UR PLAN

(revised 08-20-12)
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Introduction

Purpose:
The Utilization Review Program of Arissa Cost Strategies is predicated on the need for appropriate medical care for the injured worker based on realistic evidence based criteria which is reasonably medically necessary to cure or relief the effects of that injury or illness. It is the goal of the Arissa Cost Strategies to enhance the communication between the necessary parties to support the medical standards and guidelines used in the decision.

Document Scope:
The following document will provide the description of the Utilization Review Program and the processes necessary to fulfill the intent of the program including the:

1. Utilization Review Criteria Documentation
2. The medical team participating in the decisions
3. The communication management guidelines
4. The time frames and processes followed to manage compliance with the regulations.

Definitions:

Utilization Review:


Authorization: means assurance that the 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 the section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code.

Concurrent Review: means utilization review conducted during the hospital stay.

Emergency Healthcare Services: means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity that would place the patient in serious jeopardy.

Expedited Review: means utilization review conducted when the injured employee’s condition is such that the injured worker faces imminent and serious threat to his/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 employee’s life or health or could jeopardize the injured ability to regain maximum function.

**Expert Reviewer:** means a medical doctor, a doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner, licensed in any state or District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and these services are within the scope of their practice qualifications, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.

**MTUS:** means the Medical Treatment Utilization Schedule set forth in 8 CCR 9792.20 et seq.

**Prospective Review:** means any utilization review conducted, except for an inpatient stay, prior to the delivery of the requested medical services.

**Request for Authorization:** means a written confirmation of an oral request for a specific course of treatment pursuant to the Labor Code section 4610(h) or a written request for a specific course of proposed medical treatment. If the request is oral, a written request must be followed by a written confirmation of the request within 72 hours. All requests must be attached to a recognizable report such as the DLSR 5021, or on a Primary Treating Physician Progress report or in a narrative form containing the same information as would be found on the PR-2 form. The request should be clearly marked.

**Retrospective Review:** means utilization review conducted after medical services have provided and for which prior authorization has not been addressed.

**Reviewer:** means a medical doctor, osteopathic doctor, psychologist, acupuncturists, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate specific clinical issues involved in the medical treatment services and within the scope of their practice.

**Utilization Review Process:** means utilization management functions that prospectively, retrospectively, or concurrently, review and approve, modify, delay or deny based on the reasonably medical necessity, to cure or relieve the work related injury or disease based on the treatment recommendations of the treating physician defined in the labor code section 3209.3, prior to, retrospectively or concurrently with the provision of medical treatment services per the Labor Code section 4600.

**NOTE:** written includes a facsimile as well as communications in paper format.
Utilization Review Policy and Procedure
Prospective, Concurrent and Retrospective Review

Pursuant to Labor Code Section 4610, Arissa Cost Strategies will conduct Utilization Review consistent with the regulations contained in Labor Code Section 4610 and Title 8. Industrial Relations, Division 1. Department of Industrial Relations, Chapter 4.5 Division of Workers’ Compensation, Subchapter 1. Administrative Director – Administrative Rules, Article 5.5.1 Utilization Review Standards and 8 CCR Section 9792.6 et seq (incorporated herein in its entirety by this reference).

This Utilization Review Process will be coordinated through the services of Utilization Review Nurses, Physician Advisors, Medical Advisors and/or the Medical Director. The MTUS (Medical Treatment Utilization Guidelines), since its adoption as of April 15, 2007, and the guidelines adopted into the MTUS are considered presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury. For all conditions or injuries not addressed by MTUS, authorized treatment shall be in accordance with other established evidence based medical treatment guidelines, including but not limited to the ACOEM Practice Guidelines, the Medical Disability Advisor (Presley-Reed, M.D.), the Official Disability Guidelines (O.D.G.) or Interqual will be applied to cases where the MTUS does not cover the specific injury sustained by the injured employee. Subscriptions to each of the guidelines indicated above have been secured which provide updates as developed. These updates are incorporated into the review process as they are issued. Review criteria shall be updated automatically to include any and all changes in said guidelines upon notification of any such published changes. Arissa Cost Strategies shall contact each of the above named publishers a minimum every 6 months to determine if any changes have occurred and obtain said information immediately. These guidelines and procedures will be in accordance with all the rules, regulations, laws and guidelines of the State of California, as adopted by the California governing bodies.

The following Medical Treatment Utilization Schedule (MTUS) have been included in the Utilization Review Plan Effective June 1, 2007 as amended:

Workers’ compensation final regulations
Medical treatment utilization schedule regulations
Title 8, California Code of Regulations
Sections 9792.20 - 9792.26

Additional regulations have been filed with secretary of state June 18, 2009 Effective July 18, 2009

Article 5.5.2 Medical Treatment Utilization Schedule, inclusive of all Sections:

Section 9792.20 – Medical Treatment Utilization Schedule – Definitions
(a) – (l) – inclusive of all subsections
Section 9292.21 – Medical Treatment Utilization Schedule
(a) – (c) – inclusive of all subsections
Section 9792.22 – Presumption of Correctness, Burden of Proof and Strength of Evidence
(a) – (c) – inclusive of all subsections
Section 9792.23 – Medical Evidence Evaluation Advisory Committee
Regulations Effective May, 2007

The following Medical Treatment Utilization Schedule (MTUS) have been included in the Utilization Review Plan Effective July 18, 2007 as amended:

Article 5.5.2 Medical Treatment Utilization Schedule, inclusive of all Sections:

Section 9792.24 – Special Topics – Inclusive of all subsections

- Section 9792.24.1 – Acupuncture Medical Treatment Guidelines (a) – (e) – inclusive of all subsections
- Section 9792.24.2 – Chronic Pain Medical Treatment Guidelines (a) – (e) – inclusive of all subsections

Regulations Effective July 18, 2009 in addition as other guidelines are adopted by MTUS, these will also be considered as primary, as well.

1. Upon receipt of the request for Utilization Review, the Utilization Review Process is initiated within one (1) business day. Where the request is submitted by the patient, attending provider, or facility rendering service the process is initiated within one (1) business day of receipt.

   A. When the UR staff receives a telephone call or written correspondence from the treating physician, requesting authorization for a proposed treatment the UR staff, the Medical Director, or other Medical Advisor shall obtain the medical information necessary to make a determination to certify, delay, modify or deny a request for services. However, only a licensed physician can make the decision to delay, modify or deny decisions.

   Section 9792.6(s)—treatment recommendations must be from physicians, as defined in Labor Code section 3209.3. The written request must be set forth on the “Doctor’s First Report of Occupational Injury or Illness,” Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization. (Section 9792.6(o)) The physician’s request often is sent in by the claims adjuster, but the request is made by the treating physician.

   B. Authorization of requested service means the assurance that the appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code.

   C. In the event there is a requirement for Emergency health care services, defined as 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, the Utilization Review Process shall be initiated within one (1) business day after notification of such an event. Utilization Review determinations shall be made in accordance with Section 4 B or 4 C of the Utilization Review Plan. 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. Documentation for emergency health care services shall be made available.

2. Information collected will include:
Patient name, address, phone number, date of birth, insurance ID number, employee name, social security number, address, phone number, employer group, treating physician, address, phone number and tax ID number, facility name, address phone number and tax ID number, diagnosis, proposed treatment plan, and medical information to support the treatment plan. Data is entered into a secure computer application and information is shared with all disciplines within the UR department that have a need to know in order to complete the review process.

A. When conducting prospective review, concurrent review or retrospective review, the UR staff:

   (1) Will collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services;

   (2) Will request from hospitals, physicians, and other providers the numerical code of the diagnosis (ICD-9) or procedure (CPT code) to be considered for certification;

   (3) May request appropriate information which is necessary to render a decision that was not provided with the original request for authorization;

   (4) Requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; and

B. In situations where there is insufficient information to conduct the review, the UR staff will make at least two (2) attempts to notify attending provider, provider, or facility rendering service (as applicable), within the UR process timeframes required by law, of the need for additional information, the information needed, and the method by which to submit it. One attempt must be by fax or mail as well as by phone. The provider (physician) has 14 calendar days from the receipt of the original notice (RFA) to respond with the requested information.

C. If attending provider, provider, or facility rendering service does not give medical information for pre-certification determination, when such information is requested within the first five days of receipt of the RFA, and not received within the first 14 days of receipt of the original RFA, then the case is referred to our Medical advisor or Medical Director for a non-certification due to lack of information, with the stated condition that the request will be reconsidered upon receipt of the information requested.

Our non-certification correspondence indicates reason for non-certification and is accompanied with our appeals process and forwarded to the patient, attending provider, provider, or facility rendering service within one (1) business day of the determination. If the treatment plan is non-certified for lack of information and the patient, attending provider, provider, or facility rendering service subsequently provides complete clinical information within the allowable timeframe, the UR staff can certify the treatment plan. If the UR staff is unable to certify the treatment plan, the original Medical advisor or Medical Director who denied the treatment plan for lack of information can re-review the treatment plan to make a determination.

3. The Initial Clinical Review is conducted by the UR staff who reviews the proposed treatment plan for medical appropriateness and necessity using MTUS and/or other medically recognized criteria when an MTUS guideline does not address the condition or requested treatment. MTUS must be used first, then if the treatment or condition is not addressed in MTUS, the other evidence based criteria may be used If the treatment plan is not supported by the initial clinical information provided, or if the provider is unable to be contacted, then the case will be referred for Physician Peer Clinical Review within 24 hours. No person other than a California licensed physician
who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician’s practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.(“reasonably medically necessary”).

A. Peer Clinical Reviews are only performed by individuals who:

(1) Are licensed physicians qualified, as determined by the medical director or clinical director, to render a clinical opinion about the medical condition, procedures, and treatment under review;
(2) Hold a current and valid license to practice medicine in the State of California in the same license category as the ordering provider; and
(3) Meet all applicable State Utilization Review requirements.

B. Health Professionals conducting Peer Clinical Reviews will be available, by telephone, or in person, to discuss, review determinations with attending physicians or other ordering providers.

4. UR process timeframes are inclusive of the entire UR process from receipt of the request for a UR decision to the issuance of the decision. Issuance of review determinations are made in accordance with the following timeframes:

A. For Prospective Review, Arissa Cost Strategies will issue a determination:

(1) Within 24 hours of the request for a utilization management determination, if it is a case involving urgent care, or
(2) Within 5 working days of the request for a utilization management determination, if it is a non-urgent case. However, if appropriate information which is necessary to render a decision is not provided with the original request, such information may be requested within the first 5 days of receipt of the RFA to make the proper determination, but in no event shall the determination be made more than fourteen (14) calendar days from the date of the original request by the provider. If the Utilization Review Determination is a denial based upon the lack of receipt of the requested appropriate information within fourteen (14) days to make the proper determination, upon receipt of such reasonable information all requests will be reconsidered and the normal time frames for a Prospective Review shall be applied.
(3) Within 72 hours for an expedited review after the receipt of the written information reasonably necessary to make the determination.

B. For Concurrent Review, defined as utilization review conducted during an in-patient stay, Arissa Cost Strategies will issue a determination:

(1) Within 24 hours of the request for a utilization management determination, if it is a case involving urgent care; or
(2) Within 5 working days of the request for a utilization management determination, if it is a non-urgent case. However, if appropriate information which is necessary to render a decision is not provided with the original request, such information may be requested within the first 5 days of receipt of the RFA to make the proper determination, but in no event shall the determination be made more than 14 days from the date of the original request by the provider. If the Utilization Review Determination is a denial
based upon the lack of receipt of the requested appropriate information within fourteen (14) days to make the proper determination, upon receipt of such reasonable information all requests will be reconsidered and the normal time frames for a Concurrent Review shall be applied. If a denial due to lack of information has been sent and then requested information is received after 14 days, the request will be considered and a decision rendered within 5 working days from the date of receipt of the requested necessary information.

In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

(3) Within 72 hours for an expedited review after the receipt of the written information reasonably necessary to make the determination.

(4) In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker.

C. For Retrospective Review, Arissa Cost Strategies will issue a determination:

(1) Within 30 calendar days of the request for a utilization review determination. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

5. Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to injured workers, shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in approval, modifications, delay, or denial of all or part of the requested health care services shall be communicated to physicians initially by telephone or facsimile, and to the physician, injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

A. The UR staff will recommend certification of the proposed treatment plan that appear medically appropriate, according to medical criteria.

(1) Notification of certification decision is communicated to the requesting physician within 24 hours of the decision. (Types of notification include telephone, voicemail, facsimile or letter).

(2) Confirmation of certification for continued hospitalization or services includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

B. In Non-Certification decisions, notification is provided to the attending physician or other ordering provider or facility rendering service through a method
that will be received within 24 hours of the non-certification decision. (Types of notification include telephone, voice mail, facsimile or letter).

(1) Written notification of a non-certification decision is sent to the patient, attending physician if the injured worker is represented by counsel, the injured worker’s attorney, or other ordering provider or facility rendering service within 24 hours of the decision for concurrent review or within 2 business days of the decision for prospective review. In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

(2) Written notification of non-certification, modifications, delay or other adverse decisions will contain the date on which the decision was made, the name and specialty of the reviewer, or expert reviewer, the telephone number in the United States of the reviewer, or expert reviewer and hours of availability of the reviewer, expert reviewer or Medical Director shall be, at a minimum, four (4) hours per week, to be available during normal business hours, 8:00 AM and 5:30 PM, Pacific Time or an agreed upon scheduled time to discuss the decision, a clear and concise explanation of the reasons for the decision, a description of the medical criteria and the specific guidelines used, the clinical reasons for the decisions regarding medical necessity, statement that any dispute shall be resolved in accordance with Labor Code Section 4062, and details about the insurer’s appeals process, if any, and clearly state that the appeals process is on a voluntary basis as consistent with Labor Code Section 4062(a). In addition, such written notification shall include the following statements:

“If you want further information, you may contact the local state Information and Assistance office by calling (enter district I & A office telephone number closest to the injured worker) or you may receive recorded information by calling 1-800-736-7401.

and, “You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney’s fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.”

and, “If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in the claims administrator’s internal utilization review appeals process.”

C. When a determination is made to issue a non-certification and no peer-to-peer conversation has occurred, Arissa Cost Strategies will provide, within one (1) business day of a request by the attending physician or ordering provider, the opportunity to discuss the non-certification decision with the Clinical Peer Advisor making the initial determination, or, with a different Clinical Peer if the original Clinical Peer Advisor cannot be available within one (1) business day.
6. Prospective and concurrent review determinations are solely based on the information obtained by the UR staff or Medical Advisor at the time of the review determination; for retrospective review, the determinations are solely based on medical information available to the attending or ordering provider at the time medical care was provided. A reverse of certification can only occur when there is receipt of additional medical information that is materially different from that which was reasonably available at the time of the original determination. Based on Labor Code 4610.3 which states an employer that authorizes medical treatment shall not rescind or modify that authorization after the medical treatment has been provided based on that authorization for any reason, including but not limited to, the employer's subsequent determination that the physician treating the employee was not eligible to treat that injured employee. If there is a series of treatments, only those treatments not completed may be rescinded or modified.

7. The frequency of reviews for the extension of initial determinations is based on the severity or complexity of the patient’s condition or on necessary treatment and discharge planning activity.

8. Upon request by the public, Arissa Cost Strategies shall make available the complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process.

   A. Arissa Cost Strategies may make available the complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process through electronic means. If a member of the public requests a hard copy of the utilization review plan, Arissa Cost Strategies may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed $0.25 per page plus actual postage costs.

All Utilization Review procedures will be in accordance with any applicable rules, regulations, guidelines or laws in the state of California.

TELEPHONE # 1 714-259-1053
FACSIMILE # 1 949-734-7272
Appeals Procedure

Any dispute regarding a non-certification/denial or modification of services decision shall be resolved in accordance with California Labor Code Section 4062. In the event of a non-certification/denial or modification of services decision, an appeal may be filed as outlined below. The appeals process is on a voluntary basis as consistent with Labor Code Section 4062 (a). Only the requesting physician may appeal a utilization review decision. The appeal must be in writing, and must be received within 10 days of the UR decision. Note: The 10 day time frame does not extend or alter the statuary 20 day timeframe for dispute resolution outlined in Labor Code 4062.

1. In the event that an attending physician, ordering provider, enrollee, injured worker, facility, patient, patient representative or other health care provider has additional medical information that may impact an initial non-certification/denial or modification recommendation, he/she may submit a written or telephonic request to Arissa Cost Strategies within twenty (20) days of receipt of any such determination, unless timeframes otherwise mandated by state statutes, to have the additional medical information reviewed via an Expedited or Standard Appeals Process by a Medical/clinical peer who did not make the original determination not to certify or to modify.

   (a) Copies of the medical record documentation supporting the additional medical information must be included with the request for the standard appeal. UR vendor will take into account all documents, records, or other information submitted by the patient, provider, or facility rendering service relating to the case, without regard to whether such information was submitted or considered in the initial consideration of the case.

   (b) Appeals consideration conducted by a Board-Certified (if applicable) clinical peer holding an active, unrestricted license to practice medicine in the State of California in the same profession, similar specialty as typically manages the medical condition, procedure or treatment as mutually deemed appropriate, AND is neither the individual who made the original non-certification decision, nor the subordinate of such an individual.

2. Appeal timeframes are inclusive of the entire appeals process from receipt of the request to issuance of a written determination. All requests for appeal are completed and issuance of the appeal decision in accordance with the following timeframes:

   (a) Expedited Appeals are completed as soon as possible, and no later than 72 hours after the initiation of the appeals process;

   (b) Standard Appeals are completed within 30 calendar days of the initiation of the appeal process.

   (c) All appeal procedures will be in compliance with state statutes.

3. Arissa Cost Strategies will notify the Attending Physician or other Ordering Provider or Facility rendering service of the appeals determination through a method that will be received within 24 hours of the appeals determination (types of notification include verbal, voicemail, email, fax or letter); and issues written notification within one (1) business day of the appeals determination to the patient and Attending Physician or other ordering provider and facility rendering service (if applicable). If the patient is a child under the age of 18, the notification will go to the insured.
(a) Written notification of adverse appeals determinations includes the principal reasons for the determination to uphold the non-certification; a statement that the clinical rationale used in making the appeal decision will be provided, in writing, upon request (exception--the written notification shall not include the rationale, criteria or guidelines used for the decision for any non-physician provider of goods or services.); and in the case of expedited appeals, the method to initiate the standard appeal process.

(b) Upon request, Arissa Cost Strategies will provide the attending physician or other ordering provider and patient who has been unsuccessful in an attempt to reverse a determination not to certify, the clinical rationale for that determination in writing.

4. The Medical Advisor, Medical Director or clinical peer will be available within 1 business day to discuss by telephone the determination with the attending physician and/or other ordering provider.

5. Records will be kept for each appeal that include:

   (a) Name of the patient, provider, and/or facility rendering service;

   (b) Copies of all correspondence from the patient, provider, or facility rendering service and UR Vendor regarding the appeal;

   (c) Dates of appeal reviews, documentation of actions taken, and final resolution; and

   (d) Minutes or transcripts of appeal proceedings (if any)

If a request to perform spinal surgery is denied, disputes will be directed to the insurance Adjuster to follow the disputed Spinal Surgery protocol in accordance with subdivision (b) of Section 4062.

6. It is the policy of Arissa Cost Strategies that a maximum of two (2) appeals can be submitted with new information, which might impact the reviewers’ decision. Once the review has been performed for the second time and there is still a non-certification (denial) or modification, further reviews will not be undertaken. There will be a letter of notice to all parties as required by the current law.
Requests for Reconsideration

1. Anytime an initial determination not to certify treatment is made and no contact has occurred with the attending physician or ordering provider, the attending physician or ordering provider can request reconsideration by the clinical peer that made the initial determination. This reconsideration process is to be used when there is disagreement of procedural notification of non-certification determinations.

A. The UR staff or a Medical Advisor informs the attending physician or ordering provider that within (1) business day the original Medical Advisor or designated physician (if the original is not available) will contact them.  
B. The UR staff will inform their supervisor and Medical advisor of the attending physician or ordering provider’s reconsideration request.  
C. The UR staff will maintain documentation of the attending physician or ordering provider’s reconsideration request, including date and time.  
D. The Medical Advisor or Medical Director will be notified and given all case information.  
E. If the Medical Advisor or Medical Director and the attending physician/ordering provider are not in agreement, the attending physician/ordering provider will be notified immediately of their right to initiate an expedited or standard appeal.  
F. All results of the reconsideration will be maintained by Arissa Cost Strategies/DecisionUR.  
G. The attending physician/provider, claimant and/or patient can request the disclosure of information.  
H. The attending physician/provider, claimant and/or patient can request the disclosure of criteria used to render non-certification.  
I. The name of the criteria, edition and diagnosis of the criteria will be supplied in writing upon request within 1 business day.  
J. Only a UR staff or Medical Advisor or Medical Director can release this information.  
K. The disclosure of criteria used to render non-certification will be in compliance with the laws of California.
Utilization Review Miscellaneous Policies and Procedures

Arissa Cost Strategies will maintain an 800 toll free number that the review staff can be accessed from between 8:00 a.m. to 5:30 p.m. Pacific Time of each standard business day (Monday – Friday) in the provider’s local time zone.

1. The Medical Director shall bear the responsibility of oversight of the Utilization Review Program and all processes including compliance with all California Regulations detailed in Title 8, California Code of Regulations, and Sections 9792.6 et seq.

2. The Medical Director shall be responsible for all Utilization Review decisions and determinations made by Physician Advisors and Medical Advisors utilized to perform the initial Utilization Review Determinations, Reconsideration Determinations and Appeal determinations. The Medical Director is responsible for all decisions as stated in section 9792.6. The Medical Director shall routinely audit a minimum of 1 of every 25 determinations, or an amount equal to any regulatory requirement should they be enacted, on a random basis and/or upon request of claims administrator.

2. a. The Medical Director for Arissa Cost Strategies is:

Lester L. Sacks, M.D., PhD

15901 Red Hill, Suite 201

Tustin, CA 92780

Telephone # 1 714-259-1503

California License #A28341

The Medical Director of Arissa Cost Strategies is responsible for the oversight of all utilization activities, ensures that the utilization review process is in accordance with this document, consistent with the applicable labor codes of the State of California. The Medical Director is responsible for all decisions made in the utilization review process. The Medical Director is a board-certified occupational physician with an unrestricted license to practice in California.

The Arissa Cost Strategies medical director is responsible for:

- Developing and disseminating the overall policy and philosophy of the UR program
- Responsible for the quality assurance program governing the UR decisions
- Responsible for all decisions made in the utilization review process.
- Provides periodic review of the UR database including identifying the educational opportunities for the staff
- Oversees the clinical guidelines used in the decision making for the utilization team and conducts the management of the State specific guidelines, such as the MTUS and ACOEM.
• The Medical Director is responsible for evaluating the performance of both the internal utilization team and the contracted providers associated with the functions of utilization.

3. Requests for Utilization Reviews must be made via mail to:

   Arissa Cost Strategies
   15901 Red Hill, Suite 201
   Tustin, CA 92780

   OR

Requests for Utilization Reviews may be made via fax to:

   Arissa Cost Strategies
   (949) 734-7272

Telephone access will be made available by Arissa Cost Strategies between 8:00 a.m. to 5:30 p.m., Pacific time on normal business days. For requests made at times other than these, Arissa Cost Strategies shall maintain a voice mail system to handle all incoming requests and/or messages.

4. All outgoing communications related to utilization management will be conducted during providers’ reasonable and normal business hours, unless otherwise mutually agreed.

5. The review staff will identify themselves when calling by name, title and name of organization when contacting attending physician/provider, enrollee/patient/injured worker, facility, claims payor or patient representative.

6. There will be access to the 714-259-1053 line after hours with the capability to leave a message on a recorder.

7. If Arissa Cost Strategies is closed due to unforeseen emergencies, such as inclement weather or catastrophes, a detailed message will be left on the recorder, providing the caller with applicable directions for medical care or treatment or methods to obtain authorization for care.

8. All calls that are received during business hours from providers and patients/injured workers will be returned within one-business day.

9. Upon request, utilization review staff member(s) orally inform patients, injured workers, designated facility personnel, the attending physician, and other ordering providers of specific utilization review requirements; and patient, injured workers, hospitals, physicians, and other health professionals of Arissa Cost Strategies review procedures.
UR DISPUTE RESOLUTION

When a medical treatment decision is disputed, the issue will be resolved through Labor Code 4062 per the statutory requirements. When treatment requests are modified, delayed, or denied, notification letters shall include the following language:

Notice to Injured Worker

All utilization disputes will be resolved in accordance with Labor Code Section 4062.

If you disagree with the utilization review decision and wish to dispute it, you must send a written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with the Labor Code section 4062. You must meet the deadline even if you are participating in the claims administrator’s internal utilization review appeals process.

The 20 day time limit may be extended for good cause by mutual agreement of the parties. You also have the right to file an Application for Adjudication of Claim and Request for Expedited Hearing form WCAB 1 and DWC-CA form 10252.1 is used,, showing a bona fide dispute as to entitlement to medical treatment in accordance with Title 8, CCR sections 10136 (b)(1), 10400, and 10408.n These forms are available on the DWC website at: http://www.dir.ca.gov/dwc/forms.html.

If you want further information, you may contact the local state Information and Assistance office by calling [enter district I & A office telephone number closest to the injured worker] or you may receive recorded information by calling 1-800-736-7401. You may consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney’s fee will be deducted from any award you might receive for disability benefits.

MEDICAL PROVIDER NETWORK

If the employee is subject to the rules governing the Medical Provider Network (MPN) and he/she disputes the diagnosis or treatment of the primary treating physician, the dispute will be resolved in accordance with Labor Code 4616.3 ©. These disputes are not considered utilization review disputes.
Confidentiality Procedures

All patient information obtained during the utilization review process is considered part of the Arissa Cost Strategies business record. All medical information is subject to state and federal regulations protecting confidentiality of medical information, and is subject to release only within strict guidelines of confidentiality. Medical information is released only within the requirements of such regulations and in accordance with strict corporate guidelines. Listed below are the procedures in place to protect the confidentiality of the patient’s medical information.

1. Employees are required to review our confidentiality and non-disclosure agreement upon employment. This agreement is to be signed by the new employee and yearly thereafter, and is kept in the employee’s personnel file.

2. Upon request, there is a patient confidentiality of medical information form that is forwarded to the patient describing how the medical information will be kept confidential while utilization review is being completed.

3. Detailed patient-identified information is released only with the patient’s authorization or, where applicable, state laws, rules and regulations provide authorization. This includes all communications and records transmitted or stored, including cellular phones, fax or electronic systems.

4. All medical information will be maintained in a secure environment, which has a sophisticated security system. Only authorized personnel can access the system with appropriate password codes.

5. Each state and federal statute regarding confidentiality and non-disclosure is adhered to and updated when applicable.

6. Provider specific data obtained during the review process is not publicly released. It can be shared only with those agencies that have the legal and contractual authority to receive such information. This includes all communications and records transmitted or stored, including cellular phones, fax or electronic systems.

   A. Special care is taken when faxing information that includes patient specific medical and identifying information. All fax correspondence cover pages will contain a confidentiality clause statement.

   B. All email transmissions will contain a confidentiality clause statement. Utilization Review Letters and Activity Notes may only be emailed to authorized parties.

7. Medical Information collected is used solely for the purpose of utilization review, quality assurance, discharge planning and catastrophic case management.

8. UR patient information includes any information captured within the utilization review process such as demographics, medical treatment requests/approvals, provider and case activities/results. Worker specific information includes injury cause, job type and any return-to-work information. Provider specific information is any clinical, treatment outcomes or provider specific information capture through the utilization process for a specific patient.

9. Review notifications containing information that might suggest a diagnosis such as non-certification rationale, are sent only to the patient, physician, facility or other health care provider. Review notifications to employers do not contain medical information.
Statement Of Regulatory Compliance

As noted, this Utilization Review plan has been developed in accordance with Labor Code Section 4610, 4604.5 and any or all other duly enacted Labor Code Sections, or DWC regulation that may apply currently. If any changes to the Labor Code, Department of Workers’ Compensation Administrative Rules or current regulations that govern any part of this Utilization Review plan are enacted, they are hereby incorporated herein and take precedence over any provision of this Utilization Review plan that is in conflict with these enacted regulations. If during the course of time any term, provision, covenant or condition of this Utilization Review plan is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remainder of the provisions herein shall remain in full force and effect and shall in no way be affected, impaired or invalidated as a result of such decision.