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WORKERS' COMPENSATION UTILIZATION MANAGEMENT
CALIFORNIA UTILIZATION REVIEW PLAN

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Ethos Risk Services' California Utilization Review Plan contains California specific regulatory and operational requirements. The Utilization Review Plan sets forth policies and procedures ensuring compliance with prospective, concurrent, and retrospective utilization reviews per Labor Code section 4610 and Title 8, California Code of Regulations, sections 9792.6.1 et seq., effective April 1, 2026.

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I. INTRODUCTION

Program Description

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

Mission Statement

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

Program Objectives

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

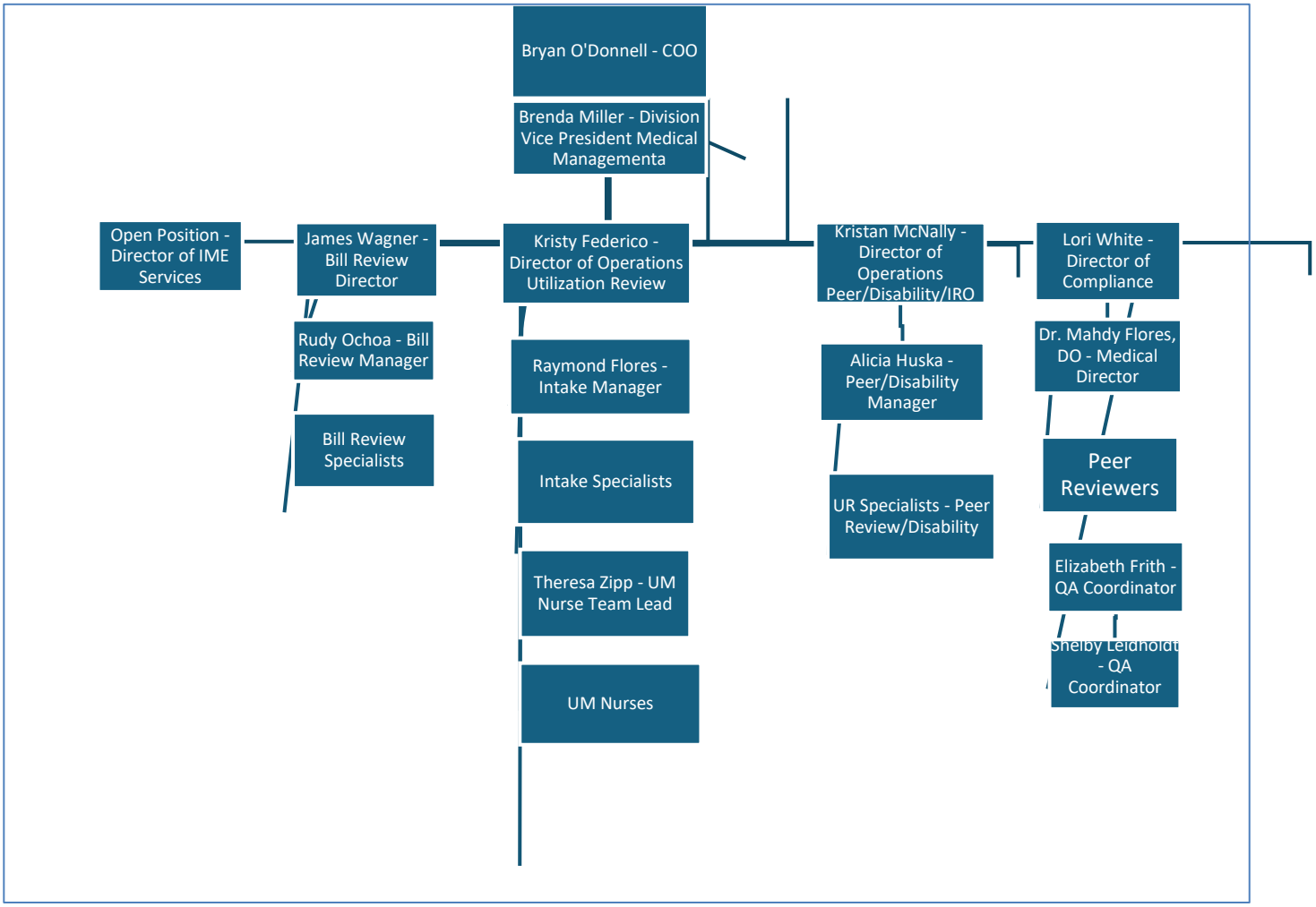
Scope

This document applies to the Ethos Risk Services California Utilization Review Program. All staff adhere to the policies and procedures as set forth within this California Utilization Review Plan.

Policy and Procedure Management

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

Organizational Overview



The California Utilization Review Program executive leadership includes the CEO, Director of Operations Utilization Review, Director of Compliance. Management of the program is conducted by the Director of Compliance and Director of Operations Utilization Review, with clinical oversight by the Medical Director.

Key Organizational Roles

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

Director of Operations Utilization Review: responsible for overseeing all functions of the utilization management program including operations, quality assurance, performance management, and regulatory compliance. Consults with the Medical Director for clinical decision-making oversight.

Director of Compliance: The Director of Compliance is responsible for compliance across the spectrum of the Medical Management product lines, oversees the Quality Management Program and serves as the Compliance Officer for all Medical Management services.

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

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

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

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

Peer Clinical Reviewer: responsible for reviewing the available medical information to address the medical necessity and appropriateness of the level of care for the requested treatment, service or procedure.

II. DEFINITIONS

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

"Authorization" or "Certification" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to Labor Code section 4600, subject to Labor Code section 5402, based on a completed request for authorization submitted by the primary treating physician or secondary physician on the DWC Form RFA, or on another written request accepted as complete under applicable regulation, and transmitted to the claims administrator. Authorization shall be given pursuant to the applicable timeframe, procedure, and notice requirements of Title 8, California Code of Regulations, sections 9792.9.1 through 9792.9.8.

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

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

"**Course of treatment**" means the course of medical treatment set forth in the treatment plan contained on the Doctor's First Report of Occupational Injury or Illness, DIR Form 5021, or on the applicable physician reporting forms authorized by section 9785, including narrative reports containing the same required information.

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

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

“**Emergency health care services”** means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient’s health in serious jeopardy.

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

“Expert reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Colombia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual’s scope of practice, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.

"Health care provider" means a provider of medical services, as well as, related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.

“Immediately” means within one business day.

“**Material modification**” means a change requiring reporting on DWC Form UR-01, including but not limited to a change in utilization review vendor, medical director, address, company name, corporate structure, or utilization review standards as specified by applicable regulation.

“Medical Director” is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California. The Medical Director is responsible for all decisions made in the utilization review process.

“Medical Treatment Utilization Schedule (MTUS)” means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of Title 8, California Code of Regulations, beginning with section 9792.20. The MTUS includes the MTUS Drug Formulary and related formulary rules.

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

(A) The guidelines, including the drug formulary, adopted by the Administrative Director pursuant to section 5307.27 (MTUS).
(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
(C) Nationally recognized professional standards.
(D) Expert opinion.

(E) Generally accepted standards of medical practice.
(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

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

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

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

"Request for authorization" means a written request for a specific course of proposed treatment. The request shall be set forth on a Request for Authorization (DWC Form RFA) completed by the primary treating physician or secondary physician, except that the claims administrator may voluntarily accept another written request as complete only to the extent permitted by applicable regulation. To be complete, the request must identify the employee and requesting provider, identify with specificity the recommended treatment or treatments, be accompanied by documentation substantiating the medical necessity for the requested treatment, and be signed as permitted by regulation. The request may be transmitted to the claims administrator by mail, facsimile, electronic mail, electronic data interchange, or other written means permitted by the claims administrator and applicable regulation.

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

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

"Non-physician reviewer" means a reviewer permitted by regulation to approve treatment requests, discuss criteria with the requesting physician, and request additional information reasonably necessary to render a decision, but who may not modify or deny a request for authorization.

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

"Utilization review decision" means a decision pursuant to Labor Code section 4610 to approve, modify or deny, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code sections 4600 or 5402(c).

"Utilization review plan" means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization review process.

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

RFA is first received by the claims administrator or utilization review organization, or when another written request is accepted as complete under applicable regulation, or, in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

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

III. PROGRAM REQUIREMENTS

Contracted Provider Mandate

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

Limitations

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

Accreditation, Statutory or Regulatory Compliance

This Plan has been developed in accordance with URAC accreditation standards for Workers' Compensation Utilization Management, California utilization review regulations, and applicable provisions of the Labor Code. To the extent required by law, any utilization review process that modifies or denies treatment requests shall maintain current URAC Workers' Compensation Utilization Management accreditation unless exempt under applicable law.

For DWC Form UR-01 compliance, Ethos shall maintain current documentation of accreditation status, including original accreditation date, most recent accreditation date, and expiration date, and shall update the filing whenever a material modification occurs. The Plan shall also maintain current Medical Director, contact, client, vendor, and delegation information consistent with the UR-01 filing.

Amendments and Modifications

The Plan may be modified or amended as needed to maintain regulatory compliance and operational accuracy. Material modifications shall be reported in accordance with current California utilization review regulations and DWC Form UR-01 requirements. Non-material updates may be implemented and maintained in the ordinary course provided the Plan remains compliant with applicable law.

Medical Information System

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

Annual Evaluation

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

IV. QUALITY MANAGEMENT COMMITTEE OVERSIGHT

Delegation of Responsibility

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

Confidentiality

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

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

V. UTILIZATION REVIEW PROGRAM

Functions

The functions of the utilization review program include:

- To implement, monitor, review and evaluate utilization review guidelines, as well as monitoring criteria, as they apply to professional and institutional practice and performance. The guidelines and criteria must be objective, measurable, clinically valid, and compatible with established principles of patient care.
- To collect utilization review data; to identify, track, trend and analyze collected data; recommend appropriate educational programs and corrective actions based on data; and monitor the implementation and the outcomes of the recommended programs and actions.
- To oversee and support all utilization review activities of physician and non-physician personnel.
- To provide educational information on health promotion and disease prevention to injured workers and health care providers.
- To educate providers concerning inappropriate utilization of care or delivery of services identified by utilization review data.
- To continuously review the appropriateness and effectiveness of the Utilization Review Plan, to present an annual evaluation of current activities and an outline of proposed activities to the Quality Management Committee.

Certification of Medical Necessity of Care or Services

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

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

The Medical Treatment Utilization Schedule (MTUS) is incorporated into this plan and supersedes ACOEM as the primary guideline for those conditions to which it applies. ACOEM Guidelines will be used as mandated by the California State Regulatory Agency for conditions or injuries that are not addressed by the MTUS. The Official Disability Guidelines (ODG) is utilized for conditions not addressed by the MTUS or ACOEM. For those medical conditions not addressed by the MTUS, ACOEM or ODG, other commercially developed evidence-based criteria will be used as a secondary resource.

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

Clinical Guidelines for Developing Utilization Review Standards and Monitoring Criteria

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

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

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

Prospective Review

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

Concurrent Review

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

from the effects of the industrial injury.

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

Emergency Health Care Services
An emergency health care service is a health care service or services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the injured worker's health in serious jeopardy.

Failure to obtain prior authorization for emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services, however, may be subject to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator on request.

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

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

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

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

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

- Ethos Client (the organization or adjuster)
- Injured Worker (Patient)
- Injured Worker's Authorized Representative
- Insurance Carrier, TPA

- Employer
- Attending or Ordering Provider
- Facility Rendering Service
- Developer or manufacturer of the drug, device, procedure or therapy being recommended.

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

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

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

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

VI. VOLUNTARY INTERNAL APPEALS

Purpose

In the case of a modification or denial of a requested service, the parties may participate in the Ethos voluntary internal appeal process. The original modification or denial notice shall advise that the voluntary internal appeal process is optional, does not replace or delay Independent Medical Review, and neither triggers nor bars use of the dispute resolution procedures under Labor Code sections 4610.5 and 4610.6. For formulary disputes, objections must be communicated within ten (10) days after service of the utilization review decision to the employee; for other medical treatment disputes, objections must be communicated within thirty (30) calendar days after service.

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

Process

Any request for a voluntary internal appeal must be submitted within ten (10) days after receipt of the utilization review decision unless a different shorter statutory objection period applies to preserve IMR rights. Voluntary appeal requests are accepted from the injured worker, the injured worker's representative, the provider, or the facility rendering service. Participation in the voluntary internal appeal process is optional and does not extend any statutory deadline for objection or Independent Medical Review.

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

- An active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States.
- Unless expressly allowed by state or federal law or regulation, are located in a state or territory

of the United States when conducting appeal considerations.

- Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate.
- Are neither the individual who made the original non-certification, nor the subordinate of such an individual; and
- Are board-certified (if applicable).

Timeframes for Responding to Voluntary Internal Appeals

Standard Appeals:

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

Concurrent and Expedited Appeals:

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

VII. UTILIZATION REVIEW STANDARDS

Applicability

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

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

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

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

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

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

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

(7) Disclosure of the utilization review process descriptions for modifying or denying requests for

authorization of medical treatment and accompanying policies and procedures of the Plan to employees and physicians. If a member of the public requests a hard copy of the Plan, Ethos may charge reasonable copying and postage expenses, not to exceed $0.25 per page plus actual postage costs. A complete copy of the Plan will be made available by posting on the Ethos website at www.ethosrisk.com

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

Mandatory Prospective Review List

For the first thirty (30) days after the date of injury, a treating physician specified in Labor Code section 4610(b) may render medically necessary treatment or services without prospective utilization review only to the extent permitted by section 9792.9.7. To qualify, the treatment must be for an accepted body part or condition, be consistent with the applicable MTUS guideline, and be identified in the required physician reporting and request for authorization documents submitted to the claims administrator. Treatment that is excluded from the first 30-days exemption, including non-exempt pharmaceuticals and other services identified by regulation, remains subject to prospective utilization review.

(1) Pharmaceuticals, to the extent that they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.
(2) Nonemergency inpatient and outpatient surgery, including presurgical and postsurgical services.
(3) Psychological treatment services.
(4) Home health care services.
(5) Imaging and radiology services, excluding X-rays.
(6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule.
(7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
(8) Any other service designated and defined through rules adopted by the Administrative Director.

Medically Based Criteria

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

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

CALIFORNIA DRUG FORMULARY AND DEFINITIONS

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

(b)(1) For injuries occurring prior to January 1, 2018, the MTUS Drug Formulary should be phased in to ensure that injured workers who are receiving ongoing drug treatment are not harmed by an abrupt change to the course of treatment. The physician is responsible for requesting a medically appropriate and safe course of treatment for the injured worker in accordance with the MTUS, which may include use of a Non-Exempt drug or unlisted drug, where that is necessary for the injured worker's condition or necessary for safe weaning, tapering, or transition to a different drug.

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

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

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

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

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

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

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

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

(2) Physician-dispensed drugs are subject to section 9792.27.8 ((a) Drugs dispensed by a physician must be authorized through prospective review prior to being dispensed, except as provided in subdivision (b), section 9792.27.12 ("Special Fill"), and section 9792.27.13 ("Perioperative Fill"). (b) A physician may

dispense up to a seven-day supply of one or more drugs that are designated as “Exempt” in the MTUS

Drug List without obtaining authorization through prospective review, if the drug treatment is in accordance with the MTUS Treatment Guidelines and the up-to-seven-day supply is dispensed at the time of an initial visit that occurs within 7 days of the date of injury. (c) Nothing in this Article shall invalidate a provision in a Medical Provider Network agreement which restricts physician dispensing by medical providers within the network. (d) Nothing in this Article shall permit physician dispensing where otherwise prohibited by a pharmacy benefit contract pursuant to subdivision (a) of Labor Code section 4600.2).

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

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

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

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

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

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

“Compounded drug” means any drug subject to:

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

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

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

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

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

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

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

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

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

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

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

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

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

"Unlisted drug" means a drug that does not appear on the MTUS Drug List and which is one of the following: an FDA-approved or a nonprescription drug that is marketed pursuant to an FDA OTC

Monograph. An "unlisted drug" does not include a compounded drug but does include a combination drug.

Procedures, Timeframes and Notice Content

Procedures

Receipt of Request for Authorization (DWC Form RFA):

A request for authorization for a course of treatment shall be submitted in writing on the Request for

Authorization (DWC Form RFA), as contained in California Code of Regulations, title 8, section 9785.5, except to the limited extent that the claims administrator voluntarily accepts another written request as complete under applicable regulation.

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

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

Ethos may treat a written request that is not submitted on the DWC Form RFA as complete only if acceptance of that written request is permitted under applicable regulation and the claims administrator voluntarily elects to accept it. Any such accepted written request must, at a minimum, clearly identify the employee and requesting provider, identify with specificity all requested medical services, goods, or items on the first page or by clear page reference, include substantiating medical documentation created within the time permitted by regulation, and be signed as permitted by regulation.

Upon receipt of a request for authorization as described in subdivision (c)(2)(B), or a DWC Form RFA:

If Ethos receives a DWC Form RFA, or another written request that it is authorized to accept, that is missing one or more elements required for a completed request for authorization, a non-physician reviewer or reviewer may either treat the request as complete and proceed within the applicable decision timeframe, or return the request marked incomplete no later than five (5) normal business days after receipt. Any return marked incomplete shall specify each reason the request is incomplete. If the request is returned as incomplete, the applicable utilization review decision timeframe shall begin anew upon receipt of a completed request for authorization.

Timeframes

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

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

Standard Review:

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

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

Expedited Review:

Prospective or concurrent decisions to approve, modify or deny a request for authorization related to an *expedited review* shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under subdivision (c)(3) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (c)(3).

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

Retrospective Review:

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

A written decision to deny part or all of the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.

Concurrent Review Denials:

The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment:

(A) Medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee

(B) Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.

Utilization Review Decision Applicability:

A utilization review decision to modify or deny a 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.

Notice Content

Decisions to approve a request for authorization:

All decisions to approve a request for authorization shall specify the required approval elements under section 9792.9.4, and the Approval, Appeal Overturned – Approved, Concurrent – Approval, and Concurrent – Appeal Overturned – Approval templates in Section XII shall use the same required approval fields and timing references:

- the date the complete request for authorization was received
- the medical treatment service requested
- the specific medical treatment service approved
- the date of the decision, and, where applicable
- the date additional information, examination, or consultation was requested and received.

Decisions modifying or denying treatment authorization:

The written decision shall be signed by either the claims administrator or the reviewer, as permitted by regulation, and shall contain the information required by current California utilization review regulations, including all items required by section 9792.9.5 for the specific type of denial or modification notice being issued. The corresponding Denial, Modified, Concurrent Modified, Appeal Upheld, and Appeal Partially Upheld letter templates in Section XII must mirror these requirements.

1. The date on which the completed or accepted request for authorization was first received.
2. 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.
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.

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

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

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

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

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 (Rev. 04/01/2026), which is hereby incorporated by reference. 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 ten (10) days after the

service of the utilization review decision to the employee for formulary disputes and thirty (30) calendar days after service of the decision for all other medical treatment disputes.

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

Decision to Deny due to Incomplete/Insufficient Information (Administrative Denial):

If a utilization review decision to deny a medical service is due to incomplete or insufficient information, the Administrative Denial notice and the corresponding Request for Additional Information and Administrative Denial for Lack of Information templates in Section XII shall specify all information required by the current regulations, including the reason for the decision, the specific missing information, documented outreach attempts, the manner of communication, and notice that the request will be reconsidered upon receipt of the requested information:

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

Modification after Internal Voluntary Appeal:

Internal voluntary appeals that result in a modification of the original decision must include the current Application for Independent Medical Review, DWC Form IMR, and must clearly identify the decision as a modification after appeal. The accompanying notice shall preserve the applicable objection deadline: ten (10) days after service of the utilization review decision for formulary drug disputes and thirty (30) calendar days after service of the utilization review decision for all other medical treatment disputes.

Utilization Review Deferral/Liability Dispute:

Utilization review of a medical treatment request made on the DWC Form RFA may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity. A claims administrator that determines Labor Code section 4610(k) precludes the need for utilization review shall comply with the applicable deferral notice requirements. A request that expressly and unequivocally documents a change in facts material to the basis of the prior denial of the same treatment may not be deferred on that basis and must be reviewed by a physician reviewer.

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

(A) The date on which the DWC Form RFA was first received.
(B) A description of the specific course of proposed medical treatment for which authorization was requested.
(C) A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.
(D) A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.
(E) The following mandatory language advising the injured employee:
“You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me.
and
“For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.”
(2) If utilization review is deferred pursuant to this subdivision, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, the time for the claims administrator to conduct retrospective utilization review in accordance with this section shall begin on the date the determination of the claims administrator's liability becomes final. The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a DWC Form RFA after the final determination of liability.

Dispute Resolution

If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6. Neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is modified or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review or the Workers' Compensation Appeals Board under this Article.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the provided Application for Independent Medical Review, DWC Form IMR, within ten (10) days after the service of the utilization review decision to the employee for formulary disputes and thirty (30) calendar days after service of the decision for all other medical treatment disputes.

Independent Medical Review – Medical Records:
Within fifteen (15) days following the mailing of the notification from the independent review organization that the disputed medical treatment has been assigned for independent medical review, or within twelve (12) days if the notification was sent electronically, or for expedited review within twenty- four (24) hours following receipt of the notification, the independent medical review organization shall receive from the claims administrator all of the following documents:
(A) A copy of all reports of the physician relevant to the employee's current medical condition produced within six months prior to the date of the request for authorization, including those that are specifically identified in the request for authorization or in the utilization review determination. If the requesting physician has treated the employee for less than six months prior to the date of the request for authorization, the claims administrator shall provide a copy of all reports relevant to the employee's current medical condition produced within the described six-month period by any prior treating physician or referring physician.
(B) A copy of the written Application for Independent Medical Review, DWC Form IMR, that was included with the written determination, issued under section 9792.9.1(e)(5), which notified the employee that the disputed medical treatment was denied or modified. Neither the written determination nor the application's instructions should be included.
(C) Other than the written determination by the claims administrator issued under section 9792.9.1(e)(5), a copy of all information, including correspondence, provided to the employee by the claims administrator concerning the utilization review decision regarding the disputed treatment.
(D) A copy of any materials the employee or the employee's provider submitted to the claims administrator in support of the request for the disputed medical treatment.
(E) A copy of any other relevant documents or information used by the claims administrator in determining whether the disputed treatment should have been provided, and any statements by the claims administrator explaining the reasons for the decision to deny or modify the recommended treatment on the basis of medical necessity.
(F) The claims administrator's response to any additional issues raised in the employee's application for independent medical review.
(2) The claims administrator shall, concurrent with the provision of documents under subdivision (a), forward to the employee or the employee's representative a notification that lists all of the documents submitted to the independent review organization under subdivision (a). The claims administrator shall

provide with the notification a copy of all documents that were not previously provided to the employee or the employee's representative excluding mental health records withheld from the employee pursuant to Health and Safety Code section 123115(b).
(3) Any newly developed or discovered relevant medical records in the possession of the claims administrator after the documents identified in subdivision (a) are provided to the independent review organization shall be forwarded immediately to the independent review organization. The claims administrator shall concurrently provide a copy of medical records required by this subdivision to the employee, or the employee's representative, or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law.

At any time following the submission of documents under this section, the independent review organization may reasonably request appropriate additional documentation or information necessary to make a determination that the disputed medical treatment is medically necessary. Additional documentation or other information requested under this section shall be sent by the party to whom the request was made, with a copy forwarded to all other parties, within five (5) business days after the request is received in routine cases or one (1) calendar day after the request is received in expedited cases.

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

VIII. UTILIZATION REVIEW PROCESS

Receipt of Request for Authorization

Ethos provides access to submit requests for authorization in writing by facsimile, secure electronic transmission, mail, or other designated written channel consistent with applicable California utilization review regulations. Ethos also maintains a toll-free telephone number and voicemail during normal business days to receive inquiries, coordinate peer-to-peer communications, and facilitate administrative communications related to utilization review. Twenty-four-hour coverage is provided through secure facsimile and voicemail.

Telephone: 888-705-1070
Facsimile: 888-667-9572
Address: P.O. Box 99
Broussard, LA 70518

Requests for authorization for medical treatment are accepted when submitted in writing by the primary treating physician or secondary physician on the DWC Form RFA, or in another written format only if the claims administrator voluntarily accepts the request as complete under applicable regulation. Records, status information, and administrative communications from a facility, injured worker, injured worker's representative, or claims administrator do not substitute for a required request for authorization unless the written submission is expressly accepted as complete under applicable regulation.

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

- Accept information from any reasonable reliable source that will assist in the certification process;
- Collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency and duration of service;
- Do not routinely require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for certification, but we may request such codes, if available;

- Do not routinely request copies of all medical records on all patients reviewed;
- Require only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; and
- Administer a process to share all clinical and demographic information on individual patients among our various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from enrollees or providers.

Identification

Upon receipt, the request for authorization is screened by an Ethos Intake Specialist for routing, receipt date, completeness indicators, and collection of non-clinical data. The Intake Specialist is a non-clinical administrative role and does not make medical necessity determinations, modification decisions, denial decisions, or other substantive utilization review determinations. Intake Specialists screen for completeness of service request information, collect and transfer non-clinical data, enter demographic information, and upload supporting documentation into the Ethos Utilization Management System for clinical review.

Data collected at the time of review initiation includes:

- Request date
- Request type
- Occupational injury claim information
- Requested service or treatment with corresponding CPT code(s) when available
- Diagnosis(es) with corresponding ICD-10 code(s) when available
- Supporting clinical documentation necessary to conduct the review
- Requesting/Ordering Provider name/address/contact information
- Facility rendering service name/address/contact information, as applicable
- Authorized representative/attorney name/address/contact information, as applicable

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

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

Assignment

Once the request for authorization is confirmed, the case is assigned to an Initial Clinical Reviewer (Utilization Management Nurse) based on availability, jurisdiction, and timeframe requirements. Upon new case assignment, the Utilization Management Nurse receives an automatic electronic notification from the Ethos Utilization Management System and proceeds with administrative and clinical screening functions permitted for a non-physician reviewer.

Initial Review

The Utilization Management Nurse is responsible for coordinating the utilization review process, ensuring timely routing, complete and accurate documentation, requests for additional information as permitted, and proper administrative notifications. The Utilization Management Nurse may approve requests that meet applicable criteria but may not modify or deny a request for authorization.

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

A non-physician reviewer (Utilization Management Nurse) may discuss applicable criteria with the requesting physician when the treatment for which authorization is sought appears inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization if it meets applicable criteria. Additionally, a non-physician reviewer may request additional information reasonably necessary to render a decision, but in no event shall such request extend beyond the time limitations imposed by applicable regulation.

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

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

Request for Additional Information

Requests for additional information, additional examination or testing, and expert review consultation shall be handled only within the circumstances and timeframes permitted by applicable California utilization review regulations. Ethos may request only the information reasonably necessary to make a determination and shall issue the required notice identifying the information, examination, test, or consultation needed, together with the anticipated decision date, within the timeframe required by regulation.
(A) The claims administrator or reviewer is not in receipt of all of the information reasonably necessary to make a determination; or
(B) The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice; or
(C) The reviewer needs a specialized consultation and review of medical information by an expert reviewer.

If a decision cannot be made because Ethos is not in receipt or possession of all information reasonably necessary to make a determination, Ethos shall timely notify the requesting physician and any other parties required by the applicable prospective, concurrent, retrospective, or expedited review provisions that a decision cannot be made within the otherwise applicable timeframe and shall specify the information needed for a determination.

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

- Except for treatment requests made pursuant to the California formulary, prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five (5) normal business days from receipt of a request for authorization and supporting information reasonably necessary to make the determination, but in no event more than fourteen (14) days from the date of the medical treatment

recommendation by the physician.

- Prospective decisions regarding requests for treatment covered by the California formulary shall be made no more than five (5) normal business days from the date of receipt of the medical treatment request.
- For prospective or concurrent decisions related to an expedited review, a determination will be made within 72-hours of receipt of the information, but no more than fourteen (14) calendar days from receipt of the initial request.
- For retrospective review decisions, a determination will be made within thirty (30) calendar days of receipt of the information, but no more than thirty (30) days from receipt of the initial request.

If the information reasonably necessary to make a decision is not received within the timeframe permitted by applicable regulation after Ethos has timely requested it, the reviewer may issue the appropriate administrative denial or other notice authorized by regulation, with the stated condition that the request will be reconsidered upon receipt of the information, examination results, or consultation requested, as applicable.

If any of the circumstances set forth in (B) or (C) above are deemed to apply following the receipt of a DWC Form RFA or accepted request for authorization, the reviewer shall, within five (5) normal business days from receipt of the request for authorization, provide the required written notice identifying the additional examination or test required, or the specialty of the expert reviewer to be consulted, and the anticipated date on which a decision will be rendered, examinations or tests required, or the specialty of the expert reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered.

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

If the results of the additional examination or test required under section (B), or the specialized consultation under section (C), that is requested by the reviewer is not received within thirty (30) days from the date of the request for authorization, the reviewer shall deny the treating physician's request with the stated condition that the request will be reconsidered upon receipt of the results of the additional examination or test or the specialized consultation.

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

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

Upon receipt of the information requested pursuant to sections (A), (B), or (C), Ethos, for retrospective review, shall make the decision to approve, modify or deny the request for authorization within thirty (30)

calendar days of receipt of the information requested. The decision shall include the date it was made.

Whenever a reviewer issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the file will document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail.

The Request for Information will identify:

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

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

Referral to Reviewer

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

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

The assigned Reviewer reviews the request for authorization, the submitted medical documentation, and the applicable clinical review criteria. When a decision to approve the request for authorization cannot be made, the Reviewer may attempt to contact the requesting provider for a peer-to-peer discussion before issuing a decision when time and circumstances permit. If a peer-to-peer discussion occurs, the Reviewer considers the discussion together with the submitted documentation. If a peer-to-peer discussion does not occur, the Reviewer may issue a decision based on the available documentation within the applicable timeframe.

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

Peer-to-Peer Conversation

The purpose of a peer-to-peer discussion is to allow the attending or other requesting provider an opportunity to discuss the utilization review request with the reviewer before or after a decision, depending on timing and circumstances. A peer-to-peer discussion may resolve disagreements or clarify clinical issues, but it is not a substitute for the required utilization review decision and notice process.

Denial and modification letters include written notice of the availability of a peer-to-peer discussion when a discussion was not successfully completed before the decision issued. The notice shall identify how the requesting physician may discuss the decision with the reviewer, expert reviewer, or medical director during disclosed normal business hours or by agreed scheduled time.

When a peer-to-peer discussion does not occur prior to a prospective or concurrent denial or modification decision, Ethos will make a qualified reviewer available within one normal business day of a request by the attending or ordering provider, either through the original reviewer if available or another qualified reviewer competent to address the clinical issues involved.

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

When a peer-to-peer discussion or review of additional information does not result in approval, Ethos issues the applicable modification or denial notice and advises the provider and injured worker of available dispute rights, including optional voluntary internal appeal language where applicable and Independent Medical Review rights as required by law. When the peer-to-peer discussion results in approval, Ethos issues a notice of approval to all required parties.

Ethos Reviewers are available for scheduled peer calls between 9:00 AM and 5:30 PM Pacific Time on normal business days.

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

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

Determination

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

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

The Initial Reviewer (Utilization Management Nurse) completes the utilization review documentation and prepares administrative determination notices in accordance with the Utilization Review Plan and required timeframes. Any substantive decision to modify or deny remains the responsibility of the qualified Reviewer, and approvals by a non-physician reviewer are limited to approvals permitted by regulation.

Notification

Closure documentation and notifications are prepared administratively by the Initial Reviewer (Utilization Management Nurse). All notifications are then issued to the appropriate parties in accordance with the requirements set forth in the Utilization Review Plan and the decision rendered by the authorized reviewer or non-physician reviewer, as applicable.

Delegation of Utilization Review Functions to External Vendors

Ethos no longer delegates any review activities; however, Ethos has retained its policies and procedures regarding delegation in case its need to delegate changes. As such, Ethos may contract with Reviewers and/or contract with external Reviewer organizations to supplement the utilization review program. All contracted external vendors are in strict compliance with Ethos policies and procedures, URAC standards and California utilization review regulations. Ethos maintains responsibility for any delegated functions and oversight responsibility of any delegated function is held by the Quality Assurance and Compliance Manager.

If Ethos delegates any utilization review function, the delegate, the delegated function, and all entities that utilize or contract for UR Plan services shall be identified and kept current in the UR-01 filing and supporting Plan materials. If no functions are delegated, the Plan and UR-01 should expressly state that no delegation is in effect.

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

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

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

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

IX. MEDICAL DIRECTOR

Ethos maintains a contracted Medical Director who serves as the senior clinical oversight physician for the California utilization review program. The Medical Director is responsible for clinical governance, reviewer oversight, quality assurance, and compliance oversight for the utilization review process. Individual decisions to modify or deny treatment are made by qualified reviewers or by the Medical Director, as permitted by applicable law and regulation.

The Medical Director identified in this Plan must match the current DWC Form UR-01 filing and related supporting records. The Plan shall maintain the current Medical Director name, California unrestricted license number, National Provider Identifier (NPI), business address, telephone number, facsimile number, and email/contact information, and shall update this information promptly whenever a material modification occurs.

Mahdy Flores, DO, MS, MMM
100 N. Barranca St., Suite 900G
West Covina, CA 91791
Telephone: 888-705-1070; C: 909-268-3624
Fax: 888-667-9572
E-mail: precert@ethosrisk.com

Ethos shall maintain current documentation showing that the Medical Director holds an unrestricted California license, current NPI, and any board certification or other credential identified in this Plan or in the UR-01 filing. Any credential listed in the Plan is periodically validated for continued accuracy.

Role/Responsibilities

Medical Director responsibilities include clinical governance of the utilization review program, oversight of reviewer qualifications and competency, supervision of guideline governance and annual review, support for staff training and escalation pathways, participation in quality assurance and compliance activities, and availability for clinical discussion as required by regulation. The Medical Director may personally perform utilization review functions as permitted by law, but individual modification or denial decisions may also be rendered by other qualified reviewers acting within their lawful scope. Medical Director responsibilities include the following:

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

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

- Development and evaluation of clinical operational Utilization Management standards throughout the program;
- Clinical decision-making consultation and direction in all aspects of the program;
- Direction and oversight to the Quality Management Committee regarding clinical aspects of the program;
- Consultation with the Policy & Procedure Committee regarding any policies/procedures involving clinical issues; Review, evaluation, and approval of clinical-decision support tools and treatment guidelines as needed, but no less than annually;
- Facilitation and coordination of Quality Management Program objectives to provide continued delivery of quality healthcare;
- Guidance, interpretation, and training, as applicable, on issues of medical appropriateness and level of care issues within the Utilization Management review process;
- Oversight of clinical credentialing activities;
- Evaluation and implementation of processes to ensure contracted clinical peer reviewer compliance with evidence-based treatment protocols;
- Clinical peer reviewer orientation and/or training and education and/or re-education counseling;
- Participation in URAC training and accreditation activities as applicable;
- Clinical oversight of consumer safety activities;
- Acts as the clinical liaison to regulatory and oversight agencies;
- Performs or delegates peer discussion activities as needed;
- Serves as provider/client resource within the program; and
- Analysis and trending of data as it relates to quality management activities and overall consumer and client satisfaction.

Curriculum Vitae

LICENSURE:

States A-I	License Number	States J-N	License Number	States O-Z	License Number
Alabama 2994	2994	Kansas	05-48327	Ohio	34C.000008
Arizona	009930	Kentucky	C0941	Oklahoma	8257
California	**20A 11663**	Louisiana	333005	South Dakota	14718
Colorado	DR. 0064412	Maryland	H0098360	Tennessee	4194
Connecticut	75897	Michigan	EMC0003801	Texas	T9298
DC	DO210012290	Minnesota	75039	Utah	13532353-1204
Florida	OS-18016	Mississippi	30736	Washington	OP61476927
Georgia	96933	Nebraska	2684	West Virginia	4167
Illinois	036.162082	New York	308755	Wisconsin	1801-321
Indiana	02007442A	New York Work Comp Board Authorization	308755-8B		
Iowa	DO-06479				

EDUCATION:
MBA, Medical Management, University of Southern California
MS, Environmental Toxicology, University of California Irvine
Doctor of Osteopathic Medicine, Western University of Osteopathic Medicine, Pomona, CA
BS, Biology, Pennsylvania State University, University Park, PA

PROFESSIONAL TRAINING:
University of California Irvine, Irvine, CA
Occupational and Environmental Medicine Residency

Kaiser Permanente Hospital, Riverside, CA
Family Medicine Internship and Residency

CERTIFICATIONS:
American Board of Preventive Medicine, Occupational Medicine 026421
American Board of Family Medicine 1014097889
Medical Review Officer Certification 121202136

PROFESSIONAL ORGANIZATIONS:
American College of Occupational and Environmental Medicine
Western Occupational and Environmental Medical Association
American Academy of Family Physicians

HONORS:
Kaiser Permanente Hospital, Riverside, CA
Chief Resident, Family Medicine
Western Occupational and Environmental Medicine Association
Scholarship Recipient

X. POLICIES AND PROCEDURES – GENERAL

Complaints

Policy Number/Title:	**UM-018 - Consumer Complaint Process**
Effective Date:	05/01/2018
Review Dates:	04/22/2026, 01/16/2025, 06/06/2024; 01/19/2024; 01/25/2023
Revised:	04/22/2026
Date approved by QMC:	07/30/2026; 04/24/2026
Next Review Date:	January 2027

Purpose/Objective:

To establish a complaint resolution process for collecting and resolving consumer complaints under the UM program.

Scope:

This policy applies to all complaints involving UM program services.

Policy:

The ERS, UM program maintains a formal process to address consumer complaints that includes:

- A process to receive and respond to complaints in a timely manner;
- Notice (written or verbal) of final result with an explanation;
- Informs consumers of the avenues to seek further review if available;
- Evidence of meeting the specified time frame for resolution and response; and
- Complaint summary reported to the Quality Management Committee (QMC) for analysis.

Procedure(s):

Complaint Receipt and Tracking

Consumer complaints related to UM program services may be initiated either verbally or in writing. Some verbal complaints may be resolved by the front line Intake staff upon receipt of a telephone call. When this occurs, the Intake staff member logs the complaint as a new CFR in Sightline and assigns to the applicable Operations Manager and Assigned User.

All other complaints are immediately forwarded to the Utilization Review Manager and when appropriate, the Director of Operations or Director of Compliance for investigation.

For tracking and trending purposes, all received complaints are entered into the case file within the database with the following information identified:

- Company Name
- Requestor Name
- Client File #
- Account Manager

- Operations Manager
- CFR Origin – Email, Phone, Website, Internal, Other
- Priority – High, Medium, Low
- Feedback Type and Description of Complaint
- Source – Client or Internal
- Recommended Resolution
- Subject
- Assigned User

Investigation

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

Time Frame for Resolution and Response

A verbal or written final notice regarding the complaint resolution is issued as soon as possible but no later than thirty (30) calendar days of receipt of the complaint. In the event that additional information is required to fully investigate and resolve the complaint, the time frame for resolution begins on the date of receipt of the information required. For those complaints requiring an immediate response, a telephone call is placed to the complainant with a follow-up written notice within thirty calendar days of receipt of the complaint.

Final Result Notice

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

Complaint Resolution Form and Record Retention

For all received complaints, the Director of Operations documents the final investigation findings and resolution in the database.

Reporting Analysis

A summary of all complaint activity is provided to the Quality Management Committee (QMC) as needed, but no less than quarterly. The QMC reviews complaint summary data for performance analysis and provides recommendations for corrective actions and/or operational process improvements as applicable. Analysis of complaints does not include a discussion of individual complaints, but rather, an analysis of trends and/or opportunities for improvement. Additionally, the QMC confirms that complaint resolution and response timeframes are being met.

Policy Number/Title:	**UM-021 - Financial Incentives**
Effective Date:	05/01/2018
Review Dates:	04/22/2026, 01/16/2025, 06/06/2024; 01/19/2024; 01/25/2023
Revised:	04/22/2026
Date approved by QMC:	07/30/2026; 04/24/2026
Next Review Date:	January 2027

Purpose/Objective:

To ensure that financial incentives based directly on consumer utilization of health care services are not offered or available under the UM program.

Scope:

This policy applies to all staff, including full-time employees, part-time employees, and contractors under the UM program.

Policy:

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

Procedure(s):

Ethos recognizes that financial incentives can negatively influence decision making related to health care services. All compensation to UM staff for work performed is solely based on individual staff member performance and not based on consumer utilization of services. Compensation to contracted review staff is solely based on contractual rates per review conducted and not based on consumer utilization of services.

None of the following influence the amount of compensation provided to an Ethos employee or a contracted reviewer:

- Increases or decreases in the level of care
- Withholding of appropriate medical services
- Increases in medically unnecessary services
- Denial of consumer access to appropriate medical services

XI. JOB DESCRIPTIONS/STAFF QUALIFICATIONS

Consultant: Medical Director

Reports to: Vice President Medical Management

Position Overview

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

Roles and Responsibilities

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

Qualifications/Requirements

Education/Licensure/Certification

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

Experience

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

Skills/Knowledge

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

Job Description: Director of Utilization Management

Reports to: General Manager Medical Management

Position Overview

The *Director of Utilization Management is responsible for overseeing the handling and coordinating of all functions of the utilization management department, including all staff and budgetary requirements.*

Roles and Responsibilities

- Oversees the Utilization and Bill Review department staff, operations, service processes and outcomes, work schedules, conducts meetings, interviews, reviews, new employee orientations and disciplinary counseling.
- This position assists in IT management, budgeting, coordinating services, problem solving, establishing policies and procedures, and overall functioning of the Utilization Management Department.
- This position works closely with Sales, Case Management, Utilization Management, IME, and Accounting Departments to reach the common goal.
- Perform a variety of duties necessary to run an efficient department.
- Comply with State and National regulations; ability to follow instructions along with communicates these instructions based on various resources such as: insurance rules, billing practices, local government, national/state regulations.
- Plan and schedule meetings and appointments; organize and maintain paper and electronic files; manage projects; conduct research; and disseminate information by using the telephone, mail services, Web sites, and e-mail; ability to maintain confidential information for claimants and physicians along with work product and proprietary information.
- Provide training and orientation for new staff along with staff of longevity when rules/laws and/or business practices change.
- Assists staff when there is an influx of business, staff shortage, and or special circumstance; ability to use good judgment; thoroughness; dependability; tact; and courtesy.
- Reviews Intake process for accuracy and timely completion of assignments.
- Oversee the review of injury and claim information to select the appropriate physician for the peer exam or record review.
- Provides customer service functions including but not limited to:
    - Meeting clients with sales and calls with clients
    - Stewardship Meetings
- Assists in resolution of customer complaints and quality assurance issues as needed.
- Adhere to all deadlines and state statutes.
- Adhere to Ethos Policies and Procedures and as appropriate to job functions.
- Assists in promoting and furthering the objectives of the Utilization Management Division.
- Maintains confidentiality and security in all aspects of performance.
- Performs other related duties incidental to the work described herein.

Qualifications

Education/Licensure

- RN with unencumbered multi-state license.
- CCM Preferred.
- Bachelor’s degree or higher preferred

Experience

- 3+ years of customer service experience.
- 5+ years of utilization management experience.
- URAC Accreditation experience required.
- Healthcare or medical administrative experience preferred.

Skills/Knowledge

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

Job Title: Director of Compliance

Reports To: VP, Complex Litigation

FLSA: Exempt

Revision Date: 12/8/2025

JOB DESCRIPTION:

The Director of Compliance is responsible for compliance across the spectrum of the Medical Management product lines, oversees the Quality Management Program and serves as the Compliance Officer for all Medical Management services.

RESPONSIBILITIES:

- Tracks applicable laws and regulations for the state jurisdictions of claims handled by the Medical Services Department. Advises Medical Services Department staff on applicable state laws and regulations.
- Maintains state workers' compensation summaries, including state utilization review and telephonic case management rules (if any), in the current software system or other application software. Monitors and updates business rules consistent with regulatory changes. Monitors and updates artifact (UR letters, etc.) for accurate verbiage where mandated by state regulation.
- Works closely with the Medical Director, the Medical Management Services Supervisor(s), Utilization Review Process and Quality Assurance Analyst, and executive leadership in creating and revising policies taking into account applicable state laws and regulations and current URAC workers' compensation utilization management standards.
- Completes and files the various state utilization review agent applications as well as the URAC workers' compensation utilization management accreditation application. These include initial and renewal applications and as well as notification to states of material changes to application materials within 30 days of such changes taking effect. Reviews completed applications, if needed, with legal department for approval prior to signature by appropriate senior level employee. Answers requests for utilization review data from various state regulatory agencies.
- Attends utilization review Quality Committee meetings to help insure compliance with applicable laws and regulations.
- Assures credentialing of contracted physicians and licensed employees.
- Assists Medical Services Department supervisors in answering complaints from state regulatory agencies.
- Requests assistance from the legal department as necessary to complete job responsibilities and functions as departmental liaison.
- Researches other issues/items as directed including but not limited to: workers' compensation managed care organization regulations, panel posting/provider choice regulations by state, and auto precertification regulations.
- Contribute to training and education of UM staff.
- Under the oversight and direction of the Medical Director, ensures clinical peer reviewer orientation, training, education and/or re-education counseling compliance.
- Coordination and oversight of client/consumer satisfaction activities.
- Oversight and coordination of the development of consumer-facing communications.
- Serve as provider/client/vendor resource for utilization review.
- Collaborates cross functionally to maintain organizational compliance with information security, confidentiality, and HIPAA standards.

EDUCATION:

- Bachelor's degree

SKILLS:

- Knowledge of workers' compensation laws and regulations.
- Excellent interpersonal, verbal, and written communication skills to interface with senior management, staff and clients.

- Computer knowledge required, including Microsoft Office products.
- Leadership/management/motivational skills.
- Analytical and interpretive skills.
- Strong organizational skills.
- Knowledge of regulatory and accreditation agencies and requirements.
- Ability to manage multiple priorities in an efficient and decisive manner.
- Ability to develop routine reports and correspondence and to present information in one-on-one, small group and large group settings.

EXPERIENCE:

- Required:
    - 3 years of clinical or legal/regulatory compliance experience.
    - 2 years of utilization management experience; OR
    - Equivalent combination of training, education, and experience.
- Preferred experience: The ideal candidate will have prior experience interacting with regulatory agency contacts, writing policies and procedures for URAC compliance, authoring state utilization review certification applications and renewals, and have familiarity with legal and regulatory research related to workers' compensation utilization management laws, regulations, rules and URAC standards interpretation.

LICENSES/CERTIFICATIONS/INSURANCE:

- Licensure or Certification as follows:
    - Active, unrestricted professional license or certification to practice as a health professional in a state or territory of the United States (e.g., RN).

WORKING CONDITIONS:

Work environment is indoors in a home office (work from home), working in front of a computer, viewing a computer monitor throughout the working day. Requires frequent sitting and typing, with intermittent breaks, for up to 8 hours per day. Regular, sometimes frequent, use of a telephone, instant messaging software and email communication is required.

Job Description: Utilization Management Nurse Team Leader

Reports to: Utilization Management Nurse Manager

Position Overview

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

Roles and Responsibilities

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

Qualifications

Education/Licensure/Certification

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

Experience

- 3 years of clinical nursing experience.

- 1-year experience with workers' compensation/utilization management preferred.

Skills/Knowledge

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

Job Description: Utilization Management Nurse

Reports to: Utilization Management Nurse Manager

Position Overview

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

Roles and Responsibilities

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

Qualifications

Education/Licensure/Certification

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

Experience

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

Skills/Knowledge

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

Job Description: Utilization Management Intake Manager

Reports to: Director of Utilization Management

Position Overview

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

Roles and Responsibilities

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

Qualifications

Education

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

Experience

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

Skills/Knowledge

- Good customer service skills.
- Strong oral and written communication skills.
- Computer knowledge required, including Microsoft Office products.
- Leadership/management/motivational skills.
- Analytical and interpretive skills.

- Able to perform as part of a team.
- Strong organizational skills.
- Excellent interpersonal skills.
- Discretion and confidentiality.
- Ability to multi-task.

Job Description: Utilization Management Intake Specialist

Reports to: Utilization Management Intake Manager

Initial Screening Oversight: Utilization Management Nurse, Utilization Management Nurse Team Leader, Utilization Management Nurse Manager

Position Overview

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

Roles and Responsibilities

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

Qualifications

Education

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

Experience

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

Skills/Knowledge

- Good customer service skills.
- Strong oral and written communication skills.
- Computer knowledge required, including Microsoft Office products.
- Able to perform as part of a team.
- Strong organizational skills.

- Excellent interpersonal skills.
- Discretion and confidentiality.
- Ability to multi-task.

XII. CALIFORNIA UTILIZATION REVIEW LETTERS

REQUEST FOR ADDITIONAL INFORMATION

To: Addressee Name
Address Line one
City, State and Zip code

Date: Letter Date

ETHOS provides utilization management in accordance with California Labor Code 4610. ETHOS has been retained by Client to review the medical treatment requested for:

Claimant: Claimant
Date of Birth: DOB
DOI: DOI
Employer: Employer
Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: Client Date Received
RFAI Sent: 00/00/0000 or NA
RFAI Received: 00/00/0000 or NA
UR Reference #: CASE_NUM

REQUEST FOR ADDITIONAL INFORMATION

Requested Service:
Requested Service

A request for authorization has been received for the above referenced service/treatment, however we are not in receipt of all of the information reasonably necessary to make a decision and cannot make a decision within the required timeframe.

Additional Information Requested:
Additional Information

Please forward this letter and the above requested information via fax to Ethos within two (2) business days of receipt of this notice.

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

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

Send requested information to:
Ethos Utilization Review
Fax: 888-667-9572

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.

Ethos Complaint Process: Ethos is committed to providing outstanding customer service. If you have an issue or a problem with the services provided by Ethos, you may contact us by telephone at 888-705-1070 or in writing at Ethos Complaint Process, EthosAddress or at precert@ethosrisk.com or via fax at 888-667-9572. A verbal or written final result notice in response to a complaint will be issued as soon as possible, but no later than thirty (30) calendar days of receipt of the complaint. You may also file a complaint with the State of California Department of Industrial Relations, Division of Workers' Compensation by filing a utilization review complaint form. You can obtain the form online at https://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf

Ethos utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days by calling 888-705-1070.

CC_Section

Client Config Letter Footer
Confidentiality Notice: The information contained in this communication and any files transmitted with it may be confidential and legally privileged, including patient information protected by federal and state privacy laws. It is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. If you have received this communication in error, please immediately notify Ethos at 888-705-1070 and destroy and/or delete all copies of the original message.

PROOF OF SERVICE

I am a citizen of the United States and a resident of Lafayette, LA; 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, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Broussard, LA, addressed as follows:

Via US Mail/Via Electronic Mail

Injured Worker: Injured Worker's address

Requesting Provider: Requesting HCP Fax, Requestion HCP Address

Plaintiff Attorney: Plaintiff Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

ADMINISTRATIVE DENIAL FOR LACK OF INFORMATION

To: Addressee Name
Address Line one
City, State and Zip code

Date: Decision Date

ETHOS provides utilization management in accordance with California Labor Code 4610. ETHOS has been retained by Client to review the medical treatment requested for:

Claimant: Claimant
Date of Birth: DOB
DOI: DOI
Employer: Employer
Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: Client Received Date
RFAI Sent: 00/00/0000 or NA
RFAI Received: 00/00/0000 or NA
Decision Date: Decision Date
UR Reference #: CASE_NUM

REVIEW OUTCOME:
Diagnosis:
Diagnosis

Requested Service:
Requested Service

Type of Review/Level: Request Type
RECOMMENDATION: ADMINISTRATIVE DENIAL
CUSTOM_CLIENT

I have reviewed the above case and attest that I do not have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the health care provider, the health provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of this review. I do not accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.

I attest that I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review as well as current, relevant experience and/or knowledge to render a determination for the case under review. I am currently providing direct patient care in this field of expertise and have done so for a minimum of five years.

I attest that I am the assigned reviewer for this case and that I personally rendered the review determination without delegation to another individual.

For appeal reviews, I further attest that I was not involved in the initial denial, non-certification, or modification determination, and I am not subordinate to the individual who made the initial denial, non-certification, or modification determination.

Ethos Reviewer Consulted:

Clinical Peer Reviewer Consulted

UR Rationale and Clinical Review Criteria

We have issued an Administrative Denial on the above referenced case due to insufficient information to conduct a review. As of this date, there has been no response to our attempt(s) to obtain the information necessary to conduct the review. If you would like to submit the information that was requested, your request for authorization will be reconsidered within the applicable timeframes, as follows: Except for treatment requests made pursuant to the California formulary, prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five (5) working days from receipt of a request for authorization and supporting information reasonably necessary to make the determination, but in no event more than fourteen (14) days from the date of the medical treatment recommendation by the physician. Prospective decisions regarding requests for treatment covered by the California formulary shall be made no more than five (5) working days from the date of receipt of the medical treatment request. For prospective or concurrent decisions related to an expedited review, a determination will be made within 72-hours of receipt of the information, but no more than fourteen (14) calendar days from receipt of the initial request. For retrospective review decisions, a determination will be made within thirty (30) calendar days of receipt of the information, but no more than thirty (30) days from receipt of the initial request.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (Adjuster Name) at Adjuster Phone. 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.

Ethos Complaint Process: Ethos is committed to providing outstanding customer service. If you have an issue or a problem with the services provided by Ethos, you may contact us by telephone at 888-705-1070 or in writing at Ethos Complaint Process, EthosAddress or at precert@ethosrisk.com or via fax at 888-667-9572. A verbal or written final result notice in response to a complaint will be issued as soon as possible, but no later than thirty (30) calendar days of receipt of the complaint. You may also file a complaint with the State of California Department of Industrial Relations, Division of Workers' Compensation by filing a utilization review complaint form. You can obtain the form online at
https://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf
Ethos utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days by calling 888-705-1070.
Peer-to-Peer Availability: If a peer-to-peer conversation did not occur prior to this notice of administrative non-certification, the attending physician/ordering provider will be provided an opportunity, within one (1) business day of a request, to discuss the non-certification decision. In the event the clinical peer reviewer that made the initial determination cannot be made available within one (1) business day, another qualified clinical peer reviewer will be made available to conduct the discussion. Clinical peer reviewers are available for scheduled calls between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days.

Refer all claim questions to Client at:
Claim Adjuster: Adjuster Telephone: Adjuster Phone Fax: Adjuster Fax

CC Section

Client Config Letter Footer
Confidentiality Notice: The information contained in this communication and any files transmitted with it may be confidential and legally privileged, including patient information protected by federal and state privacy laws. It is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. If you have received this communication in error, please immediately notify Ethos at 888-705-1070 and destroy and/or delete all copies of the original message.

PROOF OF SERVICE

I am a citizen of the United States and a resident of Lafayette, LA; 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, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Broussard, LA, addressed as follows:

Via US Mail/Via Electronic Mail

Injured Worker: Injured Worker's address

Requesting Provider: Requesting HCP Fax, Requestion HCP Address

Plaintiff Attorney: Plaintiff Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

APPROVAL

txtHeaderText

To: Addressee Name
Address Line one
City, State and Zip code

Date: Decision Date

ETHOS provides utilization management in accordance with California Labor Code 4610. ETHOS has been retained by Client to review the medical treatment requested for:

Claimant: Claimant
Date of Birth: DOB
DOI: DOI
Employer: Employer
Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: Client_Date
RFAI Sent: 00/00/0000 or NA
RFAI Received: 00/00/0000 or NA
Decision Date: Decision Date
UR Reference #: Case_number

REVIEW OUTCOME:
Diagnosis:
Diagnosis

Requested Service:
Requested Service

Type of Review/Level: Request Type
RECOMMENDATION: APPROVAL
CUSTOM_CLIENT

Precertification #: Precert
Start Date: Start Date

End Date: End Date

MPN Label
MPN
Screening Criteria:
Screening Criteria

I have reviewed the above case and attest that I do not have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the health care provider, the health provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of any principal drug, device, procedure, or other

therapy being recommended for the covered person whose treatment is the subject of this review. I do not accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.

I attest that I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review as well as current, relevant experience and/or knowledge to render a determination for the case under review. I am currently providing direct patient care in this field of expertise and have done so for a minimum of five years.

I attest that I am the assigned reviewer for this case and that I personally rendered the review determination without delegation to another individual.

For appeal reviews, I further attest that I was not involved in the initial denial, non-certification, or modification determination, and I am not subordinate to the individual who made the initial denial, non-certification, or modification determination.

Ethos Reviewer Consulted:

Clinical Peer Reviewer Consulted

UR Rationale and Clinical Review Criteria

The above referenced treatment/service request was reviewed for medical necessity in accordance with California Labor Code 4610. The medical provider has been notified that this specific service meets established criteria for medical necessity based on the information provided and according to the California MTUS or approved secondary guidelines per California Code of Regulations 9792.20.

This review applies only to the specific service requested. Additional services require a separate request for authorization.

This is a certification for medical necessity. Per California Code of Regulations 9792.6(b), appropriate reimbursement will be made for the specific service listed. Contact the claim adjuster for an explanation of coverage.

Ethos Complaint Process: Ethos is committed to providing outstanding customer service. If you have an issue or a problem with the services provided by Ethos, you may contact us by telephone at 888-705-1070 or in writing at Ethos Complaint Process, EthosAddress or at precert@ethosrisk.com or via fax at 888-667-9572. A verbal or written final result notice in response to a complaint will be issued as soon as possible, but no later than thirty (30) calendar days of receipt of the complaint.

Complaint Process Text

This review is based on medical necessity only. For issues of compensability please contact your adjuster [AdjusterName] at [AdjusterPhone].

Ethos utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days by calling 888-705-1070.

CC Section

Client Config Letter Footer
Confidentiality Notice: The information contained in this communication and any files transmitted with it may be confidential and legally privileged, including patient information protected by federal and state privacy laws. It is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. If you have received this communication in error, please immediately notify Ethos at 888-705-1070 and destroy and/or delete all copies of the original message.

PROOF OF SERVICE

I am a citizen of the United States and a resident of Lafayette, LA; 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, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Broussard, LA, addressed as follows:

Via US Mail/Via Electronic Mail

Injured Worker: Injured Worker's address

Requesting Provider: Requesting HCP Fax, Requestion HCP Address

Plaintiff Attorney: Plaintiff Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

DENIAL

txtHeaderText

To: Addressee Name
Address Line one
City, State and Zip code

Date: Decision Date

ETHOS provides utilization management in accordance with California Labor Code 4610. ETHOS has been retained by Client to review the medical treatment requested for:

Claimant: Claimant
Date of Birth: DOB
DOI: DOI
Employer: Employer
Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: CLIENT_DATE
RFAI Sent: 00/00/0000 or N/A
RFAI Response Received: 00/00/0000 or N/A
Decision Date: Decision Date
UR Reference #: CASE_FILE_NUMBER

REVIEW OUTCOME:
Diagnosis:
Diagnosis

Requested Service:
Requested Service

Type of Review/Level: Request Type
RECOMMENDATION: DENIAL
CUSTOM_CLIENT

Screening Criteria:
Screening Criteria

Principal Reason(s) for the Determination:
Principal Reasons

I have reviewed the above case and attest that I do not have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the health care provider, the health provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of this review. I do not accept

compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.

I attest that I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review as well as current, relevant experience and/or knowledge to render a determination for the case under review. I am currently providing direct patient care in this field of expertise and have done so for a minimum of five years.

I attest that I am the assigned reviewer for this case and that I personally rendered the review determination without delegation to another individual.

For appeal reviews, I further attest that I was not involved in the initial denial, non-certification, or modification determination, and I am not subordinate to the individual who made the initial denial, non-certification, or modification determination.

Ethos Reviewer Consulted:

Clinical Peer Reviewer Consulted

UR Rationale and Clinical Review Criteria

The above referenced treatment/service request was reviewed for medical necessity in accordance with California Labor Code 4610. The medical provider has been notified that this specific service DOES NOT meet established criteria for medical necessity based on the information provided and according to the California MTUS or approved secondary guidelines per California Code of Regulations 9792.20.

{The ensuing paragraph is excluded for clients declining participation in the voluntary appeal process}
Voluntary Appeal

Independent Medical Review (IMR) Process: 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 Review, DWC Form IMR*, within the timeframe indicated on the last page of the application. The physician whose request for authorization of medical treatment that was denied or modified may join with or otherwise assist the employee in seeking an independent medical review.

Any dispute under §9792.9.2 shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

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 Phone. 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.

Ethos Complaint Process: Ethos is committed to providing outstanding customer service. If you have an issue or a problem with the services provided by Ethos, you may contact us by telephone at 888-705-1070 or in writing at Ethos Complaint Process, EthosAddress or at precert@ethosrisk.com or via fax at 888-667-9572. A verbal or written final result notice in response to a complaint will be issued as soon as possible, but no later than thirty (30) calendar days of receipt of the complaint.

Complaint Process Text

This review is based on medical necessity only. For issues of compensability please contact your adjuster [AdjusterName] at [AdjusterPhone].

Ethos utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days by calling

888-705-1070.

Peer-to-Peer Availability: If a peer-to-peer conversation did not occur prior to this notice of non-certification, the attending physician/ordering provider will be provided an opportunity, within one (1) business day of a request, to discuss the non-certification decision. In the event the clinical peer reviewer that made the initial determination cannot be made available within one (1) business day, another qualified clinical peer reviewer will be made available to conduct the discussion. Clinical peer reviewers are available for scheduled calls between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days.

Enclosure: *Application for Independent Review, DWC Form IMR*

CC Section

Client Config Letter Footer
Confidentiality Notice: The information contained in this communication and any files transmitted with it may be confidential and legally privileged, including patient information protected by federal and state privacy laws. It is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. If you have received this communication in error, please immediately notify Ethos at 888-705-1070 and destroy and/or delete all copies of the original message.

PROOF OF SERVICE

I am a citizen of the United States and a resident of Lafayette, LA; 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, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Broussard, LA, addressed as follows:

Via US Mail/Via Electronic Mail

Injured Worker: Injured Worker's address

Requesting Provider: Requesting HCP Fax, Requestion HCP Address

Plaintiff Attorney: Plaintiff Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

MODIFIED

txtHeaderText

To: Addressee Name
Address Line one
City, State and Zip code

Date: Decision Date

ETHOS provides utilization management in accordance with California Labor Code 4610. ETHOS has been retained by Client to review the medical treatment requested for:

Claimant: Claimant
Date of Birth: DOB
DOI: DOI
Employer: Employer
Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: Client_date
RFAI Sent: 00/00/0000 or N/A
RFAI Response Received: 00/00/0000 or N/A
Decision Date: Decision Date
UR Reference #: File_Number

REVIEW OUTCOME:
Diagnosis:
Diagnosis

Modified To:
Modified To

Type of Review/Level: Request Type
RECOMMENDATION: MODIFIED
CUSTOM_CLIENT

Requested Service:
Requested Services

Determination:

After careful review of the submitted medical information listed below, your initial prospective request has received a recommendation of: Modified

Determination, CPT Code Service Line Description

Precertification #: Precert
Start Date: Start Date
End Date: End Date

MPN Label
MPN
Screening Criteria:
Screening Criteria

Principal Reason(s) for the Determination:
Principal Reasons

I have reviewed the above case and attest that I do not have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is the

subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the health care provider, the health provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of this review. I do not accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.

I attest that I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review as well as current, relevant experience and/or knowledge to render a determination for the case under review. I am currently providing direct patient care in this field of expertise and have done so for a minimum of five years.

I attest that I am the assigned reviewer for this case and that I personally rendered the review determination without delegation to another individual.

For appeal reviews, I further attest that I was not involved in the initial denial, non-certification, or modification determination, and I am not subordinate to the individual who made the initial denial, non-certification, or modification determination.

Ethos Reviewer Consulted:

Clinical Peer Reviewer Consulted

UR Rationale and Clinical Review Criteria

The above referenced treatment/service request was reviewed for medical necessity in accordance with California Labor Code 4610. The medical provider has been notified that this specific service DOES NOT meet established criteria for medical necessity and has been MODIFIED based on the information provided and according to the California MTUS or approved secondary guidelines per California Code of Regulations 9792.20.

{The ensuing paragraph is excluded for clients declining participation in the voluntary appeal process}
Voluntary Appeal

Independent Medical Review (IMR) Process: 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 Review, DWC Form IMR*, within the timeframe indicated on the last page of the application. The physician whose request for authorization of medical treatment that was denied or modified may join with or otherwise assist the employee in seeking an independent medical review.

Any dispute under §9792.9.2 shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

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 Phone. 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.

Ethos Complaint Process: Ethos is committed to providing outstanding customer service. If you have an issue or a problem with the services provided by Ethos, you may contact us by telephone at 888-705-1070 or in writing at Ethos Complaint Process,

EthosAddress or at precert@ethosrisk.com or via fax at 888-667-9572. A verbal or written final result notice in response to a complaint will be issued as soon as possible, but no later than thirty (30) calendar days of receipt of the complaint.

Complaint Process Text

This review is based on medical necessity only. For issues of compensability please contact your adjuster [AdjusterName] at [AdjusterPhone].

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Enclosure: *Application for Independent Review, DWC Form IMR*

CC Section

Client Config Letter Footer
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PROOF OF SERVICE

I am a citizen of the United States and a resident of Lafayette, LA; 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, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Broussard, LA, addressed as follows:

Via US Mail/Via Electronic Mail

Injured Worker: Injured Worker's address

Requesting Provider: Requesting HCP Fax, Requestion HCP Address

Plaintiff Attorney: Plaintiff Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

APPEAL OVERTURNED - APPROVED

txtHeaderText

To: Addressee Name
Address Line one
City, State and Zip code

Date: Decision Date

ETHOS provides utilization management in accordance with California Labor Code 4610. ETHOS has been retained by Client to review the medical treatment requested for:

Claimant: Claimant
Date of Birth: DOB
DOI: DOI
Employer: Employer
Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: CLIENT_DATE
RFAI Sent: 00/00/0000 or NA
RFAI Received: 00/00/0000 or NA
Decision Date: Decision Date
UR Reference #: FILE_NUMBER

REVIEW OUTCOME:
Diagnosis:
Diagnosis

Requested Service:
Requested Service

Type of Review/Level: Request Type
RECOMMENDATION: APPROVAL (PRIOR DENIAL OVERTURNED)
CUSTOM_CLIENT

Precertification #: Precert
Start Date: Start Date
End Date: End Date

MPN Label
MPN
Screening Criteria:
Screening Criteria

UR Rationale and Clinical Review Criteria

I have reviewed the above case and attest that I do not have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the health care provider, the health provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of this review. I do not accept

compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.

I attest that I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review as well as current, relevant experience and/or knowledge to render a determination for the case under review. I am currently providing direct patient care in this field of expertise and have done so for a minimum of five years.

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This review applies only to the specific service requested. Additional services require a separate request for authorization.

This is a certification for medical necessity. Per California Code of Regulations 9792.6(b), appropriate reimbursement will be made for the specific service listed. Contact the claim adjuster for an explanation of coverage.

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Complaint Process Text

This review is based on medical necessity only. For issues of compensability please contact your adjuster [AdjusterName] at [AdjusterPhone].

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CC Section

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PROOF OF SERVICE

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I served the within letter(s) on the parties in said action, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Broussard, LA, addressed as follows:

Via US Mail/Via Electronic Mail

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Requesting Provider: Requesting HCP Fax, Requestion HCP Address

Plaintiff Attorney: Plaintiff Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

APPEAL UPHELD - DENIED

txtHeaderText

To: Addressee Name
Address Line one
City, State and Zip code

Date: Decision Date

ETHOS provides utilization management in accordance with California Labor Code 4610. ETHOS has been retained by Client to review the medical treatment requested for:

Claimant: Claimant
Date of Birth: DOB
DOI: DOI
Employer: Employer
Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: CLIENT_DATE
RFAI Sent: 00/00/0000 or NA
RFAI Received: 00/00/0000 or NA
Decision Date: Decision Date
UR Reference #: E_FILE_NUMBER

REVIEW OUTCOME:
Diagnosis:
Diagnosis

Requested Service:
Requested Service

Type of Review/Level: Request Type
RECOMMENDATION: DENIAL (PRIOR DENIAL UPHELD)
CUSTOM_CLIENT

Screening Criteria:
Screening Criteria

Principal Reason(s) for the Determination:
Principal Reasons

I have reviewed the above case and attest that I do not have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the health care provider, the health provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of this review. I do not accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.

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I attest that I am the assigned reviewer for this case and that I personally rendered the review determination without delegation to another individual.

For appeal reviews, I further attest that I was not involved in the initial denial, non-certification, or modification determination, and I am not subordinate to the individual who made the initial denial, non-certification, or modification determination.

Ethos Reviewer Consulted:

Clinical Peer Reviewer Consulted

UR Rationale and Clinical Review Criteria

The above referenced treatment/service request was reviewed for medical necessity in accordance with California Labor Code 4610, by a peer reviewer not involved in the initial denial. The voluntary appeal process involved a review of the original information, supplemented by discussion(s) with the requesting provider and/or review of written medical records. The medical provider has been notified that this specific service DOES NOT meet established criteria for medical necessity based on the information provided and according to the California MTUS or approved secondary guidelines per California Code of Regulations 9792.20. This concludes the voluntary internal appeal process with Ethos.

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See reattached original application.) If you have questions about the information in this notice, please call me (Adjuster Name) at Adjuster Phone. 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.

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Complaint Process Text

This review is based on medical necessity only. For issues of compensability please contact your adjuster [AdjusterName] at [AdjusterPhone].

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Peer-to-Peer Availability: If a peer-to-peer conversation did not occur prior to this notice of non-certification, the attending physician/ordering provider will be provided an opportunity, within one (1) business day of a request, to discuss the non-certification decision. In the event the clinical peer reviewer that made the initial determination cannot be made available within one (1) business day, another qualified clinical peer reviewer will be made available to conduct the discussion. Clinical peer reviewers are available for scheduled calls between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days.

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PROOF OF SERVICE

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Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

APPEAL PARTIALLY UPHELD - MODIFIED

txtHeaderText

To: Addressee Name
Address Line one
City, State and Zip code

Date: Decision Date

ETHOS provides utilization management in accordance with California Labor Code 4610. ETHOS has been retained by Client to review the medical treatment requested for:

Claimant: Claimant
Date of Birth: DOB
DOI: DOI
Employer: Employer
Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: Date_received
RFAI Sent: 00/00/0000 or N/A
RFAI Response Received: 00/00/0000 or N/A
Decision Date: Decision Date
UR Reference #: FILE_NUMBER

REVIEW OUTCOME:
Diagnosis:
Diagnosis

Modified To:
Modified To

Type of Review/Level: Request Type
RECOMMENDATION: MODIFIED (PRIOR DENIAL PARTIALLY UPHELD)
CUSTOM_CLIENT

Requested Service:
Requested Service

Determination:

After careful review of the submitted medical information listed below, your initial prospective request has received a recommendation of: Modified

Determination, CPT Code Service Line Description

Precertification #: Precert
Start Date: Start Date

End Date: End Date

MPN Label
MPN
Screening Criteria:
Screening Criteria

Principal Reason(s) for the Determination:
Principal Reasons

I have reviewed the above case and attest that I do not have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the health care provider, the health provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of this review. I do not accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.

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Ethos Reviewer Consulted:

Clinical Peer Reviewer Consulted

UR Rationale and Clinical Review Criteria

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CONCURRENT - APPROVAL

txtHeaderText

To: Addressee Name
Address Line one
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Date: Decision Date

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REVIEW OUTCOME:
Diagnosis:
Diagnosis

Requested Service:
Requested Service

Type of Review/Level: Request Type
RECOMMENDATION: APPROVAL
CUSTOM_CLIENT

Precertification #: Precert
Start Date: Start Date
Date of Admission/Onset of Services: Date of Admission

End Date: End Date
# of Days/Units of Service Approved: Days Approved
New Total # of Days/Services Approved: New Total Approved
Next Anticipated Review Date: Next Anticipated Date

MPN Label
MPN
Screening Criteria:
Screening Criteria

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Ethos Reviewer Consulted:

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PROOF OF SERVICE

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Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

CONCURRENT - MODIFIED

txtHeaderText

To: Addressee Name
Address Line one
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Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: Client_Date
RFAI Sent: 00/00/0000 or N/A
RFAI Response Received: 00/00/0000 or N/A
Decision Date: Decision Date
UR Reference #: FILE_NUMBER

REVIEW OUTCOME:
Diagnosis:
Diagnosis

Requested Service:
Requested Service

Modified To:
Modified To

Type of Review/Level: Request Type
RECOMMENDATION: MODIFIED
CUSTOM_CLIENT

Precertification #: Precert
Start Date: Start Date
Date of Admission/Onset of Services: Date of Admission

End Date: End Date
# of Days/Units of Service Approved: Days Approved
New Total # of Days/Services Approved: New Total Approved
Next Anticipated Review Date: Next Anticipated Date

MPN Label
MPN
Screening Criteria:
Screening Criteria

Principal Reason(s) for the Determination:
Principal Reasons

I have reviewed the above case and attest that I do not have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review; the covered person whose treatment is the subject of the review and the covered person's

authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the health care provider, the health provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of this review. I do not accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.

I attest that I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review as well as current, relevant experience and/or knowledge to render a determination for the case under review. I am currently providing direct patient care in this field of expertise and have done so for a minimum of five years.

I attest that I am the assigned reviewer for this case and that I personally rendered the review determination without delegation to another individual.

For appeal reviews, I further attest that I was not involved in the initial denial, non-certification, or modification determination, and I am not subordinate to the individual who made the initial denial, non-certification, or modification determination.

Ethos Reviewer Consulted:

Clinical Peer Reviewer Consulted

UR Rationale and Clinical Review Criteria

The above referenced treatment/service request was reviewed for medical necessity in accordance with California Labor Code 4610. The medical provider has been notified that this specific service DOES NOT meet established criteria for medical necessity and has been MODIFIED based on the information provided and according to the California MTUS or approved secondary guidelines per California Code of Regulations 9792.20.

{The ensuing paragraph is excluded for clients declining participation in the voluntary appeal process}
Voluntary Appeal

Independent Medical Review (IMR) Process: 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 Review, DWC Form IMR*, within the timeframe indicated on the last page of the application. The physician whose request for authorization of medical treatment that was denied or modified may join with or otherwise assist the employee in seeking an independent medical review.
Any dispute under §9792.9.2 shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

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 Phone. 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.

Ethos Complaint Process: Ethos is committed to providing outstanding customer service. If you have an issue or a problem with the services provided by Ethos, you may contact us by telephone at 888-705-1070 or in writing at Ethos Complaint Process, EthosAddress or at precert@ethosrisk.com or via fax at 888-667-9572. A verbal or written final result notice in response to a

complaint will be issued as soon as possible, but no later than thirty (30) calendar days of receipt of the complaint.

Complaint Process Text

This review is based on medical necessity only. For issues of compensability please contact your adjuster [AdjusterName] at [AdjusterPhone].

Ethos utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days by calling 888-705-1070.

Peer-to-Peer Availability: If a peer-to-peer conversation did not occur prior to this notice of non-certification, the attending physician/ordering provider will be provided an opportunity, within one (1) business day of a request, to discuss the non-certification decision. In the event the clinical peer reviewer that made the initial determination cannot be made available within one (1) business day, another qualified clinical peer reviewer will be made available to conduct the discussion. Clinical peer reviewers are available for scheduled calls between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days.

Enclosure: *Application for Independent Review, DWC Form IMR*

CC Section

Client Config Letter Footer
Confidentiality Notice: The information contained in this communication and any files transmitted with it may be confidential and legally privileged, including patient information protected by federal and state privacy laws. It is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. If you have received this communication in error, please immediately notify Ethos at 888-705-1070 and destroy and/or delete all copies of the original message.

PROOF OF SERVICE

I am a citizen of the United States and a resident of Lafayette, LA; 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, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Broussard, LA, addressed as follows:

Via US Mail/Via Electronic Mail

Injured Worker: Injured Worker's address

Requesting Provider: Requesting HCP Fax, Requestion HCP Address

Plaintiff Attorney: Plaintiff Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

CONCURRENT – APPEAL OVERTURNED - APPROVAL

To: Addressee Name
Address Line one
City, State and Zip code

Date: Decision Date

ETHOS provides utilization management in accordance with California Labor Code 4610. ETHOS has been retained by Client to review the medical treatment requested for:

Claimant: Claimant
Date of Birth: DOB
DOI: DOI
Employer: Employer
Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: Client_Date
RFAI Sent: 00/00/0000 or NA
RFAI Received: 00/00/0000 or NA
Decision Date: Decision Date
UR Reference #: File_Number

REVIEW OUTCOME:
Diagnosis:
Diagnosis

Requested Service:
Requested Service

Type of Review/Level: Request Type
RECOMMENDATION: APPROVAL (PRIOR DENIAL OVERTURNED)
CUSTOM_CLIENT

Precertification #: Precert
Start Date: Start Date
Date of Admission/Onset of Services:
ADMISSION_DATE
New Total # of Days/Services Approved: NEW_DAYS

End Date: End Date
# of Days/Units of Service Approved:
DAYS_APPROVE
Next Anticipated Review Date:
ANTICIPATED_DATE

MPN Label
MPN
Screening Criteria:
Screening Criteria

UR Rationale and Clinical Review Criteria

I have reviewed the above case and attest that I do not have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the health care provider, the health provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of this review. I do not accept

compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.

I attest that I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review as well as current, relevant experience and/or knowledge to render a determination for the case under review. I am currently providing direct patient care in this field of expertise and have done so for a minimum of five years.

I attest that I am the assigned reviewer for this case and that I personally rendered the review determination without delegation to another individual.

For appeal reviews, I further attest that I was not involved in the initial denial, non-certification, or modification determination, and I am not subordinate to the individual who made the initial denial, non-certification, or modification determination.

Ethos Reviewer Consulted:

Clinical Peer Reviewer Consulted

The above referenced treatment/service request was reviewed for medical necessity in accordance with California Labor Code 4610. The medical provider has been notified that this specific service meets established criteria for medical necessity based on the information provided and according to the California MTUS or approved secondary guidelines per California Code of Regulations 9792.20.

This review applies only to the specific service requested. Additional services require a separate request for authorization.

This is a certification for medical necessity. Per California Code of Regulations 9792.6(b), appropriate reimbursement will be made for the specific service listed. Contact the claim adjuster for an explanation of coverage.

Ethos Complaint Process: Ethos is committed to providing outstanding customer service. If you have an issue or a problem with the services provided by Ethos, you may contact us by telephone at 888-705-1070 or in writing at Ethos Complaint Process, EthosAddress or at precert@ethosrisk.com or via fax at 888-667-9572. A verbal or written final result notice in response to a complaint will be issued as soon as possible, but no later than thirty (30) calendar days of receipt of the complaint.

Complaint Process Text

This review is based on medical necessity only. For issues of compensability please contact your adjuster [AdjusterName] at [AdjusterPhone].

Ethos utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days by calling 888-705-1070.

CC Section

Client Config Letter Footer
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PROOF OF SERVICE

I am a citizen of the United States and a resident of Lafayette, LA; 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, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Broussard, LA, addressed as follows:

Via US Mail/Via Electronic Mail

Injured Worker: Injured Worker's address

Requesting Provider: Requesting HCP Fax, Requestion HCP Address

Plaintiff Attorney: Plaintiff Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

CONCURRENT – APPEAL PARTIALLY UPHELD - MODIFIED

txtHeaderText

To: Addressee Name
Address Line one
City, State and Zip code

Date: Decision Date

ETHOS provides utilization management in accordance with California Labor Code 4610. ETHOS has been retained by Client to review the medical treatment requested for:

Claimant: Claimant
Date of Birth: DOB
DOI: DOI
Employer: Employer
Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: Client_Date
RFAI Sent: 00/00/0000 or N/A
RFAI Response Received: 00/00/0000 or N/A
Decision Date: Decision Date
UR Reference #: File_Number

REVIEW OUTCOME:
Diagnosis:
Diagnosis

Modified To:
Modified To

Type of Review/Level: Request Type
RECOMMENDATION: MODIFIED (PRIOR DENIAL PARTIALLY UPHELD)
CUSTOM_CLIENT

Requested Service:
Requested Services

Determination:

After careful review of the submitted medical information listed below, your initial prospective request has received a recommendation of: Modified

Determination, CPT Code Service Line Description

Precertification #: Precert
Start Date: Start Date
Date of Admission/Onset of Services: Date of Admission

New Total # of Days/Services Approved: New Total Approved

End Date: End Date
# of Days/Units of Service Approved: Days Approved
Next Anticipated Review Date: Next Anticipated Date

MPN Label
MPN
Screening Criteria:
Screening Criteria

Principal Reason(s) for the Determination:
Principal Reasons

I have reviewed the above case and attest that I do not have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the health care provider, the health provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of this review. I do not accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.

I attest that I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review as well as current, relevant experience and/or knowledge to render a determination for the case under review. I am currently providing direct patient care in this field of expertise and have done so for a minimum of five years.

I attest that I am the assigned reviewer for this case and that I personally rendered the review determination without delegation to another individual.

For appeal reviews, I further attest that I was not involved in the initial denial, non-certification, or modification determination, and I am not subordinate to the individual who made the initial denial, non-certification, or modification determination.

Ethos Reviewer Consulted:

Clinical Peer Reviewer Consulted

UR Rationale and Clinical Review Criteria

The above referenced treatment/service request was reviewed for medical necessity in accordance with California Labor Code 4610, by a peer reviewer not involved in the initial denial. The voluntary appeal process involved a review of the original information, supplemented by discussion(s) with the requesting provider and/or review of written medical records. The medical provider has been notified that this specific service DOES NOT meet established criteria for medical necessity and has been MODIFIED based on the information provided and according to the California MTUS or approved secondary guidelines per California Code of Regulations 9792.20. This concludes the voluntary internal appeal process with Ethos.

Independent Medical Review (IMR) Process: 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 Review, DWC Form IMR*, within the timeframe indicated on the last page of the application. The physician whose request for authorization of medical treatment that was denied or modified may join with or otherwise assist the employee in seeking an independent medical review.

Any dispute under §9792.9.2 shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

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 Phone. 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.

Ethos Complaint Process: Ethos is committed to providing outstanding customer service. If you have an issue or a problem with the services provided by Ethos, you may contact us by telephone at 888-705-1070 or in writing at Ethos Complaint Process, EthosAddress or at precert@ethosrisk.com or via fax at 888-667-9572. A verbal or written final result notice in response to a complaint will be issued as soon as possible, but no later than thirty (30) calendar days of receipt of the complaint.

Complaint Process Text

This review is based on medical necessity only. For issues of compensability please contact your adjuster [AdjusterName] at [AdjusterPhone].

Ethos utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days by calling 888-705-1070.

Peer-to-Peer Availability: If a peer-to-peer conversation did not occur prior to this notice of non-certification, the attending physician/ordering provider will be provided an opportunity, within one (1) business day of a request, to discuss the non-certification decision. In the event the clinical peer reviewer that made the initial determination cannot be made available within one (1) business day, another qualified clinical peer reviewer will be made available to conduct the discussion. Clinical peer reviewers are available for scheduled calls between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days.

Enclosure: *Application for Independent Review, DWC Form IMR*

CC Section

Client Config Letter Footer
Confidentiality Notice: The information contained in this communication and any files transmitted with it may be confidential and legally privileged, including patient information protected by federal and state privacy laws. It is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. If you have received this communication in error, please immediately notify Ethos at 888-705-1070 and destroy and/or delete all copies of the original message.

PROOF OF SERVICE

I am a citizen of the United States and a resident of Lafayette, LA; 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, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Broussard, LA, addressed as follows:

Via US Mail/Via Electronic Mail

Injured Worker: Injured Worker's address

Requesting Provider: Requesting HCP Fax, Requestion HCP Address

Plaintiff Attorney: Plaintiff Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

RFA INCOMPLETE NOTICE

txtHeaderText

To: Addressee Name
Address Line one
City, State and Zip code

Date: Decision Date

ETHOS provides utilization management in accordance with California Labor Code 4610. ETHOS has been retained by Client to review the medical treatment requested for:

Claimant: Claimant
Date of Birth: DOB
DOI: DOI
Employer: Employer
Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: CLIENT_DATE_REC
RFAI Sent: 00/00/0000 or NA
RFAI Received: 00/00/0000 or NA
Decision Date: Decision Date
UR Reference #: CASE_NUMBER

RFA NOT COMPLETE:

RFA Reason

Requested Service:
Requested Service

The RFA received is not complete secondary to the reason stated above. This letter serves as notification that no further utilization management action is required to be taken at this time. The submission is withdrawn.

If you have any questions or concerns regarding this notice, an Ethos utilization review nurse is available between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days by calling 888-705-1070.

Claim Adjuster: Adjuster Telephone: Adjuster Phone
Refer all claim questions to Client at:
Telephone: Adjuster Phone Fax: Adjuster Fax

CC:
Ordering/Attending Provider: Requestor, Requesting HCP address
Claim Adjuster: Adjuster, Adjuster address

Client Config Letter Footer

Confidentiality Notice: The information contained in this communication and any files transmitted with it may be confidential and legally privileged, including patient information protected by federal and state privacy laws. It is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. If you have received this communication in error, please immediately notify Ethos at 888-705-1070 and destroy and/or delete all copies of the original message.

PROOF OF SERVICE

I am a citizen of the United States and a resident of Lafayette, LA; 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, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Broussard, LA, addressed as follows:

Via US Mail/Via Electronic Mail

Injured Worker: Injured Worker's address

Requesting Provider: Requesting HCP Fax, Requestion HCP Address

Plaintiff Attorney: Plaintiff Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

RFA NO CHANGE NOTICE

txtHeaderText

To: Addressee Name
Address Line one
City, State and Zip code

Date: Decision Date

ETHOS provides utilization management in accordance with California Labor Code 4610. ETHOS has been retained by Client to review the medical treatment requested for:

Claimant: Claimant
Date of Birth: DOB
DOI: DOI
Employer: Employer
Claim #: Claim #
Client: Client

Requestor: Requesting HCP
Facility: UR Facility
DWC Form RFA First Received: Client_Date
RFAI Sent: 00/00/0000 or N/A
RFAI Response Received: 00/00/0000 or N/A
Decision Date: Decision Date
UR Reference #: File_Number

NO FURTHER ACTION REQUIRED

Requested Service:
Requested Service

The request is for a treatment previously modified or denied within the prior 12 months as previously recommended by this provider. There is no documented change in the facts material to the basis of the prior utilization review decision(s) to modify or deny the request for authorization. **Previous Denial Date:** Previous service denial date

A utilization review decision to modify or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

This letter serves as notification that no further utilization management action is required to be taken at this time.

I have reviewed the above case and attest that I do not have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the health care provider, the health provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of this review. I do not accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.

I attest that I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review as well as current, relevant experience and/or knowledge to render a determination

for the case under review. I am currently providing direct patient care in this field of expertise and have done so for a minimum of five years.

I attest that I am the assigned reviewer for this case and that I personally rendered the review determination without delegation to another individual.

For appeal reviews, I further attest that I was not involved in the initial denial, non-certification, or modification determination, and I am not subordinate to the individual who made the initial denial, non-certification, or modification determination.

Ethos Reviewer Consulted:

Clinical Peer Reviewer Consulted

{The ensuing paragraph is excluded for clients declining participation in the voluntary appeal process}
Voluntary Appeal

Independent Medical Review (IMR) Process: 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 Review, DWC Form IMR*, within the timeframe indicated on the last page of the application. The physician whose request for authorization of medical treatment that was denied or modified may join with or otherwise assist the employee in seeking an independent medical review.

Any dispute under §9792.9.2 shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

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 Phone. 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.

Ethos Complaint Process: Ethos is committed to providing outstanding customer service. If you have an issue or a problem with the services provided by Ethos, you may contact us by telephone at 888-705-1070 or in writing at Ethos Complaint Process, P.O. Box 99, Broussard, LA 70518 or at precert@ethosrisk.com or via fax at 888-667-9572. A verbal or written final result notice in response to a complaint will be issued as soon as possible, but no later than thirty (30) calendar days of receipt of the complaint.

Complaint Process Text

This review is based on medical necessity only. For issues of compensability please contact your adjuster [AdjusterName] at [AdjusterPhone].

Ethos utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days by calling 888-705-1070.

Peer-to-Peer Availability: If a peer-to-peer conversation did not occur prior to this notice of non-certification, the attending physician/ordering provider will be provided an opportunity, within one (1) business day of a request, to discuss the non-certification decision. In the event the clinical peer reviewer that made the initial determination cannot be made available within one (1) business day, another qualified clinical peer reviewer will be made available to conduct the discussion. Clinical peer reviewers are available for scheduled calls between 9:00 a.m. and 5:30 p.m. Pacific Time on normal business days.

Enclosure: *Application for Independent Review, DWC Form IMR*

CC Section

Client Config Letter Footer
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PROOF OF SERVICE

I am a citizen of the United States and a resident of Lafayette, LA; 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, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mailbox at Broussard, LA, addressed as follows:

Via US Mail/Via Electronic Mail

Injured Worker: Injured Worker's address

Requesting Provider: Requesting HCP Fax, Requestion HCP Address

Plaintiff Attorney: Plaintiff Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

Defense Attorney: Defense Attorney Address, Address 2, City, State/Region, Country, Zip/Postal Code, Phone, Fax, Email, Attorney Name, Attorney Title, Company Name

XIII. OVERSIGHT DOCUMENTS

Contracted Physician Review Organizations

Ethos' California Utilization Review program no longer delegates any utilization review function.

All utilization review activities are performed directly by Ethos or by individually contracted reviewers operating under Ethos' oversight, policies, and procedures, in compliance with California Labor Code section 4610, Title 8 California Code of Regulations section 9792.6 et seq., and applicable URAC standards.

In the event Ethos elects to delegate any utilization review function in the future, such delegation shall be disclosed as a material modification and reported in accordance with DWC Form UR-01 requirements. Appropriate oversight, auditing, and accountability mechanisms shall be implemented and documented consistent with regulatory and accreditation standards.

California Client List

Ethos maintains and updates a current list of California utilization review clients as part of its regulatory compliance and UR-01 filing readiness.

The California Client List reflects claims administrators, insurers, self-insured employers, and other entities for whom Ethos performs utilization review services within the State of California.

The Client List is reviewed and updated on an ongoing basis and is retained as an oversight document supporting regulatory filings, audits, and accreditation activities.

CLIENT NAME	ADDRESS	TELEPHONE
Berkshire Hathaway Homestate Companies	15851 Dallas Pkwy, #1120, Addision, TX 75001	800-661-6029
Berkshire Hathaway Homestate Insurance Company	1314 Douglas St., #1400, Omaha, NE 68102	800-661-6029
CCMSI/ABS1, Inc. DBA National HR Solutions, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Acosta	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Advanced Micro Devices	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Advantage Resourcing of America	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AgReserves, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Alliance Interstate Risk – Safety First	P.O. Box 53550, Irvine, CA 92619	866-965-1595

CCMSI/Allied Specialty Vehicles	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS AlphaStaff	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS CBR Management Services, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Cohesive Networks 2, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Employer HR, LLC	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSSI/AmWINS Employers Resource Mgmt. Co.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Geneva Services, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Geneva Staffing	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Harbor American Holdings	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Healthcare Captive	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Infiniti HR Benefits	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Insured Solutions (SS)	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS IS Enterprise	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Key HR, LLC	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS OnePay HR	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Pacific HR, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS PLP Entertainment	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Propel PEO, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS QTI Human Resources, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Resort Program	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Rethink Human Capital Mgmt., Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595

CCMSI/AmWINS Shiftable HR	P.O. Box 53550, Irvine, CA 92619	866-965-1595

CCMSI/AmWINS Shiftable (SS)	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Trion Solutions, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS Vensure Employer Services, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/AmWINS WL Acquisitions, LLC	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/ATA Comp Fund	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Auto Club of Southern California	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Ativus Group (SS)	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Baron HR	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Bunge	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Caesars Entertainment	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Clarendon	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Clear Spring - Fit	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Clear Spring Property and Casualty Co.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/CoAdvantage	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Core Specialty	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Covenant Logistics Group, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/CPC Logistics	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Cracker Barrel	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Diamond PEO	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/E3 HR, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Employco USA, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Employer Solutions Services, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595

CCMSI/Employers Resource	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Engage PEO	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/ESS Employee Leasing, LLC	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/FAR	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Fastcomp	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Ferguson Enterprises, LLC	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Firm Foundation HR, LLC	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Football Northwest, LLC DBA Seattle Seahawks	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Forest River, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Fortune HR DBA Allow Employer Services	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Genesis Insurance Company	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Hansen & Adkins Auto Transport	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/HR Advantage, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/In-N-Out Burger	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Insurance Auto Auctions	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Investment Transportation Services, LLC	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Invo PEO, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/KAR Auction Services	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Kenco Group	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Landcare	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Legendary Staffing	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/LKQ Corp.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Louisiana Pacific	P.O. Box 53550, Irvine, CA 92619	866-965-1595

CCMSI/Marten Transport	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/McKee Foods Corporation	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Medical Solutions	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Motorist Commercial Mutual	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Oasis Outsourcing, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Old Republic	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/One Source Employee Management	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Opportunity Business Services, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Paragon Insurance Holdings	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Pillar Captive	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Pilot Travel Centers	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/ Prosight Artisan Contractors	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Quorom Health Corporation	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Raising Canes	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Red Robin	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/REV Group, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Rollins	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Samuel Hale, LLC	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Sandia Laboratories	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/SAPPI Fine Paper	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/SBM Management Services, LP	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Shutterfly and Lifetouch, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Southern Glazer's Wine & Spirits, LLC	P.O. Box 53550, Irvine, CA 92619	866-965-1595

CCMSI/Southwest Risk Agency Services	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/St. Johns Knits, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Staffmark	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Starstone	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Steadfast Segregated Portfolio	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Tanimura & Antle, Inc.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Terra Captive	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/The Gray Insurance Company	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/The Macerich Company	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/The Neil Jones Food Company	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Transcore	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Trion Solutions Pronto Personnel	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/United Row Towing	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Valero	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Vensure Employer Services	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/VL Best PEO	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Watlow Electric Mfg. Co.	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Wright Tree Service	P.O. Box 53550, Irvine, CA 92619	866-965-1595
CCMSI/Young's Market Company, LLC	P.O. Box 53550, Irvine, CA 92619	866-965-1595
La Quinta	909 Hidden Ridge, Suite 600, Irving, TX 75038	469-417-7447
NovaPro Risk Solutions	401 W. A St, ste 1400, San Diego, CA 92101	949-660-1441
Springfield Insurance	909 E. Republic Rd., Ste C200, Springfield, MO 65807	714-259-1053
US Administrator Claims/Accident Injury Company	P.O. Box 2005, Oakridge, TN 37831	865-481-7950

US Administrator Claims/Republic Group	P.O. Box 2005, Oakridge, TN 37831	865-481-7950
US Administrator Claims/State National	P.O. Box 2005, Oakridge, TN 37831	865-481-7950
Sierra Pacific Industries	P.O.Box 496011 Redding CA 96049	(530) 378-8290
Berkley Medical Management	99 Summer St #1000 Boston, MA 02111	(714) 559-6440
Prime Administrators	7576 N Ingram Ste 101 Fresno, CA 93711	(559) 481-7100
Summit Holdings	117 N Massachusetts Ave, Lakeland, FL 33801	(863) 606-7321
Sutter Health	P.O. Box 160066 Sacramento, CA 95813	(916) 561-6525
UEBTF	1515 Clay St 17th Floor Oakland, CA 94612	(510) 286-7081
UEBTF	320 W. 4th St., 6th floor, Los Angeles, CA 90013	(510) 286-7081