TRISTAR MANAGED CARE

UTILIZATION REVIEW PLAN

ACCREDITED

Workers' Compensation Utilization Management
Expires 06/01/2024

Utilization Review Plan California

TRISTAR Managed Care provides Utilization review services compliant with the State of California regulations and URAC standards. Utilization review (UR) is the process used by employers or claims administrators to review treatment to determine if it is medically necessary. All employers or their workers' compensation claims administrators are required by law to have a UR program. This program is used to decide whether or not to approve medical treatment recommended by a physician, which must be based on the medical treatment guidelines.

The Utilization Review process is governed by Labor Code section 4610 and regulations written by the CA Division of Workers' Compensation (DWC), which lay out timeframes and other rules for conducting UR. The rules, contained in Title 8, California Code of Regulations, sections 9792.6.1 et seq, and Title 8, California Code of Regulations sections 9792.11 – 9792.15. TRISTAR Managed Care conducts Utilization Review in compliance with UR regulations. The TRISTAR Utilization Review Plan is available upon request A copy of this Utilization Review Plan is available to the public by request electronically without a cost. A hard copy of this Utilization Review Plan is available upon request and upon payment of reasonable copying and postage expenses that shall not exceed $0.25 per page plus actual
Postage costs.

9792.6.1 Utilization Review Standards - Definitions - On or After January 1, 2013

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

"Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on either a completed "Request for Authorization," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2), that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Authorization," DWC Form RFA if that form was initially submitted by the treating physician.

"Baseline" Utilization review system portal.

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

"Concurrent Review" is defined as the utilization review conducted during an inpatient hospital stay. The timeframe for making the decision is the same as for prospective reviews. There is a difference in the time allotted for the written communications. A written decision must be sent within 24 hours for concurrent reviews instead of the two business days allotted for prospective reviews.

"Course of treatment" means the course of medical treatment set forth in the treatment plan contained on the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or on the "Primary Treating Physician's Progress Report, DWC Form PR-2, as contained in section 9785.2 or in the narrative form contained the same information required in the DWC Form PR-2.

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

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

"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 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 workers' permanent ability to regain maximum function. Expedited reviews must be completed within 72 hours or less if, the injured worker's condition warrants a shorter timeframe. When an expedited review is needed, the requesting physician must alert the reviewer, by checking the "Expedited Review" box at the top of the RFA

"Expert Reviewer": means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, 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 care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.

"Immediately" means within one business day.

"Material Modification" is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

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

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

"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 this subchapter, beginning with section 9792.20.

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

"Prospective Review" means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the required medical services. The decision on an RFA submitted for prospective review must be made within five business days from first receipt of the request, unless additional reasonable medical information is needed to make the decision. In that case, the additional reasonable medical information must be requested by the fifth business day, then up to 14 calendar days from the date of receipt of the original RFA are allowed for making the decision on the RFA. In California, the terms prospective review and pre-authorization mean the same thing, and prospective review and pre-authorization are different from prior authorization

"Prior Authorization" Prior authorization is an arrangement written into the UR plan that describes the specific conditions or circumstances under which a treating physician will be assured of appropriate reimbursement for specific treatment, without submitting an RFA before, during or after the treatment. As long as that treatment fits the description of prior authorization in the UR plan, the treating physician may treat and then submit the bill for payment. Referral criteria attached to UR plan.

"Request for authorization," means a written request for a specific course of proposed medical treatment. Unless accepted by a claims administrator under section 9792.9.1(c)(2), a request for authorization must be set forth on a "Request for Authorization for Medical Treatment (DWC Form RFA)," completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5. Prior to March 1, 2014, any version of the DWC Form RFA adopted by the Administrative Director under section 9785.5 may be used by the treating physician to request medical treatment."

"**Completed,"** for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization must identify both the employee and the provider, identify with specificity a recommended treatment or treatments, and be accompanied by documentation substantiating the need for the requested treatment.
The request for authorization must be signed by the treating physician and may be mailed, faxed or e-mailed to, if designated, the address, fax number, or e-mail address designated by the claims administrator for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

"RFA/Request for Authorization" An RFA is a form that the doctor is required to use to request treatment, diagnostic tests or other medical services for an injured worker. If the treatment request was first made verbally, it must be confirmed in writing. The treating physician must fill out the form and attach the doctor's first report of occupational injury or illness (form DLSR 5021), the primary treating physician progress report (DWC form PR-2), or a narrative report that contains the same information required in the primary treating physician progress report form

"Retrospective Review" means utilization review conducted after medical services have been provided, and for which approval has not already been given. Retrospective reviews must be completed within 30 days of receiving the necessary information required to make a decision.

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

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

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

"Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. The utilization review process begins when the completed DWC Form RFA, or a request for authorization accepted as complete under section 9792.9.1(c)(2), is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

"Written" includes a facsimile as well as communications 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.

MEDICAL NECESSITY:

The following describe what is considered “medically necessary or appropriate”. The procedure, test or service is:

- Necessary to cure or relieve the effects of the injury
- Safe and effective
- Consistent with the patient’s symptoms, diagnoses, condition or injury
- Likely to provide a clinically meaningful benefit
- Likely to produce the intended health result
- Likely to be more effective than more conservative or less costly services
- Provided not only as a convenience to the patient or the provider
- Represents a benefit that outweighs any risk
- Reasonably expected to diagnose, correct, cure, alleviate or prevent the worsening of illnesses or injuries
- Enables the patient to make reasonable progress in treatment
- Meets the prevailing standard for medical care as outlined in the MTUS or other accepted evidence-based guidelines [unless the treating physician has presented reasonable information to explain why the particular patient does need atypical, unexpected treatment.]

ACCESSIBILITY, INITIATION & INFORMATION

1. Purpose

1.1. This procedure establishes guidelines and requirements for access to TRISTAR Managed Care as well as the initiation of and the use of information in the utilization review process

2. Legislation/Regulation and/or URAC

2.1. Core: 34

2.2. WCUM: 2, 3, 4, 5, 6, 7, 8, 29, 30, 31, 32, 33,

2.3. California Code of Regulations, Title 8, Chapter 4.5,Division of Workers' Compensation, Article 5.5.1 Utilization Review Standards § 9792.10, Labor Code 4610

3. Policy

3.1. The policy of TRISTAR Managed Care is to ensure that all patients and clients have access to TRISTAR staff and services during established business hours.

3.2. TRISTAR Managed Care's policy is to ensure that all requests for utilization review services are accepted and processed in accordance with company policy and procedure and state regulatory rules and requirements

4. Procedure

4.1. Accessibility

4.1.1. TRISTAR Managed Care offices are open from 8:00 am to 8:30 pm EST/EDT on all regular business days Monday through Friday. Access can be accomplished during normal business hours via:

4.1.1.1. Toll free telephone: 855-626-7827

4.1.1.2. Facsimile: 562-506-0355

4.1.1.3. Email: tmc.casemgmt@tristargroup.net

4.1.1.4. Internet: http://tristarmanagedcare.com

4.1.2. All TRISTAR Managed Care staff are trained to identify the company name, their first name and their title when answering or placing outbound calls

4.1.3. TRISTAR Managed Care staff is trained in the procedures for UM and are able to advise callers regarding the procedures and requirements. Procedures and requirements are also included in written notifications and determinations

4.1.4. After business hours, calls to TRISTAR Managed Care's toll-free number are routed to a voice messaging system allowing callers the opportunity to leave a confidential message. All calls received by TRISTAR Managed Care are returned no later than the end of the next business day.

4.1.5. TRISTAR Managed Care staff make outbound calls to providers and facilities during normal business hours (8:00 am to 5:00 pm in the time zone of the provider) unless the parties have agreed to a prior arrangement

4.1.6. TRISTAR Managed Care routinely monitors the TRISTAR Managed Care referral email box for referrals during regular business hours, ensuring access to TRISTAR Managed Care's UM Program

4.1.7. TRISTAR Managed Care staff conduct all review activities telephonically and/or electronically and do not conduct on-site visits to hospitals or patients

4.2. Initiation of Utilization Management Process Standards

4.2.1. TRISTAR Managed Care accepts requests for authorizations from clients and anyone they designate. Typically, TRISTAR Managed Care accepts requests from insurance carriers, managed care companies, employers, patients/injured workers and their legal representatives, requesting/treating physicians, providers, and facilities, or state agencies/regulators.

4.2.2. Requests for appeals are accepted by any party affected by an adverse determination.

4.2.3. TRISTAR Managed Care follows all state rules and regulations regarding the initiation of the utilization management process related to 9792.9.1(a)(1). For purposes of this section, the DWC RFA form shall be deemed to have been received by the claims administrator or its 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 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

4.2.4. Each client determines triggers for utilization management; TRISTAR Managed Care offers consultative services on selection of triggers and recommends a standard list. (Criteria document attached.)

4.2.5. TRISTAR Managed Care does not require pre-certification for emergency admissions or treatment in compliance with 9792.9.1(e)(2). Failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request

4.2.6. Requests are received via telephone, facsimile, email and electronically via the TRISTAR Managed Care secure internet site

4.2.7. Upon receipt of a request for authorization management request, a Case Management Assistant compares the request against the client's program to determine if utilization management is required. Requests that are not part of the client's program are returned to the referring entity with information on how to contact the responsible entity. If a request is identified as a duplicate, it is returned to the referring entity.

4.3. The Case Management Assistant for initial screening processes requests accepted for utilization review compliant with 9792.9.1(c)(2) (A).

4.3.1. Intake does not accept verbal clinical information; calls are transferred to an Utilization Review Medical Case Manager if verbal medical information is provided

4.3.2. All information and medical records received are date stamped if received via paper manually and by the system if received electronically. Handling of all medical information and records is in accordance with URAC Standards.

4.3.3. Upon receipt of a request for authorization or a DWC Form RFA that does not identify the employee or provider, does not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity for the requested treatment, or is not signed by the requesting physician marked "not complete", specifying the reasons for the return of the request no later than five (5) business days from receipt. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

4.3.4. Information received is entered/imaged into the UR portal/Baseline for ease of access among only authorized TRISTAR Managed Care staff and affiliates:

4.3.4.1. Demographic information to include patient full name, date of birth, claim number and all other information provided by referring entity/client

4.3.4.2. Treatment/procedure requested

4.3.4.3. ICD-10 and CPT4/HCPCS codes if indicated but not required

4.3.4.4. Supplied medical records and clinical information

4.3.5. Compensability of claim and accepted body parts may be requested and, in some states, required before the review process can begin

4.3.6. TRISTAR Managed Care accepts information from any reliable source including but not limited to the requesting physician/provider, referring case manager, claim adjuster, employer, patient and/or patient representative.

4.3.7. TRISTAR Managed Care only requests the information reasonably necessary to conduct a review of the medical treatment or service under review; the entire medical record is generally not required for review

4.3.8. The due date of the request is calculated pursuant to state rules/regulations, client requirements and/or TRISTAR Managed Care policy

4.3.9. When a request is accompanied by a request for an expedited review, TRISTAR Managed Care processes according to the expedited review standards. (see Time Frames policy on pg. 41)

4.3.10. All administrative staff have access to licensed health care professionals for any questions during the intake process

4.4. Information for Conducting Utilization Management

4.4.1. TRISTAR Managed Care bases all prospective and concurrent determinations on the medical information and records that was available at the time the review was conducted

4.4.2. TRISTAR Managed Care bases all retrospective determinations on the medical information and records available to the treating physician at the time the care was delivered

4.4.3. For files that require information beyond what was submitted with the request:

4.4.3.1. Utilization Review Medical Case Manager or designated Case Management Assistant requests additional information from the referring party via telephone and facsimile:

- Within one business day of receipt of a concurrent request
- Within three business days of receipt of a prospective request

4.4.3.2. If information is not received within one business day of initial request, then a second request is made via telephone and written request via facsimile to the requesting/treating physician/provider and the following is requested:

4.4.3.3. Specific medical or clinical information required to complete the review
4.4.3.4. Missing critical demographic information required to complete the review
4.4.3.5. The letter provides a facsimile number that information can be faxed to
4.4.3.6. The letter provides a telephone number that information can be called into
4.4.3.7. Requests for reimbursement for copying/sending of medical records and information are handled based on client direction and questions regarding same are directed to the client
4.4.3.8. Any receipt of an invoice for copying/sending medical records or information is forwarded to the client for consideration and action
4.4.3.9. Information received is date stamped and the review process resumes; review due date is adjusted as necessary
4.4.3.10. If the information is not received within one day prior to the due date, then the Utilization Review Medical Case Manager refers to the URAC accredited peer vendor for determination.
4.4.3.11. TRISTAR Managed Care utilizes the URAC accredited peer review services of the follow URAC accredited IRO organizations as listed in the Cover Letter. TRISTAR Managed Care will ensure that the process by which TRISTAR performs its Utilization Review complies with California state law.

- Physician and Surgeons Network
- EZ UR
- Dane Street

CONSUMER PROTECTION AND EMPOWERMENT

1. Purpose

1.1. This policy establishes guidelines to ensure TRISTAR's Utilization Management program has consumer satisfaction and protection processes in place as well as methods and metrics to ensure ongoing compliance.

2. Legislation/Regulation and/or URAC

2.1. Core: 10, 35, 36, 37, 38, 39

2.2. WCUM: 4, 24, 25, 26

2.3. California Code of Regulations, Title 8, Chapter 4.5, Division of Workers' Compensation, Article 5.5.1 Utilization Review Standards §9792.10, Labor Code 4610

3. Policy

3.1. The policy of TRISTAR Managed Care is to ensure that all patients/consumers are educated on their rights and responsibilities as it relates to TRISTAR Managed Care programs and services, to provide for their safety and satisfaction throughout all interactions and to provide a mechanism to allow for feedback regarding access and services provided by TRISTAR Managed Care.

4. Procedure

4.1. Consumer Rights and Responsibilities

4.1.1. Utilization Management (UM) Non-Certifications

4.1.1.1. TRISTAR Managed Care notifies patients/consumers in writing of their rights and responsibilities regarding all appeal options and the appeal process whenever a UM determination results in a non-certification. Letters are sent via US Mail.

4.1.1.2. All TRISTAR Managed Care's written non-certification letters include the specific clinical rationale for which the non-certification was based

4.1.1.3. TRISTAR Managed Care provides information and forms with the UM notification letter for consumers to file complaints and/or appeals with state agencies where such services are available to the consumer. TRISTAR Managed Care cooperates with all external agencies on behalf of TRISTAR clients and the consumer per §9792.10.1.

4.1.2. TRISTAR Managed Care requires all sales & marketing material be reviewed for content and language as it relates this policy

4.2. Client Satisfaction and Complaint System

4.2.1. TRISTAR Managed Care is committed to delivering quality services that provide value to patients/consumers and collects patient satisfaction information to measure. TRISTAR Managed Care will provide each client a mechanism to provide feedback regarding access to services provided by the organization and all urgent matters will be handled immediately by the VP of Operations and/or designee

4.2.2. Client satisfaction will be monitored and measured by collecting satisfaction results through client meetings, and/or complaints and grievances to evaluate our business services provided to clients. The collection of this data will be compiled and presented to the VP of Operations for review monthly. The results will be compiled and presented to the Executive Committee and the Quality Management Committee on a quarterly basis according to established performance initiatives.

4.2.3. TRISTAR Managed Care collects all complaints received, both verbal and written, and maintains a Complaint Log. Complaints will be reviewed upon receipt by a Manager of Case Management Services and a written response will be provided within 30 business days. The collection of this data will be compiled and presented to the VP of Operations for review monthly. The results will be compiled and presented to the Executive Committee and the Quality Management Committee on a quarterly basis according to established performance initiatives.

4.2.4. Consumers are advised of their right to file complaints and/or appeals in all UR notification letters. A manager reviews complaints upon receipt and a written response is provided within 30 business days.

4.2.4.1. If the consumer files an internal appeal, a manager will forward for processing pursuant to standard appeal process and policy

4.2.4.2. If the consumer files an external appeal, a manager will comply with all requests of the external agency and will reply/respond with requested documents as directed and in accordance with TRISTAR Managed Care policy and all applicable rules and regulations. §9792.10.1. Independent medical review (IMR).

4.2.4.3. 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. A request for independent medical review must be communicated by the employee, the employee's representative, or the employee's attorney by mail, facsimile, or electronic transmission to the Administrative Director, or the Administrative Director's designee, within "10 days after the service of the utilization review decision the employee for formulary disputes and within 30 days after the service of the utilization review decision to the employee for all other medical treatment disputes." 4610(h)(1)(A)(B). The request must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision denying or modifying the request for authorization of medical treatment.

4.2.4.4. The physician whose request for authorization of medical treatment was denied or modified, may join with or otherwise assist the employee in seeking an independent medical review. The physician may submit documents on the employee's behalf to the independent medical review organization and may respond to any inquiry by the independent review organization.

4.2.4.5. A provider of emergency medical treatment when the employee faced 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, may submit an application for independent medical review on its own behalf within 30 days of receipt of the utilization review decision that either denies or modifies the provider's retrospective request for authorization of the emergency medical treatment. If expedited review is requested for a decision eligible for independent medical review, the Application for

Independent Medical Review, DWC Form IMR, shall include, unless the initial utilization review decision was made on an expedited basis, a certification from the employee's treating physician indicating that the employee faces an imminent and serious threat to his or her health.

4.2.4.6. If at the time of a utilization review decision the claims administrator is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit an application for independent medical review is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

4.3. Consumer/Patient Safety Mechanism

4.3.1. TRISTAR Managed Care trains all Utilization Review Medical Case Managers to screen for real or potential safety issues during the prospective review process and to refer for Peer Clinical Review and/or notify the patient's/consumer's treating physician as indicated. All files identified during the screening process are also referred to the Manager, Case Management Services for additional referral and resolution as needed. Utilization Review Medical Case managers are trained to screen for:

4.3.1.1. Contraindicated treatment

4.3.1.2. Conservative treatment not addressed or ruled out

4.3.1.3. Adverse drug interactions

4.3.1.4. Inappropriate treatment

4.3.2. TRISTAR Managed Care's UM program requires all Utilization Review Medical Case Managers to be familiar with mechanisms to respond to consumer reports of immediate threats to consumer safety, such as suicidal threats, child abuse, elder abuse, spousal abuse, medication interactions, medical device and drug recalls and/or any other recalls. Upon suspicion of immediate or suspected threats, Utilization Review Medical Case Managers will provide assessment and document findings in the Baseline UR portal. The incident will be immediately reported to the VP of Operations. All medical or psychosocial emergencies will be routed to 911. TRISTAR Managed Care staff complies with the American's with Disabilities Act, workers' compensation and other laws protecting the rights of consumers.

CLINICAL REVIEW PROCESS

1. Purpose

1.1. This procedure establishes guidelines or requirements for the Clinical Review process.

2. Legislation/Regulation and/or URAC

2.1. URAC WCUM: 12, 13, 16, 17, 18, 27, 28, 37, 41

2.2. Utilization Review Standards §9792.1 -9792.8

2.3. California Code of Regulations, Title 8, Chapter 4.5, Division of Workers' Compensation, Article 5.5.1 Utilization Review Standards §9792.10, Labor Code 4610

3. Policy

3.1. The policy of TRISTAR Managed Care is to ensure that the referral process for Peer Clinical Review is consistently applied to all cases when Initial Clinical Review determines the requested treatment/service is outside of approval guidelines.

4. Procedure

4.1. Standards

4.1.1. TRISTAR Managed Care utilizes Utilization Review Medical Case Managers to conduct Initial Clinical Review

4.1.2. The Utilization Review Medical Case Manager cannot issue medical necessity non-certification based on the Initial Clinical Review determination

4.1.3. In cases where the Utilization Review Medical Case Manager cannot issue a medical necessity certification of the requested treatment/service, the file is referred for Peer Clinical Review

4.1.4. Utilization Review Medical Case Manager may certify a portion of the requested service/treatment but only if the requesting/treating physician/provider agrees. If the requesting/treating physician/provider disagrees, then the file is referred for Peer Clinical Review.

4.1.5. TRISTAR Managed Care accesses Peer Clinical Review through the third party, delegated entities that are certified by URAC, meet specific TRISTAR Managed Care need(s), and follow TRISTAR Managed Care policy/procedure.

4.1.6. TRISTAR Managed Care does not reverse certification determinations.

4.1.7. TRISTAR Managed Care does not conduct daily reviews through the concurrent review process unless a client directs otherwise due to the severity or complexity of the injured worker's condition. The frequency of continued review is based on the severity of the patient's condition or necessary treatment and discharge planning activity

4.2. Initial Clinical Review Process

4.2.1. With all information necessary to conduct the review is available, the Utilization Review Medical Case Manager, determines the applicable guideline according to the 'Review Criteria' policy and applies to the supplied medical records and the requested treatment.

4.2.2. When conducting drug utilization management, Initial and Peer Clinical Reviewers must address the following when appropriate:

4.2.2.1. Therapeutic appropriateness

4.2.2.2. Over and underutilization

4.2.2.3. Generic use

4.2.2.4. Therapeutic interchange

4.2.2.5. Duplication
4.2.2.6. Drug-disease contraindications
4.2.2.7. Drug-drug or drug-allergy interactions
4.2.2.8. Drug dosage
4.2.2.9. Duration of treatment
4.2.2.10. Clinical abuse or misuse
4.2.2.11. Drug-age precautions
4.2.2.12. Drug-gender precautions
4.2.2.13. Drug-pregnancy precautions
4.2.2.14. Regulatory limitations
4.2.2.15. Benefit design

4.2.3. If the Utilization Review Medical Case Manager, is not able to recommend the medical necessity of the requested treatment, a referral is made for Peer Clinical Review.

4.2.4. Peer to Peer conversation
Peer Clinical Reviewers are also available to requesting/treating physicians/providers after a non-certification has been rendered but where no conversation occurred prior to the determination being issued.

4.2.4.1. When a request is received, TRISTAR Managed Care attempts to assign to the same entity and Peer Clinical Reviewer who issued the non-certification if available
4.2.4.2. If the original entity and/or Peer Clinical Reviewer is not available, then another entity and/or Peer Clinical Reviewer is assigned.
4.2.4.3. This conversation is conducted before the appeal process begins and within one business day of request from the requesting/treating physician/provider.
4.2.4.4. This process is available for prospective and concurrent requests only; retrospective reviews are based solely on the supplied medical records.
4.2.4.5. If the conversation does not result in a certification of medical necessity, the requesting/treating physician/provider is notified of their right to initiate an appeal and the process of how to request the appeal.

4.3. Internal Appeals

4.3.1. If additional information has been provided, then the Utilization Review Medical Case Manager conducts another clinical review considering the new information. If new information allows, the Utilization Review Medical Case Manager issues a certification.
4.3.2. If no new information is provided or if the Utilization Review-Medical Case Manager is still unable to issue certification after review of the new/additional information, then a referral for Peer Clinical Review is made
4.3.3. If an expedited appeal is upheld, the standard appeal process is offered.

4.4 External Appeals- Independent Medical Review

4.4.1 Following receipt of the Application for Independent Medical Review, DWC Form IMR, the Administrative Director shall determine whether the disputed medical treatment identified in the application is eligible for independent medical review. The Administrative Director may reasonably request additional appropriate information from the parties to determine that a disputed medical treatment is eligible for independent medical review. The Administrative Director shall advise the claims administrator, the employee, and the employee's

provider, as appropriate, by the most efficient means available. The parties shall respond to any reasonable request made within fifteen (15) days following receipt of the request.

4.4.2 A request for independent medical review shall be deferred if, at the time of a UR decision, the claims administrator is also disputing liability for the treatment for any reason besides medical necessity. The parties may appeal an eligibility determination by the Administrative Director that a yes disputed medical treatment is not eligible for independent medical review by filing a petition with the Workers' Compensation Appeals Board. Within one business day following a finding that the disputed medical treatment is eligible for independent medical review, the independent review organization delegated the responsibility to conduct an independent medical review by the administrative director. Within fifteen (15) days following receipt of the mailed 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 claims administrator shall provide to the independent medical review organization all of the following documents.

A. A copy of all reports of the employee's treating physician relevant to the employee's current medical condition produced within one year 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.
B. A copy of the adverse determination by the claims administrator notifying the employee and the employee's treating physician that the disputed medical treatment was denied or modified.
C. A copy of all information, including correspondence, was 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 based on medical necessity.
F. The claims administrator's response to any additional issues raised in the employee's Application for independent medical review.

4.4.3 TRISTAR shall send the employee or the employee's representative a notification that lists all of the documents submitted to the independent review organization and provide a copy of all documents that were not previously provided to the employee or the employee's representative. Any newly developed or discovered relevant medical records will be forwarded to the Independent Review Organization, the claims administrator, the employee or employee's representative or employee's treating physician unless declined or prohibited by law. California Health and Safety Code § 123115(b).

4.4.3.1 Any newly developed or discovered relevant medical records in the possession of TRISTAR after the documents are provided to the independent review organization shall be forwarded to the independent review organization within one (1) business day. TRISTAR shall concurrently provide a copy of the newly developed or discovered

relevant medical records to the employee, or the employee's representative, unless the offer of medical records is declined or otherwise prohibited by law. If the independent review organization requests additional documentation or information from TRISTAR, the additional documentation or other information shall be sent by TRISTAR to the independent review organization, 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.

4.5 Termination of Independent Medical Review

TRISTAR may terminate the independent medical review process at any time upon Written Authorization of the Disputed Medical Treatment.

4.5.1 In the event that the Disputed Medical Treatment is authorized, a settlement or award resolves the Disputed Medical Treatment, or the requesting physician withdraws the Request for Authorization while independent medical review is pending, TRISTAR shall notify the independent medical review organization within five (5) days.

4.6 Implementation of Determination after Independent Medical Review Upon receiving the final determination of the Administrative Director that a Disputed Medical Treatment is Medically Necessary, TRISTAR shall promptly implement the determination unless an appeal is filed or TRISTAR is Disputing Liability for the medical treatment on grounds other than Medical Necessity. If, at the time of receiving the final determination, TRISTAR is Disputing Liability for the medical treatment on grounds other than Medical Necessity, implementation of the final determination shall be deferred until the liability dispute has been resolved.

4.6.1 In the case of reimbursement for services already rendered, TRISTAR shall reimburse the provider or employee, whichever applies, within (20) days after receipt of the final determination, subject to resolution of any remaining issue of the amount of payment pursuant to LC § 4603.2 to 4603.6, inclusive.

4.6.2 In the case of services not yet rendered, TRISTAR shall authorize the services within (5) working days of receipt of the final determination, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the Authorization

4.6.3 In the case of reimbursement for services already rendered, TRISTAR shall reimburse the provider or employee, whichever applies, within 20 days after receipt of the final determination, subject to resolution of any remaining issue of the amount of payment pursuant to LC §§ 4603.2 to 4603.6, inclusive.

4.6.4 In the case of services not yet rendered, TRISTAR shall authorize the services within (5) working days of receipt of the final determination, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the Authorization

4.7 Documentation:

4.7.1 All TRISTAR Managed Care staff are required to document the date, time, and outcome of all calls, contacts, and file activities into the appropriate fields in EHS/Baseline to reduce duplicate requests for information.

4.72 TRISTAR Managed Care requires delegated entities providing Peer Clinical Reviewers to document the following in the final report for every file reviewed:

Date and time of all attempts to reach the requesting/treating physician/provider. Summary of any conversation with the requesting/treating physician/provider

1. A list of all medical records reviewed along with the summary of each record
2. The specific clinical rationale that supports the recommendation
3. The evidence-based guideline/criteria or citation that support the recommendation
4. Attestation regarding credentials (scope of licensure or certification), knowledge and/or current relevant experience, and no conflict(s) of interest
5. Name, credentials with specialty, licensure, and hours of their availability compliant with 9792.9.1(e)(5)(K). 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.

4.7.3 TRISTAR Managed Care maintains appeal files that include the following documentation: The injured worker's name, treating provider, a facility providing treatment Copies of correspondence from the injured worker, treating provider, facility, or organization regarding the appeal. Dates of appeal reviews, documentation of actions taken, and final resolution. Minutes or transcripts of appeal proceedings if applicable. Name and credentials, specialty, licensure, and hours of the clinical peer reviewer compliant with 9792.9.1(e)(5)(K)

LICENSURE AND CREDENTIALING

1. Purpose

1.1. This procedure establishes licensure requirements and qualifications for all staff and establishes guidelines for routine credentialing of professional licensed staff.

2. Legislation/Regulation and/or URAC

2.1. Core: 30, 31, 33

2.2. WCUM: 10, 12, 13, 14, 15, 35, 36, 37

2.3. California Code of Regulations, Title 8, Chapter 4.5, Division of Workers' Compensation, Article 5.5.1 UR Standards, Labor code 4610 Utilization Review Standards 9792.9

3. Policy

3.1. The policy of TRISTAR is to ensure that all professional staff holds the current, proper, and unencumbered license and certifications as well as the required qualifications and experience as defined in the job description to perform their assigned job duties.

4. Procedure

4.1. Standards

4.1.1. TRISTAR Managed Care's Professional Utilization Management (UM) staff are required to hold an unrestricted license in their respective field in the state where they perform their job duties

4.1.1.1. TRISTAR Managed Care Utilization Review- Medical Case Manager must hold one of the following licensures in order to conduct Utilization Management: RN, LPN, and Pharmacist.

4.1.2. TRISTAR Managed Care's professional staff may be required to obtain additional licensure in states as directed by TRISTAR Managed Care who provides reimbursement of costs associated with obtaining and maintaining the same

4.1.3. TRISTAR Managed Care's Utilization Review- Medical Case Managers are paid a salary, hourly wage, or per case/unit fee regardless of the utilization review determination or the consumer's utilization of health care services. Compensation or incentive based on outcomes is not permitted.

4.1.4. TRISTAR Managed Care delegates Peer Clinical Review to URAC certified third parties which are required to comply with TRISTAR Managed Care policy and procedure

4.1.5. The Utilization Review Medical Case Manager who conduct initial clinical review possess an active, professional license or certification;

4.1.5.1. To practice as a health professional in a state or territory of the United States: and

4.1.5.2. With a scope of practice that is relevant to the clinical areas addressed in the initial clinical review.

4.1.5.3. TRISTAR Managed Care does not use Pharmacy Technicians for initial clinical review.

4.1.5.4. The Utilization Review Medical Case Manager is not permitted to issue non-certifications for medical necessity of medical treatment or services. Requests that Utilization Review Medical Case Manager reviewers are not able to issue certification for are referred for Peer Clinical Review

4.1.6. Utilization Review Medical Case Manager does not issue administrative non-certifications due to lack of information.

4.1.7. Peer Clinical Reviewers must meet the minimum qualifications to conduct the review:

4.1.7.1. Hold a current, active, unrestricted license or certification to practice medicine or a health profession in a state, District of Columbia, or territory of the US.
4.1.7.2. Is in the same licensure category as the ordering provider OR is an MD or DO. TRISTAR Managed Care does not utilize pharmacists (RPh) to conduct drug utilization management.
4.1.7.3. Physician Reviewers can modify or denial decisions. The physician reviewers are available to providers at least 4 hours per week in accordance with 9792.9.1 (e)(5)(k)
4.1.7.4. Conducts the review in a US state or territory in compliance with (LC 4610(g))
4.1.7.5. Is deemed qualified by the URAC accredited vendor's Medical Director to conduct the review
4.1.7.6. TRISTAR does not offer or provide any financial incentive or consideration to physicians based on the number of modifications or denials made by the physician in performing utilization reviews. LC 4610(g)

4.1.8. Peer Clinical Reviewers that conduct appeal level review are:
4.1.8.1. Reviewers who meet all of the requirements under 4.1.7
4.1.8.2. Are board-certified by either the ABMS, ABOS, ADA/ABGD, or ABPS/ABPM in their respective specialty if an MD or DO
4.1.8.3. Not the reviewer who issued the original adverse determination
4.1.8.4. Clinical peers of the requesting physician in the same or similar specialty typically manages the medical condition, procedure, or treatment or as mutually deemed appropriate
4.1.8.5. Not the subordinate of the individual who issued the original non-certification

4.2. Process
4.2.1. Peer Clinical Reviewers must evaluate and ensure they have the necessary qualifications and experience to conduct every case they accept. Each case they accept must include an attestation that indicates the reviewer:
4.2.1.1. Has the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review
4.2.1.2. Has current, relevant experience and/or knowledge to render a determination for the case under review
4.2.1.3. The length of time providing direct patient care
4.2.1.4. How recent their relevant direct patient care experience is
4.2.1.5. Compensation is not based on the UR determination

4.3. Third Parties/Peer Clinical Reviewers that do not hold the necessary credentials and experience must return the file for reassignment

4.4. TRISTAR Managed Care's Medical Director is designated as the senior clinical staff person who:
4.4.1. Holds a current, unrestricted clinical license(s) as an MD in the State of California.
4.4.2. Oversees of the CA Workers' Compensation UR program for all decisions made in the UR process
4.4.3. Has the qualifications to perform clinical oversight of the services provided
4.4.4. Is responsible for the overall quality of physician reviews
4.4.5. Has post-graduate experience in direct care and is board certified
4.4.6. Participates in quarterly QMC meetings and assist in the evaluation of outcomes data
4.4.7. Supports TRISTAR's Utilization Review-Medical Case, Manager.

4.5 Credentialing

4.5.1 Full primary source verification of licensure and any certifications is conducted upon hire. On-line verification of license is conducted.

4.5.2 Full primary source verification is performed upon expiration.

4.5.3 TRISTAR Managed Care uses a custom-built credentialing module that does not allow assignment of reviews to individuals if license and/or certifications are not up-to-date.

4.5.4 Maintenance of credentials and licenses is delegated to the Manager, Case Management Services, with the Medical Director maintaining ultimate responsibility.

4.6 Failure to Comply/Non-Renewal

4.6.1 Licensed professional staff is required to notify TRISTAR Managed Care of an adverse change in their licensure or certification status immediately and may not conduct a review until cleared by TRISTAR Managed Care. Immediately is defined as soon as the staff member is aware of the situation and before they conduct a review.

4.6.2 Staff who do not possess a current, valid, and unrestricted license to practice in their respective field are placed in a probationary status and cannot conduct reviews until they obtain active licensure status.

4.6.3 Staff who do not resolve licensure or credentialing issues in a timely manner may be terminated.

4.7 Financial Incentive Policy

4.71.1 TRISTAR does not offer or provide any financial incentive or consideration to physicians based on the number of modifications or denials made by the physician in performing utilization reviews.

NOTIFICATION OF REVIEW DETERMINATIONS

1. Purpose

1.1. To outline the process and method of notifying requesting providers, facilities, and/or injured workers of utilization review determinations.

2. Legislation/Regulation and/or URAC

2.1. WCUM: 22, 23, 24, 25, 33, 34, 40 – California Code of Regulations §9792.9

2.2. State exceptions on resource tool

2.3. California Code of Regulations, Title 8, Chapter 4.5, Division of Workers' Compensation, Article 5.5.1 UR Standards, Labor Code 4610, Utilization Review Standards 9792.1

3. Policy

3.1. TRISTAR Managed Care provides timely notification of all utilization review determinations.

4. Procedure

4.1. Certification Decision Notice and Tracking

4.1.1. For Prospective Review, Concurrent Review, or Expedited Review, Approvals shall be communicated to the requesting physician within 24 hours of the decision and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for Concurrent Review and within two (2) business days for Prospective Review. The written and verbal notification will include the following:

4.1.1.1. Date request for authorization (RFA) was first received

4.1.1.2. Type of review performed;

4.1.1.3. Date on which decision was made;

4.1.1.4. Description of the proposed medical treatment requested;

4.1.1.5. The principal reasons for the certification determination including medical criteria and guidelines and, the rationale used; and

4.1.1.6. Specific description of medical treatment approved.

4.1.2. All utilization management requests are assigned a reference number at the time of receipt. This reference number is included in all correspondence related to the review.

4.1.3. Upon request from the requesting provider, facility rendering service, or worker, TRISTAR Managed Care provides written notification of any certification.

4.2. In addition to 4.1, Concurrent Review Certification Determinations include the following:

4.2.1. All certification determinations for continued hospitalization or services will include the following:

4.2.1.1. Number of extended days/ units of service certified;

4.2.1.2. Next anticipated review point;

4.2.1.3. New total number of days or services approved; and

4.2.1.4. Date of admission or onset of services.

4.3. Written Notice of Non-Certification Decisions and Rationale

4.3.1 For non-certifications, TRISTAR Managed Care issues written notification of the non-certification decision compliant with 9792.9.1(e)(5)(A-K) to the injured worker, the injured worker

representative, requesting provider and/or facility rendering service, and claims examiner that includes:

4.3.1.1 Type of review performed;

4.3.1.2 Date when DWC Form RFA was first received and date on which determination was made; description of the proposed medical treatment requested;

4.3.1.3 List of all medical records received.

4.3.1.4 The principle reasons for the non-certification determination including clinical reasons regarding medical necessity and a description of medical criteria and guidelines and rationale used pursuant to section 9792.8; if a decision to modify or deny medical service is due to incomplete of insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

4.3.1.5 Alternate length of treatment or alternate treatment setting approved, if any; and

4.3.1.6 Instructions in plain language for initiating an appeal of the non-certification.

4.3.1.7 The application of Independent Medical Review, DWC Form IMR. All fields of the form except for the employee's signature will 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 designee.

4.3.1.8 Including 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 workers attorney on behalf of the injured worker on the enclosed Application for IMR DWC form IMR within 10 days after the service of utilization review decision to employee for formulary disputes, and within 30 days after the service of the utilization review decision to the employee for all other medical treatment disputes.

4.3.1.9 The following mandatory language set forth in 9792.9.1(e)(5)(I) 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."

4.3.1.10 Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a clear statement that the internal appeals process is voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but maybe pursued on an optional basis. 9792.9.1(e)(5)(J).

4.3.1.11 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 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. 9792.9.1(e)(5)(K).

4.4 Written Notifications of Appeal Upheld

4.4.1 For upheld non-certifications, TRISTAR Managed Care issues written notification of the upheld non-certification decision of the determination to the injured worker, injured worker representative, requesting provider and/or facility rendering service, and claims examiner that includes

4.4.1.1 The type of review performed

4.4.1.2 Date on which determination was made;

4.4.1.3 Description of the proposed medical treatment requested;

4.4.1.4 The principal reasons for the non-certification determination including medical criteria and guidelines and rationale used;

4.4.1.5 The specific clinical rationale used in making the non-certification determination;

4.4.1.6 Alternate length of treatment or alternate treatment setting approved, if any; and

4.4.1.7 When applicable, information regarding regulatory appeal mechanisms is available to the injured worker. TRISTAR fully cooperates with all state and regulatory appeals processes and will supply information as requested by the client and/or state/regulatory body.

4.5 Independent Medical Review (IMR)

4.5.1 Following receipt of the Application for Independent Medical Review, DWC Form IMR, the Administrative Director shall determine whether the disputed medical treatment identified in the application is eligible for independent medical review. The Administrative Director may reasonably request additional appropriate information from the parties in order to make a determination that a disputed medical treatment is eligible for independent medical review. The Administrative Director shall advise the claims administrator, the employee, and the employee's provider, as appropriate, by the most efficient means available. The parties shall respond to any reasonable request made within fifteen (15) days following receipt of the request.

4.5.2 A request for independent medical review shall be deferred if, at the time of a utilization review decision, the claims administrator also disputes liability for the treatment for any reason besides medical necessity. The parties may appeal an eligibility determination by the Administrative Director that a disputed medical treatment is not eligible for independent medical review by filing a petition with the Workers' Compensation Appeals Board. Within one business day following a finding that the disputed medical treatment is eligible for independent medical review, the independent review organization delegated the responsibility by the Administrative Director to

conduct the independent medical review. Within fifteen (15) days following receipt of the mailed 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 claims administrator shall provide to the independent medical review organization all of the following documents:

A. A copy of all reports of the employee's treating physician relevant to the employee's current medical condition produced within one year prior to the date of the request authorization or in the utilization review determination authorization or in the utilization review determination.
B. A copy of the adverse determination by the claims administrator notifying the employee and the employee's treating physician that the disputed medical treatment was denied or modified.
C. 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 representative provided 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.

4.5.3 TRISTAR shall send the employee or the employee's representative a notification that lists all of the documents submitted to the independent review organization and provide a copy of all documents that were not previously provided to the employee or the employee's representative. Any newly developed or discovered relevant medical records will be forwarded to the independent review organization, the claims administrator and the employee or employee's representative, or the employee's treating physician unless declined or prohibited by law. California Health and Safety Code § 123115(b).

4.5.4 Any newly developed or discovered relevant medical records in the possession of TRISTAR after the documents are provided to the independent review organization shall be forwarded to the independent review organization within one (1) business day. TRISTAR shall concurrently provide a copy of the newly developed or discovered relevant medical records to the employee or the employee's representative unless the offer of medical records is declined or otherwise prohibited by law. If the independent review organization requests additional documentation or information from TRISTAR, the additional documentation or other information shall be sent by TRISTAR to the independent review organization, 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.

4.6 Termination of Independent Medical Review

4.6.1 TRISTAR may terminate the independent medical review process at any time upon Written Authorization of the Disputed Medical Treatment. In the event that the Disputed Medical Treatment is authorized, a settlement or award resolves the Disputed Medical Treatment or the requesting physician withdraws the Request for Authorization while an independent medical review is pending, TRISTAR shall notify the independent medical review organization within five (5) days.

4.7 Implementation of Determination after Independent Medical Review

4.7.1 Upon receiving the final determination of the Administrative Director that a Disputed Medical Treatment is Medically Necessary, TRISTAR shall promptly implement the determination unless an appeal is filed or TRISTAR is Disputing Liability for the medical treatment on grounds other than Medical Necessity. If, at the time of receiving the final determination, TRISTAR is Disputing Liability for the medical treatment on grounds other than Medical Necessity, implementation of the final determination shall be deferred until the liability dispute has been resolved.

4.7.2 In the case of reimbursement for services already rendered, TRISTAR shall reimburse the provider or employee, whichever applies, within (20) days after receipt of the final determination, subject to resolution of any remaining issue of the amount of payment pursuant to LC § 4603.2 to 4603.6, inclusive.

4.7.3 In the case of services not yet rendered, TRISTAR shall authorize the services within (5) working days of receipt of the final determination, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the Authorization.

4.7.4 In the case of reimbursement for services already rendered, TRISTAR shall reimburse the provider or employee, whichever applies, within 20 days after receipt of the final determination, subject to resolution of any remaining issue of the amount of payment pursuant to LC §§ 4603.2 to 4603.6, inclusive.

4.7.5 In the case of services not yet rendered, TRISTAR shall authorize the services within (5) working days of receipt of the final determination, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the Authorization.

REVIEW CRITERIA

1. **Purpose**
   1.1. This procedure establishes guidelines and requirements for the selection, review, implementation, and application of clinical review criteria and guidelines.
2. **Legislation/Regulation and/or URAC**
   2.1. URAC Core: 28
   2.2. URAC WCUM: 1, 9,15
   2.3. California Code of Regulations, Title 8, Chapter 4.5, Division of Workers' Compensation, Article 5.5.1 UR Standards California Code Regulation §9792.8.
3. **Policy**
   3.1. The policy of TRISTAR Managed Care is that all clinical decisions are determined and based on the application of the appropriate evidence-based medicine guidelines and criteria.
4. **Procedure**
   4.1. Standards
      4.1.1. The Medical Director and the Quality Management Committee (QMC) provide oversight and direction regarding all clinical guidelines and criteria utilized by TRISTAR Managed Care staff.
      4.1.2. TRISTAR Managed Care utilizes commercially prepared clinical guidelines and criteria. This ensures that the guidelines are developed with the involvement of appropriate clinical providers with current knowledge relative to the criteria and that they are based on current clinical processes and principles
      4.1.3. TRISTAR Managed Care Utilization Review-Medical Case Managers access online guidelines and criteria to ensure the most currently available guideline is used
      4.1.4. The QMC conducts an annual review of the guidelines and criteria to ensure proper updates have occurred, guidelines still meet needs, etc.
      4.1.5. TRISTAR Managed Care's Medical Director has ultimate responsibility for approving all clinical guidelines and criteria
      4.1.6. TRISTAR Managed Care does not issue non-certification based on initial screening.
5. **Selection and Application**
   5.1. TRISTAR Managed Care Utilization Review- Medical Case managers are required to use the state-mandated guidelines/criteria for the treatment under review. Refer to the training document titled "State Guidelines & Exceptions Resource Tool for Utilization Management" to determine individual state requirements regarding guidelines and criteria.
      5.1.1. The primary guideline utilized in California is the Medical Treatment Utilization Schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM). Adopted pursuant to Labor Code section 5307.27
      5.1.2. Guidelines from the Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM), Official Disability Guidelines (ODG), Presley Reed Medical Disability Advisor/MD Guidelines, Lexicomp Clinical Drug Information, or Milliman Care Guidelines can also be used by the Utilization Review Medical Case Manager, as secondary sources

5.1.3. The Utilization Review Medical Case Manager can recommend certification of requested medical treatment in situations where clinical guidelines are not met and where extenuating clinical information is present to support the recommendation.

5.2. Peer Clinical Review is delegated to URAC-certified third parties who are required to support all recommendations with appropriate evidence-based medicine guidelines and criteria, journal citations/literature, etc.

5.3 The Utilization Review Medical Case Manager and Peer Clinical Reviewers are required to document the selected guideline and the application of the guideline to the clinical picture under review in the appropriate system fields as well as in the final report. The final report contains the entire guideline.

5.4 When selected guidelines and literature searches do not address the treatment/service under review, other relevant specialists, regulatory bodies, and other non-affiliated agencies are used to evaluate and assess emerging technology, experimental and/or investigational treatment, and services.

5.4.1 Available information is reviewed and assessed by the Quality Management Committee (QMC)

5.4.2 The Medical Director has access to other actively practicing physicians and chiropractors, as well as physicians involved in research and academia, for input and feedback.

5.4.3 The QMC approves all medical criteria and guidelines for use by TRISTAR Managed Care clinical staff.

TIMEFRAMES/APPEALS

1. Purpose

This policy defines TRISTAR's timeframes for utilization management (UM) decisions and notification of those decisions.

2. Legislation/Regulation and/or URAC

2.1. WCUM: 19, 20, 21, 38, 39
2.2. State exceptions defined on resource tool
2.3. California Code of Regulations, Title 8, Chapter 4.5, Division of Workers' Compensation, Article 5.5.1 Utilization Review Standards 9792.10, Labor Code 4610

3. Policy

The policy of TRISTAR is to make utilization management processes and decisions in a timely manner to accommodate the clinical urgency of the situation. TRISTAR adheres to this policy unless State or Federal regulations require otherwise and are in compliance with LC 4610 (b)(c).

4. Procedure

Non-Urgent Prospective or Concurrent Review decisions to approve, modify or deny a request for authorization shall be made within five (5) business days from the time of receipt of the completed DWC Form RFA.

4.1 For prospective, concurrent, or expedited review, approvals shall be communicated to the requesting physician within 24 hours of the decision and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.

For prospective, concurrent, or expedited review, a decision to modify or deny shall be communicated to the requesting physician within 24 hours of the decision and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request

4.1.1 For non-urgent cases, this period may be extended one time by TRISTAR Managed Care for up to 14 days from receipt of the RFA if:

4.1.1.1 TRISTAR Managed Care determines the extension is necessary because of matters outside of our control and

4.1.1.2 TRISTAR Managed Care notifies the worker, prior to the expiration of the initial 5 calendar day period, of the circumstances requiring the extension and date when a decision will be made; and

4.1.1.3 If the information reasonably necessary to make a determination/ a worker fails to submit necessary information to decide the case 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. 9792.9.1(f)(3)(A).

4.2 Prospective reviews that are Expedited/Urgent in nature will receive a determination as soon as possible based on the clinical situation, but in no case later than 72 hours of the receipt of the request for a utilization management determination compliant with 9792.9.1(c)(4). Determinations 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).

4.3 Concurrent review determinations will adhere to the following timeframes:

4.3.1 The timeframe for making the decision is the same as for prospective reviews. There is a difference in the time allotted for the written communications. A written decision must be sent within 24 hours for concurrent reviews instead of the two business days allotted for prospective reviews. 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 9792.9.1(e)(6)(A)

4.3.2 For requests to extend a current course of treatment, TRISTAR Managed Care will issue a determination

4.3.2.1 Within 24 hours of the request, per TRISTAR policy, if it is a case involving Expedited/Urgent care and the request for an extension was received at least 24 hours before the expiration of the currently certified period or treatments; or

4.3.2.2 Within 72 hours of the request, if it is a case involving urgent care and the request for extension was received less than 24 hours before the expiration of the currently certified period or treatments.

4.3.2.3 For reductions or terminations in a previously approved course of treatment, TRISTAR Managed Care will issue the determination early enough to allow the injured worker to request a review and receive a review decision before the reduction or termination occurs.

4.4 Retrospective review –Retrospective decisions to approve, modify, or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination. The decision shall include the date it was made and be communicated pursuant to subdivisions 9792.9.1 (d)(3) or (e)(4), whichever is applicable. Payment, or partial payment consistent with the provisions of California Code Regulations, title 8, section 9792.5, of a medical bill for services requested on the DWC for RFA, within the 30-day timeframe set forth in subdivision (c)(4), shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete. A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured employee who received the medical services, and his or her attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

4.5 Internal Appeals and Reconsiderations

4.5.1 Expedited appeals are completed with verbal notification of determination to the requesting Provider within 72 hours of the request followed by a written confirmation of the notification within three (3) calendar days to the injured worker, ordering provider, or facility rendering services.

4.5.2 Standard appeals are completed, and written notification of the appeal decision is issued within five (5) calendar days of the receipt of the request to appeal to the injured worker and attending physician or other ordering provider or facility rendering service.

4.5.3 Appeal and Reconsideration – Within ten (10) calendar days of receipt of the adverse determination, the prescribing physician may submit a written appeal to TRISTAR. The appeal should include any documentation the prescribing physician would like the appellate reviewer to consider. A specialty-matched reviewer will be assigned to review the request and all submitted documentation. This TRISTAR peer reviewer must not have been involved in any previous non-certification determination pertaining to this particular episode of care, nor can the appellate reviewer report to the clinician who performed the original review. TRISTAR will complete the appeal and notify the prescribing physician of the results within thirty (30) calendar days

4.5.4 Reconsiderations - If an adverse determination was rendered due to insufficient information, and previously requested information is subsequently provided, TRISTAR will reconsider the adverse determination within five (5) working days of receipt of the requested information.

4.6 Timeframes – California Extension of Timeframes for utilization review compliant with 9792.9.1(f)

4.6.1 9792.9.1(f)(1) The timeframe for decisions specified in subdivision (c) may only be extended under one or more of the following circumstances:

(A) The claims administrator or reviewer is not in receipt of all of the information reasonably necessary to make a determination

(B) The reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice

(C) The reviewer needs a specialized consultation and review of medical information by an expert reviewer.

(2)(A) If the circumstance under subdivision (f)(1)(A) applies, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization.

(B) If any of the circumstances set forth in subdivisions (f)(1)(B) or (C) are deemed to apply following the receipt of a DWC Form RFA or accepted request for authorization, the reviewer shall within five (5) business days from the date of receipt of the request for authorization notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered.

(3)(A) If the information reasonably necessary to make a determination under subdivision (f)(1)(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.
(B) If the results of the additional examination or test required under subdivision (f)(1)(B), or the specialized consultation under subdivision (f)(1)(C), that is requested by the reviewer under this subdivision 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.
(4) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent review, shall make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information. The requesting physician shall be notified by telephone, facsimile, or electronic mail within 24 hours of making the decision. The written decision shall include the date the information was received, and the decision shall be communicated in the manner set out in section 9792.9.1(d) or (e), whichever is applicable.
(5) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A)(B), or (C), the claims administrator or reviewer, for prospective or concurrent decisions related to an expedited review, shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information. The requesting physician shall be notified by telephone, facsimile, or electronic mail within 24 hours of making the decision. The written notice of decision shall include the date the requested information was received and be communicated pursuant to subdivisions (d)(2) or (e)(3), whichever is applicable.
(6) Upon receipt of the information requested pursuant to subdivisions (f)(1)(A), (B), or (C), the claims administrator or reviewer, for retrospective review, shall make the decision to approve, modify, delay, 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 and be communicated pursuant to subdivisions (d)(3) or (e)(4), whichever is applicable.
(g) 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 claims administrator's file must 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.

4.7 Labor Code 4610

For purposes of this section, "utilization review" means utilization review or 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 and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. For treatment rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer-selected physician, the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.

(c) Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

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

Utilization Management Program Description

1. Purpose

1.1. The purpose of the TRISTAR Managed Care Utilization Management program is to evaluate the medical necessity, appropriateness, and efficiency of any medical services, procedures, facilities, and practitioners as referred by clients. The goal of the program is to provide clients with medical necessity recommendations that are supported by current evidence based medicine and that promote positive patient outcomes.

2. Legislation/Regulation and/or URAC

2.1. URAC Core: 2, 27, 29, 31, 32 – LC 4610, 9792

2.2. URAC WCUM: 2, 7, 10, 11, 12, 13, 33

2.3. California Code of Regulations, Title 8, Chapter 4.5, Division of Workers' Compensation, Article 5.5.1 Utilization Review Standards 9792.10, Labor Code 4610

3. Mission

3.1. Excellence is the constant endeavor in our commitment to quality, service and professional standard in the pursuit of customer satisfaction. We are steadfast in achieving and maintaining excellence in the quality of our work, the professionalism of our teammates and the service we provide to both our customers and their employees. We deliver cost effective outcomes that provide significant value to our customers through teamwork, innovation and employee development.

4. Responsibility

4.1. Responsibility for TRISTAR Managed Care's Utilization Management program (UM) resides with the Medical Director. Development and implementation of the program is delegated to the Vice President of Operations- TRISTAR Managed Care whose responsibilities include:

- 4.1.1. Supervision of all medical management staff including performance assessments, development of key performance metrics/indicators and disciplinary activities including corrective action plans
- 4.1.2. All operational aspects of program implementation and execution including evaluation of program results and outcomes
- 4.1.3. Implementation and application of evidence based clinical guidelines and criteria
- 4.1.4. Regulatory compliance
- 4.1.5. Delegation oversight

4.2. Responsibility for all clinical aspects and decision-making of the UM program is delegated to the Medical Director

- 4.2.1. Requirements of the Medical Director:
  - 4.2.1.1. Holds an unrestricted license to practice medicine in the State of California
  - 4.2.1.2. Is board certified in their respective medical specialty(ies)
  - 4.2.1.3. Has performed direct patient care within the last two years OR has post-graduate experience in direct patient care
  - 4.2.1.4. Holds the necessary qualifications to perform clinical oversight for all company clinical service
- 4.2.2. Responsibilities of the Medical Director:
  - 4.2.2.1. Designated senior clinical staff member

4.2.2.2. The leadership of the Quality Management Committee (QMC) which reviews all medical and clinical policy and process including review and approval of all evidence-based medicine guidelines, criteria, and clinical decision-making tools, complaints, appeals, patient and client satisfaction surveys, delegation oversight, quality assurance program, results and outcomes

4.2.2.3. Oversight and direction of all clinical decision-making tools, guidelines, and criteria

4.2.2.4. Leadership and oversight of the quality assurance program, including studies, projects, and overall outcomes

4.2.2.5. Overall UM program evaluation and effectiveness

4.2.2.6. The Medical Director is responsible for all UR decisions, oversight, and accountability of all clinicians. Ensures clinicians are qualified and accountable to the organization for clinical decision making that affects patients

4.2.2.7. Consultative services and clinical support to the Utilization Review Medical Case Managers.

4.2.2.7.1. The Utilization Review Medical Case Manager can access the Medical Director via a centralized email address or via telephone during normal business hours. The Medical Director designates a licensed doctor of medicine or osteopathy to serve in this capacity to cover his/her absence or times when he/she is not available.

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5. Utilization Management Services

5.1. Prospective reviews evaluate and make medical necessity recommendations on proposed health care services/treatments before services are administered/delivered to the patient. Prospective review is used for elective admissions and non-urgent services. Supporting medical records are requested and at least one treating physician/provider contact attempt is required.

5.2. Concurrent reviews evaluate and make medical necessity recommendations on concurrent and ongoing hospitalizations and/or health care services/treatments. Supporting medical records are requested and at least one treating physician/provider contact attempts are required.

5.3. Retrospective reviews evaluate and make medical necessity recommendations on hospitalizations and/or medical treatment/services that have already been administered/delivered to the patient. Relevant medical records are requested for review, and treating physician/provider contact is not required.

5.4. Appeal reviews evaluate and make medical necessity recommendations on previously non-certified medical treatments and services.

5.4.1. TRISTAR Managed Care offers an expedited and standard internal appeal process when a non-certification has been issued

5.4.2. Appeals are available to all affected parties and/or those specified by the client

5.4.3. Information on the internal appeal processes is included in all written and verbal notifications of non-certifications. The internal appeals process is a voluntary process that neither triggers nor

bars the use of the dispute resolution procedures of LC 4610.5 and 4610.6, but may be pursued on an optional basis. 9792.9.1 (e)(5)(j)

5.4.4. Any dispute will be resolved in accordance with the independent medical review provisions of LC section 4610.5, 4610.6, and 9792.9.1 (e)(5)(H).

6. Access to Company

6.1. TRISTAR Managed Care UM staff are available telephonically each business day for all UM services from 8:00 am to 8:30 pm EST. TRISTAR Managed Care UM staff can be accessed via telephone, facsimile, or email.

6.2. Voice messaging options are provided for callers after business hours. Messages are returned within one business day of receipt.

6.3. TRISTAR Managed Care places no requirements or responsibilities on the injured worker for the UM Process.

7. Staffing

7.1. All clinical staff maintains an unencumbered license to practice in their respective professional field and states. License verification and credentialing is completed according to the 'Licensure & Credentialing policy.

7.2. TRISTAR Managed Care utilizes Utilization Review Medical Case Managers who hold an RN, LVN/LPN, and RPH for Initial Clinical Review.

7.3. Peer Clinical Reviewers (MD, DO, DC, DMD/DDS, DPM, Ph.D.) are available through delegated third-party arrangement(s).

7.4. Non-clinical staff is limited to accepting demographic information and medical records and transferring/imaging the information into TRISTAR Managed Care's system. Non-clinical staff does not interpret medical information.

7.5. TRISTAR Managed Care staff undergo new hire training upon employment/affiliation and receive ongoing training covering the following:

7.5.1. Orientation to managed care, insurance and worker's compensation

7.5.2. Regulatory requirements/rules/regulations

7.5.3. Client expectations and requirements

7.5.4. TRISTAR Managed Care systems

7.5.5. Evidence based medicine guidelines and criteria

7.5.6. Confidentiality, HIPAA, patient privacy

7.5.7. Conflict of interest

7.5.8. URAC

7.6. TRISTAR Managed Care staff receives an annual performance evaluation, which includes an assessment of the quality and accuracy of documentation, clinical decision-making capabilities, adherence to program and customer requirements, communication skills and problem solving ability.

7.7. All TRISTAR Managed Care UM activity is conducted telephonically. TRISTAR Managed Care's corporate office is located in Summerville, SC and staff works in multiple remote locations. Secure log-on procedures and processes both inside TRISTAR Managed Care offices and from any remote access point protect access to TRISTAR Managed Care's systems and data.

8. Utilization Management Process

8.1. The Utilization Review Medical Case Manager's apply evidence based medicine guidelines and criteria to determine if the requested treatment meets the guideline

8.1.1. If the requested treatment meets the guideline, the Utilization Review Medical Case Manager, issues a recommendation for certification of medical necessity.

8.1.2. If the requested treatment does not meet the guideline, the Utilization Review Medical Case Manager, refers the file for Peer Clinical Review. The Utilization Review Medical Case Managers, cannot issue a non-certification for medical necessity.

8.2. Peer Clinical Reviewers conduct a review of supplied medical records and attempt conversation with requesting/treating physician/provider to obtain necessary information to support the request and make a recommendation.

8.3. All determinations and notification of determinations are made within regulatory timeframes and in accordance with applicable regulations in compliance with 9792.9.1 -9792.10.9.

9. Evidence Based Guidelines/Criteria

9.1. TRISTAR Managed Care clinical staff is required to utilize guidelines required by regulation. TRISTAR utilizes the MTUS guidelines as the primary guideline, in the State of California. Absent a mandatory guideline, TRISTAR Managed Care clinical staff utilize evidence-based medicine guidelines and criteria when performing all review activities. Recommended guidelines are accessed via internet to ensure most recent, up-to-date guidelines are used in every review.

9.2. Guidelines and criteria are selected and approved by the Quality Management Committee (QMC).

9.3. The Utilization Review Medical Case Managers are required to utilize only QMC approved guidelines and criteria.

9.4. Peer Clinical Reviewers are accessed through delegated, third-party relationships and are required to follow TRISTAR Managed Care policy and procedure which requires them to support all of their recommendations with appropriate evidence based medicine guidelines and criteria, journal citations/literature, etc.

9.5. When selected guidelines and literature searches do not address the treatment/service under review, other relevant specialists, regulatory bodies, and other non-affiliated agencies are used to evaluate and assess emerging technology, experimental and/or investigational treatment and services.

10. Quality Management & Improvement

10.1. TRISTAR Managed Care's Continuous Quality Improvement Program (CQI) is multi-faceted and designed to both identify potential and/or real quality concerns and issues and to implement expeditious resolution once identified and validated.

10.2. The CQI program assesses staff and affiliate work product to determine:

10.2.1. Compliance with TRISTAR Managed Care policy and procedure.

10.2.2. Compliance with applicable regulatory rules/regulations/URAC.

10.2.3. If timeframes for review were met.

10.2.4. If proper evidence-based guideline was selected and applied to the clinical picture under review.

10.2.5. If action/recommendation was supported in documentation.

10.2.6. If productivity goals were achieved.

10.3. Complaints are opportunities to improve TRISTAR Managed Care services and products. All TRISTAR Managed Care staff and affiliates are required to participate and cooperate with the Complaint Management Process. Complaints are reviewed and handled by the Manager of Case Management and may be referred to the Medical Director and/or Vice President- Medical Management as necessary. All complaints are reviewed in the quarterly Quality Management Committee (QMC).

10.3.1. Quality Improvement Projects (QIP's) are implemented when TRISTAR Managed Care-wide recognition and change is needed to improve TRISTAR Managed Care products and services. The

QMC approves and provides oversight for all QIP's. Two QIP's are always active as part of the CQI cycle.

10.4. TRISTAR Managed Care's Quality Management Committee (QMC) is comprised of the Medical Director, Vice President of Operations- TRISTAR Managed Care, Vice President- Medical Management, Manager of Case Management, and Supervisor of Case Management, Utilization Review. The role of QMC is to provide oversight and direction for all TRISTAR Managed Care products and services. The QMC meets at a minimum quarterly and performs an annual assessment of TRISTAR Managed Care's programs which includes:

10.4.1. Entire CQI Program results and outcomes including QIP's.
10.4.2. Policy and procedure
10.4.3. Complaints and Appeal Data
10.4.4. Key Performance Indicators (KPI) including pertinent statistical data, call center statistics, etc.
10.4.5. Annual Work Plan
10.4.6. Review of delegated entities services and outcomes
10.4.7. Overall effectiveness of CQI Program
10.4.8. Review and approval of all evidence-based medicine guidelines for use by the Utilization Review Medical Case Managers.

10.5. Delegation of any TRISTAR Managed Care products and services may be required for reasons including but not limited to geographic coverage, legal/regulatory compliance, capacity, and appeal requirements. TRISTAR Managed Care maintains program responsibility for all delegated activities and conducts thorough due diligence prior to entering into an agreement. Ongoing oversight of delegated entities is the responsibility of the QMC.

11. Corporate Support

11.1. TRISTAR Managed Care utilizes a customized, proprietary system to house all data and medical information collected during the course of conducting review. The centralization of all data received allows access for all necessary staff and affiliates. High-level assignment and log-on procedures ensure staff and affiliate only see assigned cases and files. All information and data received is stored on the cloud requiring several layers of passwords. TRISTAR Managed Care does not utilize or store data on hard servers.

11.2. Confidentiality of patient medical information and associated information collected during the review process is maintained with the highest level of rigor and integrity. All staff and affiliates are bound by the TRISTAR Managed Care confidentiality policy and are required to review and sign annually. All information is maintained in accordance with all federal, state, and external accreditation agency requirements and regulations.

11.3. TRISTAR Managed Care provides Worker's Compensation services to the following payer source:

11.3.1. Worker's Compensation