URO #122

ATHENS MANAGED CARE

UTILIZATION REVIEW PLAN

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Athens Managed Care
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I. Utilization Review Plan Evaluations

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II. Introduction

1. Athens Managed Care Utilization Review

Athens Administrators is an industry leading claims administration partner that provides services to the employer community and insurance industry, focusing on Workers' Compensation claims. Our Utilization Review Program provides prospective, retrospective, and concurrent review of treatments and services to determine the medical appropriateness of care, as well as the frequency, duration, and setting. The goal of our Utilization Review Program within our Managed Care department is to provide medical care that renders positive outcomes and ensures high-quality, timely, cost-effective medical care for Injured Workers, while avoiding unnecessary, unsafe, or inappropriate medical treatment. This Utilization Plan is available to the public upon request.

III. Utilization Review Definitions

Per CCR 9792.6.1, the following definitions apply to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the decision on the request for authorization of medical treatment is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(a) "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed "Request for Authorization," as defined in §9792.6.1., that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, sections 9792.9.1 through 9792.12.

(b) "Claims Administrator" is a self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). "Claims Administrator" includes any utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.

(c) “Concurrent review” means utilization review conducted during an inpatient stay.

(d) “Course of treatment” means the course of medical treatment set forth in the treatment plan contained on the “Doctor's First Report of Occupational Injury or Illness,” FIR Form 5021, found at California Code of Regulations, title 8, section 14006, or on the applicable physician reporting forms authorized under section 9785.

(e) “Denial” means a decision by a physician reviewer that the requested treatment or service is not authorized.

(f) “Dispute liability” means an assertion by the claims administrator that a factual, medical, or legal basis exists, other than medical necessity, that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.

(g) “Disputed medical treatment” means medical treatment that has been modified or denied by a utilization review decision.

(h) “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.

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

(j) “Expert reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, whose consultation for a specialized review has been requested by the claims administrator or utilization review organization, necessitating an extension of time, under section 9792.9.6, prior to the determination of medical necessity.

(k) “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.

(l) “Immediately” means within one business day.

(m) “Material modification” is when the claims administrator changes utilization review vendor(s); makes a change to the utilization review standards as specified in section 9792.7; or changes its medical director, address, company name or corporate structure.

(n) “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.

(o) “Medical services” means those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(p) “Medical Treatment Utilization Schedule” means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20.

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

(r) "MTUS Drug Formulary" means the drug formulary adopted by the Administrative Director under Labor Code section 5307.27 and defined in section 9792.27.1(m). The MTUS Drug Formulary contains the MTUS Drug List, which is set forth in section 9792.27.15.

(s) “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

(t) “Request for authorization” means a written request for a specific course of proposed medical treatment that meets all of the following criteria:

(1) Unless accepted by a claims administrator under section 9792.9.1(c)(2), a request for authorization must be set forth on a “Request for Authorization (DWC Form RFA)” as contained in California Code of Regulations (CCR), title 8, section 9785.5, completed by a treating physician and as further outlined in this subdivision and in section 9785(h).

(2) “Completed,” for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization must identify both the employee and the requesting provider; identifies with specificity all the recommended treatments in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used; and is accompanied by documentation, issued or created no

earlier than 30 days before the date of submission of the request for authorization, that substantiates the need for the requested treatment. A request for authorization shall be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.6.

(3) The request for authorization must be signed by the treating physician and may be mailed, faxed, or, if available, sent electronically through the use of an encrypted email system or via electronic data interchange (EDI) to the address, fax number, e-mail address, or clearinghouse designated by the claims administrator under section 9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

(u) “Retrospective review” means utilization review conducted after medical services have been provided and for which approval has not already been given.

(v)(1) “Reviewer” or “physician reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's practice or physician reviewer’s practice.

(2) “Non-physician reviewer” means an individual designated by the claims administrator or utilization review organization to assist in determining the medical necessity of the requested treatment. A non-physician reviewer may not modify or deny a treatment request.

(w) "URAC" is the non-profit organization, located at 1220 L Street, NW, Suite 900, Washington, D.C., 20005, or as indicated online at www.urac.org, that provides accreditation for workers’ compensation utilization review programs.

(x) “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).

(y) “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.

(z) "Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. The utilization review process begins when a completed

request for authorization, or a request for authorization accepted as complete under section 9792.9.1(b) is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

(aa) “Written” includes a communication transmitted by facsimile or in paper form. Electronic mail or electronic data interchange (EDI) may be used by agreement of the parties although an employee’s health records shall not be transmitted via electronic mail or by EDI, unless sent through the use of an encrypted electronic mail or EDI system.

(bb) “Normal business day” or “business day” does not include Saturday, Sunday, or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website.

(cc) “Working day” as used in this article is the same as “business day” or “normal business day.”

IV. Utilization Review Standards

1. Medical Director

Athens Managed Care designated medical director is Dale P. Curtis, MD, FACEP. Dr. Curtis has a current, valid, unrestricted license, G 86164, to practice medicine in the State of California issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. He is board-certified in Emergency Medicine. Over many years, Dr. Curtis has had extensive medical experience across a variety of clinical settings Dr. Curtis has direct oversight and responsibility for all UR decisions and processes. As the Medical Director, he shall ensure that the process by which the claims administrator reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with Labor Code section 4610 and these implementing regulations. Dr. Curtis is located at 2552 Stanwell Drive, Concord, CA 94520, and he can be reached at (916) 300-5348. CV is attached. (*See Exhibit A*).

2. Utilization Review Process

Athens Managed Care (AMC) Utilization Review Program will conduct medical necessity reviews on prospective, concurrent, and retrospective treatment in compliance with California Labor Code Section 4610 in order to approve, modify, or deny, based in whole or in part on the necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code Section 3209.3, with the provision of medical treatment services pursuant to Labor Code Section 4600. Utilization Review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were billed.

Athens complies with all aspects of the standards established by the California Labor Code regarding Utilization Review Standards within the State of California for Workers' Compensation. Standards are monitored and material changes made to the Utilization Review plan and processes when indicated by changes in the standards for California Workers' Compensation. AMC will submit a modified Utilization Review plan along with a completed DWC Form UR-01 to the Administrative Director within 30 calendar days of any material modification to the plan.

This plan shall be made public upon request in accordance with section 9792.7(m). This complete Utilization Review plan, consisting of the policies and procedures and a description of the Utilization Review process is available, through electronic means. If a member of the public requests a hard copy of the utilization review plan, there will be a charge for reasonable copying and postage expense related to disclosing the complete

Utilization Review plan. Such charge shall not exceed $0.25 per page plus actual postage costs.

(a) Hours of Operation

Athens Managed Care maintains 24-hour facsimile access for physicians to submit requests for authorization. This information is noted on the after-hours telephone line at (877) 494-4300. A request for authorization transmitted by facsimile, electronic mail, or electronic data interchange after 5:30PM, Pacific Time, is considered to be received by the claims administrator for utilization review on the following business day as per section 9792.9.1(a)(1) as defined in Labor Code Section 4600.4 and in Civil Code Section 9, except for expedited or concurrent reviews. Telephone (877-494-4300) and facsimile (888-673-6364) lines are maintained during normal business hours between 9:00AM and 5:30PM, Pacific Time, Monday through Friday. After hours communication is maintained via facsimile and voicemail systems.

(b) Confidentiality

Information obtained during the review process will be used solely for the purposes of Utilization Review, discharge planning and case management. Information will be shared with third parties authorized to receive such information and in accordance with State and Federal confidentiality guidelines.

Employees of AMC shall refrain from disclosing confidential information during or after employment unless they receive a written release from the injured employee or are obligated by subpoena. Confidential information is to be used solely for internal business purposes. Employees are not to discuss case information except when working on a case in conjunction with quality assurance or for training purposes within the company.

(c) Initial Requests

Treatment requests are initially reviewed by a non-physician reviewer[1] using evidence based medical guidelines. All guidelines utilized will be the most current versions available. If supported by guidelines, non-physician reviewers may approve requests for authorization of medical services. They are also permitted to discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization.

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 9792.9.3 and 9792.9.4. Any time beyond the time specified in these sections is subject to the provisions of section 9792.9.6.

[1] Utilization Review (UR) Nurse

Any treatment request initially reviewed that fails to meet standards of care and/or evidence-based guidelines are referred to an Athens Physician Advisor. All AMC Physician Advisors are board certified physicians, chiropractors, and acupuncturists. Only an AMC Physician Advisor will make a determination to deny or modify a treatment request by a treating physician. All decisions from Physician Advisors will be based on California Medical Treatment Utilization Schedule (MTUS). In the absence of an applicable MTUS guideline, the Physician Advisors will base their decisions on other evidence based, scientific, nationally recognized treatment guidelines.

Treatment requests that are certified will be eligible for reimbursement based on the fee schedule and/or contracted rates by the payor or their designee. Patient channeling may occur to diagnostic imaging, DME and other select preferred provider organizations when indicated by client instructions or in the event the employer has an active MPN in place. Coordination of discharge planning, DME, and other services may take place.

When a treatment request is denied during a concurrent review, the treatment shall not be discontinued until the treating physician is notified of the denial, and an alternative care plan is agreed on that is appropriate for the injured worker's medical condition.

The Utilization Review Process can be initiated via telephone – followed by faxed or emailed medicals and RFA within 24 hours – facsimile, electronic data interface or via email by the claims administrator, employer, requesting provider, or facility; whichever method is most convenient and efficient on a case-by-case basis. Once the determination has been made, the provider will be notified of the decision via fax within 24 hours of the determination. Determination letters will be sent to the claims administrator, provider, facility, applicant attorney and injured worker within 24 hours for Concurrent Review and within two (2) business days for Prospective and Retrospective Reviews and done so in accordance with the California Utilization Review Regulations noted in Section 9792.9.4.

Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a claims administrator, non-physician reviewer as allowed by section 9792.7, or physician reviewer must either accept the request as a complete request for authorization and comply with the governing statutes or mark it "not complete" and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt. Upon return of the completed request for authorization, the timeframe for a decision shall begin anew.

(d) Prospective or Concurrent Reviews

Prospective or concurrent determinations shall be made in timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed request for authorization. Athens will only request the reasonable and pertinent medical information necessary to

determine the medical appropriateness and necessity of the treatment being requested by a provider or facility of care. If the reasonable information requested is not received after three (3) attempts (one of which is made via fax), the case will be referred to a Physician Advisor who shall recommend non-certification due to lack of medical information. All efforts to obtain additional information is documented prior to issuing a denial based on lack of reasonable and necessary information pursuant to Title 8 CCR Section 9792.9.6. All non-certifications due to lack of medical information will be made within 14-days from the date of receipt of the original written request for authorization and will include a statement that the request will be reconsidered upon receipt of the information requested. Pharmacy requests will not exceed five (5) working days from the date of receipt regardless of whether additional information is needed.

Upon receipt of the information requested pursuant to 9792.9.6(a)(1)(A), (B), or (C), the claims administrator or reviewer, 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 and attorneys, if any, shall be notified by facsimile within 24 hours of making the decision, unless the request is a concurrent review in which the requesting physician will be contacted via telephone and a facsimile will follow. The written decision shall include the date the information was received, and the decision shall be communicated in the manner set out in section 9792.9.4 or 9792.9.5, whichever is applicable.

(e) Expedited Reviews

Prospective or concurrent determinations 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 (b) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in section 9792.9.3(b).

(f) Emergency Healthcare Services

Emergency healthcare services would be 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.

If a request for treatment is submitted by the treating physician and is identified as emergency healthcare services and requiring a determination in less time than the parameters for an expedited review, AMC Utilization Review Department will attempt to provide a UR determination on the day of the request or within 24 hours.

Failure to obtain prior authorization for emergency healthcare services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency healthcare services. Emergency healthcare services, however, may be subjected to retrospective review.

(g) Retrospective Reviews

When a review is retrospective, decisions shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30-days of receipt of the medical information that is reasonably necessary to make the determination. In addition, the non-physician provider of goods or services identified in the request for authorization, and for who contact information has been included, shall be notified in writing of the decision modifying, or denying a request for authorization.

(h) Time Extension

In accordance with section 9792.9.6(a)(1)(A-C) timeframes for decisions may only be extended under one of 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.
- (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.
- (C) The reviewer needs a specialized consultation and review of medical information by an expert reviewer.

If the circumstance under subdivision (a)(1)(A) applies, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization. If the information requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed or accepted request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, a physician reviewer shall deny the request and include a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation (9792.9.5(e)(7)(A).

If any of the circumstances set forth in subdivisions (a)(1)(B) or (C) are deemed to apply following the receipt of a complete or accepted request for authorization, the physician reviewer shall within five (5) business days from the date of receipt of the request for authorization notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or indicate that a consultation by an expert reviewer is needed, in which case, the specialty of the expert reviewer to

be consulted must be identified. If the results of the additional examination or test, or the specialized consultation, that is requested by the physician 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 and include a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation (9792.9.5(e)(7)(A).

Upon receipt of the information requested pursuant to (a)(1)(A), (B), or (C), the claims administrator of reviewer shall make the decision to approve, modify, or deny the request for authorization in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5:

- Within five (5) business for prospective or concurrent reviews.
- Within 72 hours for prospective or concurrent decisions related to an expedited review.
- Within thirty (30) calendar days for retrospective reviews.

The requesting physician and attorneys, if any, shall be notified by facsimile within 24 hours of making the decision.

Prospective or concurrent reviews conducted on formulary-only requests will be completed within five (5) business days of receipt of the request for authorization. Request for additional information may be issued within four (4) business days from the date of receipt of the request for authorization, however, review timeframes will not be extended.

(i) Reconsiderations

A denial based on the absence of response to a request for additional information necessary to complete the UR determination will indicate to the requesting provider that the request will be reconsidered upon receipt of the information requested in accordance with 9792.9.5(e)(7)(A).

(j) Appeal Process

Under 9792.10.1(f), an internal utilization review appeal process can be provided on a voluntary basis. The dispute resolution process outlined in 9792.10.1 does not preclude the parties from participating in an internal utilization review appeal process on a voluntary basis provided the employee and, if the employee is represented by counsel, the employee's attorney, have been notified of the timeframes in which to file an application for independent medical review. Any request for an internal utilization review appeal process conducted under this subdivision must be submitted within ten (10) days after the receipt of the utilization review decision.

The requesting provider or primary treating physician may request in writing an appeal of the notification of a determination to modify or deny a proposed treatment. The

appeal must be in writing and forwarded with any supporting documentation to Athens Managed Care Utilization Review Department or the claims administrator.

A request for an internal appeal must be completed, and determination issued, within thirty (30) days after receipt of the request. If the initial decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the internal appeal must be completed, and determination issued, within ten (10) days after receipt of request.

If there is a request for an expedited appeal (as defined by section 9792.6.1(j)) and the circumstances are consistent with the situations for an expedited review, a determination will be provided in a timely fashion appropriate to the injured worker's condition, but not to exceed 72 hours after the date of receipt of the written information reasonably necessary to make the determination.

(k) Determination Letters

In compliance with California Labor Code Section 4610, written communication regarding pre-certified treatments or services shall clearly specify the treatment service approved. Letters of approval will be indicated by a certification determination. For all decisions (including approvals, denials, and modifications) the requesting physician and attorneys, if any, will be notified by facsimile within 24 hours of the determination, unless the request is a concurrent review in which the requesting physician will be contacted via telephone and a facsimile will follow. Facilities are considered non-physician providers of goods and services and therefore will be provided a "decision" only, without rationale or guidelines. Written notification is required for all decision types, with timeframes applied, depending on whether the decision is concurrent or prospective. For concurrent and prospective reviews, DWC requires that approvals be sent to requesting physician, although any adverse decision (denial or modification) will be sent to the injured worker and attorney. When the review is retrospective, all decisions shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the medical information that is reasonably necessary to make this determination (Section 9792.9.3).

Decisions to approve a request for authorization will include the following per §9792.9.4(a)(1):

- The date the complete, or accepted as complete, request for authorization was first received.
- The medical treatment service requested.
- The specific medical treatment service approved.
- The date of the decision.
- As applicable, the date the request for information, exam, or consultation under section 9792.9.6, subdivision (a)(1)(A), (B), or (C) was requested, and the date the information was received.

Decisions to approve a request for authorization for medication will include the following per §9792.9.4(a)(2-3):

- "Generic substitute authorized", or words to that effect and meaning, when the request for authorization did not indicate "Do Not Substitute" or "Dispense as Written".
- "Exempt per MTUS Drug Formulary" or words to that effect and meaning, for approvals of medications listed as exempt on the Drug Formulary.

Decisions to approve a request for authorization during the First 30 Days will include the following per §9792.9.4(a)(4):

- "30-day exemption" or words to that effect and meaning, for approvals of a request for authorization of non-drug treatment that are exempt under section 9792.9.7.
- For a full list of services not covered under the 30-day exemption rule, refer to section 9792.9.7(b)(1-8). Unless previously authorized by the claims administrator or rendered as emergency medical treatment, they shall require prospective utilization review.

Decisions to modify or deny a request for authorization shall be signed by either the claims administrator or the physician reviewer, and shall only contain the following information specific to the request per §9792.9.5(e)(1-14):

- The date on which the completed or accepted request for authorization was first received
- If the timeframe for decision was extended under section 9792.9.6, a specific description of the information needed to make a medical necessity determination of the treatment request; the date(s) and time(s) the request(s) for information, exam, or consultation under subdivision (a)(1)(A), (B), or (C) of section 9792.9.6 were requested; the manner in which the requests were made; and the date the information was first received The date on which the decision is made.
- The date on which the decision is made.
- A description of the specific course of medical treatment set forth on the request for authorization.
- A list of all medical records reviewed.
- A specific description of the medical treatment service approved, if any.
- A clear, concise, and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity or; if applicable, that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation.

- Where the requesting physician has expressly opined that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be overlooked or is irrelevant to the requested treatment, the reviewing physician shall provide an explanation for why the requesting physician's explanation is insufficient.
- For decisions based on medical necessity, a citation to and a description of the relevant medical criteria or guidelines used to reach the decision.
- Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.
- The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee, must be completed by the claims administrator. The written decision provided to the injured worker, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.
- A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.
- Include the following mandatory language advising the injured employee:

    - "You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me."

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

- Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, including with respect to disputes over the necessity of or availability of the requested information, and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.
- The written decision modifying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or,

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

3. Utilization Review Criteria

All guidelines utilized by the Athens Managed Care Utilization Review Department will be the most current versions available. The Utilization Review process is mandatory and is done in accordance with California Labor Code Section 4610. The Medical Treatment Utilization Schedule is utilized in the determination process, as required in Title 8, California Code of Regulation 9792.6.1. For all conditions or injuries not address by the Medical Treatment Utilization Schedule (MTUS), authorized treatment and diagnostic services shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community. Such guidelines may include, but are not limited to, the following:

- *ACOEM – Medical Practice Guidelines*, American College of Occupation & Environmental Medicine
- *Official Disability Guidelines* – Work Loss Data Institute
- *Medical Disability Advisor* – Presley Reed, M.D.
- *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Proceedings of the Mercy Center Consensus Conference
- *Physicians as Assistants at Surgery,* American College of Surgeons
- *MCG Care Guidelines*

AMC Utilization Reviewers are trained to make recommendations to claims administrator regarding necessity of treatment utilizing nationally accepted, medically based criteria. Medical criteria will be evidence based, evaluated at least annually and will be the most current edition available to the public.

4. Staff Qualifications

Athens quality assurance begins with the hiring of the appropriate individuals for its Utilization Review staff. Athens employs only professional Utilization Reviewers to perform utilization review services.

The goals are:

- To assist in the continuing development and operation of the Athens Utilization Review services.
- To meet quality standards for Utilization Review to ensure delivery of an accurate, cost-effective service for Athens customers.

Clinical Non-Physician Reviewer[2]:

- Hold an active and unrestricted professional license or certification:
  - To practice as a health professional in the United States or the District of Columbia, and
  - With a scope of practice that is relevant to the clinical area(s) addressed in the initial clinical review.
- Minimum of two years clinical experience in one or more of the following fields:
  - Medical/Surgical
  - Orthopedic
  - Neurosurgical
  - Occupational Health
  - Psychiatric
- Athens urges all professional staff to obtain certification in one of the nationally recognized nursing and/or case management fields.

Physician Reviewer:

- AMC contracts Physician Advisors, in full compliance with internal Credentialing Policies, who:
  - Have an active and unrestricted license or certification to practice medicine or a health profession in the United States or the District of Columbia,
  - Unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting a peer clinical review,
  - Are qualified, as determined by the medical director, to render a clinical opinion about the medical condition, procedures and treatment under review, and
  - Hold a current and valid license:
    - In the same licensure category as the ordering provider, or
    - As a doctor of medicine or doctor of osteopathic medicine.
  - Have an active medical practice,
  - Are Board Certified in a medical specialty(ies), and
  - Meet credentialing requirements as outlined by their respective Peer Review Physician Group.
- Physician Advisors perform reviews of requests for authorization within their scope of practice.

[2] UR Nurses

- Ethos Risk (Ethos), a URAC Accredited Independent Medical Review Organization (IRO), provides additional physician review services to Athens on an as-needed basis. Ethos is responsible for the credentialing process of its providers to ensure all members meet the credentialing requirements. They are required to supply updated credentialing information to Athens when a change in the provider status occurs and/or bi-annually.

Athens Managed Care Utilization Review program has a quality management program to ensure the competency of the Utilization Reviewers and the review decisions made meet the needs of the customers without reduction in the quality of care and medical service provided to injured workers. The quality management program assures general overall quality of the program, monitors, and evaluates reviewers, review results and impact on aspects of care through use of measurable indicators. The quality management program, additionally, tracks and reviews treatment guidelines for changes or updates. Action is taken to improve service, solve problems and evaluate the effectiveness of the processes. Quality assurance reviews are done monthly and review the following criteria:

- Adherence to time standards
- Claims administrator, employer, date of injury noted
- Name of person providing clinical information noted
- Referral entered correctly
- Adherence to customer special handling guidelines

Review results are assessed by the department management team. Results are discussed overall with Utilization Reviewers. Changes or updates are discussed with team and incorporated appropriately into the workflow. Comparisons and follow ups are done to assure correction of any problems outlined are completed.

No parties associated with the utilization review decision process neither offer nor provide any financial incentive or consideration to a reviewing physician based on the number of modification or denials made by the reviewing physician in accordance with Labor Code 4610(g)(3)(B)(i).

5. Claims Administrators Approval Criteria

Athens Managed Care Utilization Review program provides claims administrators the opportunity to directly approve basic treatment requests for injured workers, should the request be made for an accepted body part and/or claim. Claims administrators are encouraged to refer to Utilization Review any treatment requests made where there may be questions regarding the medical necessity of the request or fall outside their approval plan.

The following items are part of the claims administrator’s approval plan:

- Plain x-rays for all orthopedic injuries
- Initial MRIs/accepted body part
- CT after major trauma, or with documentation of neurological deficit
- EMG/NCS after four (4) weeks of conservative treatment (CTS/cubital tunnel syndrome, cervical/lumbar radiculopathy), or less than four (4) weeks of conservative treatment with documented neurological deficit
- Routine pre-op testing (CBC, chem. panel, CXR, EKG)
- Generic DME up to $500
- Chiropractic treatment – 10 visits or less
- Pre-Op Physical Therapy / Occupational Therapy – 12 visits or less
- Post-Op Physical Therapy /Occupational Therapy –12 visits or less
- Acupuncture – 10 visits or less
- Home Health Care – post-op 6 visits or less for assistance with daily activities only; medical Home Health Care (wound care) through UR
- Initial Specialist Referral for consult only (Surgeons should go through UR)
- Psych Consults for Psych Claims
- Ergonomic Evaluations
- Pre-op COVID-19 testing
- Generic MTUS Exempt Medications – up to $250 per fill
- All PTP Follow-Ups
- All Urine Drug/Tox Screens
- All Transfer of Care Requests
- Second Opinion
- Initial Injections (TPI, Cortisone, Orthovisc)

Clients that choose to customize their authorization guidelines are listed below. Copies of their guidelines are attached to this plan.

a. *Attachment A: California Contractors Network Self-Insured Group Adjuster Authorization Guidelines*
b. *Attachment B: City of Modesto Adjuster Authorization Guidelines*
c. *Attachment C: Ventura County Schools Self-Funding Authority, Simi Valley Unified School District, Downey Unified School District and Conejo Valley Unified School District Adjuster Authorization Guidelines*
d. *Attachment D: California JPIA Adjuster Authorization Guidelines*
e. *Attachment E: AHMC Healthcare Adjuster Authorization Guidelines*
f. *Attachment F: City of Ventura Adjuster Authorization Guidelines*
g. *Attachment G: PERMA Adjuster Authorization Guidelines*
h. *Attachment H: CSRM Adjuster Authorization Guidelines*
i. *Attachment I: BART Adjuster Authorization Guidelines*
j. *Attachment J: City of Fairfield Adjuster Authorization Guidelines*
k. *Attachment K: San Diego JPA Adjuster Authorization Guidelines*
l. *Attachment L: Household Industries SIG Adjuster Authorization Guidelines*
m. *Attachment M: City of Ontario Adjuster Authorization Guidelines*
n. *Attachment N: County of San Mateo Adjuster Authorization Guidelines*
o. *Attachment O: Riverside Community College District Adjuster Authorization Guidelines*
p. *Attachment P: City of Westminster Adjuster Authorization Guidelines*
q. *Attachment Q: Central County Fire Department*
r. *Attachment R: City of Carlsbad*

Treatment requests that fall outside of these items should be referred directly to the Utilization Review Program. A suggested referral criterion to UR is below but does not necessarily encompass all treatment options:

- All repeat diagnostics
- MRI requests ordered within the first 14 days of DOI, unless injury appears to be serious in nature
- CT exams (except abdomen or head)
- EEG, SSEP (Somatosensory evoked potential), VEP (visual evoked potential) (brain)
- EMG/NCV – requested for more than one extremity; All surface EMG testing (SEMG)
- ECSWT – Extracorporeal Shockwave Therapy
- CT Myelogram
- Discograms
- All Carpal Tunnel Evaluations
- Tens Unit – purchases and rentals greater than two (2) months
- Interferential Unit – rentals or purchases
- Custom DME (prosthetics)
- All DME priced greater than $500.00

- DME supply requests – if DME purchase date is older than one (1) year from date of the request
- Non-formulary medications All IV or IM Antibiotics administered in the home setting
- All Botox
- All Synvisc, Hyalagon, Supartz injections (knee joint injection therapies)
- All psych evaluations, testing, or treatments
- All specialty referrals for care outside of initial consultations (i.e. Neurologist, Neurosurgeon, Rheumatologist, etc.)
- All Pain Management/Rehabilitation Programs or Chemical Dependency Clinics
- All passive or active physical medicine (PT, OT, Chiropractic, Acupuncture) exceeding visits on approval list
- Post-op physical therapy beyond initial 12 visits
- Work Rehabilitation – includes work conditioning and work hardening
- Non-Medical, exercise or treatment programs (reflexology, aerobics, Pilates, Gym memberships, personal trainers, aquatics, etc.)
- Massage, Bio-feedback, Feldenkrais
- Inpatient and outpatient surgeries
- Epidurals, Facet nerve blocks, Chemonucleolysis, Trigger point
- Spinal cord stimulators
- External and internal bone growth stimulators
- Pain pumps – post-op and for chronic pain
- Prolotherapy
- IDET (Intradiscal Electrothermal Therapy)
- Artificial Disc Replacement
- Radiofrequency lesioning of any nerve
- Concurrent review or Retrospective review of transfer level of care (i.e., acute setting to rehab)
- Concurrent review or Retrospective review of non-emergency hospitalizations; non-emergency transfers; ambulatory surgery care centers
- All RSD – Reflex Sympathetic Dystrophy; CRPS – Complex Regional Pain Syndrome
- Home Health Requests (nursing, support, custodial, PT/OT)
- Weight loss programs
- Non-emergency dental services (i.e., reconstructive, restorative dental care or implants)
- All computerized muscle testing
- All uncommon or experimental services or devices

6. Prior Authorization Guidelines

Per section 9792.7, the Utilization Review process may include a prior authorization process where authorization is provided without the submission of the request for

authorization. The below customers have implemented a prior authorization process for the treatments outlined below. The customer and the claims administration team will notify the providers of the conditions under which treatment will qualify under the prior authorization process.

Athens Managed Care, the medical director, customer and claims administrator's will review the prior authorization process on an ongoing basis to ensure adherence to the process and possible amendments, as needed. Treating physicians will be monitored to ensure they are treating within the conditions outlined.

Customer: Palomar Health
Provider: Palomar Health Provider
Treatment within the Prior Authorization Process:

- Initial physical therapy visits up to 12 visits
- Initial diagnostic testing (EMG/NCV; MRI; CT Scan and Plain X-rays only)
- Initial single steroid injection (tendinitis; epicondylitis; joints only)
- Initial CBT evaluation and up to 6 visits of CBT for delayed recovery/chronic pain
- Initial acupuncture visits up to 12 visits

7. Utilization Review Exclusions

Notwithstanding the requirements of CCR §§9792.9.1 through 9792.9.6, a treating physician as defined in Labor Code §4610(b) may render medically necessary treatment or services without prospective utilization review during the first thirty (30) days following the date of injury, provided that all of the following conditions are met:

- The treatment is for a body part or condition accepted as compensable
- The treatment is consistent with the Medical Treatment Utilization Schedule (MTUS) adopted pursuant to Labor Code §5307.27
- The treating physician submits the Doctor's First Report of Occupational Injury or Illness (Form 5021) in accordance with CCR §9785(e), including the anticipated treatment plan
- A complete Request for Authorization (RFA), consistent with CCR §9785(h), is submitted concurrently with the First Report and includes all anticipated treatment for the first 30 days
- Subsequent treating physicians must submit an RFA following their initial evaluation
- Medical bills are submitted timely:
- Within 30 days for non-emergency services
- Within 180 days for emergency services

Pursuant to 9792.9.7(b), the following services are not eligible for the 30-day exemption and require prospective utilization review unless previously authorized or rendered as emergency care:

- Pharmaceuticals (unless MTUS formulary exempt)
- Non-emergency surgery and related services
- Psychological or psychiatric treatment
- Home health care services
- Imaging and radiology (excluding X-rays)
- DME/prosthetics/orthotics/supplies > $250
- Electrodiagnostic medicine
- Spinal injections

8. Utilization Review Clients

AC Transit
AHMC Healthcare
American Apparel
American Brass & Iron (ABI)
American Textiles
Antelope Valley Medical Center
(Formerly Antelope Valley Hospital)
Arch-NSM Staffing WC
Arkansas Best Corp
ASCIP
Azusa USD
Bal Seal Engineering
Baldwin Park USD
Baseline WC Sutton
Bay Area Housing Authority
BART (Bay Area Rapid Transit)
Belmont-San Carlos Fire Protection
BLP JPA
Bridgepoint Education, Inc.
California Contractors Network Self-Insured Group (CCNSIG)
California Joint Powers Insurance Authority (CJPIA)
California Sanitation Risk Management Authority (CSRMA)
CAMSIG
Caitac Garment Processing
California Schools Risk Management
Calmat (Vulcan Materials Company)
Capistrano Unified School District
CAPS-SIG
CBHI Church
CCN LPT
Central Coast Cities S.I.
Central County Fire
CharterSAFE
Children's Hospital of Los Angeles
Church Mutual
City of Alhambra
City of Azusa
City of Carlsbad
City of El Cajon
City of El Centro
City of Fairfield
City of Fountain Valley
City of Hemet
City of Hemet Tail
City of Hermosa Beach
City of Hesperia Tail
City of Lemon Grove
City of Modesto
City of Monrovia
City of Mountain View
City of Oceanside
City of Ontario
City of Pacific Grove
City of San Diego
City of San Gabriel
City of San Luis Obispo
City of San Marcos
City of San Marcos Tail
City of San Mateo
City of Santa Clarita
City of Seal Beach
City of Seaside
City of Stanton

City of Stockton
City of Suisun
City of Ventura
City of West Covina
City of West Hollywood
City of Westminster
Co-Action
Colton Joint Unified School District
Commerce and Industry Greencrest
Community Hospital of Monterey Peninsula
Community Memorial Health
Companion Casualty Company
Conejo Valley Unified School District
County of Imperial
County of Marin
County of Placer
County of San Mateo
County of Solano
County of Tulare
Coverco
Corvina Valley Unified School District
Crestwood/Greencrest
CSRMA
Delos Insurance
Diocese of San Jose
Downey Unified School District
Eastern Municipal Water District
Eisenhower Medical Center
El Centro Regional Medical Center
Elite Golf
Ensign
Eskaton Properties, Inc.
Fender Musical Instruments Corp.
Fire Agencies Self-Insurance System (FASIS)
Fontana Unified School District
GAR Laboratories, Inc.
Garvey Unified School District
Generous Brands/Bolthouse
Gillig LLC
Gillig LLC PreCaptive
Golden Gate Bridge Highway & Transport. District
Goodwill Industries
Grand Auto / O'Reilly Auto
Grate Vitae LLC
Grimmway Farms
GuardianComp, Inc.
OC Sports & Entertainment
Hawthorne Machinery
Hesperia Fire Protection Tail
HIIG-CA Imperium
HNG Enterprises, Inc.
Household Industries SIG
Huntington Hospital
Imperium Insurance Company
JT Wimsatt
King's Seafood Company
KPC Healthcare, Inc.
Las Virgenes
Las Virgenes Tail
Long Beach Transit
Magic Laundry
Marin General Hospital
Marin Municipal Water District
McKesson Corporation
MERGE JPA
Monrovia Unified School District
Montage Health
North American Client Services (previously NAHCI and Clients)
North Marin Water District
North Orange County Community College District (NOCCCD)
Northgate Gonzalez
NOVA
Novato Fire Protection
O.C. Jones
Ontario-Montclair School District
Orora North America
Pacific Captive Insurance Company (PCIC)
PacWest
Palomar Health
PERMA
Phoenix / Altim
PIH Downey

PIH Good Samaritan
PIH Whittier
Poway Unified School District (USD)
Quality Comp, Inc.
Quinn Company
Riverside Community College District
San Diego County Schools Risk Management JPA
Santa Cruz Metropolitan Transportation District
Seneca Family of Agencies
Simi Valley Unified School District
SIPE
Sony Corporation
Southern California Pizza Company
Summit Premier Insurance
Sunsweet Growers, Inc.
Superior Grocers
Temecula Valley USD
The Conco Companies
The Hartford
The Hofmann Company
The Permanente Medical Group (TPMG)
Town of Corte Madera
Tri-County Schools Insurance Group JPA
Tustin USD
UPI (Formerly USS-POSCO Industries)
Upland Unified School District
Valley Indemnity
Valley Insurance Program
Valley Presbyterian Hospital
Ventura County Schools Self-Funding Authority
Vintage Senior Living
Yamanouchi Consumer
YMCA of Metropolitan Los Angeles
Zovio LPT

V. Exhibit A

1. Medical Director Curriculum Vitae

DALE P. CURTIS, M.D., FACEP

916.300.5348
dpcurtismd@aol.com

SUMMARY OF QUALIFICATIONS

Pragmatic and passionate healthcare professional who excels at developing team members to ensure the needs of the patient are met within a timely and efficient manner. Skilled at reviewing medical records to provide insight into the patients' medical condition and how to best treat their ailment or condition. Capable of leading facilities to ensure goals are met and provide expert testimony as needed for insurance and accident claims.

Core competencies include:
Patient Relations | Operations Management | Healthcare Administration | Records Management | Leadership | Administrative Review | Medical Management | Communication | Staff Development | Time Management

EDUCATION

UNIVERSITY OF WISCONSIN - MADISON, M.D., Madison, WI, 1992

MARQUETTE UNIVERSITY, BA in Psychology, Cum Laude, Milwaukee, WI, 1988

PROFESSIONAL DEVELOPMENT

Diplomat of American Board of Emergency Medicine Recertification, 2014

Emergency Medicine Physicians / Emergency Physicians Medical Group Scholars Program, Intensive and Focused Leadership / Managerial Program, Canton, OH, 2008

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, Fellow, 2005

Diplomat of American Board of Emergency Medicine Board Certification, 2004

EMORY UNIVERSITY SCHOOL OF MEDICINE, Emergency Medicine Residency, Atlanta, GA, 2001

NAVAL AEROSPACE MEDICAL INSTITUTE, Certificate in Aerospace Medicine, Pensacola, FL, 1996

MOUNT SINAI MEDICAL CENTER / CASE WESTERN RESERVE, Transitional Medicine Internship, Cleveland, OH, 1993

CA State License: G 86164
Additional State Licensure in WI, GA, AZ, OH, PA, TX, IL, NY and KY

PROFESSIONAL EXPERIENCE

ATHENS MANAGED CARE, Concord, CA 2026-Present
Medical Director

LANDMARK HEALTHCARE, Huntington Beach, CA 2021-Present
Medical Director, Implementation and Resource (Delta) Team

VERDE VALLEY MEDICAL CENTER EMERGENCY DEPARTMENT, Cottonwood / Sedona, AZ 2016 – 2020
Medical Director / EMS Medical Director / Department Chairman
Committees: Quality Improvement Committee, Utilization Management / Review Committee, Grievance Committee Medical Executive Committee, Pharmacy and Therapeutics Committee, and Code Blue Committee

ETHOS RISK (Formerly CLAIMS EVAL), Granite Bay, CA 2005-Present
Claims Reviewer and Expert Witness / Testimony

VERDE VALLEY MEDICAL CENTER, Cottonwood / Sedona, AZ 2001-2020
MERCY SAN JUAN MEDICAL CENTER EMERGENCY DEPARTMENT, Carmichael, CA
Staff Physician

BANNER CASA GRANDE MEDICAL CENTER EMERGENCY DEPARTMENT 2016
Medical Director / Department Chairman
Committees: Credentials Committee, Medical Executive Committee

US ACUTE CARE SOLUTIONS, Canton, OH 2015
Traveling / Resource Physician

VERDE VALLEY MEDICAL CENTER, Cottonwood / Sedona, AZ 2010-2012 / 2012-2015
MERCY SAN JUAN MEDICAL CENTER EMERGENCY DEPARTMENT, Carmichael, CA
Assistant Medical Director

VERDE VALLEY MEDICAL CENTER, Cottonwood / Sedona, AZ 2012-2015
Quality Improvement Director

MERCY SAN JUAN MEDICAL CENTER EMERGENCY DEPARTMENT, Carmichael, CA 2006-2010
Quality Improvement Director

EMORY UNIVERSITY SCHOOL OF MEDICINE, Atlanta, GA 1998-2001
Resident Physician, Department of Emergency Medicine

UNITED STATES NAVY, MARINE CORPS AIR STATION, Beaufort, SC 1996-1998
Flight Surgeon

UNITED STATES NAVY, MARINE CORPS AIR GROUND COMBAT CENTER, Twentynine Palms, CA 1993-1995
Battalion Surgeon

MOUNT SINAI MEDICAL CENTER, Cleveland, OH 1992-1993
Intern Physician, Department of Medicine

ORGANIZATIONS AND AFFILIATIONS

ACEP
AZCEP

VI. Exhibit B

1. URAC Certification

urac

CERTIFICATE OF AWARD

in recognition of

Athens Managed Care, Inc.
750 The City Drive South, Suite 350
Orange, California 92868

for compliance with

Workers' Compensation Utilization Management 8.1
Accreditation Program

is awarded

Full Accreditation

Effective from 01/01/2025 through 01/01/2027

Shawn Griffin MD

Shawn Griffin, MD
President & Chief Executive Officer

Certificate Number: WUM010029

urac®
ACCREDITED

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

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

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

VI. Exhibit C

1. Letter Examples

Certification Letter
Non-Certification Letter
Partial-Certification Letter
Adjuster Authorization Letter
Non-Certification Appeal Letter
Partial-Certification Appeal Letter
Information Request Letter

ATHENS MANAGED CARE

CERTIFICATION LETTER

Date: {{REVIEW_COMPLETIONDATE}}

NOTICE OF UTILIZATION REVIEW DETERMINATION

{{ADDRESSTO_NAME}} {{if ADDRESSTO_CREDENTIAL}} {{ADDRESSTO_CREDENTIAL}}{{endif}}
{{if ADDRESSTO_ADDRESS}}{{ADDRESSTO_ADDRESS}}{{endif}}
{{if ADDRESSTO_LOCATION}}{{ADDRESSTO_LOCATION}}{{endif}}
Fax #: {{ADDRESSTO_FAX}}

Regarding Employee:
{{CLAIMANT_FIRSTNAME}}
{{CLAIMANT_LASTNAME}}
{{CLAIMANT_ADDRESS}}

Claim Number: {{CLAIM_CLAIMNUMBER}}
DOI: {{CLAIM_INJURYDATE}}
Client: {{CUSTOMER_NAME}}
Claims Adjuster: {{ADJUSTER_NAME}}
Phone: {{ADJUSTER_PHONENUMBER}}

Reference #: {{REFERRAL_REFERRALNO}}

Dear {{ADDRESSTO_NAME}}{{if ADDRESSTO_CREDENTIAL }} {{ADDRESSTO_CREDENTIAL}}{{endif}},

The {{REFERRAL_SOURCEREFERRALDATE}} request for medical treatment was first received on {{REFERRAL_DATERECEIVEDBYADJUSTER}} and reviewed{{if CALIFORNIA}} in accordance with title 8, California Code of Regulations section 9792.9.1{{endif}}. On **{{REVIEW_COMPLETIONDATE}}** a decision was made in regard to the requested medical treatment.

The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision	Authorized Provider
{{loop TREATMENTREQUESTS}} {{TreatmentRequestNumber}} }	{{Description}} QTY: {{RequestedQuantity}} {{if IsMedication}} Refills: {{RequestedRefills}} {{endif}}	{{DeterminedDescription}} Qty:{{ DeterminedRequestedQuantity}} {{if IsMedication}}Refills: {{DeterminedRequestedRefills}}{{endif}}	{{**RequestDetermination**}}	{{if Approval}}{{if ProviderContact}}{{if ProviderContact.IsPreferred}}{{ProviderContact.Name}}{{if ProviderContact.PhoneNumber}}{{ProviderContact.PhoneNumber}}{{endif}}{{endif}}{{endif}}{{endif}}{{endif}}{{endloop}}

If indicated above, all approved medications are authorized in generic form, except where brand is specifically requested, medically necessary, or no generic equivalent exists.

{{if RIN}}**Date Request for Information Issued via Fax:** {{DATERINSENT}}
Date Requested Information Received, if applicable: {{DATERINREVEIVED}}
Description of Information Requested: {{RINDetails}}{{endif}}

If your employer is enrolled in a Medical Provider Network (MPN), indicated above as applicable, all approved services must be scheduled within the Network, unless otherwise authorized by your claims adjuster.

***All authorized services are subject to bill review upon receipt of the invoice. Authorization by UR is limited solely to the medical necessity of the treatment(s) requested on the CA Form RFA and does not constitute agreement to, approval of, any billed charges, reimbursement rates, pricing terms, or financial conditions referenced on the RFA or otherwise referenced by the provider.*

*Reimbursement shall be made in accordance with the applicable California Official Medical Fee Schedule (OMFS), contracted rates, and/or all governing statutes and regulations in effect on the date of service. Charges exceeding allowable amounts under the OMFS or applicable contract are not authorized and are expressly disputed.***

The portion approved for this request, if any, expires on {{REVIEW_COMPLETION_ADDDAYS_180}}. Extensions or changes in the treatment plan will require additional requests for authorization.{{endif}}{{endif}}

Please note the utilization review process is mandatory and has been done in accordance with California Labor Code Section 4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.6.1(q).

Sincerely,

{{SIGNEDBY_SIGNATURE }}
{{SIGNEDBY_NAME }}
{{SIGNEDBY_CREDENTIAL}}
{{if SIGNEDBY_PHONENUMBER}}Phone: {{ SIGNEDBY_PHONENUMBER}}{{endif}}
{{if SIGNEDBY_EMAIL}}Email: {{ SIGNEDBY_EMAIL}}{{endif}}
Utilization Review Department Hours of Availability: Monday through Friday, 8am to 5:30pm

PROOF OF SERVICE

I am a citizen of the United States and employed in the county where the mailing occurred; my business address is: **2552 Stanwell Drive, Concord, CA 94520**. I am over the age of eighteen years and not a party to the within entitled action.

I served the within letter(s) on the parties in said action, either by facsimile or electronic mail where indicated, or by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Concord, California, addressed where indicated.

If fax transmissions fail, letters will be sent via US Mail to the addresses listed below.

{{CLAIMANT_FIRSTNAME}} {{CLAIMANT_LASTNAME}}
{{CLAIMANT_ADDRESS1}}, {{CLAIMANT_ADDRESS2}}
{{CLAIMANT_CITY}}, {{CLAIMANT_STATE}} {{CLAIMANT_POSTALCODE}}

{{REQUESTINGPHYSICIAN_FIRSTNAME}} {{REQUESTINGPHYSICIAN_LASTNAME}}
{{REQUESTINGPHYSICIAN_CREDENTIALS}}
{{REQUESTINGPHYSICIAN_ADDRESS1}}, {{REQUESTINGPHYSICIAN_ADDRESS2}}
{{REQUESTINGPHYSICIAN_CITY}}, {{REQUESTINGPHYSICIAN_STATE}}
{{REQUESTINGPHYSICIAN_ZIP}}
Fax: {{REQUESTINGPHYSICIAN_FAX}}

{{ADJUSTER_FIRSTNAME}} {{ADJUSTER_LASTNAME}}
P.O. Box 4010
Concord, CA 94524

{{APPLICANTATTORNEY_FIRSTNAME}} {{APPLICANTATTORNEY_LASTNAME}}
{{APPLICANTATTORNEY_LOCATION}}
{{if APPLICANTATTORNEY_FAX}}Notified Via Fax: {{APPLICANTATTORNEY_FAX}}{{endif}}
{{if not (APPLICANTATTORNEY_FAX)}}Notified via mail: {{APPLICANTATTORNEY_ADDRESS1}},
{{APPLICANTATTORNEY_ADDRESS2}}
{{APPLICANTATTORNEY_CITY}}, {{APPLICANTATTORNEY_STATE}}
{{APPLICANTATTORNEY_ZIP}}{{endif}}{{endif}}

{{DEFENSEATTORNEY_FIRSTNAME}} {{DEFENSEATTORNEY_LASTNAME}}
{{DEFENSEATTORNEY_LOCATION}}
{{if DEFENSEATTORY_FAX}}Notified Via Fax: {{DEFENSEATTORNEY_FAX}}{{endif}}
{{if not (DEFENSEATTORNEY_FAX}}Notified via mail: {{DEFENSEATTORNEY_ADDRESS1}},
{{DEFENSEATTORNEY_ADDRESS2}}
{{DEFENSEATTORNEY_CITY}}, {{DEFENSEATTORNEY_STATE}}
{{DEFENSEATTORNEY_ZIP}}{{endif}}{{endif}}

Executed on **{{REVIEW_COMPLETIONDATE}}**.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

{{PRIMARYREVIEWER_NAME}}
{{PRIMARYREVIEWER_SIGNATURE}}
Signature

File:{{REFERRAL_REFERRALNO}}
Enclosures: Athens Determination

ATHENS MANAGED CARE

NON-CERTIFICATION LETTER

Date: {{REVIEW_COMPLETIONDATE}}

NOTICE OF UTILIZATION REVIEW DETERMINATION[3]

{{ADDRESSTO_NAME}} {{if ADDRESSTO_CREDENTIAL}} {{ADDRESSTO_CREDENTIAL}}{{endif}}
{{if ADDRESSTO_ADDRESS}}{{ADDRESSTO_ADDRESS}}{{endif}}
{{if ADDRESSTO_LOCATION}}{{ADDRESSTO_LOCATION}}{{endif}}
Fax #: {{ADDRESSTO_FAX}}

Regarding Employee:
{{CLAIMANT_FIRSTNAME}}
{{CLAIMANT_LASTNAME}}
{{CLAIMANT_ADDRESS}}

Claim Number: {{CLAIM_CLAIMNUMBER}}
DOI: {{CLAIM_INJURYDATE}}
Client: {{CUSTOMER_NAME}}
Claims Adjuster: {{ADJUSTER_NAME}}
Phone: {{ADJUSTER_PHONENUMBER}}

Reference #: {{REFERRAL_REFERRALNO}}

Dear {{ADDRESSTO_NAME}}{{if ADDRESSTO_CREDENTIAL }} {{ADDRESSTO_CREDENTIAL}}{{endif}},

The {{REFERRAL_SOURCEREFERRALDATE}} request for medical treatment was first received on {{REFERRAL_DATERECEIVEDBYADJUSTER}} and reviewed{{if CALIFORNIA}} in accordance with title 8, California Code of Regulations section 9792.9.1{{endif}}. On **{{REVIEW_COMPLETIONDATE}}** a decision was made in regard to the requested medical treatment.

The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision	Authorized Provider
{{loop TREATMENTREQUESTS}} {{TreatmentRequestNumber}}	{{Description}} QTY: {{RequestedQuantity}} {{if IsMedication}} Refills: {{RequestedRefills}} {{endif}}	{{DeterminedDescription}} Qty:{{DeterminedRequestedQuantity}} {{if IsMedication}}Refills: {{DeterminedRequestedRefills}}{{endif}}	{{**RequestDetermination**}}	{{if Approval}}{{if ProviderContact}}{{if ProviderContact.IsPreferred}}{{ProviderContact.Name}}{{if ProviderContact.PhoneNumber}}{{ProviderContact.PhoneNumber}}{{endif}}{{endif}}{{endif}}{{endif}}{{endloop}}

If indicated above, all approved medications are authorized in generic form, except where brand is specifically requested, medically necessary, or no generic equivalent exists.

{{if RIN}}**Date Request for Information Issued via Fax:** {{DATERINSENT}}
Date Requested Information Received, if applicable: {{DATERINREVEIVED}}
Description of Information Requested: {{RINDetails}}{{endif}}

[3] This template is also used for Lack of Information denials. In those cases, the determination will further read: "The clinical reason for non-certification was due to lack of medical information. Telephonic requests for medical information were made on: (date) and (date). A faxed request for medical information was made on (date). The decision will be reconsidered once the requested information is received.".

If your employer is enrolled in a Medical Provider Network (MPN), indicated above as applicable, all approved services must be scheduled within the Network, unless otherwise authorized by your claims adjuster.

***All authorized services are subject to bill review upon receipt of the invoice. Authorization by UR is limited solely to the medical necessity of the treatment(s) requested on the CA Form RFA and does not constitute agreement to, approval of, any billed charges, reimbursement rates, pricing terms, or financial conditions referenced on the RFA or otherwise referenced by the provider.*

*Reimbursement shall be made in accordance with the applicable California Official Medical Fee Schedule (OMFS), contracted rates, and/or all governing statutes and regulations in effect on the date of service. Charges exceeding allowable amounts under the OMFS or applicable contract are not authorized and are expressly disputed.***

Reports Reviewed:
{{loop LINKEDDOCUMENTS}}{{if IsDocumentIn}} {{ReportDate}} – {{Title}} {{endloop}}

Rationale:
{{loop TREATMENTREQUESTS}}**Regarding the request for {{Description}}:**
Per Evidence-based medical guidelines: {{ReviewGuidelinePlain}}
Based on the guidelines cited above: {{ReviewRationalPlain}}
{{endloop}}{{endif}}

Please note the utilization review process is mandatory and has been done in accordance with California Labor Code Section 4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.6.1(q).

A utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical necessity shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician, 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.

DISPUTE RESOLUTION:
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 enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

Notice to Injured Worker:

"You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision (see attached application). If you have questions about the information in this notice, please call me {{ADJUSTER_NAME}} at {{ADJUSTER_PHONENUMBER}}. However, if you are represented by an attorney, please contact your attorney instead of me."

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

Notice to Requesting Physician:

Athens Managed Care offers a voluntary internal utilization review appeals process. This process, as outlined below, is voluntary and neither triggers nor bars use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6 as noted above for the Injured Worker, but may be pursed on an optional basis.

The requesting provider or primary treating physician may request in writing an appeal immediately to Athens Managed Care or the claims examiner. You may include any additional pertinent clinical information which has not previously been submitted to be reviewed by a different reviewing physician. Request for the voluntary internal appeal must be received within 10 calendar days of this determination. A response to your appeal will be rendered within 5 days from the date of receipt of the request for appeal for formulary disputes or 30 days from the date of receipt of the request for appeal for all other medical treatment disputes.

In accordance with regulation section 9792.9.5(e)(14), if the requesting physician wishes to speak to the reviewing physician regarding the determination, you can call Athens Managed Care at (877) 494-4300 to arrange an agreed upon scheduled time between the hours of 9:00am and 5:30pm, PST, Monday through Friday. Should the reviewing physician be unable to speak to you during the scheduled time, you may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Sincerely,

{{SIGNEDBY_SIGNATURE }}
{{SIGNEDBY_NAME }}
{{SIGNEDBY_CREDENTIAL}}
{{if SIGNEDBY_PHONENUMBER}}Phone: {{ SIGNEDBY_PHONENUMBER}}{{endif}}
{{if SIGNEDBY_EMAIL}}Email: {{ SIGNEDBY_EMAIL}}{{endif}}
Utilization Review Department Hours of Availability: Monday through Friday, 8am to 5:30pm

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

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

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

Type of Utilization Review:

Regular ☐ Expedited ☐ Modification after Appeal ☐

Medication Only – MTUS Formulary Drug List ☐ Retrospective for Exempt Treatment (Non-Drug) ☐ Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter:

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

Reason:

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

1.

2.

3.

4.

Request for Review and Consent to Obtain Medical Records

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

Employee Signature Date

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☐30 days from the mailing date of the written determination letter.

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

INSTRUCTIONS FOR COMPLETNG THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

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

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

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

- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.

- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.

- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.

- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

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

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

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

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.

- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.

- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.

- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

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

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

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

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

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

Employee Signature:		Date:

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

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

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

PROOF OF SERVICE

I am a citizen of the United States and employed in the county where the mailing occurred; my business address is: **2552 Stanwell Drive, Concord, CA 94520**. I am over the age of eighteen years and not a party to the within entitled action.

I served the within letter(s) on the parties in said action, either by facsimile or electronic mail where indicated, or by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Concord, California, addressed where indicated.

If fax transmissions fail, letters will be sent via US Mail to the addresses listed below.

{{CLAIMANT_FIRSTNAME}} {{CLAIMANT_LASTNAME}}
{{CLAIMANT_ADDRESS1}}, {{CLAIMANT_ADDRESS2}}
{{CLAIMANT_CITY}}, {{CLAIMANT_STATE}} {{CLAIMANT_POSTALCODE}}

{{REQUESTINGPHYSICIAN_FIRSTNAME}} {{REQUESTINGPHYSICIAN_LASTNAME}}
{{REQUESTINGPHYSICIAN_CREDENTIALS}}
{{REQUESTINGPHYSICIAN_ADDRESS1}}, {{REQUESTINGPHYSICIAN_ADDRESS2}}
{{REQUESTINGPHYSICIAN_CITY}}, {{REQUESTINGPHYSICIAN_STATE}}
{{REQUESTINGPHYSICIAN_ZIP}}
Fax: {{REQUESTINGPHYSICIAN_FAX}}

{{ADJUSTER_FIRSTNAME}} {{ADJUSTER_LASTNAME}}
P.O. Box 4010
Concord, CA 94524

{{if APPLICANTATTORNEY}}{{APPLICANTATTORNEY_FIRSTNAME}}
{{APPLICANTATTORNEY_LASTNAME}}
{{APPLICANTATTORNEY_LOCATION}}
{{if APPLICANTATTORNEY_FAX}}Notified Via Fax: {{APPLICANTATTORNEY_FAX}}{{endif}}
{{if not (APPLICANTATTORNEY_FAX)}}Notified via mail: {{APPLICANTATTORNEY_ADDRESS1}},
{{APPLICANTATTORNEY_ADDRESS2}}
{{APPLICANTATTORNEY_CITY}}, {{APPLICANTATTORNEY_STATE}}
{{APPLICANTATTORNEY_ZIP}}{{endif}}{{endif}}

{{if DEFENSEATTORNEY}}{{DEFENSEATTORNEY_FIRSTNAME}}
{{DEFENSEATTORNEY_LASTNAME}}
{{DEFENSEATTORNEY_LOCATION}}
{{if DEFENSEATTORY_FAX}}Notified Via Fax: {{DEFENSEATTORNEY_FAX}}{{endif}}
{{if not (DEFENSEATTORNEY_FAX}}Notified via mail: {{DEFENSEATTORNEY_ADDRESS1}},
{{DEFENSEATTORNEY_ADDRESS2}}
{{DEFENSEATTORNEY_CITY}}, {{DEFENSEATTORNEY_STATE}}
{{DEFENSEATTORNEY_ZIP}}{{endif}}{{endif}}

Executed on **{{REVIEW_COMPLETIONDATE}}**.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

{{PRIMARYREVIEWER_NAME}}
{{PRIMARYREVIEWER_SIGNATURE}}
Signature

File:{{REFERRAL_REFERRALNO}}
Enclosures: Athens Determination and DWC Form IMR

PARTIAL CERTIFICATION LETTER

Date: {{REVIEW_COMPLETIONDATE}}

NOTICE OF UTILIZATION REVIEW DETERMINATION

{{ADDRESSTO_NAME}} {{if ADDRESSTO_CREDENTIAL}} {{ADDRESSTO_CREDENTIAL}}{{endif}}
{{if ADDRESSTO_ADDRESS}}{{ADDRESSTO_ADDRESS}}{{endif}}
{{if ADDRESSTO_LOCATION}}{{ADDRESSTO_LOCATION}}{{endif}}
Fax #: {{ADDRESSTO_FAX}}

Regarding Employee:
{{CLAIMANT_FIRSTNAME}}
{{CLAIMANT_LASTNAME}}
{{CLAIMANT_ADDRESS}}

Claim Number: {{CLAIM_CLAIMNUMBER}}
DOI: {{CLAIM_INJURYDATE}}
Client: {{CUSTOMER_NAME}}
Claims Adjuster: {{ADJUSTER_NAME}}
Phone: {{ADJUSTER_PHONENUMBER}}

Reference #: {{REFERRAL_REFERRALNO}}

Dear {{ADDRESSTO_NAME}}{{if ADDRESSTO_CREDENTIAL }} {{ADDRESSTO_CREDENTIAL}}{{endif}},

The {{REFERRAL_SOURCEREFERRALDATE}} request for medical treatment was first received on {{REFERRAL_DATERECEIVEDBYADJUSTER}} and reviewed{{if CALIFORNIA}} in accordance with title 8, California Code of Regulations section 9792.9.1{{endif}}. On **{{REVIEW_COMPLETIONDATE}}** a decision was made in regard to the requested medical treatment.

The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision	Authorized Provider
{{loop TREATMENTREQUESTS}} {{TreatmentRequestNumber}}	{{Description}} QTY: {{RequestedQuantity}} {{if IsMedication}} Refills: {{RequestedRefills}} {{endif}}	{{DeterminedDescription}} Qty:{{DeterminedRequestedQuantity}} {{if IsMedication}}Refills: {{DeterminedRequestedRefills}}{{endif}}	{{**RequestDetermination**}}	{{if Approval}}{{if ProviderContact}}{{if ProviderContact.IsPreferred}}{{ProviderContact.Name}}{{if ProviderContact.PhoneNumber}}{{ProviderContact.PhoneNumber}}{{endif}}{{endif}}{{endif}}{{endif}}{{endloop}}

If indicated above, all approved medications are authorized in generic form, except where brand is specifically requested, medically necessary, or no generic equivalent exists.

{{if RIN}}**Date Request for Information Issued via Fax:** {{DATERINSENT}}
Date Requested Information Received, if applicable: {{DATERINREVEIVED}}
Description of Information Requested: {{RINDetails}}{{endif}}

If your employer is enrolled in a Medical Provider Network (MPN), indicated above as applicable, all approved services must be scheduled within the Network, unless otherwise authorized by your claims adjuster.

***All authorized services are subject to bill review upon receipt of the invoice. Authorization by UR is limited solely to the medical necessity of the treatment(s) requested on the CA Form RFA and does not constitute agreement to, approval of, any billed charges, reimbursement rates, pricing terms, or financial conditions*

referenced on the RFA or otherwise referenced by the provider.

*Reimbursement shall be made in accordance with the applicable California Official Medical Fee Schedule (OMFS), contracted rates, and/or all governing statutes and regulations in effect on the date of service. Charges exceeding allowable amounts under the OMFS or applicable contract are not authorized and are expressly disputed.***

The portion approved for this request, if any, expires on {{REVIEW_COMPLETION_ADDDAYS_180}}. Extensions or changes in the treatment plan will require additional requests for authorization.{{endif}}{{endif}}

Reports Reviewed:
{{loop LINKEDDOCUMENTS}}{{if IsDocumentIn}} {{ReportDate}} – {{Title}} {{endloop}}

Rationale:
{{loop TREATMENTREQUESTS}}**Regarding the request for {{Description}}:**
Per Evidence-based medical guidelines: {{ReviewGuidelinePlain}}
Based on the guidelines cited above: {{ReviewRationalPlain}}
{{endloop}}{{endif}}

Please note the utilization review process is mandatory and has been done in accordance with California Labor Code Section 4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.6.1(q).

A utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical necessity shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician, 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.

DISPUTE RESOLUTION:
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 enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

Notice to Injured Worker:

"You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision (see attached application). If you have questions about the information in this notice, please call me {{ADJUSTER_NAME}} at {{ADJUSTER_PHONENUMBER}}. However, if you are represented by an attorney, please contact your attorney instead of me."

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

Notice to Requesting Physician:

Athens Managed Care offers a voluntary internal utilization review appeals process. This process, as outlined below, is voluntary and neither triggers nor bars use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6 as noted above for the Injured Worker, but may be pursed on an optional basis.

The requesting provider or primary treating physician may request in writing an appeal immediately to Athens Managed Care or the claims examiner. You may include any additional pertinent clinical information which has not previously been submitted to be reviewed by a different reviewing physician. Request for the voluntary internal appeal must be received within 10 calendar days of this determination. A response to your appeal will be rendered within 5 days from the date of receipt of the request for appeal for formulary disputes or 30 days from the date of receipt of the request for appeal for all other medical treatment disputes.

In accordance with regulation section 9792.9.5(e)(14), if the requesting physician wishes to speak to the reviewing physician regarding the determination, you can call Athens Managed Care at (877) 494-4300 to arrange an agreed upon scheduled time between the hours of 9:00am and 5:30pm, PST, Monday through Friday. Should the reviewing physician be unable to speak to you during the scheduled time, you may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Sincerely,

{{SIGNEDBY_SIGNATURE }}
{{SIGNEDBY_NAME }}
{{SIGNEDBY_CREDENTIAL}}
{{if SIGNEDBY_PHONENUMBER}}Phone: {{ SIGNEDBY_PHONENUMBER}}{{endif}}
{{if SIGNEDBY_EMAIL}}Email: {{ SIGNEDBY_EMAIL}}{{endif}}
Utilization Review Department Hours of Availability: Monday through Friday, 8am to 5:30pm

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

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

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

Type of Utilization Review:

Regular ☐ Expedited ☐ Modification after Appeal ☐

Medication Only – MTUS Formulary Drug List ☐ Retrospective for Exempt Treatment (Non-Drug) ☐ Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter:

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

Reason:

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

5.

6.

7.

8.

Request for Review and Consent to Obtain Medical Records

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

Employee Signature Date

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☐30 days from the mailing date of the written determination letter.

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

INSTRUCTIONS FOR COMPLETNG THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

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

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

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- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.

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- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.

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

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

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

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.

- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.

- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.

- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

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

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

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

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

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

Employee Signature:		Date:

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

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

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

PROOF OF SERVICE

I am a citizen of the United States and employed in the county where the mailing occurred; my business address is: **2552 Stanwell Drive, Concord, CA 94520**. I am over the age of eighteen years and not a party to the within entitled action.

I served the within letter(s) on the parties in said action, either by facsimile or electronic mail where indicated, or by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Concord, California, addressed where indicated.

If fax transmissions fail, letters will be sent via US Mail to the addresses listed below.

{{CLAIMANT_FIRSTNAME}} {{CLAIMANT_LASTNAME}}
{{CLAIMANT_ADDRESS1}}, {{CLAIMANT_ADDRESS2}}
{{CLAIMANT_CITY}}, {{CLAIMANT_STATE}} {{CLAIMANT_POSTALCODE}}

{{REQUESTINGPHYSICIAN_FIRSTNAME}} {{REQUESTINGPHYSICIAN_LASTNAME}}
{{REQUESTINGPHYSICIAN_CREDENTIALS}}
{{REQUESTINGPHYSICIAN_ADDRESS1}}, {{REQUESTINGPHYSICIAN_ADDRESS2}}
{{REQUESTINGPHYSICIAN_CITY}}, {{REQUESTINGPHYSICIAN_STATE}}
{{REQUESTINGPHYSICIAN_ZIP}}
Fax: {{REQUESTINGPHYSICIAN_FAX}}

{{ADJUSTER_FIRSTNAME}} {{ADJUSTER_LASTNAME}}
P.O. Box 4010
Concord, CA 94524

{{if APPLICANTATTORNEY}}{{APPLICANTATTORNEY_FIRSTNAME}}
{{APPLICANTATTORNEY_LASTNAME}}
{{APPLICANTATTORNEY_LOCATION}}
{{if APPLICANTATTORNEY_FAX}}Notified Via Fax: {{APPLICANTATTORNEY_FAX}}{{endif}}
{{if not (APPLICANTATTORNEY_FAX)}}Notified via mail: {{APPLICANTATTORNEY_ADDRESS1}},
{{APPLICANTATTORNEY_ADDRESS2}}
{{APPLICANTATTORNEY_CITY}}, {{APPLICANTATTORNEY_STATE}}
{{APPLICANTATTORNEY_ZIP}}{{endif}}{{endif}}

{{if DEFENSEATTORNEY}}{{DEFENSEATTORNEY_FIRSTNAME}}
{{DEFENSEATTORNEY_LASTNAME}}
{{DEFENSEATTORNEY_LOCATION}}
{{if DEFENSEATTORY_FAX}}Notified Via Fax: {{DEFENSEATTORNEY_FAX}}{{endif}}
{{if not (DEFENSEATTORNEY_FAX}}Notified via mail: {{DEFENSEATTORNEY_ADDRESS1}},
{{DEFENSEATTORNEY_ADDRESS2}}
{{DEFENSEATTORNEY_CITY}}, {{DEFENSEATTORNEY_STATE}}
{{DEFENSEATTORNEY_ZIP}}{{endif}}{{endif}}

Executed on **{{REVIEW_COMPLETIONDATE}}**.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

{{PRIMARYREVIEWER_NAME}}
{{PRIMARYREVIEWER_SIGNATURE}}
Signature

File:{{REFERRAL_REFERRALNO}}
Enclosures: Athens Determination and DWC Form IMR

ADJUSTER AUTHORIZATION LETTER

NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: {{REVIEW_COMPLETIONDATE}}

Regarding Employee:
{{CLAIMANT_FIRSTNAME}} {{CLAIMANT_LASTNAME}}
{{CLAIMANT_ADDRESS}}
{{CLAIMANT_PHONENUMBER}}

To: {{ADDRESSTO_NAME}} {{if ADDRESSTO_CREDENTIAL}}
{{ADDRESSTO_CREDENTIAL}}{{endif}}
{{if ADDRESSTO_ADDRESS}}{{ADDRESSTO_ADDRESS}}{{endif}}
{{if ADDRESSTO_LOCATION}}{{ADDRESSTO_LOCATION}}{{endif}}
Fax #: {{ADDRESSTO_FAX}}

Claim Number: {{CLAIM_CLAIMNUMBER}}
DOI: {{CLAIM_INJURYDATE}}
Client: {{CUSTOMER_NAME}}
Claims Adjuster: {{ADJUSTER_NAME}}
Phone: {{ADJUSTER_PHONENUMBER}}

Reference #: {{REFERRAL_REFERRALNO}}

NOTICE OF AUTHORIZATION

Athens Managed Care has been asked to notify you that the adjuster, {{ADJUSTER_NAME}}, has given authorization for the treatment requests noted below.

REQUEST FOR AUTHORIZATION:

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision	Authorized Provider
{{loop TREATMENTREQUESTS}} {{TreatmentRequestNumber}} }	{{Description}} QTY: {{RequestedQuantity}} {{if IsMedication}} Refills: {{RequestedRefills}} {{endif}}	{{DeterminedDescription}} Qty:{{ DeterminedRequestedQuantity}}{{if IsMedication}}Refills: {{DeterminedRequestedRefills}}{{endif}}	{{**RequestDetermination**}}	{{if Approval}}{{if ProviderContact}}{{if ProviderContact.IsPreferred}}{{ProviderContact.Name}}{{if ProviderContact.PhoneNumber}}{{ProviderContact.PhoneNumber}}{{endif}}{{endif}}{{endif}}{{endif}}{{endloop}}

If indicated above, all approved medications are authorized in generic form, except where brand is specifically requested, medically necessary, or no generic equivalent exists.

{{if RIN}}**Date Request for Information Issued via Fax:** {{DATERINSENT}}
Date Requested Information Received, if applicable: {{DATERINREVEIVED}}
Description of Information Requested: {{RINDetails}}{{endif}}

If your employer is enrolled in a Medical Provider Network (MPN), indicated above as applicable, all approved services must be scheduled within the Network, unless otherwise authorized by your claims adjuster.

***All authorized services are subject to bill review upon receipt of the invoice. Authorization by UR is limited solely to the medical necessity of the treatment(s) requested on the CA Form RFA and does not constitute agreement to, approval of, any billed charges, reimbursement rates, pricing terms, or financial conditions referenced on the RFA or otherwise referenced by the provider.*

*Reimbursement shall be made in accordance with the applicable California Official Medical Fee Schedule (OMFS), contracted rates, and/or all governing statutes and regulations in effect on the date of service. Charges exceeding allowable amounts under the OMFS or applicable contract are not authorized and are expressly disputed.***

Authorization Timeframe: this treatment authorization is valid until {{REVIEW_COMPLETION_ADDDAYS_180}}.{{endif}}

Please note this review has been done in accordance with California Labor Code Section 4610 and the California Medical Treatment Utilization Schedule has been utilized in the determination process as required in Title 8, California Code of Regulation 9792.6.1(q).{{endif}} Athens Managed Care hours of operation are from 9:00am to 5:30pm PST, Monday through Friday. Should you have additional questions on this review, please call (877) 494-4300.

Sincerely,
Athens Managed Care, Utilization Review Department

PROOF OF SERVICE

I am a citizen of the United States and employed in the county where the mailing occurred; my business address is: **2552 Stanwell Drive, Concord, CA 94520**. I am over the age of eighteen years and not a party to the within entitled action.

I served the within letter(s) on the parties in said action, either by facsimile or electronic mail where indicated, or by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Concord, California, addressed where indicated.

If fax transmissions fail, letters will be sent via US Mail to the addresses listed below.

{{CLAIMANT_FIRSTNAME}} {{CLAIMANT_LASTNAME}}
{{CLAIMANT_ADDRESS1}}, {{CLAIMANT_ADDRESS2}}
{{CLAIMANT_CITY}}, {{CLAIMANT_STATE}} {{CLAIMANT_POSTALCODE}}

{{REQUESTINGPHYSICIAN_FIRSTNAME}} {{REQUESTINGPHYSICIAN_LASTNAME}}
{{REQUESTINGPHYSICIAN_CREDENTIALS}}
{{REQUESTINGPHYSICIAN_ADDRESS1}}, {{REQUESTINGPHYSICIAN_ADDRESS2}}
{{REQUESTINGPHYSICIAN_CITY}}, {{REQUESTINGPHYSICIAN_STATE}}
{{REQUESTINGPHYSICIAN_ZIP}}
Fax: {{REQUESTINGPHYSICIAN_FAX}}

{{ADJUSTER_FIRSTNAME}} {{ADJUSTER_LASTNAME}}
P.O. Box 4010
Concord, CA 94524

{{APPLICANTATTORNEY_FIRSTNAME}} {{APPLICANTATTORNEY_LASTNAME}}
{{APPLICANTATTORNEY_LOCATION}}
{{if APPLICANTATTORNEY_FAX}}Notified Via Fax: {{APPLICANTATTORNEY_FAX}}{{endif}}
{{if not (APPLICANTATTORNEY_FAX)}}Notified via mail: {{APPLICANTATTORNEY_ADDRESS1}},
{{APPLICANTATTORNEY_ADDRESS2}}
{{APPLICANTATTORNEY_CITY}}, {{APPLICANTATTORNEY_STATE}}
{{APPLICANTATTORNEY_ZIP}}{{endif}}{{endif}}

{{DEFENSEATTORNEY_FIRSTNAME}} {{DEFENSEATTORNEY_LASTNAME}}
{{DEFENSEATTORNEY_LOCATION}}
{{if DEFENSEATTORY_FAX}}Notified Via Fax: {{DEFENSEATTORNEY_FAX}}{{endif}}
{{if not (DEFENSEATTORNEY_FAX}}Notified via mail: {{DEFENSEATTORNEY_ADDRESS1}},
{{DEFENSEATTORNEY_ADDRESS2}}
{{DEFENSEATTORNEY_CITY}}, {{DEFENSEATTORNEY_STATE}}
{{DEFENSEATTORNEY_ZIP}}{{endif}}{{endif}}

Executed on **{{REVIEW_COMPLETIONDATE}}**.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

{{COMPLETEDBY_NAME}}

{{COMPLETEDBY_SIGNATURE}}
_____
Signature

File:{{REFERRAL_REFERRALNO}}
Enclosures: Athens Determination

NON-CERTIFICATION APPEAL LETTER

Date: {{REVIEW_COMPLETIONDATE}}

NOTICE OF UTILIZATION REVIEW APPEAL DETERMINATION

{{ADDRESSTO_NAME}} {{if ADDRESSTO_CREDENTIAL}} {{ADDRESSTO_CREDENTIAL}}{{endif}}
{{if ADDRESSTO_ADDRESS}}{{ADDRESSTO_ADDRESS}}{{endif}}
{{if ADDRESSTO_LOCATION}}{{ADDRESSTO_LOCATION}}{{endif}}
Fax #: {{ADDRESSTO_FAX}}

Regarding Employee:
{{CLAIMANT_FIRSTNAME}}
{{CLAIMANT_LASTNAME}}
{{CLAIMANT_ADDRESS}}

Claim Number: {{CLAIM_CLAIMNUMBER}}
DOI: {{CLAIM_INJURYDATE}}
Client: {{CUSTOMER_NAME}}
Claims Adjuster: {{ADJUSTER_NAME}}
Phone: {{ADJUSTER_PHONENUMBER}}

Reference #: {{REFERRAL_REFERRALNO}}

Dear {{ADDRESSTO_NAME}}{{if ADDRESSTO_CREDENTIAL }} {{ADDRESSTO_CREDENTIAL}}{{endif}},

The {{REFERRAL_SOURCEREFERRALDATE}} request for medical treatment was first received on {{REFERRAL_DATERECEIVEDBYADJUSTER}} and reviewed{{if CALIFORNIA}} in accordance with Title 8, California Code of Regulations section 9792.9.1{{endif}}. On **{{REVIEW_COMPLETIONDATE}}** a decision was made regarding the requested medical treatment.

The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision	Authorized Provider
{{loop TREATMENTREQUESTS}} {{TreatmentRequestNumber}}	{{Description}} QTY: {{RequestedQuantity}} {{if IsMedication}} Refills: {{RequestedRefills}} {{endif}}	{{DeterminedDescription}} Qty:{{ DeterminedRequestedQuantity}}{{if IsMedication}}Refills: {{DeterminedRequestedRefills}}{{endif}}	{{**RequestDetermination**}}	{{if Approval}}{{if ProviderContact}}{{if ProviderContact.IsPreferred}}{{ ProviderContact.Name}}{{if ProviderContact.PhoneNumber}}{{ProviderContact.PhoneNumber}}{{endif}}{{endif}}{{endif}}{{endif}}{{endloop}}

If indicated above, all approved medications are authorized in generic form, except where brand is specifically requested, medically necessary, or no generic equivalent exists.

{{if RIN}}**Date Request for Information Issued via Fax:** {{DATERINSENT}}
Date Requested Information Received, if applicable: {{DATERINREVEIVED}}
Description of Information Requested: {{RINDetails}}{{endif}}

If your employer is enrolled in a Medical Provider Network (MPN), indicated above as applicable, all approved services must be scheduled within the Network, unless otherwise authorized by your claims adjuster.

***All authorized services are subject to bill review upon receipt of the invoice. Authorization by UR is limited solely to the medical necessity of the treatment(s) requested on the CA Form RFA and does not constitute agreement to, approval of, any billed charges, reimbursement rates, pricing terms, or financial conditions referenced on the RFA or otherwise referenced by the provider.*

*Reimbursement shall be made in accordance with the applicable California Official Medical Fee Schedule (OMFS), contracted rates, and/or all governing statutes and regulations in effect on the date of service. Charges exceeding allowable amounts under the OMFS or applicable contract are not authorized and are expressly disputed.***

Reports Reviewed:
{{loop LINKEDDOCUMENTS}}{{if IsDocumentIn}} {{ReportDate}} – {{Title}} {{endloop}}

Rationale:
{{loop TREATMENTREQUESTS}}**Regarding the request for {{Description}}:**
Per Evidence-based medical guidelines: {{DeterminedReviewGuideline}}
Based on the guidelines cited above: {{DeterminedReviewRational}}
{{endloop}}

Please note the utilization review process is mandatory and has been done in accordance with California Labor Code Section 4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.6.1(q).

A utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical necessity shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician, 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.

DISPUTE RESOLUTION:
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 previously provided Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

Notice to Injured Worker:

"You have the right to disagree with the decision affecting your claim. If you have questions about the information in this notice, please call me, {{ADJUSTER_NAME}} at {{ADJUSTER_PHONENUMBER}}. However, if you are represented by an attorney, please contact your attorney instead of me."

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

Notice to Requesting Physician:

In accordance with regulation section 9792.9.1(e)(14), if the requesting physician wishes to speak to the reviewing physician regarding the determination, you can call Athens Managed Care at (877) 494-4300 to arrange an agreed upon scheduled time between the hours of 9:00am and 5:30pm, PST, Monday through Friday. Should the reviewing physician be unable to speak to you during the scheduled time, you may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Sincerely,

{{SIGNEDBY_SIGNATURE }}
{{SIGNEDBY_NAME }}
{{SIGNEDBY_CREDENTIAL}}
{{if SIGNEDBY_PHONENUMBER}}Phone: {{ SIGNEDBY_PHONENUMBER}}{{endif}}
{{if SIGNEDBY_EMAIL}}Email: {{ SIGNEDBY_EMAIL}}{{endif}}
Utilization Review Department Hours of Availability: Monday through Friday, 8am to 5:30pm

PROOF OF SERVICE

I am a citizen of the United States and employed in the county where the mailing occurred; my business address is: **2552 Stanwell Drive, Concord, CA 94520**. I am over the age of eighteen years and not a party to the within entitled action.

I served the within letter(s) on the parties in said action, either by facsimile or electronic mail where indicated, or by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Concord, California, addressed where indicated.

If fax transmissions fail, letters will be sent via US Mail to the addresses listed below.

{{CLAIMANT_FIRSTNAME}} {{CLAIMANT_LASTNAME}}
{{CLAIMANT_ADDRESS1}}, {{CLAIMANT_ADDRESS2}}
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{{REQUESTINGPHYSICIAN_FIRSTNAME}} {{REQUESTINGPHYSICIAN_LASTNAME}}
{{REQUESTINGPHYSICIAN_CREDENTIALS}}
{{REQUESTINGPHYSICIAN_ADDRESS1}}, {{REQUESTINGPHYSICIAN_ADDRESS2}}
{{REQUESTINGPHYSICIAN_CITY}}, {{REQUESTINGPHYSICIAN_STATE}}
{{REQUESTINGPHYSICIAN_ZIP}}
Fax: {{REQUESTINGPHYSICIAN_FAX}}

{{ADJUSTER_FIRSTNAME}} {{ADJUSTER_LASTNAME}}
P.O. Box 4010
Concord, CA 94524

{{APPLICANTATTORNEY_FIRSTNAME}} {{APPLICANTATTORNEY_LASTNAME}}
{{APPLICANTATTORNEY_LOCATION}}
{{if APPLICANTATTORNEY_FAX}}Notified Via Fax: {{APPLICANTATTORNEY_FAX}}{{endif}}
{{if not (APPLICANTATTORNEY_FAX)}}Notified via mail: {{APPLICANTATTORNEY_ADDRESS1}},
{{APPLICANTATTORNEY_ADDRESS2}}
{{APPLICANTATTORNEY_CITY}}, {{APPLICANTATTORNEY_STATE}}
{{APPLICANTATTORNEY_ZIP}}{{endif}}{{endif}}

{{DEFENSEATTORNEY_FIRSTNAME}} {{DEFENSEATTORNEY_LASTNAME}}
{{DEFENSEATTORNEY_LOCATION}}
{{if DEFENSEATTORY_FAX}}Notified Via Fax: {{DEFENSEATTORNEY_FAX}}{{endif}}
{{if not (DEFENSEATTORNEY_FAX}}Notified via mail: {{DEFENSEATTORNEY_ADDRESS1}},
{{DEFENSEATTORNEY_ADDRESS2}}
{{DEFENSEATTORNEY_CITY}}, {{DEFENSEATTORNEY_STATE}}
{{DEFENSEATTORNEY_ZIP}}{{endif}}{{endif}}

Executed on **{{REVIEW_COMPLETIONDATE}}**.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

{{PRIMARYREVIEWER_NAME}}
{{PRIMARYREVIEWER_SIGNATURE}}
Signature

File:{{REFERRAL_REFERRALNO}}
Enclosures: Athens Determination

PARTIAL CERTIFICATION APPEAL LETTER

Date: {{REVIEW_COMPLETIONDATE}}

NOTICE OF UTILIZATION REVIEW APPEAL DETERMINATION

{{ADDRESSTO_NAME}} {{if ADDRESSTO_CREDENTIAL}} {{ADDRESSTO_CREDENTIAL}}{{endif}}
{{if ADDRESSTO_ADDRESS}}{{ADDRESSTO_ADDRESS}}{{endif}}
{{if ADDRESSTO_LOCATION}}{{ADDRESSTO_LOCATION}}{{endif}}
Fax #: {{ADDRESSTO_FAX}}

Regarding Employee:
{{CLAIMANT_FIRSTNAME}}
{{CLAIMANT_LASTNAME}}
{{CLAIMANT_ADDRESS}}

Claim Number: {{CLAIM_CLAIMNUMBER}}
DOI: {{CLAIM_INJURYDATE}}
Client: {{CUSTOMER_NAME}}
Claims Adjuster: {{ADJUSTER_NAME}}
Phone: {{ADJUSTER_PHONENUMBER}}

Reference #: {{REFERRAL_REFERRALNO}}

Dear {{ADDRESSTO_NAME}}{{if ADDRESSTO_CREDENTIAL }} {{ADDRESSTO_CREDENTIAL}}{{endif}},

The {{REFERRAL_SOURCEREFERRALDATE}} request for medical treatment was first received on {{REFERRAL_DATERECEIVEDBYADJUSTER}} and reviewed{{if CALIFORNIA}} in accordance with Title 8, California Code of Regulations section 9792.9.1{{endif}}. On **{{REVIEW_COMPLETIONDATE}}** a decision was made regarding the requested medical treatment.

The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision	Authorized Provider
{{loop TREATMENTREQUESTS}} {{TreatmentRequestNumber}}	{{Description}} QTY: {{RequestedQuantity}} {{if IsMedication}} Refills: {{RequestedRefills}} {{endif}}	{{DeterminedDescription}} Qty:{{ DeterminedRequestedQuantity}}{{if IsMedication}}Refills: {{DeterminedRequestedRefills}}{{endif}}	{{**RequestDetermination**}}	{{if Approval}}{{if ProviderContact}}{{if ProviderContact.IsPreferred}}{{ ProviderContact.Name}}{{if ProviderContact.PhoneNumber}}{{ProviderContact.PhoneNumber}}{{endif}}{{endif}}{{endif}}{{endif}}{{endloop}}

If indicated above, all approved medications are authorized in generic form, except where brand is specifically requested, medically necessary, or no generic equivalent exists.

{{if RIN}}**Date Request for Information Issued via Fax:** {{DATERINSENT}}
Date Requested Information Received, if applicable: {{DATERINREVEIVED}}
Description of Information Requested: {{RINDetails}}{{endif}}

If your employer is enrolled in a Medical Provider Network (MPN), indicated above as applicable, all approved services must be scheduled within the Network, unless otherwise authorized by your claims adjuster.

***All authorized services are subject to bill review upon receipt of the invoice. Authorization by UR is limited solely to the medical necessity of the treatment(s) requested on the CA Form RFA and does not constitute agreement to, approval of, any billed charges, reimbursement rates, pricing terms, or financial conditions referenced on the RFA or otherwise referenced by the provider.*

*Reimbursement shall be made in accordance with the applicable California Official Medical Fee Schedule (OMFS), contracted rates, and/or all governing statutes and regulations in effect on the date of service. Charges exceeding allowable amounts under the OMFS or applicable contract are not authorized and are expressly disputed.***

The portion approved for this request, if any, expires on {{REVIEW_COMPLETION_ADDDAYS_180}}. Extensions or changes in the treatment plan will require additional requests for authorization.

Reports Reviewed:
{{loop LINKEDDOCUMENTS}}{{if IsDocumentIn}} {{ReportDate}} – {{Title}} {{endloop}}

Rationale:
{{loop TREATMENTREQUESTS}}**Regarding the request for {{Description}}:**
Per Evidence-based medical guidelines: {{DeterminedReviewGuideline}}
Based on the guidelines cited above: {{DeterminedReviewRational}}
{{endloop}}

Please note the utilization review process is mandatory and has been done in accordance with California Labor Code Section 4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.6.1(q).

A utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical necessity shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician, 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.

DISPUTE RESOLUTION:
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 previously provided Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.

Notice to Injured Worker:

"You have the right to disagree with the decision affecting your claim. If you have questions about the information in this notice, please call me, {{ADJUSTER_NAME}} at {{ADJUSTER_PHONENUMBER}}. However, if you are represented by an attorney, please contact your attorney instead of me."

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

Notice to Requesting Physician:

In accordance with regulation section 9792.9.1(e)(14), if the requesting physician wishes to speak to the reviewing physician regarding the determination, you can call Athens Managed Care at (877) 494-4300 to arrange an agreed

upon scheduled time between the hours of 9:00am and 5:30pm, PST, Monday through Friday. Should the reviewing physician be unable to speak to you during the scheduled time, you may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Sincerely,

{{SIGNEDBY_SIGNATURE }}
{{SIGNEDBY_NAME }}
{{SIGNEDBY_CREDENTIAL}}
{{if SIGNEDBY_PHONENUMBER}}Phone: {{ SIGNEDBY_PHONENUMBER}}{{endif}}
{{if SIGNEDBY_EMAIL}}Email: {{ SIGNEDBY_EMAIL}}{{endif}}
Utilization Review Department Hours of Availability: Monday through Friday, 8am to 5:30pm

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

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

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

Type of Utilization Review:

Regular ☐ Expedited ☐ Modification after Appeal ☒

Medication Only – MTUS Formulary Drug List ☐ Retrospective for Exempt Treatment (Non-Drug) ☐ Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter:

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

Reason:

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

9.

10.

11.

12.

Request for Review and Consent to Obtain Medical Records

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

Employee Signature Date

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☐30 days from the mailing date of the written determination letter.

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

INSTRUCTIONS FOR COMPLETNG THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

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

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

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

- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.

- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.

- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.

- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

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

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

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

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.

- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.

- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.

- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

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

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

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

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

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

Employee Signature:		Date:

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

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

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

PROOF OF SERVICE

I am a citizen of the United States and employed in the county where the mailing occurred; my business address is: **2552 Stanwell Drive, Concord, CA 94520**. I am over the age of eighteen years and not a party to the within entitled action.

I served the within letter(s) on the parties in said action, either by facsimile or electronic mail where indicated, or by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Concord, California, addressed where indicated.

If fax transmissions fail, letters will be sent via US Mail to the addresses listed below.

{{CLAIMANT_FIRSTNAME}} {{CLAIMANT_LASTNAME}}
{{CLAIMANT_ADDRESS1}}, {{CLAIMANT_ADDRESS2}}
{{CLAIMANT_CITY}}, {{CLAIMANT_STATE}} {{CLAIMANT_POSTALCODE}}

{{REQUESTINGPHYSICIAN_FIRSTNAME}} {{REQUESTINGPHYSICIAN_LASTNAME}}
{{REQUESTINGPHYSICIAN_CREDENTIALS}}
{{REQUESTINGPHYSICIAN_ADDRESS1}}, {{REQUESTINGPHYSICIAN_ADDRESS2}}
{{REQUESTINGPHYSICIAN_CITY}}, {{REQUESTINGPHYSICIAN_STATE}}
{{REQUESTINGPHYSICIAN_ZIP}}
Fax: {{REQUESTINGPHYSICIAN_FAX}}

{{ADJUSTER_FIRSTNAME}} {{ADJUSTER_LASTNAME}}
P.O. Box 4010
Concord, CA 94524

{{APPLICANTATTORNEY_FIRSTNAME}} {{APPLICANTATTORNEY_LASTNAME}}
{{APPLICANTATTORNEY_LOCATION}}
{{if APPLICANTATTORNEY_FAX}}Notified Via Fax: {{APPLICANTATTORNEY_FAX}}{{endif}}
{{if not (APPLICANTATTORNEY_FAX)}}Notified via mail: {{APPLICANTATTORNEY_ADDRESS1}},
{{APPLICANTATTORNEY_ADDRESS2}}
{{APPLICANTATTORNEY_CITY}}, {{APPLICANTATTORNEY_STATE}}
{{APPLICANTATTORNEY_ZIP}}{{endif}}{{endif}}

{{DEFENSEATTORNEY_FIRSTNAME}} {{DEFENSEATTORNEY_LASTNAME}}
{{DEFENSEATTORNEY_LOCATION}}
{{if DEFENSEATTORY_FAX}}Notified Via Fax: {{DEFENSEATTORNEY_FAX}}{{endif}}
{{if not (DEFENSEATTORNEY_FAX}}Notified via mail: {{DEFENSEATTORNEY_ADDRESS1}},
{{DEFENSEATTORNEY_ADDRESS2}}
{{DEFENSEATTORNEY_CITY}}, {{DEFENSEATTORNEY_STATE}}
{{DEFENSEATTORNEY_ZIP}}{{endif}}{{endif}}

Executed on **{{REVIEW_COMPLETIONDATE}}**.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

{{PRIMARYREVIEWER_NAME}}
{{PRIMARYREVIEWER_SIGNATURE}}
Signature

File:{{REFERRAL_REFERRALNO}}
Enclosures: Athens Determination and DWC Form IMR

INFORMATION REQUEST LETTER

Request for Information Notice

Referral No: {{REFERRAL_REFERRALNO}}
Claimant Name: {{CLAIMANT_FIRSTNAME}} {{CLAIMANT_LASTNAME}}
Claim No: {{CLAIM_CLAIMNUMBER}}
Date of Birth: {{CLAIM_BIRTHDATE}}
Request Date: {{CLAIM_INJURYDATE}}
Due Date: {{CLAIM_JURISDICTIONDUEDATE}}
Requesting Physician: {{REQUESTINGPHYSICIAN_FIRSTNAME}} {{REQUESTINGPHYSICIAN_LASTNAME}}
Requested Treatment:

- {{loop TREATMENTREQUESTS}}

Please provide the following information no later than {{RIN DUEDATE}} to complete the request for authorization.

1. {{loop REQUESTEDINFORMATION}}

Please reply to this message with the requested information or fax to {{PRIMARYREVIEWER_FAX}}.

Athens Managed Care has been asked to review the below noted treatment request for medical necessity and appropriateness.

{{PRIMARYREVIEWER_NAME}}

Phone: {{PRIMARYREVIEWER_PHONE}}
Fax: {{PRIMARYREVIEWER_FAX}}
Email: ur@athensmci.com

PROOF OF SERVICE

I am a citizen of the United States and employed in the county where the mailing occurred; my business address is: **2552 Stanwell Drive, Concord, CA 94520**. I am over the age of eighteen years and not a party to the within entitled action.

I served the within letter(s) on the parties in said action, either by facsimile or electronic mail where indicated, or by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Concord, California, addressed where indicated.

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{{REQUESTINGPHYSICIAN_CREDENTIALS}}
{{REQUESTINGPHYSICIAN_ADDRESS1}}, {{REQUESTINGPHYSICIAN_ADDRESS2}}
{{REQUESTINGPHYSICIAN_CITY}}, {{REQUESTINGPHYSICIAN_STATE}}
{{REQUESTINGPHYSICIAN_ZIP}}
Fax: {{REQUESTINGPHYSICIAN_FAX}}

{{ADJUSTER_FIRSTNAME}} {{ADJUSTER_LASTNAME}}
P.O. Box 4010
Concord, CA 94524

{{APPLICANTATTORNEY_FIRSTNAME}} {{APPLICANTATTORNEY_LASTNAME}}
{{APPLICANTATTORNEY_LOCATION}}
{{if APPLICANTATTORNEY_FAX}}Notified Via Fax: {{APPLICANTATTORNEY_FAX}}{{endif}}
{{if not (APPLICANTATTORNEY_FAX)}}Notified via mail: {{APPLICANTATTORNEY_ADDRESS1}},
{{APPLICANTATTORNEY_ADDRESS2}}
{{APPLICANTATTORNEY_CITY}}, {{APPLICANTATTORNEY_STATE}}
{{APPLICANTATTORNEY_ZIP}}{{endif}}{{endif}}

{{DEFENSEATTORNEY_FIRSTNAME}} {{DEFENSEATTORNEY_LASTNAME}}
{{DEFENSEATTORNEY_LOCATION}}
{{if DEFENSEATTORY_FAX}}Notified Via Fax: {{DEFENSEATTORNEY_FAX}}{{endif}}
{{if not (DEFENSEATTORNEY_FAX}}Notified via mail: {{DEFENSEATTORNEY_ADDRESS1}},
{{DEFENSEATTORNEY_ADDRESS2}}
{{DEFENSEATTORNEY_CITY}}, {{DEFENSEATTORNEY_STATE}}
{{DEFENSEATTORNEY_ZIP}}{{endif}}{{endif}}

Executed on **{{REVIEW_COMPLETIONDATE}}**.

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

{{PRIMARYREVIEWER_NAME}}
{{PRIMARYREVIEWER_SIGNATURE}}
Signature

File:{{REFERRAL_REFERRALNO}}
Enclosures: Request for Information Letter