GBCARE LLC

CA UTILIZATION REVIEW PLAN

DWC PLAN ID 015

SUBMISSION DATE: APRIL 21, 2025

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IV Purpose and Scope

It is the policy of GBCARE, LLC to conduct all utilization review requests within the guidelines of California UR Labor Code Sections 4600.4, 4604.5, and 4610. This UR plan has been updated to pursuant to revised regulations effective April 1, 2026.

URAC has officially awarded a certificate of full accreditation to GBCARE, LLC in Workers'Compensation Utilization Management Standards.

The review process, which is periodically reviewed and updated, includes:

- screening of requested procedure/service(s) and medical information by a licensed registered nurse
- utilization of MTUS (Medical Treatment Utilization Schedule) and subsequent updates as the primary guideline and the American College of Occupational and Environmental Medicine (ACOEM) Occupational Medicine Practice Guidelines and nationally recognized screening criteria and treatment guidelines
- verbal and written notification of UR determinations to the injured employee, or designated representative, the ordering provider, facility, and claims administrator
- review determinations which result in modification, or denial of requests for authorization of medical treatment are made by a licensed physician
- an opportunity for the ordering provider to discuss requested procedure/service and rationale with a peer reviewer

GBCARE LLC's UR plan is available to the public upon request. There is no copying fee.

V Definitions

- *Authorization* means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed "Request for Authorization," as defined in this section, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, sections 9792.9.1 through 9792.12.
- *Concurrent Review* means utilization review conducted during an inpatient stay.
- *Denial* means a decision by a physician reviewer that the requested treatment or service is not authorized.
- *Dispute of Liability or Liability Dispute* 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.
- *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. Failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request.

- *Expedited review* means utilization review or independent medical review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.
- *Expert Reviewer* means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of 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.
- *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.
- *Modification* means a decision by a physician reviewer that part of the requested treatment or service is not medically necessary.
- *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.
- *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.
- *Normal Business Day / Working 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.
- *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.
- *Retrospective Review* means utilization review conducted after medical services have been provided and for which approval has not already been given.
- *Request for Authorization* means a written request for a specific course of proposed medical treatment that meets all of the following criteria:
  (1) Unless accepted by a claims administrator under section 9792.9.1(b), a request for authorization must be set forth on a “Request for Authorization (DWC Form RFA)” as contained in California Code of Regulations (CCR), title 8, section 9785.5, completed by a treating physician and as further outlined in this subdivision and in section 9785(h).
  (2) “Completed,” for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization identifies both the employee and the requesting provider; identifies with specificity all the recommended treatments in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used; and is accompanied

by documentation, issued or created no earlier than 30 days before the date of submission of the request for authorization, that substantiates the need for the requested treatment. A request for authorization shall be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.6.
(3) The request for authorization must be signed by the treating physician and may be mailed, faxed, or, if available, sent electronically through the use of an encrypted email system or via electronic data interchange (EDI) to the address, fax number, e-mail address, or clearinghouse designated by the claims administrator under section 9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

- *Utilization Review Plan* means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.
- *Utilization Review Process* means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. The utilization review process begins when 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.

VI Utilization Review Process

General Procedures and Intake Process

1. Submission of Requests for Authorization

Unless accepted by a claims administrator under section 9792.9.1(b), a request for authorization must be set forth on a “Request for Authorization (DWC Form RFA)” as contained in California Code of Regulations (CCR), title 8, section 9785.5, completed by a treating physician and as further outlined in this subdivision and in section 9785(h). A DWC Form RFA missing the following information may be treated as incomplete:

- Does not identify the employee
- Does not identify the requesting provider
- Does not identify all the recommended treatments with specificity
- is not accompanied by documentation substantiating the medical necessity for the requested treatment
- is not signed by the requesting physician

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 requirements in this article 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. A request for authorization accepted as complete shall be subject to investigation under section 9792.11 and the assessment of administrative penalties under section 9792.12. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed request for authorization.

A request for authorization shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile, electronic mail, or by electronic data interchange on the date the form was received according to the date stamp in the UR system. A request for authorization transmitted by facsimile, electronic mail, or electronic data interchange after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review. All faxed requests will indicate the date, time and place of transmission and the facsimile telephone numbers submitted from and to. Emailed requests will contain an image of the transmitted email along with the date time and emails addresses submitted from and to. Request for authorization that are sent by mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator five (5) business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service. If sent by certified mail the request shall be deemed to have been received by the claims administrator on the receipt date entered on the return receipt. In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the request for authorization shall be deemed to have been received by the claims administrator five days after the latest date the sender wrote on the document.

Requests for authorization can be submitted to GBCARE by the following methods:

- Mailing to: GBCARE, LLC 337 Riverside Dr, Suite 400 Franklin, TN 37064
- Faxing to: 615-778-5135
- Emailing via secured email to: GBCARE_UR_Referrals@gbtpa.com
- Telephone access at 888-878-6012. This number has a representative available from 9AM to 5:30PM Pacific Time on business days. There is the ability to leave a voicemail after business hours which is returned by the GBCARE UR department within 4 business hours.

2. Acknowledgement of Receipt

All RFAs received via fax and email by GBCARE are entered into our UR system and assigned a unique identifier so that all incoming referrals can be tracked. Acknowledgement of receipt of the request is transmitted to the Gallagher Bassett claim system, so the claims administrator is aware of the UR receipt of an RFA.

3. Tracking and Logging

All RFAs are entered into our UR system, asap, and assigned a unique record number. Initial logging of the request includes the time stamp of receipt of the request by the UR department and manual entry of

the date/time the request was received by the claims administrator. The disposition of all incoming requests can be tracked via the asap system.

Dispute of Liability; Deferral (§9792.9.2)

Utilization review of a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity. Dispute of 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.

A request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change. Such a request must be reviewed by a physician reviewer and any modification or denial of the request must comply with applicable requirements as set forth at section 9792.9.5.

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

(1) The date on which the request for authorization was first received.

(2) A description of the specific course of proposed medical treatment for which authorization was requested.

(3) A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.

(4) A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

(5) The following mandatory language advising the injured employee:

"You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me."

and

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

Timeframe for Decision Making (§9792.9.3)

The first day in counting any timeframe requirement is the first normal business or working day after receipt of the completed or accepted as complete request for authorization, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the request for authorization.

Expedited Prospective/Concurrent Requests: Requests involving urgent care or life-threatening conditions when the injured employee's condition is such that he/she faces an imminent and serious threat to his/her health, including, but not limited to, the potential for loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making (i.e. prospective or concurrent review) process, would be detrimental to the injured employee's life or health or could jeopardize his/her ability to regain maximum function, decisions to approve, modify or deny requests for treatment or services shall be made in a timely fashion appropriate for the injured employee's condition, *but* not to exceed 72 hours after receipt of the information 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.

Prospective or Concurrent Review: Prospective or concurrent reviews for approval, modification, or denial of services and treatment shall be completed in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the written request for authorization . If "appropriate information which is necessary to make a determination" was not included with the authorization request, then this information may be requested within the initial five (5) day period. In no event shall the determination be made more than 14 days from the receipt of the original request for authorization by the health care provider.

Any decision to deny authorization for concurrent treatment shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.

Retrospective Review: The determination (approval, denial, or modification) shall be communicated to the injured employee or his/her designee, within thirty (30) days of receipt of necessary information to make the determination.

VII Notices for Initial Decisions

Written Decision Content Requirements

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

All written decisions to approve a request for authorization shall specify the date the complete, or accepted as complete, request for authorization was first received, the medical treatment service requested, the specific medical treatment service approved, and the date of the decision. If applicable, the written decision shall also include the date the request for information, exam, or consultation under section 9792.9.6, subdivision (a)(1)(A), (B), or (C) was requested, and the date the information was received.
For approvals of a request for authorization of a drug where the request for authorization did not indicate "Do Not Substitute" or "Dispense as Written," the written decision approving the request in generic form shall indicate, "generic substitute authorized" or words to that effect and meaning.
For approvals of a request for authorization of a drug that is exempt on the Drug Formulary, the written decision approving the request shall indicate, "Exempt per MTUS Drug Formulary" or words to that effect and meaning.

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

Decisions to Modify or Deny: For prospective, concurrent, or expedited review, a decision to modify or deny a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. Written communication of the decision shall issue to the injured worker, and, if applicable, to the injured worker's representative within 24 hours of the decision for concurrent review, within two (2) business days for prospective review, and, for expedited review, within 72 hours of receipt of the request. Written communication in accordance with this paragraph shall also issue to the requesting physician where the initial communication of the decision to the physician was by telephone.
For retrospective review, a written decision to deny part or all of the requested medical treatment based on medical necessity 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 the receipt of the request for authorization and information that is sufficient for a reviewer to make a determination as to whether the treatment was medically necessary.

The written decision modifying or denying treatment authorization, shall be provided to the requesting physician, the injured worker, and, if applicable, the injured worker's representative and/or attorney. The written decision shall be signed by either the claims administrator or the physician reviewer, and shall only contain the following information specific to the request:
(1) The date on which the completed or accepted request for authorization was first received.
(2) If the timeframe for decision was extended, 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 were requested; the manner in which the requests were made; and the date the information was first received.
(3) The date on which the decision is made.
(4) A description of the specific course of medical treatment set forth on the request for authorization.
(5) A list of all medical records reviewed.
(6) A specific description of the medical treatment service approved, if any.
(7)(A) 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.
(B) 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.
(8) For decisions based on medical necessity, a citation to and a description of the relevant medical criteria or guidelines used to reach the decision.
(9) Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.
(10) 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.
(11) 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.
(12) 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."
and
"For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."
(13) 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.
(14) 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.

Extension of Timeframe for Decision

If additional information is needed in order to make a determination, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization. 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 information reasonably necessary to make a determination under subdivision (a) (1)(A) that is 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 in accordance with applicable rules in section 9792.9.5(e). If the results of the additional examination or test required is not received within thirty (30) days from the date of the request for authorization, the reviewer shall deny the treating physician's request.

Upon receipt of the requested information, 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. For expedited reviews, the decision to

approve, modify, or deny the request for authorization must be made within 72 hours of receipt of the information. For retrospective reviews, the decision to approve, modify or deny the request for authorization must be made within thirty (30) calendar days of receipt of the information.

MTUS Drug Formulary Decisions

For Non-exempt drugs, the treating physician must request authorization through prospective utilization review by submitting a request for authorization. Prospective decisions to approve, modify, or deny a request for authorization for a non-exempt drug shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the request for treatment. The reviewer or non-physician reviewer may request the treating physician to provide additional information reasonably necessary to make a determination within four (4) business days from the date of receipt of the request for authorization. If the information is not received within five (5) business days from the date of the request for authorization of treatment, a physician reviewer may deny the request. An extension of the determination timeframe is not allowed for these drugs.

Duplicate requests

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. A request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change. If the requesting physician indicates a material change in facts, the request must be reviewed by a physician reviewer.

VIII Utilization Review Criteria

Medical Necessity

GBCARE, LLC will cite MTUS and subsequent updates as the primary treatment guideline. For all conditions or injuries not addressed in the MTUS, the authorized treatment and diagnostic services in the initial management and subsequent treatment for presenting complaints shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community.

In providing treatment using other guidelines and in the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines shall apply and supersede any applicable chronic pain guideline in accordance with section.

The American College of Occupational and Environmental Medicine (ACOEM) Guidelines are to be applied to the medical conditions addressed by said treatment guidelines. These guidelines and criteria are mandatory components of the UR program. Nationally recognized sources of treatment guidelines and review criteria will be utilized for medical conditions not covered by the ACOEM guidelines.
Postoperative Rehabilitation Guidelines: Guidance for postoperative rehabilitation treatment and evaluation are contained in the Clinical Topics guidelines, and/or Chronic Pain Guideline and/or Opioid Guideline. The post-operative rehabilitation treatment recommendations apply to visits during the post-operative period only and to surgeries as defined in those guidelines. At the conclusion of the post-operative period, treatment reverts back to the applicable 24-visit limitation for chiropractic, occupational therapy, and physical therapy pursuant to Labor Code section 4604.5(c)(1).
GBCARE, LLC's UR department utilizes these nationally recognized sources for medical management criteria and guidelines, in addition to the ACOEM guidelines:

Work Loss Data Institute: Official Disability Guidelines

MD Guidelines by The Reed Group (includes ACOEM)

All pertinent medical management criteria and guidelines are developed with input from appropriate health care providers, periodically evaluated, at least annually, and updated, accessible to the UR staff, and available to the public upon request. The screening criteria are flexible enough to allow deviations from the norm when justified on a case-by-case basis and in special circumstances.

Authorized Treatment

The nurse reviewer reviews the request and submitted medical information, within one (1) business day of receipt of the UR request, for appropriateness of setting and duration of treatment. If additional information is needed, the nurse reviewer contacts the ordering provider for additional subjective and objective necessary medical information or to verify the proposed treatment plan within 5 business days of receipt of the UR requests.
When conducting utilization review, only that information that is necessary to complete the review will be requested. This information may include, but is not limited to, identifying information about the injured employee, the ordering provider &/or facility, medical information regarding the diagnosis(es) of the injured employee & his/her medical history relevant to the diagnosis(es) and the compensable injury, the injured employee's prognosis, and the prescribed treatment plan along with the provider's justification for the treatment plan. The UR staff will not routinely require hospitals and providers to supply numerically coded diagnoses and procedures. If the plan of treatment and submitted medical information or treatment plan does not meet the criteria for appropriateness and medical necessity, the nurse reviewer shall refer the case to a peer reviewer for review. Only a licensed physician reviewer may modify or deny requests for authorization of medical treatment for reasons of medical necessity.

First 30-Day Exemption

A treating physician may render medically necessary treatment or services to an injured worker without prospective utilization review for the first thirty (30) days after the date of injury, provided that the treatment or service is for a body part or condition that has been accepted as compensable by the claims administrator; treatment or service is consistent with the recommendations set forth in the

applicable guideline of the MTUS; the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021 has been timely submitted; any anticipated treatment or services have been submitted on a request for authorization form; the bill for treatment has been submitted within 30 days of the service date.

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

(1) Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.

(2) Nonemergency inpatient and outpatient surgery, including all pre-surgical and postsurgical services.

(3) Psychological treatment services.

(4) Home health care services.

(5) Imaging and radiology services, excluding X-rays.

(6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule.

(7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.

(8) Spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections.

GBCARE, LLC may perform retrospective utilization review for any treatment provided solely for the purpose of determining if the physician is prescribing treatment consistent with the schedule for medical treatment utilization, including, but not limited to, the drug formulary . If it is found after retrospective utilization reviews that there is a pattern and practice of the physician or provider failing to render treatment consistent with the schedule for medical treatment utilization, including the drug formulary, the employer may remove the ability of the predesignated physician, employer-selected physician, or the member of the medical provider network or health care organization under this subdivision to provide further medical treatment to any employee that is exempt from prospective utilization review. The employer shall notify the physician or provider of the results of the retrospective utilization review and the requirement for prospective utilization review for all subsequent medical treatment.

The results of retrospective utilization review may constitute a showing of good cause for an employer’s petition requesting a change of physician or provider pursuant to Section 4603 and may serve as grounds for termination of the physician or provider from the medical provider network or health care organization.

The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. For treatment

rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer-selected physician, the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.

Drug Authorization

Drugs prescribed or dispensed to treat a work related injury or illness fall within Labor Code section 4600's definition of medical treatment and are subject to the relevant provisions of the MTUS. The MTUS Drug list must be used when prescribing medications. The MTUS Drug list must be used in conjunction with MTUS guidelines which contain specific treatment recommendations based on condition and phase of treatment and the drug formulary rules.

The MTUS Drug List includes Exempt, Non-Exempt and Unlisted Drugs. All of these categories of drugs are permitted to be used to treat injured works provided the usage of the drug is within MTUS guidelines and appropriate approval is obtained. If a generic drug is available for treatment of the injured worker's condition, then generic is given preference over brand name. Lower cost drugs are also preferred over higher costs therapeutic equivalent medications.

"Exempt drug" means a drug on the MTUS Drug List which is designated as being a drug that does not require authorization through prospective review prior to dispensing the drug, provided that the drug is prescribed in accordance with the MTUS Treatment Guidelines.

"Non-Exempt drug" means a drug on the MTUS Drug List which is designated as requiring authorization through prospective review prior to dispensing the drug

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

Utilization Review per MTUS Drug Formulary:

Physician Dispensed: Drugs dispensed by a physician must be authorized through prospective review prior to being dispensed, except as provided in subdivision (b), section 9792.27.12 ("Special Fill"), and section 9792.27.13 ("Perioperative Fill"). A physician may dispense up to a seven-day supply of one or more drugs that are designated as "Exempt" in the MTUS Drug List without obtaining authorization through prospective review, if the drug treatment is in accordance with the MTUS Treatment Guidelines and the up-to-seven-day supply is dispensed at the time of an initial visit that occurs within 7 days of the date of injury.

Compounded Drugs: Compounded drugs must be authorized through prospective review prior to being dispensed. When it is necessary for medical reasons to prescribe or dispense a compounded drug instead of

an FDA-approved drug or over-the-counter drug that complies with an OTC Monograph, the physician must document the medical necessity in the patient's medical chart, and in the Doctor's First Report of Injury (Form 5021) or Progress Report (PR-2) and must submit a Request for Authorization. The documentation must include the patient-specific factors that support the physician's determination that a compounded drug is medically necessary.

Exempt Drugs: A drug that is identified as "Exempt" may be dispensed to the injured worker without obtaining authorization through prospective review if the drug treatment is in accordance with the MTUS Treatment Guidelines, except:
(1) Brand name drugs are subject to section 9792.27.7;
(2) Physician-dispensed drugs are subject to section 9792.27.8.
(3) Compounded drugs are subject to section 9792.27.9 even if one or more of the ingredients is listed as "Exempt" on the MTUS Drug List.
Non-Exempt Drugs: For a drug that is identified as "Non-Exempt," authorization through prospective review must be obtained prior to the time the drug is dispensed. Expedited review should be conducted where it is warranted by the injured worker's condition.
Special Fill or Perioperative Fill: For a drug that is identified as eligible for "Special Fill" or "Perioperative Fill", the usual requirement to obtain authorization through prospective review prior to dispensing the drug is altered for these specified circumstances.
The drug identified as a Special Fill drug may be dispensed to the injured worker without seeking prospective review if all of the following conditions are met:
(1) The drug is prescribed at the single initial treatment visit following a workplace injury, provided that the initial visit is within 7 days of the date of injury;
(2) The prescription is for a supply of the drug not to exceed the limit set forth in the MTUS Drug List;
(3) The prescription for the Special Fill – eligible drug is for:
(A) An FDA-approved generic drug or single source brand name drug, or,
(B) A brand name drug where the physician documents and substantiates the medical need for the brand
name drug rather than the FDA-approved generic drug
(4) The drug is prescribed in accordance with the MTUS Treatment Guidelines.
(c) When calculating the 7-day period in subdivision (b)(1), the day after the date of injury is "day one."
Perioperative Fill: the Non-Exempt drug identified as a Perioperative Fill drug may be dispensed to the injured worker without seeking prospective review if all of the following conditions are met:
(1) The drug is prescribed during the perioperative period
(2) The prescription is for a supply of the drug not to exceed the limit set forth in the MTUS Drug List
(3) The prescription for the Perioperative Fill - eligible drug is for:
(A) An FDA-approved generic drug or single source brand name drug, or,
(B) A brand name drug where the physician documents and substantiates the medical need for the brand name drug rather than the FDA-approved generic drug
(4) The drug is prescribed in accordance with the MTUS Treatment Guidelines.
(b) For purposes of this section, the perioperative period is defined as the period from 4 days prior to surgery to 4 days after surgery, with the day of surgery as "day zero".
Unlisted Drug: For an unlisted drug, authorization through prospective review must be obtained prior to the time the drug is dispensed. A combination drug that is not on the MTUS Drug List is an unlisted drug even if the individual active ingredients are on the MTUS Drug List.
Off-Label Use: means use of a drug for a condition, or in a dosage or method of administration, not listed in the drug's FDA-approved labeling for approved use. Authorization through prospective review is

not required to dispense an Exempt drug for an off-label use if the MTUS Treatment Guideline recommends the off-label use of the drug to treat the condition.
(c) Authorization through prospective review is required prior to dispensing the following drugs for an offlabel use:
(1) Non-Exempt drug, or
(2) Unlisted drug, or
(3) Exempt drug lacking recommendation in the MTUS Treatment Guideline for the intended off-label use.

Letter of Authorization Program

GBCARE has created a Letter of Authorization (LOA) program in collaboration with the claims department at Gallagher Bassett. For all Gallagher Bassett clients, all CA RFA forms are forwarded to the UR department for review. If the treatment requested by the provider is for a compensable body part and is on the LOA treatment list, the UR system will enter an auto-approval for the treatment and send the LOA Approval letter to all relevant parties. If the treatment is not on the LOA list or the body part is not compensable, the auto approval will not trigger and the referral will be assigned to a First Level UR nurse for review utilizing our standard UR process as outlined above. The UR system will track all auto approvals to review against subsequent treatment requests to determine if eligibility is met or if escalation to a UR nurse is required.
The LOA treatments are as follows:

- Initial 12 sessions of PT/OT
- Initial 12 sessions of Chiropractic Treatment
- Initial 6 visits of Acupuncture
- Xrays/CT Scans/MRIs
- Office Visit/Consultations
- DME<$500
- EMG/NCV Nerve Conduction Studies
- Outpatient Laboratory, including Urine Drug Screens

IX Appeal and Independent Review

Internal Appeal

GBCARE participates in an internal review process. The internal appeals process neither triggers nor bars the use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may pursued on an optional basis. The internal appeal process is voluntary and the process and timeframes for appeal and independent medical review are included within determination letters provided to the employee and, if the employee is represented by counsel, the employee's attorney. Any request by the injured worker or treating physician for an internal utilization review appeal process conducted under this subdivision must be submitted to the claims administrator within ten (10) days after the receipt of the utilization review decision.

A request for an internal utilization review appeal must be completed, and a determination issued, by the claims administrator within thirty (30) days after receipt of the request. If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the internal utilization review appeal must be completed, and a determination issued, by the claims administrator within ten (10) days after receipt of the request). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6(e) that determines the medical necessity of the disputed treatment.
Any determination by the claims administrator following an internal utilization review appeal that results in a modification of the requested medical treatment shall be communicated to the requesting physician and the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney. The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter must indicate that the decision is a modification after appeal.
Appeals are identified in the UR system. The assigned UR nurse reviews the appeal for any additional information that may have been submitted in response to the initial denial/modification. If the appeal request provides additional documentation to overturn the initial denial/modification, the UR nurse will issue an approval. If the additional documentation does not support overturn the initial decision, the nurse will submit the appeal to a physician reviewer. The physician reviewer will be of the same or similar specialty of the requesting physician and will not be the same reviewer who provided the initial determination.

Independent Medical Review

A request for independent medical review of a utilization review decision that denies or modifies a medical treatment request must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days of service of the written utilization review determination. If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the request for independent medical review must be filed by the eligible party within 10 days of service of the written utilization review decision.
For regular review of a medical treatment dispute, other than a dispute that only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the independent review organization shall complete its review and make its final determination within thirty (30) days of the receipt of the Application for Independent Medical Review, DWC Form IMR, and the supporting documentation. For expedited review where the disputed medical treatment has not been provided, the independent review organization shall complete its review and make its final determination within three (3) days of the receipt of the Application for Independent Medical Review, DWC Form IMR. For review of a dispute that only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the independent review organization shall complete its review and make its final determination within five (5) business days of the receipt of the Application for Independent Medical Review, DWC Form IMR.

X Personnel and Qualifications

Medical Director

GBCARE's Medical Director is William Abraham, MD. Dr Abraham is a Board-certified Orthopedic Surgeon with over 25 years of experience in treating Workers' Compensation patients. His CA License number is G88042. His mailing address is 377 Riverside Drive, Suite 400, Franklin TN 37064. His phone number is 615-778-5080 and his fax number is 615-778-5135.

Qualifications for GBCARE, LLC.'s Senior Physician Advisor (Medical Director) include the following:

- Board certification in their specialty
- Active medical license in good standing within their state of practice
- Minimum of five (5) years active experience
- Orientation in principles and procedures of utilization management, peer review, and Workers' Compensation utilization management standards
- Malpractice insurance, as required minimum by specialty in state(s) of licensure; verification of amount with state agency completed at hire.

The UR Program's Senior Physician Advisor (Medical Director), with professional post-residency experience in direct patient care, oversees the UR process to ensure compliance with California Labor Code regulations for the UR process.

Physician Reviewers

Determinations to modify or deny requested treatment require review by licensed Physician reviewers as UR nurses are not permitted to deny or modify treatment requests based on medical necessity. GBCARE, LLC's UR department contracts with URAC Accredited peer advisor groups, which provide access to over 200 peer advisors. The peer advisors in these groups are in active practice and board certified and/or board eligible in their respective specialties. These advisors also have substantial UR experience. Each Physician/Peer Advisor group's professional staff:

- Are oriented and highly skilled in utilization management, URAC W/C standards, and peer review.
- Are in active practice and qualified to render a clinical opinion about the medical condition, procedures, and treatment under review; and
- Hold a current, unrestricted license in a state of the United States; the majority are board certified
- Are in the same licensure category and/or specialty of the attending physician or ordering provider.

The training and credentialing of the physician/chiropractic advisors are the responsibility of the companies providing the advisory staff.

GBCARE, LLC subcontracts with these URAC Accredited Peer Review groups for the purpose of physician review:
Dane Street, LLC
7121 Fairway Drive Suite 102
Palm Beach Gardens, FL • 33418
Phone: 925-357-6830

Email: lmanka@danestreet.com

Network Medical Review Co. LTD.
4960 East State Street
Rockford, IL 61108
Contact Kyle Benning
Phone: 815 964-6334 ext. 241161
Fax 815-964-1162
Email: michelle.andjus@examworks.com

CareReview, Inc.
2221 E. Lamar Blvd, Suite 600,
Arlington, TX 76006
Phone:817-583-8140
Fax: 817-652-9802
Contact: Melissa Starnes
Email: melissa.starnes@carereview.com

Non-Physician Reviewers

Nurse Reviewers
The nurse reviewers are required to have current RN licensure, minimum of three (3) years recent clinical experience which includes medical-surgical or orthopedic nursing, utilization review, workers' compensation, or managed care experience, demonstrated knowledge of utilization review process, use of criteria & ICD-9/CPT codes, good oral and written communication skills, and proficiency in decision making, problem solving, and time management. CIRS or CCM, education or experience equivalence is preferred.
The nurse reviewers will participate in a three (3) week training program, under the direction of a nurse preceptor and the lead nurse with training materials selected and reviewed by the quality assurance committee.
The UR nurse reviewer's role in the process includes:

- collection of medical information
- evaluation of the plan of treatment for medical necessity and appropriateness
- criteria review
- facilitation of peer physician review for any treatment that cannot be approved as requested
- processing of recommendations
- certifying requests for treatment

Clerical Support
The clerical support staff is required to possess a high school degree or equivalence, demonstrated knowledge of the utilization review process, knowledge of medical terminology & ICD-9 & CPT codes, good oral and written communication skills, proficiency in decision making, problem solving, and time management, and computer and typing skills.
Clerical support staff will receive two (2) weeks of training in the utilization management site under the direction of a clerical support preceptor and the lead nurse.

The involvement of the non-clinical administrative (clerical support) staff in the Utilization Management process is limited to:

- Collection of non-clinical data and transfer of that data into the software system. From the caller, the clerical support staff unit obtains initial case data (injured employee/patient information, adjuster information, provider/facility information, requested treatment, proposed date of treatment, and initial diagnosis).
- The non-clinical administrative staff (clerical support) currently is not involved in the acquisition of any structured clinical data. All collection of medical information, criteria review, facilitation of peer review, and processing of recommendations is performed by the nurse reviewer.
- The clerical support staff currently is not involved in scripted clinical screening.
- Perform their duties in the UR process under the supervision of a currently licensed R.N**.**

XI Plan Submission and Modifications

This UR Plan is submitted to the DWC in a searchable electronic format with required attachments. Any material changes to the UR plan are submitted within 30 calendar days and may include Ownership changes and/or Medical Director changes.

GBCARE certifies that this utilization review plan, as modified, continues to be in compliance with the rules governing utilization review at sections 9792.6.1 through 9792.12. (See 9792.7(c)(4).

XII Quality Assurance & Compliance Monitoring

Internal Audits

GBCARE UR Staff Audits Monthly audits of both administrative and clinical staff are conducted by the QA team. Audits represent 10% of completed files from the prior month. Audits are based upon a compendium that has been reviewed and approved by the Quality and Operational teams for each department. The quality threshold is 95% accuracy on all audited parameters.

Audit tools will be created in collaboration with the QA and Operational teams. Parameters of the audit tool focus on data integrity, accuracy of documentation for non-clinical staff, with the addition of clinical assessment, clinical guideline application and jurisdictional regulatory compliance for the clinical staff. Audits are structured for each role within the UR department and the compendium for each role is shared with the affected staff. Internal calibration exercises will be held on a Quarterly basis to verify the accuracy of the audit tool and determine the effectiveness of the compendium. Files are selected randomly, and discussions focus on the variance between the auditor and whether updates are needed as far as parameters audited, points assessed for each parameter or the definition of the assessment parameter on the compendium

Individual audit results will be shared with individual staff members with an opportunity to discuss any audit findings to ensure understanding with the audit parameters and expectations. A rebuttal process

will exist for staff to escalate any parameters of the audit to be re-reviewed by the QA team. Coaching and retraining is provided for staff that do not meet the quality audit goals.

Audit results will be shared with the Quality Management Committee on a quarterly basis. The QM reports include the overall QA score for each role within UR, Action Plan for any scores below the acceptable threshold, timeframe for completion of action plans and trend analysis.

Peer Advisor Audits Monthly audits consisting of 10% of UM cases reviewed by an external peer advisor (PA) are conducted by the Senior Physician Advisor for timeliness, clinical documentation, and compliance with UM standards including peer outreach. Audit parameters include but are not limited to:

- Timeliness of decision in accordance with state/federal regulations or accreditation standards
- Physician Advisor decision/recommendation documented clearly
- Appropriate documentation of clinical rationale
- Guidelines/criteria/references noted
- Compliance with client specific requirements as noted in the referral
- If denied, Peer Reviewer made reasonable attempts to contact attending physician (minimum of 2 attending physician office contacts in 48 hours)
- If denied, names, dates, & times of contact attempts documented.

Monthly meetings will be held with each PA vendor to review audit results, timeliness metrics and any operational issues identified by the QA team. Both the operational and QA team of the PA vendor will be in attendance. Action plans and timelines for the PA group to address any audit and/or operational issues will be outlined during the meeting.

Accreditation Requirements
GBCARE, LLC has a valid URAC Workers' Compensation Utilization Management Accreditation and will continue to maintain accreditation.

Delegated UR Functions

GBCARE, LLC conducts utilization reviews on Gallagher Bassett claims.

Financial incentive policy
GBCARE's policy describes the basis for reimbursement, bonuses, or incentives to employees, health care providers, and subcontracted peer review agencies involved in the utilization review process. GBCARE,LLC does not permit or provide compensation or anything of value to its employees or agents, condition employment or its employee or agent evaluations, or set its employees or agent performance standards based on: the amount or volume of adverse determinations; reductions or limitations on lengths of stay, duration of treatment, medical benefits, services, or charges; or on the number of frequency of telephone calls or other contacts with health care providers or injured employees, which are inconsistent with provisions of state and federal regulations or statutes.

All employees of GBCARE, LLC. are compensated according to applicable federal and state laws in either the exempt or non-exempt categories as in company policy. Employees are prohibited from accepting gifts from vendors and providers according to the company code of conduct.

XII Documentation & Recordkeeping

Records Retention
The Utilization Review Department confidentially maintains all personal and medical records and injured employee and provider information in a manner that prevents unauthorized disclosure to third parties, and which is secure and limited in access to essential personnel only.
Historical medical records will be maintained in a secured storage area on-site for a minimum of two to five years and off-site for at least two years, with access limited to essential personnel only.
Records will be destroyed by a method that induces complete destruction of the information when it is determined that the administrative, regulatory, or legal justifications have elapsed.

Confidentiality
GBCARE executes business associate agreements with business associates as required by applicable jurisdictional laws and regulations and addresses situations where an individual or entity's functions or services do not involve the use or disclosure of confidential/protected health information or individually identifiable health information, but their work puts them in the vicinity of this type of information. These individual or entity functions or services may include janitorial staff/cleaning services, off site storage and paper shredding/destruction.
GBCARE, LLC.'s database utilizes multiple levels of security to prevent the potential for breaches in confidentiality of customer, injured employee, or provider information. Security levels are assigned to allow access as necessitated by job requirement only. Every employee has an obligation to protect information including, but not limited to database information, printed documents, and verbal information.

Provider & Patient Communications
All written and oral communication between UR staff and injured worker and/or providers is documented within the UR system. The system records the date and time of the communication and staff is required to document the name of the individual that they spoke with.

Upon notification of a potential situation which poses a threat to the health or safety of an injured employee/consumer, the nurse reviewer will bring it to the attention of the UM department supervisor or manager. Examples of such potential threats may include, but are not limited to:

exposure to deadly or communicable disease or virus
anaphylactic reaction to treatment
over-utilization or prescription of controlled substances
suicide threats
threats to consumers or others
domestic violence, spousal abuse, elder abuse, child abuse
drug recalls
medical device recalls
medical emergencies

XIII Appendices