will 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 deferring UR includes:
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 Professional’s dispute of liability for the injury, claimed body part or parts, or the recommended treatment.
  4. A plain language statement advising the injured worker that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers’ Compensation Appeals Board.
  5. The following mandatory language:

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.

For information about the workers’ compensation claims process and your rights and obligations, go to [www.dwc.gov](http://www.dwc.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.

- C. If utilization review is deferred pursuant to section 9792.9.2 and it is finally determined that the Claims Administrator is liable for treatment of the injury or illness for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, the time to conduct a Retrospective utilization review in accordance 9792.9.2 shall begin on the date the determination of the Claims Administrator's liability becomes final. The time to conduct Prospective utilization review shall commence from the date of the Claims Administrator's receipt of a RFA after the final determination of liability.
- D. Upon receipt of the information for Retrospective Review, WIC will make the decision to approve the Request for Authorization or refer for Physician Review within thirty (30) days.
- E. Nothing in this Utilization Review Plan modifies or alters the Claims Administrator's ability to deny requests for treatment when WIC has:
  - 1. Officially rejected compensability of the underlying claim for workers compensation. In these situations, all s must be for lack of compensability and not on the basis of medical necessity or utilization review criteria.
  - 2. Determined that certain body parts or medical conditions are not part of or related to the accepted compensable claim and therefore, requests for treatment related to those conditions or body parts should be denied.

## **VII. ACCESS TO UTILIZATION REVIEW**

- A. WIC maintains staffed telephone access, 702-431-0765 from 9:00AM to 5:30 PM Pacific Time, on normal business days, for requesting physicians to request authorization for medical services. Voice messages may be left 24/7.
- B. WIC maintains a 24/7 facsimile number, 702-869-2386, available for physicians to request authorization for medical services.
- C. A normal business day means a business day as defined in Labor Code section 4600.4 and Civil Code section 9, and Title 8, California Code of Regulations section 9792.6.1(cc).

## **VIII. THE CLINICAL UTILIZATION REVIEW PROCESS**

- A. Pursuant to Section 9792.27.10., WIC requires medical services and drugs that are not listed as Exempt on the MTUS Drug Formulary to be preauthorized through Prospective Review. If services are performed without authorization, WIC may require Retrospective Review of the treatment. If the treatment is not found to be medically necessary, reimbursement for the service will be denied. Providers must submit medical documentation to support the medical necessity of any services rendered outside the scope of Authorized services. Those services will be reviewed for Medical Necessity through Retrospective Review. Failure to provide appropriate documentation of Medical Necessity may result in Denial of reimbursement for the services.
- B. Pursuant to 8 CCR § 9792.7(b)(3), WIC utilizes Non-Physician Reviewers to conduct initial review. Non-physician Reviewers apply the applicable medical treatment guidelines

according to the guideline hierarchy to the specified medical treatment contained in the complete RFA and:

1. Approves the request(s) for Authorization of medical services OR
  2. Discusses the 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 of the treatment in question and submit an amended RFA, and the Non-Physician Reviewer may approve the amended RFA. OR
  3. Requests appropriate additional information that is necessary to render a decision but in no event, shall this exceed the time limitations imposed in section 9792.9.3 and 9792.9.4. Any time beyond the time specified in these sections is subject to the provisions of section 9792.9.6.
    - a) If the requested documentation is not received timely, the Non-Physician Reviewer will refer the request for Physician Review
- C. WIC utilizes Physician Reviewers to conduct review on all requests where neither the Claim Professional or the Non-Physician Reviewer were able to approve the requested medical treatment/services. Only a Reviewer who is competent to evaluate the specific clinical issues, which are within the scope of the physician's practice, may modify or deny treatment requests.
1. Physician Reviewers can issue approvals based on supplied information.
  2. Telephonic contact to the Requesting physician will be attempted at the discretion of the Physician Reviewer.
  3. If the Physician Reviewer cannot approve the treatment under review based on the information provided, and telephonic attempts to obtain additional information within the standard applicable timeframe have failed, then:
    - a) If the treatment is subject to the formulary and is a standard Prospective or Concurrent Review, the Physician Reviewer will issue a Written denial for insufficient information within five working days from the receipt of the medical treatment request pursuant to Cal. Labor Code § 4610(i)(1).
    - b) If the treatment is not subject to the formulary and is a standard Prospective or Concurrent Review, then in addition to the telephonic requests, the Reviewer will issue a Written request for additional information within five working days of receipt of the Request for Authorization, pursuant to 8 CCR 9792.9.6(b)(1).
      - (i) If the information is not received within fourteen (14) days from receipt of the completed Request for Authorization for Prospective or Concurrent Review, the Physician Reviewer shall deny the request for insufficient information, pursuant to 8 CCR 9792.9.6(c)(1).
    - c) If the treatment request is an expedited Prospective or Concurrent Review, and the Physician Reviewer is not in receipt of the information reasonably necessary to make a determination, the Physician Reviewer will issue a decision to approve, modify, or deny the request within 72 hours from the receipt of the medical treatment request, pursuant to 8 CCR § 9792.9.3(c). If the requested information is subsequently received, the Physician Reviewer

shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information, pursuant to 8 CCR § 9792.9.6(d)(2).

- d) If the treatment request is a Retrospective Review, and the reviewer is not in receipt of all information reasonably necessary to make a determination, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization, pursuant to 8 CCR § 9792.9.6(b)(1). If the information reasonably necessary to make a determination is not received within thirty (30) days of the request for Retrospective Review, a physician reviewer shall deny the request for insufficient information in accordance with 8 CCR § 9792.9.6(c)(1) and the applicable rules in section 9792.9.5(e). Upon receipt of the requested information, the physician reviewer shall make the decision to approve, modify, or deny the request for authorization within thirty (30) calendar days of receipt of the information, pursuant to 8 CCR § 9792.9.6(d)(3).
  - e) If the required information is provided for reconsideration following a request for insufficient information, a new decision is issued within five working days of receipt of the information (in the case of standard Prospective or Concurrent Reviews), within 72 hours of receipt of the information (in the case of expedited Prospective or expedited Concurrent Reviews), or within 30 days of receipt of the information (in the case of Retrospective Reviews), pursuant to 8 CCR 9792.9.6(d).
  - f) All attempts to obtain the necessary medical information from the physician by either telephone, facsimile, mail, or e-mail are documented.
4. If the Physician Reviewer has asked that an additional examination or test be performed upon the injured worker, such a request must be reasonable and consistent with professionally recognized standards of medical care pursuant to 8 CCR § 9792.9.6(c)(2).
5. The Physician Reviewer or Medical Director may also seek a specialized consultation and review of medical information by an Expert Reviewer pursuant to 8 CCR § 9792.9.6(a)(1)(C). If either of these situations applies, following the receipt of RFA or accepted Request for Authorization, the Physician Reviewer shall within five (5) business days from the date of receipt of the Request for Authorization notify the Requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the Physician Reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or the specialty of the Expert Reviewer to be consulted. The Physician Reviewer shall also notify the Requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered, pursuant to 8 CCR § 9792.9.6(b)(2).
- a) Pursuant to 8 CCR § 9792.9.6(c)(2), if the results of the additional examination, test, or the requested specialized consultation have not been

received within thirty (30) days from the date of the Request for Authorization, the Reviewer shall deny the Requesting physician's request with the stated injury or illness that the request will be reconsidered upon receipt of the results of the additional examination, test, or specialized consultation.

D. Medication/Pharmacy Reviews

1. Unless exempt by law, WIC requires Prospective Review of treatment to help ensure compliance with MTUS and the appropriate timely delivery of care to Injured Employees.
2. If a generic drug is available for treatment of the Injured Employee's injury or illness, then generic is given preference over brand name. Lower cost drugs are also preferred over higher cost therapeutic equivalent drugs.
3. Exempt Drugs: "Exempt" indicates the drug may be prescribed/dispensed without seeking authorization through Prospective Review if in accordance with MTUS. Prescription/dispensing of Brand name "Exempt" drugs where a generic drug is available requires authorization through Prospective Review. Prospective Review is also required for Exempt drugs when the usage is outside of MTUS guidelines, including conditions for which the Exempt drug is not recommended.

## IX. QUALITY MANAGEMENT PROGRAM

- A. The purpose of the Quality Management Program (QMP) is to ensure compliant, timely, and high-quality Utilization Review (UR) services through continuous monitoring, evaluation, and improvement of WIC's workers' compensation managed care activities.
- B. This policy applies to all WIC staff and contracted clinical reviewers involved in Utilization Review services.
- C. WIC maintains a structured Quality Management Program designed to ensure UR services meet regulatory requirements and internal performance standards.
- D. Responsibilities:
  1. Medical Director: Provides clinical oversight for all UR activities. Participates in annual Quality Review Meeting. Reviews of clinical trends and improvement recommendations.
  2. Vice President: Oversees day to day quality monitoring processes. Manages complaint handling and documentation. Oversees QIP planning, implementation, and evaluation.
  3. Managed Care Specialist: Participate in quality monitoring activities. Cooperate with complaint investigations and corrective actions.
- E. Procedures
  1. CQI activities include evaluation of UR work product for:
    - a) Compliance with WIC policies and procedures
    - b) Compliance with state regulatory requirements, including timeframes
    - c) Adherence to client specific instructions
    - d) Findings are documented and used to develop improvement actions.
- F. Quality Oversight Structure:

1. Annual Quality Review Meeting to include the Medical Director or their designate and internal staff to evaluate:
  - a) Program performance
  - b) Clinical and operational trends
  - c) Key metrics
  - d) Complaints and appeals/IMR data
  - e) CQI findings
  - f) Improvement opportunities
2. Leadership monitors and documents:
  - a) CQI results
  - b) Policy and procedure updates
  - c) Complaint activity
  - d) Appeals/IMR analysis
  - e) Key performance indicators
  - f) Overall program effectiveness
3. Quality Improvement Projects (QIPs)
  - a) Initiated when organizational change is required.
  - b) Developed, tracked, and evaluated by WIC Operations.
  - c) Medical Director provides clinical input as necessary.
  - d) Outcomes are documented and retained in WIC systems.
4. Complaint Management: Complaints reviewed and responded to within 30 days.
  - a) Any party may submit a complaint about WIC's UR services.
  - b) The WIC Vice President reviews and manages all complaints.
  - c) Documentation is retained in WIC systems.
  - d) Written complaints receive a written response within 30 days of receipt.
  - e) Complaint trends are reviewed annually for improvement opportunities.
5. Client Satisfaction: Conducted at least annually through meetings, calls, or review sessions.
  - a) Feedback is incorporated into the CQI cycle.
  - b) Client satisfaction findings are documented and reviewed by leadership.
6. Documentation & Retention: All QMP records retained by WIC.

## **X. TIMEFRAMES FOR UTILIZATION REVIEW DECISIONS**

- A. Unless additional information is requested necessitating an extension, prospective or concurrent decisions to approve, modify, or deny a RFA must be made in a timely fashion that is appropriate for the nature of the injured worker's injury or illness, not to exceed five (5) business days from the date of receipt of the completed RFA.
- B. Prospective and Concurrent decisions to approve, modify, or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's injury or illness, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A

- request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under subdivision (b) would be detrimental to the injured workers' injury or illness, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (b).
- C. Prospective and Concurrent Reviews of Non-Formulary, Not Expedited: the decision 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 workers' injury or illness, not to exceed five (5) business days from the date of receipt of the Completed DWC Form RFA, but in no event more than 14 calendar days from the initial receipt of the Completed RFA.
  - D. Prospective and Concurrent Reviews of Formulary Requests, Not Expedited: decisions for requests for treatment covered by the formulary shall be made no more than five (5) working days from the date of receipt of the RFA.
  - E. Retrospective decisions to approve, modify, or deny a request for authorization shall be made within 30 days of receipt of the RFA and medical information that is reasonably necessary to make the decision.

## **XI. NOTIFICATION OF UTILIZATION REVIEW DECISIONS**

- A. Approvals/Authorizations
  - 1. For Prospective, Concurrent, or Expedited Review, approvals shall be communicated to the Requesting physician within 24 hours of the decision and shall be communicated to the Requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by Written notice to the Requesting physician within 24 hours of the decision for Concurrent Review and within two (2) business days for Prospective review.
  - 2. For Retrospective Review, a Written decision to approve shall be communicated to the Requesting physician who provided the medical services and to the injured worker who received the medical services, and his or her attorney/designee, if applicable.
    - a) A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured worker who received the medical services, and his or her attorney/designee, if applicable, in lieu of communication expressly acknowledging the retrospective approval.
  - 3. All approval communications include:
    - a) The date of receipt of the Completed RFA
    - b) The specific medical treatment(s)/service(s) approved/authorized
    - c) The date of the UR decision
    - d) If a Concurrent Review, approval communications also include:
      - (i) The date of admission to the hospital.
      - (ii) The number of days certified this review.
      - (iii) The total number of days certified.

4. For approvals of a RFA of a drug where it was not indicated “Do Not Substitute” or ‘Dispense as Written,’ a determination approving the request will include ‘generic substitute authorized’ or words to that effect or meaning.
5. For approvals of a RFA of a drug that is exempt per the MTUS Drug Formulary, a determination approving a request for such drug will include ‘Exempt per MTUS Drug Formulary’ or words to that effect and meaning.
6. For approvals of a RFA of a non-drug treatment that is exempt per § 9792.9.7, a determination approving a request will include ‘30-Day Exemption’ or words to that effect and meaning.
7. Payment, or partial payment, of a medical bill for services requested on a request for authorization shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete.

B. Modifications and Denials.

1. For Prospective, Concurrent, or Expedited Review, a decision to modify or deny shall be communicated to the Requesting physician within 24 hours of the decision and shall be communicated to the Requesting physician initially by telephone, facsimile, or electronic mail.
2. The initial communication shall be followed by Written notice to the Requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker’s attorney within 24 hours of the decision for Concurrent Review and within two (2) business days for Prospective review and for Expedited Review within 72 hours of receipt of the request.
3. 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. Medical care provided during a Concurrent Review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.
4. For Retrospective Review, a Written decision to deny part or all of the requested medical treatment shall be communicated to the Requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of information that is reasonably necessary to make this decision.
5. The Written decision modifying or denying treatment authorization shall be provided to the Requesting physician, the injured worker, the injured worker’s representative, and if the injured worker is represented by counsel, the injured worker's attorney and includes the following information specific to the request:
  - a) Receipt Date: The date on which the completed or accepted request for authorization (RFA) was first received.
  - b) Extension Details (if applicable): If the timeframe was extended under section 9792.9.6, a specific description of the information needed; the dates/times and manner of requests for info, exams, or consultations; and the date the info was first received.
  - c) Decision Date: The date on which the decision is made.

- d) Proposed Treatment: A description of the specific course of medical treatment set forth on the RFA.
- e) Records Reviewed: A list of all medical records reviewed.
- f) Approved Services: A specific description of the medical treatment service approved, if any.
- g) Clinical Explanation:
  - (i) A clear, concise, and appropriate explanation in plain language of the reasons for the reviewing physician's decision, including clinical reasons regarding medical necessity. If information was insufficient, a statement identifying the missing info and that the request will be reconsidered upon receipt of a new RFA.
  - (ii) If the requesting physician argued that standard guidelines should be overlooked, an explanation for why that argument was insufficient.
- h) Guidelines Cited: For decisions based on medical necessity, a citation to and description of the relevant medical criteria or guidelines (e.g., MTUS) used to reach the decision.<sup>4</sup>
- i) Liable Entity: Identification of the URAC-accredited entity, approved by the DWC, that is liable for the utilization review decision.
- j) IMR Application: The Application for Independent Medical Review (DWC Form IMR). All fields except the employee signature must be completed by the claims administrator. It must include an addressed envelope (which may be postage-paid).
- k) Dispute Statement: A clear statement advising the injured worker that disputes shall be resolved via IMR (Labor Code § 4610.5 and 4610.6) and that objections must be communicated via the enclosed form within the indicated timeframe.
- l) Mandatory Notification Language: The following exact text:

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 adjuster's or appropriate contact's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.

For information about the workers' compensation claims process and your rights and obligations, go to [www.dwc.ca.gov](http://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) 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. 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.

## **XII. DURATION OF UTILIZATION REVIEW DECISIONS**

- A. A Utilization Review Decision to modify or deny a Request for Authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the Claims Administrator with regard to any further recommendation by the same physician for the same treatment unless further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.
- B. A request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change. Such a request must be reviewed by a physician reviewer and any modification or denial of the request must comply with applicable requirements as set forth at section 9792.9.5.
- C. A Utilization Review Decision to approve a Request for Authorization of medical treatment shall remain effective for 90 days from the date of decision.

## **XIII. RECONSIDERATIONS**

- A. WIC does not offer a formal internal appeals process.
- B. WIC does offer a reconsideration process after a modification or denial has been issued. Reconsideration is conducted when:
  - 1. A requesting provider has requested a peer-to-peer discussion with the reviewing physician in compliance with 8 CCR § 9792.9.5 (e)(14)
  - 2. Additional medical information specified in the determination is received in compliance with § 9792.9.5 (e)(7)(A).
- C. Reconsideration should be requested within 10 calendar days of receipt of a modified or denied UR determination; requests received after 10 calendar days will be processed as a new RFA.
- D. If the reconsideration determination results in an approval of the previously modified or denied treatment, an authorization letter is sent pursuant to 8 CCR § 9792.9.4.
- E. If the reconsideration determination results in a modification of the previously modified or denied treatment, a modification letter is sent pursuant to 8 CCR § 9792.9.5 and a new IMR form is generated if applicable.

- F. If the reconsideration determination results in a denial of the previously modified or denied treatment, a denial letter is sent pursuant to 8 CCR § 9792.9.5. A new IMR form is not generated since there is no change from the original determination and IMR issued at that time.

#### **XIV. DISPUTE RESOLUTION THROUGH INDEPENDENT MEDICAL REVIEW**

- A. If the Request for Authorization of medical treatment is not approved, or if the Request for Authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6.
- B. 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 Application for Independent Medical Review, DWC Form IMR, within 10 calendar days after the service of the utilization review decision to the injured worker/employee for formulary (medication) disputes, and within 30 calendar days after the service of the utilization review decision to the injured worker/employee for all other medical treatment disputes.
- C. Neither the injured worker nor the Claims Administrator shall have any liability for medical treatment furnished without the authorization of the Claims Administrator if the treatment is modified or denied by a Utilization Review Decision unless the utilization review decision is overturned by independent medical review or the Workers' Compensation Appeals Board.
- D. WIC complies with all requirements set forth in 8 CCR 9792.10:
  - 1. Responds to the Administrative Director's reasonable requests within fifteen (15) days following receipt of the request.
  - 2. Within fifteen (15) days following receipt of the mailed notification from the independent review organization that the disputed medical treatment has been assigned for independent medical review, or within twelve (12) days if the notification was sent electronically, or for Expedited Review within twenty-four (24) hours following receipt of the notification, supplies the assigned Independent Review Organization with the following:
    - a) A copy of all reports of the injured worker's Requesting physician relevant to the injured worker's current injury or illness produced within one year prior to the date of the Request for Authorization, including those that are specifically identified in the Request for Authorization or in the Utilization Review Decision.
    - b) A copy of the denial by the Claims Administrator notifying the injured worker and the injured worker's Requesting physician that the disputed medical treatment was denied or modified.
    - c) A copy of all information, including correspondence, provided to the injured worker by the Claims Administrator concerning the utilization review decision regarding the disputed treatment.

- d) A copy of any materials the injured worker or the injured worker's provider submitted to the Claims Administrator in support of the request for the disputed medical treatment.
  - e) A copy of any other relevant documents or information used by the Claims Administrator in determining whether the disputed treatment should have been provided, and any statements by the Claims Administrator explaining the reasons for the decision to deny or modify the recommended treatment on the basis of medical necessity.
  - f) The Claims Administrator's response to any additional issues raised in the injured worker's application for independent medical review.
3. The Claims Administrator shall send the injured worker or the injured worker's representative a notification that lists all of the documents submitted to the independent review organization and provide a copy of all documents that were not previously provided to the injured worker or the injured worker's representative. Any newly developed or discovered relevant medical records forwarded to the independent review organization by the Claims Administrator shall also be sent to the injured worker or the injured worker's representative, or the injured worker's Requesting physician unless declined or prohibited by law.
  4. The independent review organization may reasonably request appropriate additional documentation or information necessary to make a determination that the disputed medical treatment is medically necessary. Additional documentation or other information requested of WIC shall be sent, with service on all other parties, within five (5) business days after the request is received in routine cases or one (1) calendar day after the request is received in expedited cases.
  5. The independent medical review process may be terminated at any time upon the Claims Administrator's Authorization of all disputed medical treatment.

The final determination issued by the independent review organization shall be deemed to be the determination of the Administrative Director and is binding on all parties.

Upon receipt of an IMR determination that approves all or part of a RFA, WIC will issue an authorization letter compliant with § 9792.9.4 (a)(1)(b)(c).

6. The costs of independent medical review and the administration of the independent medical review system shall be borne by the Claims Administrator.

## **XV. CONFIDENTIALITY**

- A. WIC's policy is to handle all information in a manner that ensures the privacy and security of the records. All information that identifies a specific individual shall be kept confidential and shall not be disclosed to any individual or organization outside of disclosures

- permitted or required by law. The release or re-release of confidential information to unauthorized persons is strictly prohibited.
- B. All injured workers and contractors who conduct UR, oversee UR operations, as well as all committee members and board members, shall undergo training and sign a confidentiality agreement/HIPAA statement to ensure protection of injured workers' health information.
  - C. All information that identifies a specific individual shall be kept confidential and shall not be disclosed to any individual or organization outside of disclosures permitted or required by law.
  - D. Information obtained during the Utilization Review Process will be used solely for the purposes of Utilization Review, discharge planning, case management and quality assurance. Information will only be shared with third parties authorized to receive such information and in accordance with State and Federal laws and regulations. Confidential information will be used solely for internal business purposes. WIC UR staff is prohibited from discussing case information except when actually working on a case in conjunction with quality assurance or for training purposes.
  - E. Medical records and injured worker specific information is maintained in a secure area with access limited to essential personnel only. These items are documented in the system. All medical records, documentation and other written information are scanned into the system and later shredded onsite by an authorized vendor of WIC.
  - F. Requests for medical information regarding an injured worker will be handled by the Claims Administrator to the extent allowed under the Labor Code or other applicable laws or regulations.

## **XVI. SAMPLE FORM LETTERS**

- A. Appendix B includes the following WIC UR Letter templates
  - 1. Approval/Authorization
  - 2. Modification
  - 3. Denial
  - 4. Request for Additional Information
  - 5. Denial for Lack of Information
  - 6. Reconsideration Approval
  - 7. Reconsideration Modification
  - 8. Reconsideration Denial
  - 9. Sample IMR Form w/Completed Fields
  - 10. Sample Physician Review Peer Report