Novare, LLC
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Frisco, TX 75035

WORKERS' COMPENSATION UTILIZATION MANAGEMENT
CALIFORNIA UTILIZATION REVIEW PLAN

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Novare's California Utilization Review Plan contains California specific regulatory and operational requirements. The Utilization Review Plan sets forth policies and procedures ensuring compliance with prospective, concurrent, and retrospective utilization review per § 4610, § 9792.9.1 et seq of Title 8 of the California Code of Regulations.

Review/Revision Dates:	03/19/2007; 03/15/2008; 08/07/2009; 11/09/2009; 03/01/2010; 04/15/2010; 11/18/2011; 10/22/2012; 12/16/2013; 11/21/2014; 06/01/2015; 01/04/2016; 01/06/2017; 04/26/2018; 07/02/2018; 08/31/2018;01/14/2019; 01/28/2020

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Review. Restore. Renew.

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I. INTRODUCTION

Program Description

Novare conducts prospective, concurrent, and retrospective utilization review services for clients that may include employers, third party administrators, and insurance carriers. Novare makes the California Utilization Review Plan available to the public by posting it on the Novare website at https://www.novarenetwork.com/. The Plan is also made available to the public upon request through electronic means or hard copy for a reasonable copy and postage fee that shall not exceed $0.25 per page plus actual postage costs.

Mission Statement

Novare was founded for the growing needs of employers and the insurance community seeking effective and responsible medical management services for injured workers. Our mission is to deliver personalized representation and efficient, cost-conscious services with an emphasis on optimum medical outcomes.

Program Objectives

- Timely review of treatment/service requests for medical necessity;
- Prevention of over/under utilization of healthcare services;
- Facilitation of efficient and cost-effective treatment modalities;
- Promotion and adherence to evidence-based standards of care;
- Collaboration with primary care physicians and service providers to obtain best- outcomes in healthcare;
- Review for and identification of medical safety issues and/or concerns; and
- Analysis of data and trending for continuous program improvement.

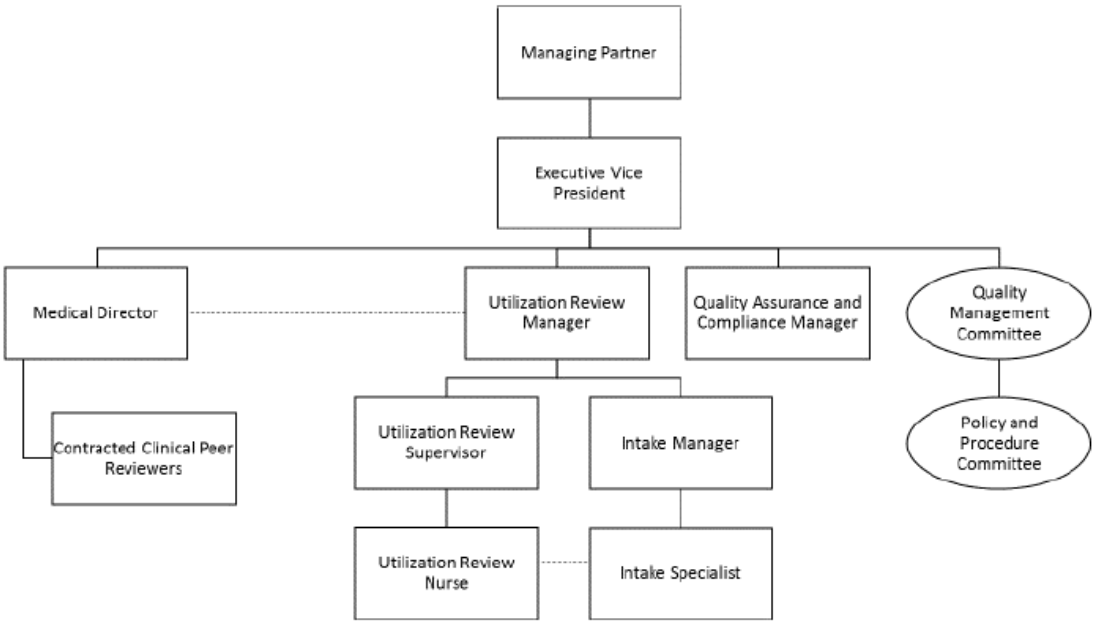
Scope

This document applies to Novare's California Utilization Review Program. All staff adhere to the policies and procedures as set forth within this California Utilization Review Plan.

Policy and Procedure Management

All operational standards comply with written policies and procedures that govern core business processes. Policies and procedures are reviewed annually for maintenance, review, and approval of changes by the Novare Policy and Procedure Committee. Review is also conducted when warranted by changes and/or recommendations issued by Federal, URAC and/or California Code of Regulations agencies to ensure continuous updates and regulatory compliance.

Organizational Overview



The California Utilization Review Program management staff includes the Managing Partner, Executive Vice President, Medical Director, Quality Assurance and Compliance Manager, Utilization Review Manager and the Intake Manager.

The Quality Assurance and Compliance Manager, Utilization Review Manager, and Intake Manager work in concert with one another and with the Medical Director to assomplish program goals and maintain daily operations of the California utilization review program. The Medical Director maintains clinical oversight of the program. Both the Quality Assurance and Compliance Manager and the Utilization Review Manager maintain direct/indirect oversight of the program.

Key Organizational Roles

Medical Director: provides guidance for clinical operational aspects of the program, oversight of clinical decision-making aspects of the program, periodic consultation with practitioners in the field and ensures the program objective to have qualified clinicians accountable to Novare for decisions affecting consumers.

Quality Assurance and Compliance Manager: responsible for managing support and coordination of the daily operations of the utilization management Quality Management Program and serves as the Compliance Officer. The Quality Assurance and Compliance Manager interfaces with other departments on quality improvement issues and reports any areas of concern to senior management, the Quality Management Committee and/or Medical Director.

Utilization Review Manager: provides leadership, operational expertise and oversight of clinical and non-clinical operations under the program and works in tandem with the Medical Director, who provides clinical decision-making oversight.

Utilization Review Team Supervisor: coordinates all components of the utilization management process, which includes timely review of treatment requests for medical necesssity, ensuring appropriate cost-effective treatment and promotion of best patient outcomes. The Utilization Review Team Supervisor must escalate cases for peer clinical review when a decision to certify a request cannot be made. The Utilization Review Team Supervisor provides training for Utilization Review Nurses and Intake Specialists.

Utilization Review Nurse: coordinates all components of the utilization management process, which includes timely review of treatment requests for medical necesssity, ensuring appropriate cost-effective treatment and promotion of best patient outcomes. The Utilization Review Team Supervisor must escalate cases for peer clinical review when a decision to certify a request cannot be made.

Intake Manager: responsible for managing administrative functions of the utilization review process and direct oversight of the Intake Specialist staff. This is a non-clinical postion.

Intake Specialist: responsible for handling and coordinating administrative functions of the utilization review process. This is a non-clinical position.

Peer Clinical Reviewer: responsible for review of the available medical information to address the medical necessity and appropriateness of the level of care for the requested treatment, service or procedure. California peer review services are provided by (2) contracted URAC accredited organizations who hold responsibility for maintaining credentialing information:

Dane Street
7121 Fairway Drive, Suite 102
Palm Beach Garden, Florida 33418
Telephone: 561-345-7739
URAC Accreditations:

- Health Utilization Management, Version 7.3
- Independent Review Organization: Internal Review, Version 5.0
- Workers' Compensation Utilization Management, Version 7.3

ExamWorks (Network Medical Review Company, LTD)
4960 East State Street
Rockford, Illinois 61108
Telephone: 815-964-6334
URAC Accreditation:

- Independent Review Organization: Comprehensive Review (Internal & External), Version 5.0

II. DEFINITIONS

"ACOEM Practice Guidelines" means the American College of Occupational Environmental Medicine's Occupational Medicine Practice Guidelines published by the Reed Group.

"Authorization" or "Certification" 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 California Labor Code, subject to the provisions of section 5402 of the Labor Code, based on either a completed "Request for Authorization," DWC Form RFA, as contained in California Code of Regulations, Title 8, section 9785.5, or a request for authorization of medical treatment accepted as completed by the claims administrator under section 9729.9.1(c)(2), 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, section 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Authorization," DWC Form RFA if that form was initially submitted by the treating physician.

"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 Guarantee Associations, 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.

"Concurrent review" means utilization review conducted during an inpatient stay.

"**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," Form DLRS 5021, found at California Code of Regulations, Title 8, section 14006, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.

"Denial" means a decision by a physician reviewer that the requested treatment or service is not authorized.

"Disputed medical treatment" means medical treatment that has been modified or denied by a utilization review decision.

"**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.

"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.

“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 Colombia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual’s scope of practice, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.

"Health care provider" 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.

“Immediately” means within one business day.

“**Material modification”** is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

“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.

“Medical Treatment Utilization Schedule (MTUS)” 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 the California Code of Regulations, Title 8, Chapter 4.5. Division of Workers’ Compensation, Subchapter 1. Administrative Director – Administrative Rules, beginning with section 9792.20. Effective 01/01/2018, the MTUS includes a drug formulary.

“Medically necessary and **medical necessity”** mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied as set forth in the medical treatment utilization schedule, including the drug formulary, adopted by the Administrative Director pursuant to section 5307.27:

(A) The guidelines, including the drug formulary, adopted by the Administrative Director pursuant to section 5307.27 (MTUS).
(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
(C) Nationally recognized professional standards.
(D) Expert opinion.
(E) Generally accepted standards of medical practice.
(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

“Modification” means a decision by a physician reviewer that part of the requested treatment or service is not medically necessary.

“Normal business day” means a business day as defined in Labor Code Section 4600.4 and in Section 9 of the Civil Code.

“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.

"Request for authorization" means a written request for a specific course of proposed treatment. (1) Unless accepted by a claims administrator under section 9792.9.1(c)(2), a request for authorization must be set forth on a "Request for Authorization (DWC Form RFA)," completed by a treating physician, as contained in California Code of Regulations, Title 8, section 9785.5. (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, and be accompanied by documentation substantiating the need for the requested treatment. (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 treatment physician may submit the request for authorization with an electronic signature.

"Retrospective Review" means utilization review conducted after the medical services have been provided and for which approval has not already been given.

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

"URAC" is an independent, nonprofit accrediting organization for utilization review processes.

"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).

"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.

"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 the completed DWC Form RFA, or a request for authorization accepted as complete under section 9792.9.1(c)(2), 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.

"Written" includes a communication transmitted by facsimile or in paper form. Electronic mail may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail.

III. PROGRAM REQUIREMENTS

Contracted Provider Mandate

All professional and institutional providers, whether directly or indirectly, are subject to the provisions of Novare's Califonial Utilization Review Plan. All components of the Plan, which detail the criteria, or describe the processes by which the Plan is implements, are to be readily available to providers, injured workers and/or their representatives, purchasers and payors.

Limitations

Nothing in the California Utilization Review Plan limits Novare's discretion in reviewing and evaluating professional and institutional providers according to the provisions of the Plan or in any other fashion. Nothing in the Plan shall be construed to interfere with or in any way affect a professsional or institutional provider's obligation to exercise independent medical judgment in rendering health care services.

Accreditation, Statutory or Regulatory Compliance

This Plan has been developed in accordance with URAC accreditation standards for Workers' Compensation Utilization Management, California Utilization Review Standards and Labor Code 4600. Novare shall amend, or develop supplementary policies and procedures, separate from this document to comply with California or Federal law requirements that exceed URAC standards.

Amendments and Modifications

The Plan may be modified or amended at any time by Novare at its' sole discretion. Any modifications or amendments to the Plan will be submitted to the California Department of Workers' Compensation within 30 days of the change in the Plan.

Medical Information System

The Novare Utilization Management System is our proprietary clinical software electronic medical information system which functions to capture utilization data, identify and track quality measures and outcomes, trend and analyze data and compare compliance with recommended clinical and administrative guidelines to assure effectiveness of medical management findings and assessments.

Annual Evaluation

Novare continually reviews and assesses the appropriateness and effectiveness of the utilization management process. An annual evaluation of activities, as well as an outline of proposed activities is prepared and presented to the Quality Management Committee. All policies and procedures are reviewed, no less than annually, by the Policy and Procedure Committee.

IV. QUALITY MANAGEMENT COMMITTEE OVERSIGHT

Delegation of Responsibility

Novare delegates responsibility for developing and implementing the Quality Management Program to the Quality Management Committee. This includes the California Utilization Review Plan, as well as regulatory compliance procedures. All activities under the Plan are subject to Quality Management Committee review and approval.

Confidentiality

All activities and deliberations which in any way involve review or evaluation of the care or services received by an injured worker, or delivered by a provider are confidential and are subject to applicable Federal, State and URAC requirements governing confidentiality. Documents and other information prepared as a function of utilization review activities will be released only as required by provisions of purchaser contracts or other agreements, subject to State and Federal law. Disclosure of confidential protected health information is made only to persons authorized to receive such information in the conduct of utilization review activities. All such information is considered strictly confidential.

The data generated and utilized within the utilization review program is maintained in a confidential manner. Only those persons who require information are provided access on a need-to-know basis. All Novare staff execute a confidentiality agreement at the time of onboarding.

V. UTILIZATION REVIEW PROGRAM

Functions

The functions of the utilization review program include:

- To implement, monitor, review and evaluate utilization review guidelines, as well as the monitoring criteria, as they apply to professional and institutional practice and performance. The guidelines and criteria must be objective, measurable, clinically valid, and compatible with established principles of patient care.

- To collect utilization review data; to identify, track, trend and analyze collected data; recommend appropriate educational programs and corrective actions based on data; and monitor the implementation and the outcomes of the recommended programs and actions;

- To oversee and support all utilization review activities of physician and non- physician personnel;

- To provide educational information on health promotion and disease prevention to injured workers and health care providers;

- To educate providers concerning inappropriate utilization of care or delivery of services identified by utilization review data.

- To continuously review the appropriateness and effectiveness of the Utilization Review Plan, to present an annual evaluation of current activities and an outline of proposed activities to the Quality Management Committee.

Certification of Medical Necessity of Care or Services

"Medically necessary and medical necessity" mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied as set forth in the medical treatment utilization schedule, including the drug formulary, adopted by the Administrative Director pursuant to section 5307.27:

(A) The guidelines, including the drug formulary, adopted by the Administrative Director pursuant to section 5307.27 (MTUS).
(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
(C) Nationally recognized professional standards.
(D) Expert opinion.
(E) Generally accepted standards of medical practice.
(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

The Medical Treatment Utilization Schedule (MTUS) is incorporated into this plan and supersedes ACOEM as the primary guideline for those conditions to which it applies. ACOEM Guidelines will be

used as mandated by the California State Regulatory Agency for conditions or injuries that are not addressed by the MTUS. The Official Disability Guidelines (ODG) is utilized for conditions not addressed by the MTUS or ACOEM. For those medical conditions not addressed by the MTUS, ACOEM or ODG, other commercially developed evidence-based criteria will be used as a secondary resource.

All information required to make a decision of medical necessity will be acquired through the appropriate review and certification processes implemented as part of the Plan. The Plan includes protocols for pre-admission and pre-procedure review and certification, hospital admission review and certification and concurrent continued stay review and certification for hospital admissions.

Clinical Guidelines for Developing Utilization Review Standards and Monitoring Criteria

Utilization review guidelines are used for screening of all utilization review activities and are not meant to constitute standards of care. Treatment shall not be denied on the sole basis that the medical condition is not addressed by the MTUS or ACOEM.

All guidelines, monitoring criteria, review process and protocols and policies and procedures are reviewed, evaluated and updated no less than annually and approved by the Medical Director in concert with the Policy and Procedure Committee and Quality Management Committee.

Consistency in the application of utilization management standards and monitoring criteria and the implementation of utilization review processes and procedures are verified by Novare's Medical Director, Utilization Review Manager, Quality Assurance and Compliance Manager and the Quality Management Committee.

Prospective Review

Prospective review encompasses any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical service(s).

Concurrent Review

Concurrent review is utilization review conducted during an inpatient stay. Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve the injured worker from the effects of the industrial injury.

Retrospective Review

Retrospective review is utilization review conducted after medical services have been provided and for which approval has not already been given.

Emergency Health Care Services

An emergency health care service is a health care service or 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 injured worker's health in serious jeopardy.

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. Emergency health care services, however, may be subject to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator on request.

Expedited Review

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

The requesting physician must indicate the need for an expedited review upon submission of the request for authorization.

Medical Director, Reviewer or Expert Reviewer

The Medical Director is the physician or surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California and is responsible for all decisions made in the utilization review process. A Reviewer or Expert Reviewer is a reviewer or expert reviewer who is a medical doctor, doctor of osteopathy, psychologist, acupuncturist, dentist, optometrist, podiatrist or chiropractic practitioner who holds a current and valid license by any state or the District of Columbia and is competent to evaluate the specific clinical issues involved in the request for authorization, where the service(s) are within the scope of their practice.

Conflict of Interest and Financial Incentives

All employees are required to screen for potential organizational conflict of interest issues. Potential conflict of interest issues are evaluated by the Initial Clinical Reviewer (Utilization Review Nurse) upon receipt of the new case assignment, to include self-screening and organizational screening for conflict of interest issues.

All reviewers should be free of any material, professional, or familial relationship or financial interest with any of the following:

- Novare's Client (the organization or adjuster)
- Injured Worker (Patient)
- Injured Worker's Authorized Representative
- Insurance Carrier, TPA
- Employer
- Attending or Ordering Provider
- Facility Rendering Service
- Developer or manufacturer of the drug, device, procedure or therapy being recommended.

When a potential or known conflict of interest issue is identified, the reviewer is recused and the case is re-assigned.

Novare does not permit or provide reimbursement, bonuses, or incentives to staff or contractors based directly on consumer utilization of health care services.

An insurer or third-party administrator shall not refer utilization review services conducted on behalf of an emplolyer to an entity in which the insurer or third-party administrator has a financial interest as defined under Section 139.32. This prohibition does not apply if the insurer or third-party adminstrator provides the employer and the administrative director with prior written disclosure of both of the following:

- The entity conducting the utilization review services; and
- The insurer or third-party admininstator's financial interest in the entity.

VI. VOLUNTARY INTERNAL APPEALS

Purpose

In the case of a modification or denial of a requested service, the parties are afforded an opportunity to participate in Novare's voluntary internal appeal process. All parties are notified, within the content of the original modification or denial notification, of the time limit to file an objection to the utilization review decision in accordance with Labor Code sections 4610.5 and 4610.6, ten (10) days after the service of the utilization review decision to employees for formulary disputes and thirty (30) days for non-formulary disputes, and that the that the voluntary internal appeal process neither triggers or bars the use of the dispute resolution procedures of Labor Code sections 4610.5 and 4610.6.

Recipients of voluntary internal appeal decisions include the injured worker, the injured worker's represenative (as applicable), the ordering/attending provider and the facility rendering service (as applicable).

Process

Any request for a voluntary internal appeal must be submitted within (10) days after receipt of the utilization review decision. Voluntary appeal requests are accepted from the injured worker, the injured workers' representative, the provider or the facility rendering service. A voluntary appeal may be submitted verbally by calling 888-705-1070 or in writing at precert@novarenetwork.com or P.O. Box 5067, Frisco, Texas 75035 or via fax at 888-667-9572.

All voluntary appeals are conducted by a Reviewer or Expert Reviewer who holds the following qualifications:

- An active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States;
- Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting appeal considerations;
- Are in the same profession and in a simlar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate;
- Are neither the individual who made the original non-certification, nor the subordinate of such an individual; and
- Are board-certified (if applicable).

Novare Timeframes for Responding to Voluntary Internal Appeals

Standard Appeals:
Decisions are completed within ten (10) business days of receipt of the request. Notification is communicated within (24) hours of the decision. When the initial communication is via telephone, this shall be followed by written notification within (2) business days.

Concurrent and Expedited Appeals:
Decisions are completed as soon as possible, but in no case later than 72-hours of receipt of the request. Novare issues a verbal decision notice to the requesting party within 72-hours of receipt followed by written notice within 24-hours of the decision.

VII. UTILIZATION REVIEW STANDARDS

Applicability

Novare's California Utilization Review Plan was developed to assist claims administrators, insurance carriers and self-insured employers establish and maintain a utilization review process in compliance with Labor Code setion 4610. The utilization review plan shall include, at a minimum, the following:

(1) The name, address, phone number, and medical license number of the employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to section 2050 or section 2450 of the Business and Professions Code.

(2) A description of the process whereby requests for authorization are reviewed, and decisions on such requests are made, and a description of the process for handling expedited reviews.

(3) A description of the specific criteria utilized routinely in the review and throughout the decision-making process, including treatment protocols or standards used in the process. The treatment protocols or standards governing the utilization review process shall be consistent with the Medical Treatment Utilization Schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27.

(4) A description of the qualifications and functions of the personnel involved in decision-making and implementation of the utilization review plan.

(5) A description of the claims administrator's practice, if applicable, of any prior authorization process, including but not limited to, where authorization is provided without the submission of the request for authorization. *Not applicable; Novare does not currently conduct any type of prior authorization process outside of the utilization review process.*

(6) Submission of a description of the utilization review process that modifies or denies requests for authorization of medical treatment and the written policies and procedures to the Administrative Director for approval.

(7) Disclosure of the utilization review process descriptions for modifying or denying requests for authorization of medical treatment and accompanying policies and procedures of the Plan to employees and physicians. If a member of the public requests a hard copy of the Plan, Novare may charge reasonable copying and postage expenses, not to exceed $0.25 per page plus actual postage costs. A complete copy of the Plan will be made available by posting on the Novare website at www.novarenetwork.com

(8) A utilization process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review services. The accreditation shall be by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including but not limited to, timeliness in issuing a utilization review decision, the scope of the medical material used in issuing a utilization review decision, peer-to-peer consultation, internal appeal procedure and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision.

Mandatory Prospective Review List

For dates of injury on and after January 1, 2018, Labor Code 4610(c)(1) states that unless authorized by the employer or rendered as emergency medical treatment, the following treatment services 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 thirty (30) days following the initial date of injury, shall be subject to utilization review under this section:

(1) Pharmaceuticals, to the extent that 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 presurgical and postsurgical services.
(3) Psychological treatment services.
(4) Home health care services.
(5) Imaging and radiology services, excluding X-rays.
(6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule.
(7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
(8) Any other service designated and defined through rules adopted by the Administrative Director.

Medically-Based Criteria

The criteria or guidelines used in the utilization review process to determine whether to approve, modify, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.
(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.
(3) Evaluated at least annually and updated if necessary.
(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify or deny services in a specified case under review.
(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

California Drug Formulary and Definitions

Except as provided in subdivision (b)(1) below, the MTUS Drug Formulary applies to drugs dispensed on or after January 1, 2018, regardless of the date of injury.

(b)(1) For injuries occurring prior to January 1, 2018, the MTUS Drug Formulary should be phased in to ensure that injured workers who are receiving ongoing drug treatment are not harmed by an abrupt change to the course of treatment. The physician is responsible for requesting a medically appropriate and safe course of treatment for the injured worker in accordance with the MTUS, which may include

use of a Non-Exempt drug or unlisted drug, where that is necessary for the injured worker's condition or necessary for safe weaning, tapering, or transition to a different drug.

If the injured worker with a date of injury prior to January 1, 2018, is receiving a course of treatment that includes a Non-Exempt drug, an unlisted drug, or a compounded drug, the physician shall submit a progress report issued pursuant to section 9785 and a Request for Authorization that shall address the injured worker's ongoing drug treatment plan. The report shall either:

- Include a treatment plan setting forth a medically appropriate weaning, tapering, or transitioning of the worker to a drug pursuant to the MTUS, or
- Provide supporting documentation, as appropriate, to substantiate the medical necessity of, and to obtain authorization for, the Non-Exempt drug, unlisted drug, or compounded drug, pursuant to the MTUS (via guidelines, Medical Evidence Search Sequence, and/or Methodology for Evaluating Medical Evidence.)

The progress report, including the treatment plan and Request for Authorization provided under this subdivision, shall be submitted at the time the next progress report is due under section 9785, subdivision (f)(8), however, if that is not feasible, no later than April 1, 2018.

Previously approved drug treatment shall not be terminated or denied except as may be allowed by the MTUS and in accordance with applicable utilization review and independent medical review regulations.

Novare shall process the progress report, treatment plan and Request for Authorization in accordance with the standard procedures and timeframes set forth in section 9792.9.1 et seq.

MTUS Drug List; Exempt Drugs, Non-Exempt Drugs, Unlisted Drugs, Prospective Review:
The MTUS Drug List is set forth by active drug ingredient(s).

(b) A drug that is identified as “Exempt” may be dispensed to the injured worker without obtaining authorization through prospective review if the drug treatment is in accordance with the MTUS Treatment Guidelines, except:

(1) Brand name drugs are subject to section 9792.27.7 (If a physician prescribes a brand name drug when a less costly therapeutically equivalent generic drug exists, and writes “Do Not Substitute” or “Dispense as Written” on the prescription in conformity with Business and Professions Code section 4073, the physician must document the medical necessity for prescribing the brand name drug in the patient's medical chart and in the Doctor's First Report of Injury (Form 5021) or Progress Report (PR-2.) The documentation must include the patient-specific factors that support the physician's determination that the brand name drug is medically necessary. The physician must submit a Request for Authorization and obtain authorization through prospective review before the brand name drug is dispensed).

(2) Physician-dispensed drugs are subject to section 9792.27.8 ((a) Drugs dispensed by a physician must be authorized through prospective review prior to being dispensed, except as provided in subdivision (b), section 9792.27.12 (“Special Fill”), and section 9792.27.13 (“Perioperative Fill”). (b) A physician may dispense up to a seven-day supply of one or more drugs that are designated as “Exempt” in the MTUS Drug List without obtaining authorization through prospective review, if the drug treatment is in accordance with the MTUS Treatment Guidelines and the up-to-seven-day supply is dispensed at the time of an initial visit that occurs within 7 days of the date of injury. (c) Nothing in this Article shall

invalidate a provision in a Medical Provider Network agreement which restricts physician dispensing by medical providers within the network. (d) Nothing in this Article shall permit physician dispensing where otherwise prohibited by a pharmacy benefit contract pursuant to subdivision (a) of Labor Code section 4600.2).

(3) Compounded drugs are subject to section 9792.27.9 (Compounded drugs must be authorized through prospective review prior to being dispensed) even if one or more of the ingredients is listed as "Exempt" on the MTUS Drug List.

(c) For a drug that is identified as "Non-Exempt," authorization through prospective review must be obtained prior to the time the drug is dispensed. Expedited review should be conducted where it is warranted by the injured worker's condition.

(d) For a drug that is identified as eligible for "Special Fill" or "Perioperative Fill", the usual requirement to obtain authorization through prospective review prior to dispensing the drug is altered for the specified circumstances set forth in sections 9792.27.12 and 9792.27.13. If the requirements set forth in section 9792.27.12 or section 9792.27.13 are not met, then the drug is considered "Non-Exempt" and is subject to the provisions set forth under subdivision (c).

(e) For an unlisted drug, authorization through prospective review must be obtained prior to the time the drug is dispensed. A combination drug that is not on the MTUS Drug List is an unlisted drug even if the individual active ingredients are on the MTUS Drug List.

Definitions for the purpose of this section include:
"Brand name drug" means a drug that is produced or distributed under an FDA original New Drug Application (NDA) or Biologic License Application (BLA) approved by the FDA. It also includes a drug product marketed by any cross-licensed producers or distributors operating under the same NDA or BLA.

"Combination drug" means a fixed dose combination of two or more active drug ingredients into a single dosage form that is FDA-approved for marketing.

"Compounded drug" means any drug subject to:

- Article 4.5 (commencing with section 1735) or article 7 (commencing with section 1751) of division 17 of title 16 of the California Code of Regulations, or
- Other regulation adopted by the State Board of Pharmacy to govern the practice of compounding, or
- Federal law governing compounding, including title 21, United State Code, sections 353a, 353a-1, 353b.

"Exempt drug" means a drug on the MTUS Drug List which is designated as being a drug that does not require authorization through prospective review prior to dispensing the drug, provided that the drug is prescribed in accordance with the MTUS Treatment Guidelines. The Exempt status of a drug is designated in the column with the heading labeled "Exempt / "Exempt / Non-Exempt."

"Generic drug" means a drug that is produced or distributed under an FDA Abbreviated New Drug Application (ANDA) approved by the FDA. A generic drug may be substituted for a therapeutic equivalent brand name drug pursuant to applicable state and federal laws and regulations.

"MTUS Drug Formulary" means the MTUS Drug List set forth in section 9792.27.15 and the formulary rules set forth in sections 9792.27.1 through 9792.27.23.

"MTUS Drug List" means the drug list and related information in section 9792.27.15, which sets forth the Exempt or Non-Exempt status of drugs listed by active drug ingredient(s).

"Non-Exempt drug" means a drug on the MTUS Drug List which is designated as requiring authorization through prospective review prior to dispensing the drug. The Non-Exempt Drug status of a drug is designated in the column labeled "Exempt / Non-Exempt."

"Nonprescription drug" or "over-the-counter drug" (OTC drug) means a drug which may be sold without a prescription and which is labeled for use by the consumer without the supervision of a health care professional.

"Off-label use" means use of a drug for a condition, or in a dosage or method of administration, not listed in the drug's FDA-approved labeling for approved use.

"Perioperative Fill" means the policy set forth in section 9792.27.13 allowing dispensing of identified Non-Exempt drugs without prospective review where the drug is prescribed within the perioperative period and meets specified criteria.

"Physician": Notwithstanding the definition in Labor Code section 3209.3, for purposes of the MTUS Drug Formulary, "Physician" means a medical doctor, doctor of osteopathy, or other health care provider whose scope of practice includes the prescription of drugs. However, for purposes of membership on the P&T Committee, "physician" means a medical doctor or doctor of osteopathy licensed pursuant to the California Business and Professions Code.

"Prescription drug" means any drug whose labeling states "Caution: Federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

"Special Fill" means the policy set forth in section 9792.27.12 allowing dispensing of identified Non-Exempt drugs without prospective review where the drug is prescribed or dispensed in accordance with the criteria set forth in subdivision (b) of section 9792.27.12.

"Therapeutic equivalent" is a drug designated by the FDA as equivalent to a Reference Listed Drug if the two drugs are pharmaceutical equivalents (contain the same active ingredient(s), dosage form, route of administration and strength), and are bioequivalent (comparable availability and rate of absorption of the active ingredient(s).) Drugs that the FDA considers to be therapeutically equivalent products are assigned a Therapeutic Equivalence Evaluation Code beginning with the letter "A" in the FDA publication "Orange Book: Approved Products with Therapeutic Equivalence Evaluations" which is available on the FDA website and accessible via a link provided on the department's website.

"Unlisted drug" means a drug that does not appear on the MTUS Drug List and which is one of the following: an FDA-approved or a nonprescription drug that is marketed pursuant to an FDA OTC Monograph. An "unlisted drug" does not include a compounded drug but does include a combination drug.

Procedures, Timeframes and Notice Content

Procedures

Receipt of Request for Authorization (DWC From RFA):
The request for authorization for a course of treatment as defined in section 9792.6.1(d) must be in written form set forth on the "Request for Authorization (DWC Form RFA)," as contained in California Code of Regulations, Title 8, section 9785.5.

The DWC Form RFA shall be deemed to have been received by the claims administrator or utilization review organization:

- By facsimile or by electronic mail on the date the form was received if the receiving facsmile or electronic mail addresss electronically date stamps the transmission when received.
- If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or the claims administrator's utilization review organization.
- A DWC Form RFA transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review.
- The copy of the DWC Form RFA or the cover sheet accompanying the form transmitted by a facsimile transmission or by electronic mail shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall display the facsimile telephone number to which the form was transmitted. The requesting physician must indicate if there is the need for an expedited review on the DWC Form RFA.
- Where the DWC Form RFA is sent by mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator five (5) business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.
- Where the DWC Form RFA is delivered via certified mail, with return receipt mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator on the receipt date entered on the return receipt.
- In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the DWC Form RFA shall be deemed to have been received by the claims administrator five days after the latest date the sender wrote on the document.

Novare may accept a request for authorization for medical treatment that does not utilize the DWC Form RFA, provided that: (1) "Request for Authorization" is clearly written at the top of the first page of the document; (2) all requested medical services, goods, or items are listed on the first page; and (3) the request is accompanied by documentation substantiating the medical necessity for the requested treatment.

Upon receipt of a request for authorization as described in subdivision (c)(2)(B), or a DWC Form RFA that a) does not Identify the employee or provider, b) does not identify a recommended treatment, c) is not accompanied by documentation substantiating the medical necessity for the requested treatment, or d) is not signed by the requesting physician, a non-physician reviewer as allowed by section 9792.7 or reviewer will either regard the request as a complete DWC Form RFA and comply with the timeframes

for decision set forth in this section or return it to the requesting physician marked "not complete," specifying the reasons for the return of the request no later than five (5) business days from receipt. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

Timeframes

The first day in counting any timeframe requirement is the day after receipt of the DWC Form RFA, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the DWC Form RFA.

A DWC Form RFA transmitted by facsmile after 5:30 PM Pacific Time shall be deemed to have been received on the following business day, except in the case of an expedited or concurrent review, where the timeframe requirement is counted in hours.

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

Notice shall be communicated to the requesting physician within 24 hours of the decision and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.

Expedited Review:
Prospective or concurrent decisions to approve, modify or deny a request for authorization related to an *expedited review* shall be made in a timely fashion 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. 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 (c)(3) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (c)(3).

Notice shall be communicated to the requesting physician within 24 hours of the decision and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, within 72 hours of receipt of the request.

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

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.

Concurrent Review Denials:
The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment:
(A) 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 employee
(B) 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.

Utilization Review Decision Applicability:
A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to a further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Notice Content

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

Decisions modifying or denying treatment authorization:
The written decision shall be signed by either the claims administrator or the reviewer, and shall only contain the following information specific to the request:
(A) The date on which the DWC Form RFA was first received.
(B) The date on which the decision is made.
(C) A description of the specific course of proposed medical treatment for which authorization was requested.
(D) A list of all medical records reviewed.
(E) A specific description of the medical treatment service approved, if any.
(F) A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section 9792.8. If a utilization review decision to modify or deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

The format for citations provided by the utilization review physician shall include the following:
When citing the MTUS:

Indicate the MTUS is being cited and the effective year of the guideline;
Title of chapter (e.g. Low Back Complaints); and
Section of chapter (e.g. Surgical Considerations).

When citing other medical treatment guidelines:
Title of organization publishing the guideline (e.g. ACOEM or ODG);
Year of publication;
Title of chapter; and
Section of chapter.

When citing a peer-reviewed study:
First author's last name and first initial;
Published article title;
Journal title (standard abbreviations may be used);
Volume number;
Year published; and
Page numbers.

If the utilization review physician provides more than one citation, then a narrative will be included within the utilization review decision explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

(G) The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee, will be completed by Novare. 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.
(H) 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 ten (10) days after the service of the utilization review decision to the employee for formulary disputes and thirty (30) calendar days after service of the decision for all other medical treatment disputes.
(I) Include 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 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."
(J) Details about Novare's internal utilization review appeals process for the requesting physician, if any, and a clear statement that the internal appeals process is 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.

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

Decision to Deny due to Incomplete/Insufficient Information (Administrative Denial):
If a utilization review decision to deny a medical service is due to incomplete or insufficient information, the Administrative Denial notice shall specify all of the following:

- The reason for the decision;
- A specific description of the information that is needed;
- The date(s) and time(s) of attempts made to contact the physician to obtain the necessary information;
- A description of the manner in which the request was communicated; and
- Notice that the request for authorization will be reconsidered upon receipt of the information requested.

Modification after Internal Voluntary Appeal:
Internal voluntary appeals that result in a modification of the original decision must include the Application for Independent Review, DWC Form IMR, identifying the modification after appeal.

Utilization Review Deferral/Liability Dispute:
Utilization review of a medical treatment request made on the DWC Form RFA may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.
(1) If the claims administrator disputes liability under this subdivision, it may, no later than five (5) business days from receipt of the DWC Form RFA, 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:
(A) The date on which the DWC Form RFA was first received.
(B) A description of the specific course of proposed medical treatment for which authorization was requested.
(C) A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.
(D) 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.
(E) 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."
(2) If utilization review is deferred pursuant to this subdivision, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, the time for the claims administrator to conduct retrospective utilization review in accordance with this section shall begin on the date the determination of the claims administrator's liability becomes final. The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a DWC Form RFA after the final determination of liability.

Dispute Resolution

If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6. Neither the employee 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 under this Article.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. 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 provided Application for Independent Medical Review, DWC Form IMR, within ten (10) days after the service of the utilization review decision to the employee for formulary disputes and thirty (30) calendar days after service of the decision for all other medical treatment disputes.

Independent Medical Review – Medical Records:
Within fifteen (15) days following the mailing of the 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, the independent medical review organization shall receive from the claims administrator all of the following documents:
(A) A copy of all reports of the physician relevant to the employee's current medical condition produced within six months prior to the date of the request for authorization, including those that are specifically identified in the request for authorization or in the utilization review determination. If the requesting physician has treated the employee for less than six months prior to the date of the request for authorization, the claims administrator shall provide a copy of all reports relevant to the employee's current medical condition produced within the described six-month period by any prior treating physician or referring physician.

(B) A copy of the written Application for Independent Medical Review, DWC Form IMR, that was included with the written determination, issued under section 9792.9.1(e)(5), which notified the employee that the disputed medical treatment was denied or modified. Neither the written determination nor the application's instructions should be included.
(C) Other than the written determination by the claims administrator issued under section 9792.9.1(e)(5), a copy of all information, including correspondence, provided to the employee by the claims administrator concerning the utilization review decision regarding the disputed treatment.
(D) A copy of any materials the employee or the employee'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 employee's application for independent medical review.
(2) The claims administrator shall, concurrent with the provision of documents under subdivision (a), forward to the employee or the employee's representative a notification that lists all of the documents submitted to the independent review organization under subdivision (a). The claims administrator shall provide with the notification a copy of all documents that were not previously provided to the employee or the employee's representative excluding mental health records withheld from the employee pursuant to Health and Safety Code section 123115(b).
(3) Any newly developed or discovered relevant medical records in the possession of the claims administrator after the documents identified in subdivision (a) are provided to the independent review organization shall be forwarded immediately to the independent review organization. The claims administrator shall concurrently provide a copy of medical records required by this subdivision to the employee, or the employee's representative, or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law.

At any time following the submission of documents under this section, 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 under this section shall be sent by the party to whom the request was made, with a copy forwarded to all other parties, within five (5) business days after the request is received in routine cases or one (1) calendar day after the request is received in expedited cases.

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

VIII. UTILIZATION REVIEW PROCESS

Receipt of Request for Authorization

Novare provides access to submit requests for authorization verbally via our toll-free telephone number on normal business days at a minimum from 9:00 AM to 5:30 PM Pacific Time. 24-hour coverage is provided through our toll-free secure facsimile number and telephone voicemail. Written requests for authorization may also be submitted to Novare at our designated P.O. Box.

Telephone: 888-705-1070
Facsimile: 888-667-9572
Address: P.O. Box 5067
Frisco, TX 75035

Requests for authorization are accepted from any involved party, to include the attending/treating physician, facility, injured worker, injured worker's representative or the claims administrator.

Novare ensures that when conducting routine prospective, concurrent and retrospective reviews, we:

- Accept information from any reasonable reliable source that will assist in the certification process;
- Collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency and duration of service;
- Do not routinely require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for certification, but we may request such codes, if available;
- Do not routinely request copies of all medical records on all patients reviewed;
- Require only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; and
- Administer a process to share all clinical and demographic information on individual patients among our various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from enrollees or providers.

Identification

Upon receipt, the request for authorization is screened by a Novare Intake Specialist. The Intake Specialist is a non-clinical role and functions in an administrative support role to collect non-clinical data, such as demographics, employer name, insurance information, physician name, facility name, etc. Intake Specialists screen for completeness of service request information and collect and transfer non-clinical data. Intake Specialists enter the demographic information and upload the supporting documentation into the Novare Utilization Management System.

Data collected at the time of review initiation includes:

- Request date
- Request type
- Occupational injury claim information
- Requested service or treatment with corresponding CPT code(s) when available
- Diagnosis(es) with corresponding ICD-10 code(s) when available

- Supporting clinical documentation necessary to conduct the review
- Requesting/Ordering Provider name/address/contact information
- Facility rendering service name/address/contact information, as applicable
- Authorized representative/attorney name/address/contact information, as applicable

Documents that are not identified as a request for authorization or are misdirected are immediately forwarded to the appropriate party. Expedited reviews and internal voluntary appeals are identified and escalated to the Initial Clinical Reviewer (Utilization Review Nurse) for priority handling.

Any party requesting emergency medical services is notified to proceed with care as needed as emergency services do not require prospective review and may be subjected to retrospective review.

Assignment

Once the request for authorization is confirmed, the case is assigned to an Initial Clinical Reviewer (Utilization Review Nurse) based on availability, jurisdiction and timeframe requirements. Upon new case assignment, the Utilization Review Nurse is sent an automatic electronic notification from the Novare Utilization Management System.

Initial Review

The Utilization Review Nurse holds responsibility to ensure adherence to all components of the Utilization Review Plan and coordinates the utilization review process to ensure timely decisions, complete and accurate documentation and proper notifications.

When clinical review criteria (California MTUS or approved secondary guidelines per California Code of Regulations 9792.20) are met, the Utilization Review Nurse issues an approval of the request for authorization in compliance with the notice and timeframes set forth in the Utilization Review Plan, Section VII. Utilization Review Standards, subsection Procedures, Timeframes and Notice Content.

A non-physician reviewer (Utilization Review Nurse) 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 of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer (Utilization Review Nurse) may approve the amended request for treatment authorization. Additionally, a non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision but in no event shall this exceed the time limitations imposed in section 9792.9.1(c) and (d).

If the requested service(s) does not meet clinical review criteria in whole or in part, the Utilization Review Nurse escalates the request for authorization review to a qualified physician/clinical peer reviewer.

Only a qualified Physician/Clinical Peer Reviewer may modify or deny a request for authorization.

Request for Additional Information

The timeframe for decisions may only be extended under one or more of the following circumstances:
(A) The claims administrator or reviewer is not in receipt of all of the information reasonably necessary to make a determination; or
(B) The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice; or
(C) The reviewer needs a specialized consultation and review of medical information by an expert reviewer.

If a decision cannot be made because Novare is not in receipt of, or in possession of, all of the information reasonably necessary to make a determination, Novare shall immediately notify the physician, the employee and the employee's representative (as applicable) that a decision cannot be made within the required timeframe and specify the information that must be provided by the physician for a determination to be made.

Upon receipt of all information reasonably necessary and requested by Novare, a decision to approve, modify or deny the request for authorization will be made as follows:

- Except for treatment requests made pursuant to the California formulary, prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five (5) working days from receipt of a request for authorization and supporting information reasonably necessary to make the determination, but in no event more than fourteen (14) days from the date of the medical treatment recommendation by the physician.
- Prospective decisions regarding requests for treatment covered by the California formulary shall be made no more than five (5) working days from the date of receipt of the medical treatment request.
- For prospective or concurrent decisions related to an expedited review, a determination will be made within 72-hours of receipt of the information, but no more than fourteen (14) calendar days from receipt of the initial request.
- For retrospective review decisions, a determination will be made within thirty (30) calendar days of receipt of the information, but no more than thirty (30) days from receipt of the initial request.

If the information reasonably necessary to make a decision is not received within fourteen (14) days from receipt of the original request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, or within five (5) working days of the request for treatment requests pursuant to the California formulary, the request shall be denied with the stated condition that the request will be reconsidered upon receipt of the information.

If any of the circumstances set forth in (B) or (C) above are deemed to apply following the receipt of a DWC Form RFA or accepted request for authorization, the reviewer shall within five (5) business days from the date of receipt of the request for authorization notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing,

that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered.

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

If the results of the additional examination or test required under section (B), or the specialized consultation under section (C), that is requested by the reviewer 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.

Upon receipt of the information requested pursuant to sections (A), (B), or (C), Novare, for prospective or concurrent review, shall make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information. The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision. The written decision shall include the date the information was received.

Upon receipt of the information requested pursuant to sections (A), (B), or (C), Novare, for prospective or concurrent decisions related to an expedited review, shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information. The requesting physician shall be notified by telephone, facsimile or electronic mail within 24 hours of making the decision. The written notice of decision shall include the date the requested information was received.

Upon receipt of the information requested pursuant to sections (A), (B), or (C), Novare, for retrospective review, shall make the decision to approve, modify or deny the request for authorization within thirty (30) calendar days of receipt of the information requested. The decision shall include the date it was made.

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 file will 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.

The Request for Information will identify:

- Specific information necessary to conduct the review (as determined by the clinical circumstance of the review); and
- Due date for submission of the additional information; and
- Timeframe in which a decision will be rendered.

All attempts to obtain the information reasonably required to render a utilization review decision, both verbally and in writing, are documented within the Novare Utilization Management System and associated correspondence is retained with the file.

Referral to Reviewer

When the Initial Reviewer (Utilization Review Nurse) is unable to approve the request for authorization, the request with the supporting documentation is referred to a qualified Reviewer.

The qualified Reviewer is a medical doctor, doctor of osteopathy, psychologist, acupuncturist, dentist, optometrist, podiatrist or chiropractic practitioner who holds a current and valid license by any state or the District of Columbia and is competent to evaluate the specific clinical issues involved in the request for authorization, where the service(s) are within the scope of their practice.

The assigned Reviewer reviews the request for authorization and submitted medical documentation and the appropriate clinical review criteria. When a decision to approve the request for authorization cannot be made, the Reviewer will make an attempt to contact the requesting provider for the purpose of a peer-to-peer discussion. If the peer-to-peer contact is successful, the Reviewer makes a determination based on the peer-to-peer discussion and the documentation submitted. If the peer-to-peer contact is not successful, the Reviewer makes a decision based on the available documentation.

Once the Reviewer has completed the decision, rationale, cited criteria and any information associated with the peer-to-peer, the Initial Reviewer (Utilization Review Nurse) is notified and final processing is completed.

Peer-to-Peer Conversation

The goal of the peer-to-peer conversation is to allow the attending or other ordering provider an opportunity to discuss the utilization review request prior to issuing a decision when the clinical case is not clear and the assigned Reviewer may be considering a modification or denial. A successful peer-to-peer conversation may resolve some disagreements without the need for the appeal process.

Denial and modification letters include written notice of the availability of a peer-to-peer conversation when peer-to-peer conversation was not successfully completed prior to the denial/modification determination notice having been issued.

When a peer-to-peer conversation does not occur prior to a prospective or concurrent denial or modification decision, Novare will provide, within one business day of a request by the attending/ordering provider, the opportunity to complete a peer-to-peer conversation:

- With the clinical peer reviewer that made the initial determination; or
- If the original clinical peer reviewer cannot be made available within one business day, another qualified clinical peer reviewer will be made available to conduct the discussion.

When the peer-to-peer conversation or review of additional information does not result in an approval, Novare informs the provider and worker of the right to initiate a voluntary internal appeal and/or Independent Medical Review and the procedure to do so. When the peer-to-peer conversation results in a recommendation for approval, Novare issues a notice of approval to all required parties.

Novare Reviewers are available for scheduled peer calls between 9:00 AM and 5:50 PM Pacific Time on normal business days.

All peer-to-peer contact attempts and successful discussions conducted by the assigned Reviewer are documented within the Novare Utilization Management System and are included within the utilization management peer Reviewer report and include:

- Date and Time
- Method of Communication
- Outcome of Communication Attempt
- Voicemail: all voicemail messages left by the Reviewer include caller's name/title, organization name, explanation of the nature of the call (potential non-certification pending), timeframe(s) for return call as applicable, and return call contact number.

Determination

For prospective review and concurrent review, Novare bases review determinations solely on the medical information obtained by the organization at the time of the review determination.

Retrospective review determinations are based only on the medical information available to the attending physician or ordering provider at the time the medical care was provided. Consideration of medical information which post-dates the date the service was rendered or was otherwise unavailable to the attending physician or ordering provider is strictly prohibited.

The Initial Reviewer (Utilization Review Nurse) completes the utilization review documentation and prepares determnation notices in accordance with the Utilization Review Plan and required timeframes.

Notification

Closure documentation and notifications are prepared by the Initial Reviewer (Utilization Review Nurse). All notifications are prepared and issued to the appropriate parties in accordance with the requirements as set forth within the Utilization Review Plan.

Delegation of Utilization Review Functions to External Vendors

Novare may contract with Reviewers and/or contract with external Reviewer organizations to supplement the utilization review program. All contracted external vendors are in strict compliance with Novare policies and procedures, URAC standards and California utilization review regulations. Novare maintains responsibility for any delegated functions and oversight responsibility of any delegated function is held by the Quality Assurance and Compliance Manager.

Novare has established and implemented an oversight mechanism for delegated functions within the scope of the California Utilization Review Plan that includes:

a) A periodic review, no less than annually, of the contractor's written policies and documented procedures and documentation of quality activites for related delegated functions;
b) A process to verify, no less than annually, the contractor's compliance with contractual requirements and written policies and documented procedures; and
c) A mechanism to monitor financial incentives to ensure that quality of care or service is not compromised.

This standard does not apply in a circumstance where a contractor performs delegated functions and is accredited by URAC for the service provided to Novare.

Novare does not, under any circumstance, offer financial incentives for delegated services.

The delegated function within the Novare California Utilization Review program is currently limited to Peer Clinical Review performed by:

Dane Street
7121 Fairway Drive, Suite 102
Palm Beach Garden, Florida 33418
Telephone: 561-345-7739
URAC Accreditations:

- Health Utilization Management, Version 7.3
- Independent Review Organization: Internal Review, Version 5.0
- Workers' Compensation Utilization Management, Version 7.3

ExamWorks (Network Medical Review Company, LTD)
4960 East State Street
Rockford, Illinois 61108
Telephone: 815-964-6334
URAC Acceditation:

- Independent Review Organization: Comprehensive Review (Internal & External), Version 5.0

IX. MEDICAL DIRECTOR

Novare maintains a contracted Medical Director who serves as the senior clinical staff member and is responsible for all utilization review decisions:

Melissa D. Tonn, MD, MBA, MPH, CPE, FACOEM, FACPM, FAADEP, DAAPM

California Medical License: A46466
Oklahoma Medical License: 31389
Texas Medical License: H2840

Certifications:
American Board of Preventive Medicine, Occupational Medicine
American College of Physician Executives, Certified Physician Executive
American Academy of Pain Management, Certified

Role/Responsibilities

Medical Director responsibilities include the following:

- Guidance for clinical operational aspects of the program;
- Oversight of clinical decision-making aspects of the program;
- Periodic consultation with practitioners in the field; and
- Ensuring the program objective to have qualified clinicians accountable to Novare for decisions affecting consumers.

The Medical Director must meet the minimal requirements as outlined above. Such requirements are met through the functions identified below:

- Development and evaluation of clinical operational Utilization Management standards throughout the program;
- Clinical decision-making consultation and direction in all aspects of the program;
- Direction and oversight to the Quality Management Committee regarding clinical aspects of the program;
- Consultation with the Policy & Procedure Committee regarding any policies/procedures involving clinical issues;
- Review, evaluation, and approval of clinical-decision support tools and treatment guidelines as needed, but no less than annually;
- Facilitation and coordination of Quality Management Program objectives to provide continued delivery of quality healthcare;
- Guidance, interpretation, and training, as applicable, on issues of medical appropriateness and level of care issues within the Utilization Management review process;
- Oversight of clinical credentialing activities;

- Evaluation and implementation of processes to ensure contracted clinical peer reviewer compliance with evidence-based treatment protocols;
- Clinical peer reviewer orientation and/or training and education and/or re-education counseling;
- Participation in URAC training and accreditation activities as applicable;
- Clinical oversight of consumer safety activities;
- Acts as the clinical liaison to regulatory and oversight agencies;
- Performs or delegates peer discussion activities as needed;
- Serves as provider/client resource within the program; and
- Analysis and trending of data as it relates to quality management activities and overall consumer and client satisfaction.

Curriculum Vitae

EDUCATION:

Master of Public Health, The UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER, Houston, Texas; School of Public Health.

Master of Business Administration, RICE UNIVERSITY, Houston, Texas Jesse H. Jones Graduate School of Administration, *Concentrations*: Health Care Management and Finance.

Doctor of Medicine, THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER, San Antonio, Texas.

Bachelor of Arts, **RICE UNIVERSITY, Houston, Texas.**

Residencies at Baylor College of Medicine and The University of Texas Health Science Center, Houston, Texas.

MEDICAL LICENSURE:

07/87	Texas Medical License, H2840
08/89	California Medical License, A46466
10/15	Oklahoma Medical License, 31389

CERTIFICATIONS:

02/92	**American Board of Preventive Medicine**, Occupational Medicine
03/01	**American College of Physician Executives**, Certified Physician Executive
04/03	**American Academy of Pain Management**, Certified

TEACHING APPOINTMENTS:

04/95 to Present	The University of Texas Health Science Center at Houston, School of Public Health, Occupational Medicine, Adjunct Assistant Professor

- Residency Program Selection Committee
- Site Preceptor
- Lecturer (Dallas/Houston)

04/03 to Present The University of Texas Health Science Center at Tyler
Department of Occupational Medicine, Site Preceptor and Associate Professor

09/95 to 10/99 The University of Texas Health Science Center at Houston,
Department of Family Practice, Adjunct Clinical Instructor

05/92 – 09/95 The University of Texas Health Science Center at Houston
Department of Family Practice, Clinical Instructor

OTHER CERTIFICATIONS:

DWC Approved Provider, Level-2
DWC Designated Doctor
AADEP, CEDIR IV Certified
AAMRO Certified - Medical Review Officer

PROFESSIONAL ASSOCIATIONS/ACTIVITIES:

American Academy of Disability Evaluation Physicians (AADEP), Fellow and President.

American College of Occupational and Environmental Medicine (ACOEM), Fellow.

Texas College of Occupational and Environmental Medicine (TxCOEM), Past President.

American Medical Association/Texas Medical Association/Dallas County Medical Society, Member.

Texas Medical Board, District Review Committee.

Texas Women's University, Board of Regents.

Rice University Alumni in Medicine, Board of Directors.

X. POLICIES AND PROCEDURES – GENERAL

Unit Access, Hours of Operation and Communication Protocols

Effective Date:	05/01/2018
Review Dates:	04/26/2018
Revision Dates:	
Next Review Date:	01/2019
Approval Authority:	Policy & Procedure Committee
URAC Standard(s) Addressed:	WCUM – 2

The utilization review program provides access to services by consumers and clients via our toll-free telephone number (with voicemail access), toll-free fax number, e-mail, and/or hard copy mail.

Novare provides access to review staff by toll-free telephone number at a minimum from 9:00 AM to 5:30 PM Pacific Time.

Telephone voicemails received during regular hours of operation are returned, at a maximum, within one business day of receipt. All after hours communications are promptly handled within one business day of receipt. Telephone activity, such as messages recevied, returned calls, and/or incoming/outgoing calls, is tracked and logged in the Novare Utilization Management System software Nurse Notes.

Incoming faxes are received through a toll-free secure electronic fax with documented received date/time. All incoming fax activity is tracked and entered into a fax log. The incoming fax log is reviewed and verified daily to ensure execution of review processes.

Complaint log activity is regularly reviewed to assess for:

- Report of dropped calls;
- Failure to return voicemail messages timely;
- Lack of receipt of determination letters; and
- Failure to process incoming fax communications.

All access to service performance activity is reported quarterly to the Quality Management Committee by the Quality Assurance and Compliance Manager for further analysis, trending, and corrective action as applicable.

Complaints

Effective Date:	05/01/2018
Review Dates:	04/26/2018
Revision Dates:	
Next Review Date:	01/2019
Approval Authority:	Policy & Procedure Committee
URAC Standard(s) Addressed:	CORE-35

Complaint Receipt/Tracking

Consumer complaints related to WCUM program services may be initiated either verbally or in writing. Some verbal complaints may be resolved by the front line Intake staff upon receipt of a telephone call. When this occurs, the Intake staff member completes a Complaint Investigation/Resolution Form and submits the document to the Quality Assurance and Compliance Manager for review and entry into the Complaint Log database. All other complaints are immediately forwarded to the Quality Assurance and Compliance Manager for log entry and investigation.

For tracking and trending purposes, all received complaints are entered into a Complaint Log database with the following information identified:

- Date/Time of Complaint Receipt
- Resolution/Response Due Date
- Date Notice of Result Issued
- Consumer Type
- Complaint Type
- Novare Case Number (as applicable)
- Jurisdiction (as applicable)

Investigation

Once the complaint has been logged into the database, the Quality Assurance and Compliance Manager initiates a comprehensive investigation, to include review of data/records associated with the complaint and staff interviews as applicable. When additional information is necessary to complete the investigation, the Quality Assurance and Compliance Manager notifies the complaint source of the additional information required and the time frame for response.

Timeframe for Resolution and Response

A verbal or written final notice regarding the complaint resolution is issued as soon as possible but no later than within thirty calendar days of receipt of the complaint. In the event that additional information is required to fully investigate and resolve the complaint, the time frame for resolution begins on the date of receipt of the information required. For those complaints requiring an immediate response, a telephone call is placed to the complainant with a follow-up verbal or written notice within thirty calendar days of receipt of the complaint.

Final Result Notice

The complaint resolution final notice is provided verbally or in writing. Such notice includes an explanation of the actions taken and the final outcome result. When further review is available through an additional consumer avenue, the consumer is provided notice of the additional complaint review process.

Complaint Investigation/Resolution Form and Record Retention

For all received complaints, in addition to entering the complaint data into the Complaint Log, the Quality Assurance and Compliance Manager completes a Complaint Investigation/Resolution Form that details the following:

- Complaint Received Date
- Mode of Submission
- Resolution/Response Due Date
- Date Notice of Result Issued/Notice Type (Verbal/Written)
- Novare Staff Conducted By
- Consumer Type
- Complaint Type
- Novare Case Number (as applicable)
- Jurisdiction (as applicable)
- Consumer Complainant Name/Contact Information
- Nature of Complaint
- Action/Investigation
- Final Result/Explanation
- Notice of Consumer Avenue(s) for Further Review Provided

The Complaint Investigation/Resolution Form, copy of any written Final Result Notice, and all other documentation associated with the complaint and subsequent investigation are retained by the Quality Assurance and Compliance Manager and available for further reporting and analysis as applicable.

Reporting Analysis

A summary of all complaint activity is provided to the Quality Management Committee (QMC) as needed, but in no case less than quarterly. The QMC reviews tracking and trending data for performance analysis and provides recommendations for corrective actions and/or operational process improvements as applicable. Additionally, as part of their analysis, the QMC performs an evaluation to confirm that complaint resolution and response timeframes are met.

Confidentiality of Individually Identifiable Health Information (IIHI)

Effective Date:	05/01/2018
Review Dates:	04/26/2018
Revision Dates:	
Next Review Date:	01/2019
Approval Authority:	Policy & Procedure Committee
URAC Standard(s) Addressed:	CORE-16

IIHI: Acceptable Use and Access

Protected health information (PHI) and IIHI shall only be used for those actions required to conduct WCUM program business operations, to include utilization management activities.

PHI and/or IIHI shall not be used or disclosed by staff members except as permitted or required by the Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws.

Access to PHI/IIHI is restricted to those staff members on a need-to-know basis in order to perform essential job functions to conduct WCUM program business. The contracted Medical Director is granted access to all review files for quality management activities. Contracted clinical peer reviewers access to IIHI is restricted to only those cases individually assigned for review. Case files (to include medical records) are accessed securely via the Novare Texas, LLC/Novare, LLC web-based portal with each user assigned a unique log-in user name and password. The unique log-in provides for secure access to the data server.

Transmission and Storage of IIHI

All forms of communication, whether oral, written, or electronic, and records that are transmitted or stored are confidential.

Confidential information is not disclosed over the telephone without first confirming that the receipient is allowed access to the information. When voicemail messages are left, the message should not state PHI and/or IIHI.

When sending or receiving written mail containing confidential information, all staff should ensure it is sent in a manner that does not allow contents to be revealed. All confidential information received in written format is immediately scanned and placed securely in the appropriate electronic file and the original document is placed in the locked shred bin.

Incoming faxes are not printed. Incoming faxes are received via a secure fax server as PDF files for management and storage. Outgoing faxes are sent via our secure fax server and include a confidentiality notice.

E-mail is hosted on an encrypted Exchange server (Microsoft Office 365) and all e-mail communications include a confidentiality disclaimer and notice.

Workstations:
To prevent unauthorized use, staff shall log off of all applications that provide access to confidential information and/or lock their computer when leaving their workstation. Unless there is a specific business need, all workstations should be shut down at the end of the business day. Automatic screen locks are deployed after (15) minutes of inactivity.

All transactions processed by a user ID and password are the responsibility of the individual to whom the ID/password was assigned. Such information must remain confidential and must not be shared with anyone. It is the responsibility of the user to change a password immediately in the event of a possible or known breach and the immediate supervisor and/or Quality Assurance and Compliance Manager should be notified immediately.

Storage of PHI/IIHI on individual computer hard drives is expressly prohibited. Transfer of PHI/IIHI via laptop, USB, DVD, CD or other mobile devices is prohibited. All Novare workstations include BitLocker encryption.

Training, Responsibility, and Understanding

The Quality Assurance and Compliance Manager serves as the WCUM program Compliance Officer and holds overall responsiblility for confidentiality of IIHI.

All staff are required to protect PHI/IIHI from unauthorized disclosure and do not disclose or provide access to PHI/IIHI except as permitted by law or Novare Texas, LLC/Novare, LLC policies and procedures. All staff who are authorized to access IIHI are responsible for protecting the confidentiality of IIHI. All employees are required to complete Confidentiality/Security/HIPAA training at the time of onboarding and annually thereafter. All employees and committee members must execute a Confidentiality Agreement, which includes individual responsibilities and requirements to protect IIHI.

Novare Texas, LLC/Novare, LLC ensures that independent contractors, vendors, and other third parties have notice of any applicable IIHI confidentiality and use requirements and, before access is granted to them, they agree to protect the confidentiality of IIHI. As appropriate to the scope of their role, independent contractors and vendors complete confidentiality and security training prior to access being provided to PHI/IIHI.

All staff are responsible for immediately reporting any known or suspected breach or violation of confidentiality to their immediate supervisor and/or the Quality Assurance and Compliance Manager.

Financial Incentive Policy

Effective Date:	05/01/2018
Review Dates:	04/26/2018
Revision Dates:	
Next Review Date:	01/2019
Approval Authority:	Policy & Procedure Committee
URAC Standard(s) Addressed:	CORE-33

The Novare utilization review program does not permit or provide reimbursement, bonuses, or incentives to staff or contractors based directly on consumer utilization of health care services.

Frequency of Continued Reviews

Effective Date:	05/01/2018
Review Dates:	04/26/2018
Revision Dates:	
Next Review Date:	01/2019
Approval Authority:	Policy & Procedure Committee
URAC Standard(s) Addressed:	WCUM – 28

Novare ensures that the frequency of reviews for an extension of an initial determination is based on the severity or complexity of the worker's clinical condition or on necessary treatment and discharge planning activity. Concurrent reviews are not routinely conducted on a daily basis.

In determining the next anticipated review date (frequency) for those utilization review requests involving concurrent review, the Utilization Review Nurse will assess and consider the following:

- Severity and/or complexity of the clinical condition; and/or
- Necessary treatment and discharge planning activity.

Approved clinical review criteria may be applied based on the diagnosis and/or level of care to aid the Utilization Review Nurse in determining the frequency of continued reviews.

The Utilization Review Nurse will ensure performance of the review early enough to allow the worker to receive a review decision before the reduction or termination occurs (as measured by the Start/End dates appropriate to the case).

XI. JOB DESCRIPTIONS/STAFF QUALIFICATIONS

Consultant: Medical Director

Reports to: Executive Vice President

Position Overview

The utilization management (UM) program *Medical Director* provides guidance for clinical operational aspects of the program, oversight of clinical decision-making aspects of the program, periodic consultation with practitioners in the field and ensures the program objective to have qualified clinicians accountable to Novare for decisions affecting consumers.

Roles and Responsibilities

- Serve as Novare's Medical Director and perform services in accordance with all applicable state laws, rules, and regulations as well as URAC standards and core requirements.
- Development and evaluation of clinical operational utilization management standards throughout the UM program.
- Clinical decision-making consultation and direction in all aspects of the WCUM program;
- Direction and oversight to the Quality Management Committee (QMC) regarding clinical aspects of the UM program.
- Consultation with the Policy & Procedure Committee (PPC) regarding any policies/procedures involving clinical issues.
- Review, evaluation, and approval of clinical-decision support tools and treatment guidelines as needed, but no less than annually.
- Facilitation and coordination of Quality Management Program objectives to provided continued delivery of quality healthcare.
- Guidance, interpretation, and training, as applicable, on issues of medical appropriateness and level of care issues within the utilization management review process.
- Oversight of credentialing activities.
- Evaluation and implementation of processes to ensure contracted clinical peer review compliance with evidence-based treatment protocols.
- Clinical peer reviewer orientation and/or training and education and/or re-education counseling.
- Participation in URAC training and accreditation activities as applicable.
- Clinical oversight of consumer safety activities.
- Act as the clinical liaison to regulatory and oversight agencies.
- Perform or delegate peer discussion activities as needed.
- Serve as provider/client resource within the UM program.
- Analysis and trending of data as it relates to quality management activities and overall consumer and client satisfaction.
- Maintains confidentiality and security in all aspects of performance.
- Perform other related duties incidental to the work described herein.

Qualifications/Requirements

Education/Licensure/Certification

- Current, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States;
- Board Certification (for M.D. or D.O.) by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association (preferred certification in Occupational Medicine or Orthopedics);
- Affiliation with State Medical Boards;
- Unrestricted license to practice medicine in the state of Texas; and
- Unrestricted license to practice medicine in the state of California.

Experience

- Minimum of five years post-graduate experience in direct patient care; and
- Recent experience or familiarity with current body of knowledge and medical practice; and
- Two years' experience with workers' compensation/utilization review preferred OR
- An equivalent combination of relevant education and/or experience.

Skills/Knowledge

- Knowledge of workers' compensation laws and regulations.
- Strong oral and written communication skills.
- Computer knowledge required, including Microsoft Office products.
- Leadership/management/motivational skills.
- Analytical and interpretive skills.
- Strong organizational skills.
- Excellent interpersonal skills.
- Good negotiation skills.
- Discretion and confidentiality.
- Ability to work in a team environment.

Acknowledgement of receipt of Consultant Medical Director Description:

Name/Credentials:	
Signature:	
Date:	

Job Description: Quality Assurance and Compliance Manager

Reports to: Executive Vice President

Position Overview

The *Quality Assurance and Compliance Manager* is responsible for managing support and coordination of the daily operations of the utilization management (UM) Quality Management Program and serves as the Compliance Officer. The *Quality Assurance and Compliance Manager* helps to plan, develop, organize, monitor, communicate and recommend modifications to the Quality Management Program and quality improvement policies and procedures. The *Quality Assurance and Compliance Manager* interfaces with other departments on quality improvement issues and reports any areas of concern to senior management, the Quality Management Committee and/or Medical Director.

Roles and Responsibilities

- Contribute to training and education of UM staff.
- Oversight of delegation activities in conjunction with the Executive Vice President.
- Administer/manage the regulatory compliance program and serve as the Compliance Officer.
- Responsible for UM program clinical staff credentialing processes with oversight provided by the Medical Director.
- Under the oversight and direction of the Medical Director, ensures clinical peer reviewer orientation, training, education and/or re-education counseling compliance.
- Coordination and oversight of client/consumer satisfaction activities.
- Oversight and coordination of the complaint investigation/resolution process.
- Promote, monitor and report on the objectives of the Quality Management Program and serve as the chair on the Quality Management Committee.
- Follow up on corrective action plans and prepare and present summary reports of performance measures.
- Interface with the Medical Director for clinical quality of care and service issues.
- Responsible for organizational compliance with information security, confidentiality and HIPAA standards.
- Serve on the Policy & Procedure Committee for review, revision and approval of policies and procedures as needed, but no less than annually.
- Interface with UM staff to ensure compliance with organizational policies and procedures and URAC standards.
- Oversight and coordination of the development of consumer-facing communications.
- Serve as provider/client/vendor resource for utilization review.
- Maintain confidentiality and security in all aspects of performance.
- Perform other related duties incidental to the work described herein.

Qualifications

Education/Licensure

- Completion of formal training in a health care field; and
- Active, unrestricted professional license or certification to practice as a health professional in a state or territory of the United States:
    a) An associate degree or higher in a health care field (RN); OR
    b) State license or state certificate in a health care field (LVN/LPN).
- Certified Case Manager (CCM), Health Care Quality & Management (HCQM) or equivalent certification preferred.

Experience

- 3 years of clinical experience.
- 2 years of utilization management experience, including 1 year of supervisory experience; OR
- Equivalent combination of training, education and experience that provides the required knowledge and abilities.

Skills/Knowledge

- Knowledge of workers' compensation laws and regulations.
- Excellent interpersonal, verbal and written communication skills to interface with senior management, staff and clients.
- Computer knowledge required, including Microsoft Office products.
- Leadership/management/motivational skills.
- Analytical and interpretive skills.
- Strong organizational skills.
- Knowledge of regulatory and accreditation agencies and requirements.
- Ability to manage multiple priorities in an efficient and decisive manner.
- Ability to develop routine reports and correspondence and to present information in one-on-one, small group and large group settings.

_____

Acknowledgement of receipt of Job Description:

Employee Name/Credentials:	
Signature:	
Date:	

Job Description: Utilization Review Manager

Reports to: Executive Vice President

Position Overview

The *Utilization Review Manager* is a working/supervisory position providing leadership, operational expertise and oversight of clinical and non-clinical operations under the utilization management (UM) program. The *Utilization Review Manager* plans, organizes and supervises the activities of UM staff and oversees and participates in the development and implementation of effective and efficient standards, policies, protocols, processes, reports and benchmarks that support and further enhance quality utilization management performance. The *Utilization Review Manager* works in tandem with the Medical Director, who provides clinical decision-making oversight.

Roles and Responsibilities

- Effectively lead, supervise and direct the workload in the UM department.
- Interview and recommend UM staff to be hired.
- Training and supervisory oversight of UM staff.
- Counsel and discipline UM staff and perform/assist with annual performance appraisals.
- Responsible for monitoring and coordination of peer clinical reviewers under the direction of the Medical Director.
- Conduct initial clinical review for medical necessity against approved evidence-based guidelines.
- Provide clinical oversight and serve as a resource for non-clinical staff.
- Serve as provider/client/vendor resource for utilization review.
- Develop, review and approve utilization management operational processes and functions with Medical Director clinical decision-making oversight.
- Assist in promoting and furthering the objectives of the Quality Management Program and serve on the Quality Management Committee.
- Manage and track consumer health and safety issues from identification to resolution.
- Analyze and trend data and report on performance measures.
- Serve on the Policy & Procedure Committee for review, revision and approval of policies & procedures as needed, but no less than annually.
- Maintain confidentiality and security in all aspects of performance.
- Perform other related duties incidental to the work described herein.

Qualifications

Education/Licensure/Certification

- Completion of formal training in a health care field; and
- Active, unrestricted professional license or certification to practice as a health professional in a state or territory of the United States:
    c) An associate degree or higher in a health care field (RN); OR

d) State license or state certificate in a health care field (LVN/LPN).

- Certified Case Manager (CCM), Health Care Quality & Management (HCQM) or equivalent certification preferred.

Experience

- 3 years of clinical nursing experience.
- 2 years of utilization management experience, including 1 year of supervisory experience; OR
- Equivalent combination of training, education and experience that provides the required knowledge and abilities.

Skills/Knowledge

- Knowledge of workers' compensation laws and regulations.
- Proficient in utilization management and review procedures and techniques.
- Discretion and confidentiality.
- Strong oral and written communication skills.
- Computer knowledge required, including Microsoft Office products.
- Leadership/management/motivational skills.
- Analytical and interpretive skills.
- Strong organizational skills.
- Excellent interpersonal skills.
- Good negotiation skills.
- Ability to work in a team environment.
- Ability to multi-task.

Acknowledgement of receipt of Job Description:

Employee Name/Credentials:	
Signature:	
Date:	

Job Description: Utilization Review Team Supervisor

Reports to: Utilization Review Manager

Position Overview

The *Utilization Review Team Supervisor* is responsible for coordinating all components of the utilization management process, which includes timely review of treatment requests for medical necessity, ensuring appropriate cost-effective treatment and promotion of best patient outcomes. When clinical requirements for medical necessity, appropriateness or effectiveness are not met and a clinical determination to certify the request cannot be made, the *Utilization Review Team Supervisor* must escalate the case for peer clinical review. The *Utilization Review Team Supervisor* provides clinical oversight and serves as a resource for non-clinical staff.

Roles and Responsibilities

- Training of Utilization Review Nurses and Intake Specialists.
- Clinical oversight and resource for non-clinical staff.
- Supervisory responsibility for assigned utilization review staff.
- Conducts initial clinical review for medical necessity against approved evidence-based guidelines.
- Evaluates need for continued or alternative treatment with provider.
- Discusses treatment options with requesting provider.
- Documents utilization review components within the Novare Utilization Management System (DDR) per State, Federal and URAC requirements, including data collection for analysis and trending.
- Refers, coordinates and interacts with peer clinical reviewers.
- Facilitates peer discussion during peer clinical review process.
- Partners with medical providers to promote best patient outcomes.
- Adheres to Novare Policies and Procedures and URAC standards as appropriate to job functions.
- Assists in promoting and furthering the objectives of the Quality Management Program.
- Maintains confidentiality and security in all aspects of performance.
- Performs other related duties incidental to the work described herein.

Qualifications

Education/Licensure/Certification

- Completion of formal training in a health care field; and
- Active, unrestricted professional license or certification to practice as a health professional in a state or territory of the United States:
    e) An associate degree or higher in a health care field (RN); OR
    f) State license or state certificate in a health care field (LVN/LPN).
- Certified Case Manager (CCM), Health Care Quality & Management (HCQM) or equivalent certification preferred.

Experience

- 3 years of clinical nursing experience.
- 1-year experience with workers' compensation/utilization management preferred.

Skills/Knowledge

- Knowledge of workers' compensation laws and regulations (preferred).
- Discretion and confidentiality.
- Good customer service skills.
- Strong oral and written communication skills.
- Computer knowledge required, including Microsoft Office products.
- Able to perform as part of a team.
- Analytical and interpretive skills.
- Strong organizational skills.
- Excellent interpersonal skills.
- Good negotiation skills.
- Ability to multi-task.

Acknowledgement of receipt of Job Description:

Employee Name/Credentials:	
Signature:	
Date:	

Job Description: Utilization Review Nurse

Reports to: Utilization Review Manager

Position Overview

The *Utilization Review Nurse* is responsible for coordinating all components of the utilization review process, which includes timely review of treatment requests for medical necessity, ensuring appropriate cost-effective treatment and promotion of best patient outcomes. The *Utilization Review Nurse* performs the initial clinical review, prepares an organized case summary and may issue certifications of medical necessity. When clinical requirements for medical necessity, appropriateness or effectiveness are not met and a clinical determination to certify the request cannot be made, the *Utilization Review Nurse* must escalate the case for peer clinical review. The *Utilization Review Nurse* provides clinical oversight and serves as a resource for non-clinical staff.

Roles and Responsibilities

- Coordinates the utilization review process for each treatment request.
- Provides clinical oversight and serves as a resource for non-clinical staff.
- Conducts initial clinical review for medical necessity against approved evidence-based guidelines.
- Evaluates need for continued or alternative treatment with provider.
- Discusses treatment options with requesting provider.
- Documents utilization review components within the Novare Utilization Management System (DDR) per State, Federal and URAC requirements, including data collection for analysis and trending.
- Refers, coordinates and interacts with peer clinical reviewers.
- Facilitates peer discussion during peer clinical review process.
- Partners with medical providers to promote best patient outcomes.
- Adheres to Novare Policies and Procedures and URAC standards as appropriate to job functions.
- Assists in promoting and furthering the objectives of the Quality Management Program.
- Maintains confidentiality and security in all aspects of performance.
- Performs other related duties incidental to the work described herein.

Qualifications

Education/Licensure/Certification

- Completion of formal training in a health care field; and
- Active, unrestricted professional license or certification to practice as a health professional in a state or territory of the United States:
    g) An associate degree or higher in a health care field (RN); OR
    h) State license or state certificate in a health care field (LVN/LPN).
- Certified Case Manager (CCM), Health Care Quality & Management (HCQM) or equivalent certification preferred.

Experience

- 3 years of clinical nursing experience.
- 1-year experience with workers' compensation/utilization management preferred.

Skills/Knowledge

- Knowledge of workers' compensation laws and regulations (preferred).
- Discretion and confidentiality.
- Good customer service skills.
- Strong oral and written communication skills.
- Computer knowledge required, including Microsoft Office products.
- Able to perform as part of a team.
- Analytical and interpretive skills.
- Strong organizational skills.
- Excellent interpersonal skills.
- Good negotiation skills.
- Ability to multi-task.

Acknowledgement of receipt of Job Description:

Employee Name/Credentials:	
Signature:	
Date:	

Job Description: Intake Manager

Reports to: Utilization Review Manager

Position Overview

The *Intake Manager* is responsible for managing administrative functions of the utilization review process. This is a non-clinical position and the *Intake Manager* is not responsible for and is prohibited from conducting any utilization management activities that require clinical information interpretation. The Utilization Review Nurse, Utilization Review Team Supervisor and/or Utilization Review Manager perform oversight of initial screening and are available to non-clinical staff.

Roles and Responsibilities

- Direct oversight of the utilization review Intake Specialist staff.
- Training and oversight of all Intake Specialists.
- Receives, screens and manages mail, faxes and calls.
- Reviews service request for completeness of information.
- Collection and data entry of structured clinical data (including diagnosis, diagnosis codes, procedures, procedure codes) and demographic information into the utilization review system.
- Assigns reviews to Utilization Review Nurse.
- Assists with written determination letter communications via fax, e-mail or written mail under the direction of the Utilization Review Nurse.
- Provides customer service functions.
- Adheres to Novare Policies and Procedures and URAC standards as appropriate to job functions.
- Assists in promoting and furthering the objectives of the Quality Management Program and serves on the Quality Management Committee.
- Maintains confidentiality and security in all aspects of performance.
- Performs other related duties incidental to the work described herein.

Qualifications

Education

- High school diploma or equivalent required.
- Associate or Bachelor degree preferred.

Experience

- 1 year of customer service assistance.
- Experience with CPT/ICD-10 coding preferred.

Skills/Knowledge

- Good customer service skills.
- Strong oral and written communication skills.
- Computer knowledge required, including Microsoft Office products.
- Leadership/management/motivational skills.
- Analytical and interpretive skills.
- Able to perform as part of a team.
- Strong organizational skills.
- Excellent interpersonal skills.
- Discretion and confidentiality.
- Ability to multi-task.

Acknowledgement of receipt of Job Description:

Employee Name:	
Signature:	
Date:	

Job Description: Intake Specialist

Reports to: Intake Manager

Initial Screening Oversight: Utilization Review Nurse, Utilization Review Team Supervisor, Utilization Review Manager

Position Overview

The *Intake Specialist* is responsible for handling and coordinating administrative functions of the utilization review process. This is a non-clinical position and the *Intake Specialist* is not responsible for and is prohibited from conducting any utilization management activities that require clinical information interpretation. The Utilization Review Nurse, Utilization Review Team Supervisor and/or Utilization Review Manager perform oversight of initial screening and are available to non-clinical staff.

Roles and Responsibilities

- Receives, screens and manages mail, faxes and calls.
- Reviews service request for completeness of information.
- Collection and data entry of structured clinical data (including diagnosis, diagnosis codes, procedures, procedure codes) and demographic information into the Novare Utilization Management System (DDR).
- Assigns reviews to Utilization Review Nurse.
- Assists with written determination letter communications via fax, e-mail or written mail under the direction of the Utilization Review Nurse.
- Provides customer service functions.
- Adheres to Novare Policies and Procedures and URAC standards as appropriate to job functions.
- Assists in promoting and furthering the objectives of the Quality Management Program.
- Maintains confidentiality and security in all aspects of performance.
- Performs other related duties incidental to the work described herein.

Qualifications

Education

- High school diploma or equivalent required.
- Associate or Bachelor degree preferred.

Experience

- 1 year of customer service assistance.
- Experience with CPT/ICD-10 coding preferred.

Skills/Knowledge

- Good customer service skills.

- Strong oral and written communication skills.
- Computer knowledge required, including Microsoft Office products.
- Able to perform as part of a team.
- Strong organizational skills.
- Excellent interpersonal skills.
- Discretion and confidentiality.
- Ability to multi-task.

Acknowledgement of receipt of Job Description:

Employee Name:	
Signature:	
Date:	