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Careworks Managed Care Services, Inc

California Utilization Management Plan

For all dates of injury occurring on or after January 1, 2018

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Prepared for California Utilization Review Program Documentation

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Revisions Table

Plan Adopted: 2019

Revision Dates		
01/21/2021	08/06/2026	
05/02/2025	10/13/2026	
06/30/2026	10/20/2026	

Utilization Management Program Description

Careworks Managed Care Services, Inc. ("Careworks"), a national workers' compensation utilization management organization, has developed and implemented this Utilization Management ("UM") Plan to promote the delivery of medically necessary health care services in an effective, timely, evidence-based, and cost-efficient manner. This Plan is designed to ensure compliance with California workers' compensation laws and regulations, including Labor Code §§ 4600, 4610, 4610.5, 5307.27, and Title 8 California Code of Regulations §§ 9792.6 through 9792.15, as amended effective April 1, 2026. The Plan establishes processes for monitoring, evaluating, and improving the appropriateness, quality, and consistency of medical treatment decisions and utilization review activities

California-specific regulatory requirements applicable to utilization review activities are incorporated into and made part of this Plan. Careworks will maintain and administer its Utilization Review ("UR") Program in accordance with all applicable statutory and regulatory requirements and shall retain responsibility for oversight of all delegated utilization review functions.

The complete Plan, including all policies, procedures, and descriptions of utilization review processes, shall be filed with the Administrative Director as required by California regulations. Careworks shall file any material modifications to its Utilization Review Plan with the Administrative Director within thirty (30) calendar days following implementation of the modification. Material modifications include, but are not limited to, changes in the Medical Director, organizational structure, company name, address, delegated utilization review arrangements, or other changes identified in applicable regulations.

Upon request, Careworks shall make available the complete Utilization Review Plan, including policies, procedures, and descriptions of the utilization review process, as required by California law. Careworks may charge reasonable copying and mailing expenses associated with providing copies of the Plan, consistent with applicable regulatory requirement.

Contracted Provider Requirements: All professional and institutional providers participating directly or indirectly in the delivery of medical services subject to utilization review are required to comply with the provisions of this Utilization Management Plan. Information regarding utilization review criteria, medical necessity standards, treatment guidelines, authorization procedures, and appeal rights shall be made available to providers, injured workers, authorized representatives, employers, payors, and other parties as required by applicable law.

Pharmacy Utilization Review and MTUS Drug Formulary: Pharmacy utilization management activities are conducted in accordance with Labor Code §§4610 and 5307.27, the Medical Treatment Utilization Schedule (MTUS) Drug Formulary, and applicable California workers' compensation regulations effective April 1, 2026. Pharmacy review activities are integrated into the Utilization Review Program and are performed using evidence-based clinical guidelines and formulary requirements established by the Division of Workers' Compensation

Prescription drug requests are evaluated using the MTUS Drug Formulary and applicable statutory exemptions from utilization review. Processes are maintained to identify medications designated as Exempt Drugs under the MTUS Formulary and to ensure such medications are administered in accordance with California law. Requests for medications that are not exempt from utilization review are reviewed for medical necessity using the MTUS Drug Formulary, MTUS treatment guidelines, and other evidence-based medical criteria authorized under California workers' compensation regulations.

Consistent with the April 1, 2026 regulations implementing Assembly Bill 1124, procedures are maintained to recognize and process formulary medications that qualify for statutory exemption from utilization review while ensuring compliance with applicable documentation, prescribing, dispensing, and claims

administration requirements. Exempt drugs are administered in accordance with California formulary requirements and Division of Workers' Compensation regulations

Pharmacists, pharmacy clinical staff, nurse reviewers, and physician reviewers may be utilized, as appropriate, to support formulary compliance, medication safety, drug utilization management, opioid stewardship, evidence-based prescribing practices, and regulatory compliance. Clinical recommendations regarding medication therapy are based on medical necessity, patient safety considerations, formulary status, MTUS guidance, and current evidence-based standards of care.

When a brand-name medication is approved and a therapeutically equivalent generic substitute is available, determination notices shall include the required generic substitution language consistent with applicable California regulations and MTUS Drug Formulary requirements, unless the prescriber has appropriately documented that substitution is not permitted.

Requests for Non-Exempt Drugs, unlisted drugs, compounded drugs, and other medication requests requiring prospective review are evaluated for medical necessity in accordance with the MTUS Drug Formulary, MTUS Treatment Guidelines, and other evidence-based medical criteria authorized under California workers' compensation regulations. Modification and denial determinations shall include all information required by applicable California utilization review regulations, including supporting clinical rationale, applicable guideline citations, and Independent Medical Review (IMR) notice requirements.

Limitations: Nothing in this Utilization Management Plan limits Careworks' authority to review and evaluate treatment recommendations, health care services, professional providers, or institutional providers in accordance with applicable laws, regulations, contractual requirements, and Plan provisions. Nothing contained in this Plan shall interfere with, substitute for, or otherwise affect a provider's independent medical judgment in rendering medically appropriate treatment to an injured worker. Medical necessity determinations made through utilization review do not dictate the practice of medicine and are intended solely to determine authorization of requested services under applicable workers' compensation requirements.

Accreditation and Regulatory Compliance: This Plan has been developed and is maintained in accordance with California Utilization Review Standards and all applicable statutory and regulatory requirements. Careworks shall revise, amend, or supplement its policies and procedures as necessary to maintain compliance with changes in California or federal law.

Consistent with Labor Code §4610 and the regulations effective April 1, 2026, Careworks maintains URAC Workers' Compensation Utilization Management Accreditation and complies with all applicable utilization review plan filing, reporting, oversight, and quality management requirements established by the California Division of Workers' Compensation.

Amendments: This Plan may be modified, supplemented, or amended by Careworks as necessary to maintain regulatory compliance, improve operational effectiveness, incorporate evidence-based practices, or address changes in applicable laws and regulations. Material modifications to the Plan shall be submitted to the California Division of Workers' Compensation in accordance with applicable filing requirements and regulatory timeframes.

Quality Management Program and Annual Evaluation: Careworks maintains an ongoing Quality Management Program designed to assess the effectiveness, consistency, timeliness, accuracy, and regulatory compliance of utilization management activities. The UM Program is subject to periodic review, audit, monitoring, and performance measurement activities.

At least annually, Careworks evaluates the effectiveness of its Utilization Management Program, including utilization review operations, decision-making consistency, reviewer qualifications, regulatory compliance, quality indicators, appeals, Independent Medical Review outcomes, pharmacy management activities, and opportunities for process improvement. Findings and recommendations are reviewed through the organization's quality management structure and incorporated into ongoing quality improvement initiatives.

Confidentiality: All activities involving the review or evaluation of medical treatment, health care services, records, or information relating to an injured worker are confidential and shall be conducted in accordance with applicable federal and state privacy and confidentiality laws.

All Careworks clinical and non-clinical personnel participating in utilization management or utilization review activities are required to execute confidentiality agreements and acknowledge their responsibility to protect confidential information. Access to confidential information is restricted based upon job responsibilities and legitimate business need. Initial and annual privacy and confidentiality training is mandatory for all personnel participating in utilization review activities.

Careworks maintains administrative, physical, and technical safeguards designed to ensure the confidentiality, integrity, and security of protected health information and other confidential records generated or obtained during utilization management and utilization review activities.

Purpose and Scope

Purpose

The purpose of the Careworks Utilization Review Program is to ensure that health care services provided to injured workers are medically necessary to cure or relieve the effects of an industrial injury, appropriate to the accepted industrial condition, consistent with the Medical Treatment Utilization Schedule (MTUS), MTUS Drug Formulary, and applicable evidence-based treatment guidelines, and provided in accordance with California workers' compensation laws and regulations.

The Utilization Review Program promotes quality, timely, and cost-effective medical care through standardized review processes, evidence-based clinical criteria, qualified reviewer oversight, and ongoing monitoring of program performance. The Program is established and administered pursuant to California Labor Code §4610 and related statutory and regulatory requirements governing utilization review. The Program supports compliance with Labor Code §§4600, 4610, 4610.5, and 5307.27, and Title 8, California Code of Regulations §§9792.6 through 9792.15.

The program administers prospective, concurrent, retrospective, and expedited utilization review processes and ensures that utilization review determinations are rendered in accordance with applicable statutory and regulatory requirements, including notification, documentation, appeal, and Independent Medical Review (IMR) requirements. The Program also incorporates applicable MTUS Drug Formulary requirements, including pharmacy utilization review processes and statutory exemptions from prospective utilization review established under California law.

This Utilization Review Plan is submitted in accordance with California Labor Code §4610 and the Division of Workers' Compensation utilization review regulations effective April 1, 2026.

Scope

- California workers' compensation claims for which Careworks performs utilization review or utilization management services.
- Employers, insurers, self-insured employer, public entities, joint power authorities, third-party administrator, and other clients identified in Appendix C, as updated from time to time.
- Prospective, concurrent, retrospective, expedited, pharmacy, appeal, and Independent Medical Review (IMR) related utilization review activities.
- Review of Requests for Authorization (RFAs) and determinations of medical necessity based on the Medical Treatment Utilization Schedule (MTUS), MTUS Drug Formulary, applicable evidence-based treatment guidelines, and other medical evidence permitted under California law.
- Pharmacy utilization review activities, including formulary compliance and applicable statutory exemptions from utilization review.
- Program governance, quality management, confidentiality, reviewer qualifications, utilization review oversight, and required communications with injured workers, providers, employers, claims administrators, purchasers, and payors.

Definitions

For purposes of this Utilization Review Plan, the following definitions shall apply. To the extent a definition is specifically established by California statute or regulation, the regulatory definition shall control. These definitions are intended to be consistent with Labor Code §4610 and Title 8 California Code of Regulations §9792.6.1, effective April 1, 2026.

Term	Definition
Administrative Director (AD)	The Administrative Director of the California Division of Workers' Compensation (DWC) responsible for oversight and enforcement of California workers' compensation utilization review requirements.
Appeal / Internal UR Appeal	A voluntary process through which the requesting physician, injured worker, or authorized representative may seek reconsideration of a utilization review decision that modifies or denies requested treatment.
Claims Administrator	An insurer, self-insured employer, third-party administrator, or other entity responsible for administration of workers' compensation claims, including utilization review activities.
Completed Request For Authorization	A Request for Authorization (RFA) that identifies the injured worker and requesting provider, specifies the requested treatment or service, and includes documentation supporting medical necessity consistent with applicable California workers' compensation regulations.
Concurrent Review	Utilization review conducted during an injured worker's course of treatment, including hospitalization or ongoing care, while treatment is being provided and the patient's condition remains under active review.
Coverage Decision	A determination regarding whether a requested service is a covered workers' compensation benefit, separate and distinct from a medical necessity determination.
Denial	A utilization review decision that refuses, in whole or in part, a request for authorization because the requested treatment or service does not meet applicable medical necessity requirements.
Dispute of Liability or Liability Dispute	A dispute concerning whether an employer is legally responsible for a claimed injury, condition, body part, treatment, or workers' compensation benefit under California law.
Emergency Health Care Services	Health care services provided for a medical condition manifesting acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the patient's health or serious impairment of bodily functions.
Expedited Review	Utilization review conducted when the injured worker's condition is such that application of standard review timeframes could seriously jeopardize the worker's life, health, recovery, or ability to regain maximum function.
Expert Reviewer	A medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia who is competent to evaluate the specific clinical issues involved in the requested treatment and whose consultation has been requested by the claims administrator or utilization review organization for a specialized review requiring an extension of time prior to a determination of medical necessity
Independent Medical Review (IMR)	The independent review process established under Labor Code §4610.5 through which an injured worker may request review of a utilization review decision modifying or denying medical treatment.
Injured Worker	An individual who has sustained an industrial injury or occupational illness arising out of and in the course of employment and who is entitled to workers' compensation benefits.
Material Modification	A significant change to the Utilization Review Plan requiring filing with the Administrative Director, including changes to the Medical Director, company name, corporate structure, address, delegated utilization review arrangements, or other modifications identified by regulation.
Medical Director	A physician licensed in California who is responsible for oversight of the Utilization Review Program, including clinical decision-making, reviewer oversight, quality activities, and regulatory compliance.
Medical Necessity	Health care services reasonably required to cure or relieve the effects of an industrial injury or illness, as determined in accordance with the MTUS and other applicable evidence-based medical treatment guidelines.
Modification	A utilization review decision that authorizes a treatment, service, or medication different from that requested by the treating physician.

MTUS Drug Formulary	The Medical Treatment Utilization Schedule Drug Formulary adopted by the Administrative Director pursuant to Labor Code §5307.27, including provisions governing formulary medications, non-formulary medications, and medications exempt from prospective utilization review.
Non-Physician Reviewer	An individual designated by the Utilization Review Organization to participate in the utilization review process and assist in determining medical necessity. A non-physician reviewer may not independently modify or deny a treatment request.
Normal Business Day / Business Day	Monday through Friday, excluding California state holidays, during Careworks' established business hours.
Working Day	A day on which the Utilization Review Organization is open and conducting utilization review activities consistent with applicable California regulations.
Physician Reviewer	A physician licensed by an appropriate licensing authority and competent to evaluate the specific clinical issues involved in the requested treatment who renders utilization review determinations in accordance with California law.
Prospective Review	Utilization review conducted before the provision of requested medical treatment or services to determine medical necessity.
Provider	A physician, practitioner, facility, or other health care professional or entity licensed or otherwise authorized to provide health care services within the scope of licensure.
Request for Authorization (RFA)	A written, electronic, or other request submitted by a treating physician seeking authorization for medical treatment, services, diagnostics, procedures, medications, durable medical equipment, or other health care interventions. A request for authorization may be submitted by a primary treating physician or secondary treating physician in accordance with applicable California regulations.
Retrospective Review	Utilization review conducted after medical treatment or services have been provided to determine medical necessity.
Reviewer	A physician reviewer or non-physician reviewer participating in the utilization review process. Only a qualified physician reviewer may issue a determination modifying or denying treatment.
URAC	The independent accreditation organization recognized under California workers' compensation regulations for purposes of utilization management accreditation requirements.
Utilization Management Plan (Plan)	The written document developed and maintained by Careworks Managed Care Services, Inc. describing the policies, procedures, clinical criteria, reviewer qualifications, and processes used to evaluate the medical necessity and appropriateness of requested health care services.
Utilization Review (UR)	The process used by a claims administrator or utilization review organization to review and evaluate requested medical treatment and determine whether the requested care is medically necessary based upon applicable treatment guidelines and regulatory requirements.
Utilization Review Organization (URO)	The entity performing utilization review services on behalf of a claims administrator. For purposes of this Plan, Careworks Managed Care Services, Inc. serves as the Utilization Review Organization.
Utilization Review Plan	The written plan maintained by Careworks describing its utilization review program, policies, procedures, quality management activities, reviewer qualifications, and compliance measures required under California law.
Utilization Review Process	The systematic process by which Careworks receives, evaluates, reviews, approves, modifies, or denies requests for medical treatment or services based on medical necessity, clinical information, evidence-based medicine, MTUS guidelines, and applicable regulatory requirements. The process includes prospective, concurrent, retrospective, expedited, pharmacy, appeal, and applicable IMR-related activities.

Utilization Review Process

General Procedures and Intake Process (8 CCR §9792.9.1)

Submission of Requests for Authorization (RFA)

Requests for Authorization (RFAs) and supporting clinical documentation are accepted from treating physicians and authorized providers through designated submission channels established to ensure timely receipt and processing of utilization review requests. RFAs may be submitted by:

- Secure facsimile transmission;
- Secure electronic mail (email);
- Electronic data interchange (EDI) or other approved electronic submission platforms;
- Designated utilization review portals, where available; and
- Other methods authorized by Careworks and permitted by applicable California workers' compensation regulations.

Requests for Authorization may be submitted by a Primary Treating Physician or a Secondary Treating Physician in accordance with applicable California regulations effective April 1, 2026.

For RFAs submitted by facsimile, electronic mail, or electronic data interchange (EDI), the request shall be deemed received on the date it is received and electronically date-stamped by the designated receiving system. If no electronic date stamp is recorded, the date of transmission shall be deemed the date of receipt. RFAs transmitted after 5:30 p.m. Pacific Time shall be deemed received on the next business day, except for expedited or concurrent review requests. Documentation submitted by facsimile, email, or EDI must include evidence of transmission, including the date and time of transmission and the destination facsimile number, email address, clearinghouse, or other electronic recipient. Requesting providers must clearly indicate when expedited review is requested.

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

If an RFA is determined to be incomplete or requires additional information to support review, Careworks shall process the request in accordance with applicable California utilization review requirements. Incomplete RFAs will be returned to the requesting provider informing of incomplete status and will indicate missing criteria as indicated in the April 1, 2026 updated regulation. If the RFA is complete but additional documentation is required, the needed documentation will be requested. Requests for additional reasonable and necessary information, examinations, or specialized consultations shall be made within the regulatory timeframes established by Title 8 California Code of Regulations. Receipt of requested information may result in an extension of the utilization review determination period as permitted by applicable regulations.

Acknowledgment of Receipt

Procedures are maintained to document receipt of all RFAs and associated medical documentation. Requests received through designated submission channels are date and time stamped upon receipt and assigned for utilization review processing.

Receipt of an RFA may be acknowledged through electronic confirmation, facsimile confirmation, system-generated notification, or other documented means when required by law, regulation, contractual obligation, or operational procedures.

Receipt of an RFA initiates the applicable utilization review timeframe, subject to any regulatory provisions permitting extension or tolling of the review period.

Tracking and Logging

An electronic utilization review management system is maintained that records, tracks, and monitors all utilization review activities and regulatory timeframes.

Upon receipt, all RFAs are:

- Date and time stamped;
- Logged into the Careworks utilization review management system;
- Assigned a unique tracking or reference number;
- Routed for clinical review, when appropriate; and
- Monitored for compliance with applicable California utilization review timeframes.

The tracking system records key utilization review activities including:

- Date of receipt of the RFA;
- Review type (prospective, concurrent, retrospective, expedited, pharmacy, or appeal);
- Requests for additional information, examinations, or expert consultation;
- Dates of reviewer assignment;
- Utilization review determinations;
- Communication of decisions; and
- Appeal and Independent Medical Review (IMR) related activities.

Tracking and monitoring processes are utilized to support compliance with Labor Code §4610 and Title 8 California Code of Regulations §§9792.6 through 9792.15.

Dispute of Liability; Deferral (8 CCR §9792.9.2)

A dispute of liability exists when there is a question regarding compensability of the injury, body part, medical condition, treatment request, or other workers' compensation benefit for which the claims administrator may not be legally responsible.

A deferral notice may be issued when permitted by California workers' compensation law and regulations. Deferral of utilization review is limited to circumstances authorized by statute or regulation and shall not be used in place of a medical necessity determination when liability for the requested treatment has been accepted.

Examples of circumstances that may result in a deferral include:

- A dispute regarding whether the claimed injury arose out of and occurred in the course of employment;
- A dispute regarding whether the requested treatment relates to the accepted industrial injury;
- A dispute concerning liability for a specific body part or medical condition;
- A question regarding employee status or entitlement to workers' compensation benefits;
- Circumstances in which compensability of the claim or treatment remains under investigation; or
- Other liability disputes recognized under California workers' compensation law.

In addition, a deferral notice may be issued when Labor Code §4610(k) applies to a treatment recommendation previously denied through utilization review and no documented material change in facts has been provided by the requesting physician. If the requesting physician documents a material change in facts supporting the treatment recommendation, the request shall be referred for utilization review in accordance with applicable regulations.

When a request is deferred, Careworks shall provide notice to the requesting physician and all required parties in accordance with applicable California regulatory requirements. Deferral notices shall identify the basis for the deferral and include all information required by Labor Code §4610 and applicable regulations.

If the claims administrator disputes liability as permitted under California regulations, utilization review may be deferred, and a written deferral decision shall be issued no later than five (5) business days from receipt of the Request for Authorization (RFA). The written decision shall be provided to the requesting physician, the injured worker, and, if represented, the injured worker's attorney, and shall include:

1. The date on which the Request for Authorization was first received;

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

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

4. A plain-language statement advising the injured employee that the dispute shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board; and

5. The following mandatory employee notice:

   "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."

Determinations regarding liability remain the responsibility of the claims administrator and are separate from determinations regarding medical necessity

Timeframe for Decision Making (§9792.9.3)

Prospective, Concurrent, and Retrospective Reviews

Prospective, concurrent, and retrospective utilization review is conducted in accordance with California Labor Code §4610 and Title 8 California Code of Regulations §§9792.9.3 through 9792.9.5.

For purposes of calculating utilization review timeframes, the first day in counting any timeframe requirement is the first normal business or working day following receipt of a completed Request for Authorization (RFA) or a request accepted as complete, except when the applicable timeframe is measured in hours. When a timeframe is measured in hours, the time for compliance shall be calculated from the time of receipt of the Request for Authorization.

- **Prospective Review:** Prospective utilization review decisions shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed **five (5) working days** from receipt of a completed Request for Authorization (RFA).

- **Concurrent Review:** Concurrent review determinations shall be made in a timely manner appropriate to the injured worker's condition and the circumstances of the treatment under review, and generally within **five (5) working days** of receipt of the completed request, subject to applicable regulatory extensions

- **Retrospective Review:** Retrospective review decisions shall be made within **thirty (30) calendar days** of receipt of the information reasonably necessary to make the determination.

All review activities are documented and monitored to ensure compliance with statutory and regulatory requirements.

Concurrent Review

Timely decision-making is essential to ensure continuity of care for injured workers is recognized for receiving ongoing treatment. Concurrent review is performed when treatment is currently being provided and additional services, continued treatment, or extension of care is requested.

When a concurrent review decision involves the modification, suspension, or termination of an ongoing course of treatment previously approved, the requesting physician shall be notified of the decision within **24 hours of the determination** by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. Written notice of the decision shall be issued to the injured worker, and, if applicable, the injured worker's representative, and attorney within 24 hours of the decision.

When the concurrent review determination modifies, suspends, or terminates an ongoing course of treatment and the requesting physician believes the determination warrants an expedited review because the injured worker faces an imminent and serious threat to health, the requesting physician may request an expedited review in accordance with applicable California utilization review requirements.

Careworks shall ensure that concurrent review determinations are communicated in a manner that minimizes disruption of medically necessary care and complies with all applicable California notice requirements.

Careworks may request additional information, examinations, or expert consultation when reasonably necessary to determine medical necessity and permitted by applicable regulations.

Expedited Reviews

expedited utilization review is provided when the injured worker's condition is such that the standard utilization review timeframe could seriously jeopardize the worker's life, health, recovery, ability to regain maximum function, or subject the worker to severe pain that cannot be adequately managed without the requested treatment.

For expedited review requests, Careworks shall make a utilization review determination as soon as medically necessary, but no later than **seventy-two (72) hours** after receipt of the request for authorization.

Expedited determinations may initially be communicated by telephone, fax, electronic transmission, or other expeditious means, followed by written notification to the requesting physician, injured worker, and other required parties as required by California law.

Careworks maintains procedures to identify, prioritize, track, and monitor expedited review requests to ensure compliance with all applicable California utilization review requirements and facilitate timely access to medically necessary care.

Notices for Initial Decisions

Written Decision Content Requirements

Approval Notices (§9792.9.4)

Written approval notices shall be issued for Requests for Authorization (RFAs) in accordance with Labor Code §4610 and Title 8 California Code of Regulations §9792.9.4, effective April 1, 2026. Approval notices shall include, as applicable:

- Identification of the injured worker.
- Date the Request for Authorization was first received.
- Description of the medical treatment, service, medication, or item requested.
- Description of the medical treatment, service, medication, or item authorized.
- Date of the utilization review determination.
- Effective period, duration, quantity, frequency, or other authorization parameters, when applicable.
- If applicable, the written decision shall include the date a request for additional information, examination, or consultation was made under to section 9792.9.6(a)(1)(A), (B), or (C), and the date the information, examination report, or consultation was received.
- Other information required by California workers' compensation statutes and regulations.

Approval determinations shall be communicated to the requesting physician and other required parties within applicable regulatory timeframes.

Modification and Denial Notices (§9792.9.5)

All modification and denial determinations shall be made by a qualified physician reviewer and communicated in writing in accordance with California workers' compensation requirements.

Modification and denial notices shall include, as applicable:

- Identification of the injured worker.
- Date the Request for Authorization was first received.
- Description of the treatment, service, medication, or item requested.
- If the timeframe for decision was extended pursuant to section 9792.9.6, the written decision shall also include a specific description of the information needed to make a medical necessity determination of the treatment request; the date(s) and time(s) the request(s) for information, examination, or expert consultation under section 9792.9.6(a)(1)(A), (B), or (C) were made; the manner in which the requests were made; and the date the requested information, examination report, or consultation was first received.
- Description of the treatment, service, medication, or item modified or denied.
- A list of all medical records reviewed.
- A specific description of the medical treatment service approved, if any.
- Identification of the URAC accredited entity, approved by the Division of Workers’ Compensation, that is liable for the utilization review decision.
- Date of the utilization review determination.
- Clear clinical rationale supporting the determination.
- Specific medical necessity criteria, guidelines, studies, or evidence relied upon in reaching the decision, including applicable MTUS provisions, MTUS Drug Formulary provisions, or other evidence-based treatment guidelines authorized by law.
- The evaluator's clinical reasons for the decision.

- The reviewer's name and specialty, the reviewer's California license number, a telephone number where the reviewer or the reviewer's designee may be contacted, and the hours of availability of the reviewer or the reviewer's designee for discussion of the determination with the requesting physician. Such availability shall be provided for a minimum of four (4) hours per week during normal business hours, defined as 9:00 a.m. to 5:30 p.m. Pacific Time.
- The Application for Independent Medical Review, DWC Form IMR (Rev. 04/01/2026), which is hereby incorporated by reference. All fields of the form, except for the signature of the employee, must be completed by the claims administrator. The written decision provided to the injured worker, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.
- A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application
- The notice shall also include details regarding the claims administrator's internal utilization review appeals process for the requesting physician, if any, including disputes regarding the necessity of or availability of requested information, and a clear statement that any internal utilization review appeals process is voluntary and neither triggers nor precludes the injured worker's right to pursue Independent Medical Review pursuant to Labor Code §§ 4610.5 and 4610.6. Participation in any internal appeals process is optional and may be pursued concurrently with, before, or instead of the statutory Independent Medical Review process, as permitted by applicable law.
- The written determination shall include the following mandatory language advising the injured employee:

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

  "For information about the workers' compensation claims process and your rights and obligations, go to Division of Workers' Compensation *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."*

  Any additional notices, disclosures, information, forms, and attachments required by Labor Code § 4610, Labor Code §§ 4610.5 and 4610.6, and applicable California utilization review and Independent Medical Review regulations

Notice language and content shall comply with California Labor Code § 4610 and Title 8, California Code of Regulations § 9792.9.5, as amended effective April 1, 2026. Written modification or denial notices shall include all information required by section 9792.9.5(e), including but not limited to: the date the completed or accepted Request for Authorization was received; any extension information required under section 9792.9.6; a description of the treatment, service, medication, or item requested; the clinical reasons for the determination; the criteria or guidelines relied upon in making the determination; the reviewing physician's name, specialty, California license number, contact information, and hours of availability; information regarding the requesting physician's right to discuss the determination with the reviewer; a description of the injured worker's rights regarding Independent Medical Review (IMR), including applicable deadlines and procedures; details regarding any voluntary internal utilization review appeals process; the mandatory

employee notices required by section 9792.9.5(e)(12); and any other notices, disclosures, forms, attachments, or information required by Labor Code §§ 4610, 4610.5, and 4610.6 and applicable regulations.

Extension of Timeframe for Decision (§9792.9.6)

When Careworks determines that an extension of the utilization review decision timeframe is necessary, the timeframe may be extended only under one or more of the following circumstances:

1. The claims administrator or reviewer is not in receipt of all information reasonably necessary to make a determination;
2. The reviewer has requested an additional examination or test to be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice; or
3. The reviewer requires a specialized consultation and review of medical information by an expert reviewer.

If the reviewer or non-physician reviewer determines that additional information is reasonably necessary to make a determination, the requested information shall be sought from the treating physician within five (5) business days from the date of receipt of the Request for Authorization (RFA).

If the physician reviewer determines that an additional examination or test is required, or that a specialized consultation is necessary, the physician reviewer shall, within five (5) business days from receipt of the completed or accepted Request for Authorization, provide written notice to the requesting physician, the injured worker, and, if represented, the injured worker's attorney, that the reviewer cannot make a decision within the required timeframe and shall request the additional examination or test required or indicate that consultation by an expert reviewer is needed. When an expert consultation is requested, the specialty of the expert reviewer shall be identified.

If the information reasonably necessary to make a determination that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed or accepted Request for Authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, a physician reviewer shall deny the request in accordance with California Code of Regulations section 9792.9.5(e).

If the results of the additional examination or test, or the specialized consultation requested by the physician reviewer, are not received within thirty (30) days from the date of the Request for Authorization, the physician reviewer shall deny the treating physician's request in accordance with California Code of Regulations section 9792.9.5(e).

Upon receipt of the information requested pursuant to section 9792.9.6(a)(1)(A), (B), or (C):

- For prospective or concurrent review, the decision to approve, modify, or deny the Request for Authorization shall be made within five (5) business days of receipt of the information
- For expedited review, the decision to approve, modify, or deny the Request for Authorization shall be made within seventy-two (72) hours of receipt of the information.
- For retrospective review, the decision to approve, modify, or deny the Request for Authorization shall be made within thirty (30) calendar days of receipt of the information.

All requests for additional information, examinations, tests, or expert consultation, including the date, time, and manner of the request and the date the requested information, examination results, or consultation was received, shall be documented in the utilization review record.

MTUS Drug Formulary Decisions (§9792.9.8)

Pharmacy utilization review and formulary determinations are administered in accordance with the MTUS Drug Formulary and regulations effective April 1, 2026.

When applicable, utilization review notices involving prescription medications shall clearly identify:

- Whether the medication is a formulary drug.
- Whether the medication qualifies for a statutory exemption from prospective utilization review.
- Whether the medication is Exempt per MTUS Drug Formulary.
- **"Generic Substitute Authorized"** when applicable
- Any applicable formulary status affecting authorization.
- The medical necessity rationale supporting approval, modification, or denial when utilization review is required.

Careworks shall utilize all required formulary-related notice language, labeling, and disclosure requirements established by the Division of Workers' Compensation for MTUS Drug Formulary determinations.

Duplicate Requests and Prior Utilization Review Determinations (§§9792.9.2(a) and 9792.9.5(g))

Pursuant to Labor Code §4610(k) and applicable California regulations, a prior utilization review denial may remain effective for twelve (12) months with respect to the same treatment recommendation from the same physician.

Careworks may issue a deferral notice when:

- The treatment request seeks authorization for the same treatment previously denied through utilization review;
- The prior denial remains within the applicable 12-month period; and
- The subsequent request does not contain documentation establishing a material change in facts relevant to the prior denial.

The twelve (12) month rule shall not apply when the repeat treatment request includes an express or unequivocal statement by the requesting physician indicating that there has been a change in facts material to the basis of the prior utilization review denial and includes documentation supporting the change.

When a requesting physician documents a material change in facts supporting the treatment recommendation, Careworks shall process the request through utilization review and obtain a medical necessity determination in accordance with applicable California workers' compensation laws and regulations.

Careworks shall provide all required notices regarding duplicate requests, prior denials, and applicability of Labor Code §4610(k) in accordance with the regulations effective April 1, 2026.

Regulatory Decision Timeframes

Careworks shall issue utilization review determinations within the timeframes required by California Labor Code §4610 and applicable regulations.

- Prospective and concurrent review decisions shall generally be made within five (5) working days from receipt of a completed Request for Authorization and in no event more than fourteen (14) calendar days from receipt of the request, except as otherwise permitted by regulation.
- Retrospective review decisions shall be made within thirty (30) calendar days of receipt of the information reasonably necessary to make the determination.
- Expedited review decisions shall be made as soon as medically necessary and no later than seventy-two (72) hours following receipt of the request.

Utilization Review Criteria(8 CCR §9792.8)

Medical Necessity

All utilization review determinations shall be based on medical necessity in accordance with California Labor Code §§4600, 4610, and 5307.27 and applicable utilization review regulations. Requested treatment shall be evaluated to determine whether the service is reasonably required to cure or relieve the effects of the industrial injury or illness. Medical necessity determinations shall be based upon the best available evidence and the hierarchy of evidence established under California workers' compensation law.

The primary basis for medical necessity determinations shall be the Medical Treatment Utilization Schedule (MTUS), including applicable treatment guidelines, chronic pain guidelines, specialty guidelines, and other evidence-based treatment recommendations adopted by the Administrative Director. When MTUS does not specifically address a requested treatment, Careworks shall apply the evaluation methodology and evidence standards authorized by California law and regulation

Authorized Treatment

Requests for Authorization (RFAs) shall be approved, modified or denied based upon medical necessity, applicable MTUS guidelines, the MTUS Drug Formulary, and other evidence-based medical criteria permitted under California workers' compensation law.

Utilization review determinations shall be made by qualified reviewers and shall be supported by documented clinical rationale. All decisions shall be consistent with applicable statutory and regulatory requirements and communicated within required regulatory timeframes. Approval, modification, and denial decisions shall include the documentation and notice requirements established under California utilization review regulations

First 30-Day Exemption (§9792.9.7)

Certain medical treatment may qualify for exemption from prospective utilization review during the first thirty (30) days following the date of injury when the conditions established by California law and regulation are satisfied. Medically necessary treatment that is consistent with the MTUS and otherwise qualifies for the statutory exemption may be provided without prospective utilization review during this period.

Requests shall be administered subject to the first 30-day exemption in accordance with Labor Code §4610 and Title 8 California Code of Regulations §9792.9.7, as effective April 1, 2026. Treatment requests that do not qualify for the exemption remain subject to utilization review requirements. Specifically, unless previously authorized by the claims administrator or rendered as emergency medical treatment, the following services are not exempt and require prospective utilization review:

1. Pharmaceuticals, except those expressly exempt from prospective review under the MTUS Drug Formulary;
2. Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician's office, including all necessary and routine pre-operative, intra-operative, and post-operative services;

3. Psychological or psychiatric treatment services, including diagnostic services, psychotherapy, other behavioral health services, and psychiatric pharmaceuticals not expressly exempt under the MTUS Drug Formulary;
4. Home health care services, including healthcare and other medically necessary services provided in the injured worker's residence;
5. Imaging and radiology services, excluding X-rays;
6. Durable medical equipment, prosthetics, orthotics, and supplies where the purchase or rental cost exceeds $250, as determined under the Official Medical Fee Schedule (OMFS), or where an unlisted item exceeds a billed amount of $250;
7. Electrodiagnostic medicine services, including electromyography (EMG), nerve conduction studies, and other neurology and neuromuscular diagnostic procedures; and
8. Spinal injections, including therapeutic medial branch nerve block injections, facet joint injections, intradiscal injections, epidural injections, and sacroiliac joint injections.

Treatment requests falling within any of the categories above shall be subject to prospective utilization review and processed in accordance with California utilization review requirements.

Drug Authorization

Pharmacy utilization review is administered in accordance with the MTUS Drug Formulary, Labor Code §§4610 and 5307.27, and the California utilization review regulations effective April 1, 2026. Medication requests shall be evaluated based upon formulary status, medical necessity, FDA-approved indications when applicable, clinical appropriateness, patient safety considerations, and applicable MTUS guidance.

Drugs identified as exempt under the MTUS Drug Formulary and applicable California regulations shall be processed in accordance with statutory and regulatory exemption requirements. Requests for medications that are not exempt from utilization review shall be reviewed for medical necessity using the MTUS Drug Formulary, MTUS treatment guidelines, and other evidence-based medical criteria authorized by California law.

Pharmacists, nurse reviewers, physician reviewers, and other qualified clinical personnel may be utilized to support formulary compliance, medication safety, opioid stewardship, and evidence-based prescribing practices. Approval, modification, and denial determinations involving prescription medications shall include all notices, rationale, and disclosures required by California workers' compensation laws and regulations, including applicable Independent Medical Review (IMR) rights.

Medication requests requiring utilization review shall be processed within the timeframes established by California Labor Code §4610 and applicable regulations. Prospective and concurrent review determinations shall be made in a timely manner appropriate to the injured worker's condition and generally within five (5) working days of receipt of a completed Request for Authorization. Requests containing both prescription medications and non-pharmaceutical treatment services shall be processed as mixed treatment requests and reviewed under the general utilization review timeframes and procedures established by California Labor Code §4610 and applicable regulations. Retrospective review determinations shall be made within thirty (30) calendar days of receipt of the information reasonably necessary to make the determination. Expedited review determinations involving prescription medications shall be made as soon as medically necessary, but no later than seventy-two (72) hours after receipt of the request.

Prescription medications designated as exempt from prospective utilization review pursuant to the MTUS Drug Formulary, Assembly Bill 1124, and applicable California regulations shall be processed

in accordance with the exemption provisions established by law and shall not be subject to prospective utilization review when the regulatory requirements for exemption have been satisfied.

Procedures shall be maintained to identify formulary medications, non-formulary medications, and medications eligible for exemption from prospective utilization review and shall communicate formulary-related determinations in accordance with applicable California workers' compensation notice and documentation requirements

Appeal and Independent Medical Review

Injured workers and treating providers have the right to challenge utilization review determinations is recognized in accordance with California Labor Code §§ 4610 and 4610.5 and Title 8 California Code of Regulations §§ 9792.10.1 et seq., effective April 1, 2026. Utilization review decisions modifying or denying requested treatment shall include information regarding applicable appeal rights and Independent Medical Review (IMR) procedures.

Internal Review and Administrative Director Appeals

A requesting physician may utilize Carework's internal utilization review appeal process, to discuss or seek reconsideration of a utilization review determination, including disputes regarding the necessity of or availability of requested information. Any request for an internal appeal must be submitted within ten (10) days after receipt of the utilization review determination. Internal appeals shall be completed within thirty (30) days of receipt of the appeal request. If the dispute involves only a drug listed on the MTUS Drug List, the internal appeal shall be completed within ten (10) days of receipt of the appeal request. Any internal utilization review appeal process is voluntary and neither triggers nor bars use of the dispute resolution procedures set forth in Labor Code §§ 4610.5 and 4610.6. Participation in the internal appeal process does not extend, toll, replace, or otherwise affect the statutory timeframes applicable to Independent Medical Review (IMR).

An injured worker who disagrees with a utilization review decision may request Independent Medical Review (IMR) by submitting an Application for Independent Medical Review. The completed IMR application must be filed within thirty (30) days of the mailing date of the utilization review determination. For disputes involving a utilization review decision concerning a drug subject to the MTUS Drug Formulary, the injured worker must request Independent Medical Review within ten (10) days of the mailing date of the utilization review determination. The IMR application and supporting documentation must be submitted in accordance with the instructions accompanying the utilization review determination and applicable California workers' compensation laws and regulations.

Procedures are maintained for the review and handling of disputes involving utilization review determinations as permitted under applicable California workers' compensation laws and regulations.

Upon receipt of an appeal, dispute, regulatory inquiry, or Administrative Director request for review, Careworks shall:

- Log and track the matter within its utilization review management system;
- Assign appropriate personnel to coordinate the response;
- Gather and review all documentation related to the utilization review determination, including the Request for Authorization (RFA), supporting medical records, reviewer notes, correspondence, and applicable treatment guidelines;
- Coordinate with the reviewing physician, Medical Director, claims administrator, and other appropriate parties, as necessary;
- Prepare and submit required documentation to the Administrative Director within applicable regulatory timeframes; and
- Maintain records of the appeal, review, and disposition in accordance with applicable record retention requirements.

Careworks shall cooperate fully with any review, audit, investigation, or appeal process conducted by the Administrative Director and shall provide requested documentation and information in accordance with applicable California regulations.

Independent Medical Review (IMR)

An injured worker may request Independent Medical Review (IMR) of a utilization review decision that modifies or denies a requested medical treatment pursuant to Labor Code §4610.5 and applicable California regulations. IMR is administered by the Division of Workers' Compensation through an independent review organization designated by the Administrative Director and is the process for resolving disputes regarding medical necessity.

For all utilization review decisions subject to IMR, Careworks shall:

- Include the DWC-required IMR application and all required notices with the modification or denial determination.
- Provide notice of the injured worker's right to request Independent Medical Review.
- Include information regarding IMR filing requirements, applicable deadlines, and submission instructions.
- Maintain records demonstrating compliance with IMR notification requirements.
- Cooperate with the claims administrator, Administrative Director, and Independent Medical Review organization throughout the IMR process.

IMR Filing Process

An injured worker may request Independent Medical Review (IMR) of a utilization review decision that modifies or denies requested treatment pursuant to Labor Code §4610.5 and applicable California regulations.

To request IMR, the injured worker, the injured worker's representative, or other authorized individual must complete and submit the required IMR Application to the Division of Workers' Compensation along with a copy of the utilization review determination and any supporting documentation.

The completed IMR application must be filed within thirty (30) days of the mailing date of the utilization review decision modifying or denying the requested treatment to the injured worker. Failure to submit the application within the required timeframe may result in dismissal of the application unless otherwise permitted by law or regulation.

For disputes involving a utilization review decision concerning a drug subject to the MTUS Drug Formulary, the injured worker must request Independent Medical Review within ten (10) days of service of the utilization review determination.

Any internal utilization review appeal process available to the requesting physician is voluntary and may be used to discuss or seek reconsideration of a utilization review determination, including disputes regarding the necessity of or availability of requested information. Participation in the internal appeal process neither triggers nor bars use of the dispute resolution procedures set forth in Labor Code §§ 4610.5 and 4610.6. Participation in an internal appeal process does not extend, toll, replace, or otherwise affect any statutory or regulatory deadlines for requesting Independent Medical Review.

Upon receipt of a completed application, the Administrative Director will determine whether the dispute is eligible for Independent Medical Review. If eligibility requirements are satisfied, the matter will be assigned to an Independent Medical Review organization designated by the Administrative Director.

IMR Timeline and Careworks Responsibilities

Upon notification that an Independent Medical Review (IMR) application has been accepted for review by the Administrative Director, Careworks shall immediately initiate its IMR coordination process and collect all records required for submission. Careworks shall submit utilization review records, medical records, treatment guidelines, reviewer reports, correspondence, and other supporting documentation to the Administrative Director or designated Independent Medical Review organization within the timeframes required by applicable California law and regulation.

Procedures are maintained that are designed to ensure the timely and complete submission of all materials required for Independent Medical Review, including coordination among utilization review staff, physician reviewers, compliance personnel, and the claims administrator, as appropriate.

All IMR requests, record submissions, determinations, and outcomes shall be logged and tracked through the Careworks utilization review management system. IMR activity and outcomes shall be reviewed as part of the Careworks Quality Management Program to evaluate decision-making consistency, identify trends, monitor regulatory compliance, and support continuous quality improvement initiatives.

EFFECT OF IMR DETERMINATION

Careworks shall implement and administer IMR determinations in accordance with California workers' compensation law and applicable regulatory requirements. IMR decisions shall be maintained in the utilization review record and incorporated into ongoing quality monitoring and compliance activities.

Recordkeeping and Monitoring

Careworks tracks and monitors appeals, Administrative Director inquiries, and Independent Medical Review activities through its utilization review management system. Appeal and IMR outcomes are reviewed as part of the Careworks Quality Management Program to identify trends, ensure regulatory compliance, evaluate consistency of decision-making, and support continuous process improvement

Personnel and Qualification (§9792.7)

Medical Director

Dr. Latifat Apatira MD MPH
Address: 10535 Boyer Blvd. Suite 100
Austin, TX 78758
Specialty: Physician and Surgeon
Licensure: A 118881

Qualifications: Dr. Apatira is licensed to practice medicine in the State of California and meets all qualifications required under Labor Code §4610 and applicable California workers' compensation utilization review regulations. Dr. Apatira possesses education, training, experience, and clinical expertise sufficient to oversee utilization review activities and ensure compliance with applicable medical necessity and treatment guideline requirements.

Responsibilities: The Medical Director is responsible for:

- Clinical oversight of the Careworks Utilization Review Program.
- Oversight of physician reviewers, non-physician reviewers, and expert reviewers.
- Ensuring utilization review determinations are based upon medical necessity and evidence-based treatment guidelines.
- Monitoring utilization review quality, consistency, and regulatory compliance.
- Reviewing utilization review policies and procedures.
- Supporting quality management, regulatory reporting, audits, and accreditation activities.
- Ensuring compliance with California Labor Code §4610 and Title 8 California Code of Regulations §§9792.6 through 9792.15.
- Providing consultation and clinical leadership regarding utilization review operations.

Changes in Medical Director shall be reported and filed with the Division of Workers' Compensation as required by applicable California workers' compensation regulations.

Physician Reviewers

Careworks utilizes qualified physician reviewers to perform utilization review determinations involving medical necessity.

All physician reviewers shall:

- Hold an unrestricted professional license in a state of the United States or the District of Columbia.
- Be competent to evaluate the specific clinical issues associated with the treatment under review.
- Possess education, training, experience, and expertise appropriate to the clinical condition and requested treatment.
- Maintain all required licensure and professional credentials.

- Comply with applicable California workers' compensation statutes and regulations.

When a utilization review determination involves modification or denial of requested treatment based upon medical necessity, the determination shall be made only by a physician reviewer competent to evaluate the specific clinical issues presented by the request.

Physician reviewers may:

- Approve requested treatment.
- Modify requested treatment based upon medical necessity.
- Deny requested treatment based upon medical necessity.
- Conduct peer-to-peer discussions with treating physicians.
- Provide clinical recommendations consistent with applicable utilization review requirements.

Reviewer assignments shall be made to ensure that the reviewer possesses expertise appropriate to the injured worker's condition and the treatment being requested.

Non-Physician Reviewers

Careworks may utilize non-physician reviewers in accordance with California regulations effective April 1, 2026.

Non-physician reviewers may include nurses, pharmacists, or other qualified clinical personnel who assist in the utilization review process through:

- Intake and review of Requests for Authorization (RFAs).
- Collection and evaluation of clinical documentation.
- Application of administrative and clinical screening criteria.
- Communication and coordination with providers and claims personnel.
- Support of pharmacy and formulary review activities.
- Preparation of cases for physician review when required.

Non-physician reviewers may approve treatment requests when permitted by applicable policies and regulatory requirements. Non-physician reviewers shall not independently modify or deny a request for authorization based on medical necessity. Any utilization review determination involving modification or denial shall be referred to a qualified physician reviewer for review and determination.

Expert Reviewer Consultants

Careworks may utilize Expert Review Consultants when specialized clinical expertise is reasonably necessary to evaluate a treatment request, medical condition, diagnostic issue, or other clinical matter requiring review beyond the expertise of the assigned reviewer.

An Expert Reviewer may be a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, chiropractic practitioner, pharmacist, or other licensed health care professional who is competent to evaluate the specific clinical issues involved in the requested treatment and whose consultation is within the individual's scope of licensure and expertise.

Expert Review Consultants may be utilized when:

- Specialized clinical expertise is required to evaluate the requested treatment;
- The treatment recommendation involves a highly specialized condition, procedure, medication, or service;
- Additional clinical input is necessary to determine medical necessity;
- A specialized consultation is required pursuant to applicable California utilization review regulations; or
- An expert consultation is necessary to support a utilization review determination.

Selection of an Expert Review Consultant shall be based upon the individual's:

- Professional licensure and credentials;
- Education and training;
- Clinical specialty;
- Professional experience;
- Board certification, when applicable; and
- Demonstrated expertise relevant to the treatment, diagnosis, body system, or clinical issue under review.

When utilized, an Expert Review Consultant provides specialized clinical input to assist in the evaluation of medical necessity. Expert Review Consultants do not independently render utilization review determinations unless otherwise qualified and acting in the capacity of a physician reviewer consistent with California workers' compensation requirements.

Consultation with an Expert Review Consultant may be requested by the Utilization Review Organization when specialized review is reasonably necessary and may support an extension of the utilization review timeframe as permitted by applicable California regulations. Any utilization review determination involving modification or denial of treatment shall comply with all applicable requirements governing physician reviewer qualifications and decision-making authority.

Careworks maintains procedures to ensure that Expert Review Consultants possess qualifications appropriate to the clinical issues under review and comply with applicable confidentiality, conflict-of-interest, licensure, credentialing, and regulatory requirements.

Reviewer Qualifications and Credentialing Documentation

Careworks maintains processes to ensure that all personnel participating in utilization review activities meet applicable qualification, licensure, training, and competency requirements. Careworks maintains documentation of reviewer qualifications, licensure, training, competency assessments, and credential verification for reviewers directly employed or retained by Careworks.

Careworks may also utilize contracted physician reviewers, non-physician reviewers, pharmacists, nurse reviewers, and expert reviewers through delegated entities and URAC-accredited organizations. In such cases, the delegated entity is responsible for maintaining reviewer credentialing files, licensure verification, training records, competency assessments, and other documentation required by applicable law, regulation, accreditation standards, and contractual requirements.

Careworks maintains oversight of delegated utilization review activities and requires delegated entities to demonstrate compliance with applicable California workers' compensation regulations,

URAC accreditation standards, and credentialing requirements. Documentation regarding reviewer qualifications and credentialing maintained by Careworks or its delegated entities shall be made available to regulatory agencies, accreditation organizations, or other authorized entities upon request.

Clinical Unit Accessibility and Hours of Operation

Clinical Unit Accessibility and Hours of Operation

Careworks maintains procedures to ensure reasonable accessibility of utilization review personnel and timely communication with treating physicians, injured workers, claims administrators, and other authorized parties.

Provider Access

A representative is personally available by telephone from 9:00 a.m. to 5:30 p.m. Pacific Time on normal business days to receive communications regarding Requests for Authorization and utilization review activities.

Telephone and Electronic Accessibility

Secure voicemail, facsimile transmission, electronic mail, and other approved communication methods are available to receive Requests for Authorization and related communications during and after normal business hours. Requests received outside normal business hours shall be processed in accordance with applicable California utilization review regulations.

Reviewer Availability

Physician reviewers, expert reviewers, or the Medical Director shall be available for peer-to-peer discussion with requesting physicians for a minimum of four (4) hours per week during normal business hours, or at another mutually agreed upon time, consistent with applicable California regulations.

After-Hours Communications

Communications received after normal business hours, weekends, or holidays are logged upon receipt and processed on the next working day unless expedited review requirements apply. Procedures are maintained to identify and prioritize urgent and expedited requests requiring immediate attention.

Phone and Fax Numbers

- toll-free phone number: 866-286-0281
- fax number: 877-922-7236

Plan Submission and Modifications

Initial Submission

Careworks Managed Care Services, Inc. submits this Utilization Review (UR) Plan to the California Division of Workers' Compensation (DWC) in accordance with Labor Code §4610 and Title 8 California Code of Regulations §9792.7. This UR Plan is submitted in a searchable electronic format together with all required forms, attestations, accreditation documentation, and supporting materials required by the Administrative Director. The Plan is maintained and administered in accordance with the utilization review regulations effective April 1, 2026.

Material Modifications

Careworks shall notify the Administrative Director and submit any required amendments to the Utilization Review Plan within thirty (30) calendar days following implementation of a material modification, as required by applicable California utilization review regulations.

Material modifications may include, but are not limited to:

- Change in ownership
- Change in Medical Director
- Change in company name
- Change in address
- Change in corporate structure
- Change in delegated utilization review arrangements
- Change in utilization review processes affecting regulatory compliance
- Change in accreditation status
- Other material changes identified by applicable law or regulation

Consistent with the April 1, 2026 regulations, changes in the Medical Director, address, company name, or corporate structure constitute material modifications requiring appropriate filing with the Division of Workers' Compensation.

Certification of Continued Compliance

Careworks certifies that any modified Utilization Review Plan submitted to the Administrative Director shall continue to comply with California Labor Code §4610 and all applicable utilization review regulations, including Title 8 California Code of Regulations §§9792.6.1 through 9792.12, as amended. Careworks further certifies that all utilization review activities shall continue to be conducted in accordance with applicable statutory requirements, regulatory standards, accreditation requirements, and Division of Workers' Compensation rules governing utilization review.

Quality Assurance and Compliance Monitoring

Internal Audits

Careworks maintains an ongoing Quality Management and Compliance Monitoring Program designed to evaluate the effectiveness, consistency, accuracy, timeliness, and regulatory compliance of its Utilization Review (UR) Program. Internal audits are conducted on a periodic basis to assess compliance with California Labor Code §4610, applicable utilization review regulations, accreditation standards, and internal policies and procedures.

Audit activities may include review of:

- Utilization review timeliness and regulatory turnaround requirements;
- Accuracy and consistency of medical necessity determinations;
- Compliance with MTUS and MTUS Drug Formulary requirements;
- Completeness of utilization review documentation and notices;
- Physician reviewer and non-physician reviewer qualifications;
- Independent Medical Review (IMR) and appeal activities;
- Pharmacy utilization review activities;
- Delegated utilization review functions; and
- Corrective actions implemented in response to identified deficiencies.

Audit findings are reviewed by management and, when appropriate, corrective action plans are developed, implemented, monitored, and documented as part of Careworks' continuous quality improvement activities.

Accreditation Requirements

Careworks shall maintain compliance with all applicable accreditation requirements governing utilization review activities.

Consistent with California Labor Code §4610 and the utilization review regulations effective April 1, 2026, Careworks and any Utilization Review Organization (URO) performing utilization review determinations that result in modifications or denials shall maintain URAC Workers' Compensation Utilization Management (WCUM) Accreditation or otherwise satisfy applicable regulatory requirements. Careworks shall maintain documentation demonstrating accreditation status and shall provide such documentation to the Division of Workers' Compensation upon request.

Careworks monitors accreditation status, compliance activities, performance standards, and corrective action requirements to ensure continued conformity with applicable accreditation standards and California regulatory requirements.

Delegated Utilization Review Functions

Careworks may contract with qualified external Utilization Review Organizations (UROs), physician review organizations, pharmacy benefit management organizations, specialty review vendors, and other qualified entities to perform designated utilization review functions.

Delegated entities performing utilization review services on behalf of Careworks shall:

- Maintain all licenses, certifications, and qualifications required by applicable law;
- Maintain URAC Workers' Compensation Utilization Management Accreditation when required by California law and regulation;
- Comply with all applicable California workers' compensation statutes and regulations;
- Maintain reviewer credentialing, licensure verification, training, and competency records;
- Permit oversight, monitoring, and auditing by Careworks; and
- Provide data, reports, and records requested by Careworks for quality and compliance purposes.

Careworks retains ultimate responsibility and oversight for all delegated utilization review activities and maintains procedures for monitoring delegated entities to ensure compliance with contractual obligations, accreditation standards, and regulatory requirements.

DELEGATED UTILIZATION REVIEW ORGANIZATIONS

External utilization review organizations utilized by Careworks to perform delegated utilization review functions, if any, shall be identified in an attached exhibit or maintained in Careworks' records and provided to the Administrative Director as required pursuant to 8 CCR §9792.7(c)(1).

Financial Incentive Policy

Careworks is committed to ensuring that all utilization review determinations are made independently and solely on the basis of medical necessity, applicable treatment guidelines, clinical evidence, and regulatory requirements.

Consistent with Labor Code §4610(g)(3)(B)(i) and Labor Code §4610(g)(4), neither Careworks nor any delegated utilization review organization, contractor, reviewer, Medical Director, physician reviewer, non-physician reviewer, expert reviewer, pharmacist, nurse reviewer, or other individual participating in utilization review activities shall be compensated, rewarded, evaluated, or otherwise incentivized based upon:

- The number of treatment requests modified or denied;
- Reductions in medical treatment utilization;
- Reductions in treatment costs;
- The outcome of utilization review determinations;
- The frequency of approvals, modifications, or denials; or
- Any other factor that could improperly influence a medical necessity determination.

Compensation, performance evaluations, productivity standards, incentive programs, vendor agreements, and contractual arrangements shall not encourage or reward utilization review decisions that are inconsistent with medical necessity, applicable treatment guidelines, or California workers' compensation laws and regulations.

All utilization review determinations shall be made based solely upon the clinical information available for review, applicable evidence-based treatment guidelines, and the independent professional judgment of qualified reviewers. Careworks maintains processes to monitor compliance with this policy and investigate any concerns regarding potential conflicts of interest or improper influence on utilization review decisions.

Documentation and Recordkeeping

Records Retention

Records related to utilization review activities are maintained in accordance with applicable California workers' compensation laws, regulations, accreditation standards, and record retention requirements.

Records maintained by Careworks may include, but are not limited to:

- Requests for Authorization (RFAs);
- Medical records and supporting clinical documentation;
- Utilization review determinations;
- Physician reviewer and non-physician reviewer notes;
- Peer-to-peer communications;
- Extension requests and supporting documentation;
- Appeal and Independent Medical Review (IMR) records;
- Utilization review correspondence and notices;
- Quality management and audit records; and
- Regulatory filings and accreditation documentation.
-

Records shall be maintained in a manner that permits timely retrieval, review, auditing, reporting, and regulatory inspection. Electronic records shall be protected through appropriate administrative, physical, and technical safeguards designed to preserve record integrity, confidentiality, and availability.

When utilization review functions are delegated to external entities, Careworks shall maintain oversight processes to ensure that required utilization review records are retained and available in accordance with applicable contractual, regulatory, and accreditation requirements.

Confidentiality

The organization is committed to protecting the confidentiality, integrity, and security of medical, personal, and proprietary information obtained or created during utilization review activities.

All utilization review activities involving the review, evaluation, processing, storage, disclosure, or transmission of medical records and health information shall be conducted in accordance with applicable federal and state privacy and confidentiality requirements, including HIPAA and California workers' compensation laws and regulations.

All colleagues participating in utilization review activities, including employees, contractors, physician reviewers, non-physician reviewers, pharmacists, nurses, consultants, and delegated entities, are required to:

- Execute confidentiality agreements or otherwise acknowledge confidentiality obligations;
- Complete required privacy and confidentiality training upon hire or engagement and periodically thereafter;
- Access confidential information only as necessary to perform assigned job responsibilities; and
- Protect confidential information from unauthorized access, use, disclosure, alteration, or destruction.

Access to confidential information shall be limited to individuals with a legitimate business need to know and authority to receive such information.

Provider & Patient Communications

Procedures are maintained to ensure timely, accurate, and compliant communications with treating providers, injured workers, claims administrators, authorized representatives, employers, and other parties entitled to receive utilization review information.

Communications may include Requests for Authorization acknowledgements, requests for additional information, approval notices, modification notices, denial notices, deferral notices, formulary determinations, appeal communications, Independent Medical Review notices, and other communications required by California workers' compensation laws and regulations.

All utilization review communications shall be documented and maintained as part of the utilization review record.

Appendices

Appendix A – DWC Form UR-01

Careworks shall maintain and submit the current DWC Form UR-01, and all supporting documentation required by the California Division of Workers' Compensation for Utilization Review Plan approval, amendment, renewal, material modification, and ongoing regulatory compliance. Such documentation may include Medical Director information, accreditation records, delegated utilization review information, certifications, and other materials required by applicable California workers' compensation laws and regulations.

Appendix B – Sample Decision Letter Templates

Careworks maintains standardized utilization review notice templates designed to comply with California Labor Code §4610 and applicable utilization review regulations. Sample templates maintained by Careworks may include, but are not limited to:

- Appeal Recommendation Certified
- Appeal Recommendation Modified
- Appeal Recommendation Non-Certification
- Incomplete RFA
- Request for Additional Information Letter
- Recommendation – Modification
- Recommendation – Non-Certification
- Recommendation – Certified
- Recommendation- No Decision Rendered
- Prospective Review Not Required – Exempt Medication
- Deferred Letter

Careworks reviews and updates utilization review notice templates periodically to ensure continued compliance with applicable statutory, regulatory, accreditation, and operational requirements.

careworks

8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123

Date

UTILIZATION REVIEW APPEAL RECOMMENDATION
CERTIFIED

Referral Number

Notification Date:

Injured Claimant Name:	Client:
Claim Number:	Adjuster:
Date of Injury:	

Date Request First Received:	
Physician Reviewer:	
UR Nurse:	
Additional Medicals Requested:	
Method of Request:	
Medicals Requested:	
Medicals Received Date:	
Decision Date:	

Requester:

Careworks has been asked to review the appeal of the treatment request listed below for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor made the following determination recommendation.

Services Requested	Determination	Qty Requested	Qty Authorized	Qty Denied

Diagnosis Codes/Descriptions:

Services Approved From:

The full clinical rationale for the determination follows in the Physician Advisor Determination.

This evaluation has been conducted entirely on the basis of the medical information/documentation provided for review. If additional information becomes available, it may alter the conclusions contained in this report. Careworks's decisions are based on internally developed criteria, which are based on one or more of the following: guidelines from specialty societies or other national organizations, when available; review of medical literature; and the individual training and experience of the physician reviewer. Upon written request from the worker, attending physician, or other ordering provider or facility rendering service, Careworks provides the clinical rationale for the adverse determination, including the specific clinical review criteria upon which the adverse determination was based.

These findings apply only to the specific treatment proposed by the treating physician or facility. A separate review will be necessary if the treating physician proposes additional types of treatment. The treating physician or facility should contact Careworks at (800) 580-2273 if additional types of treatment are proposed.

Careworks's utilization review findings are intended solely as clinical opinions to determine whether proposed treatment is medically reasonable and necessary, based on the information provided. Careworks expresses no legal opinion through these findings regarding the liability of any party to pay for any treatment that may be provided to a non-compensable area. Careworks's authorization or non-authorization of treatment or procedures is not intended in any way to relieve the treating physician’s responsibility for patient care.

In compliance with HIPAA regulations, this e-mail/telefax message and any documents accompanying this transmission is intended solely for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under the applicable law. If the receiver of this message is not the intended recipient or the agent responsible, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you are not the intended addressee/recipient, please reply to the sender advising of the error in transmission and immediately destroy/delete the message and any accompanying documents.

Contact	Role	Delivery Method	Address

Physician Advisor Determination

Date of Physician Determination:
Treatment Requested:
List of Medical Records Reviewed:

Clinical Summary:

Decision:

APPEAL:

Clinical Rationale:

EBM Citations:

California Medical Treatment Utilization Schedule (MTUS)/ACOEM Practice Guidelines

Peer to Peer Contact Information:

Contact Date	Peer To Peer Action	Phone Number	Spoke To	Comment

Physician Advisor
License

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

careworks

8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123

Date

UTILIZATION REVIEW APPEAL RECOMMENDATION
MODIFIED

Referral Number

Claimant Name:	Client:
Claim Number:	Adjuster:
Date of Injury:	

Date RFA First Received:	
Physician Reviewer:	
UR Nurse:	
Additional Medicals Requested:	
Method of Request:	
Medicals Requested:	
Medicals Received Date:	
Decision Date:	

Requester:

Careworks has been asked to review the treatment request listed below for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Reviewer made the following determination recommendation and is available to the provider a (800) 580-2273 between the hours of 8:00am to 5:30pm Pacific Time.

Services Requested	Determination	Qty Requested	Qty Authorized	Qty Denied

Diagnosis Codes/Descriptions:

Services Approved From:

The full clinical rationale for the determination follows in the Physician Reviewer Determination.

This evaluation has been conducted entirely on the basis of the medical information/documentation provided for review. Careworks' decisions are based on the recommendation of the CA MTUS. If it is “silent” on an issue, one or more of the following evidence-based guidelines may be consulted: ACOEM Guidelines, Official Disability Guidelines, guidelines from specialty societies or other national organizations.

These findings apply only to the specific treatment proposed by the treating physician or facility. A separate review will be necessary if the treating physician proposes additional types of treatment. The treating physician or facility should contact Careworks at (800) 580-2273 if additional types of treatment are proposed.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code Section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured worker’s representative or the injured workers’ attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, 10 calendar days from the mailing date of the utilization review decision to the employee for formulary disputes, and within 30 calendar days from the mailing date of the utilization review decision to the employee for all other medical treatments. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, was included with the original decision.

You have a right to disagree with decisions affecting your claim, which includes seeking IMR of the decision (see attached application). If you have questions about the information in this notice, please call me (insert CE Name) at (insert CE phone number) . However, if you are represented by an attorney, please contact your attorney instead of me.

Careworks's utilization review findings are intended solely as clinical opinions to determine whether proposed treatment is medically reasonable and necessary, based on the information provided. Careworks expresses no legal opinion through these findings regarding the liability of any party to pay for any treatment that may be provided to a non-compensable area. Careworks's authorization or non-authorization of treatment or procedures is not intended in any way to relieve the treating physician’s responsibility for patient care.

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.

The internal appeals process is voluntary and does not trigger or bar the use of dispute resolution procedures of Labor Code 4610.5 and 4610.6 but may be used on an optional basis.

MPN preauthorization requests received from an out-of-network provider without approval from the claims examiner or network administrator will be processed based on medical necessity only. Authorization(s) and medical necessity approval(s) of a procedure or service do not guarantee

payment of all or part of your charges. Out-of-network provider treatment for MPN claimants requires network approval.

In compliance with HIPAA regulations, this e-mail/telefax message and any documents accompanying this transmission is intended solely for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under the applicable law. If the receiver of this message is not the intended recipient or the agent responsible, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you are not the intended addressee/recipient, please reply to the sender advising of the error in transmission and immediately destroy/delete the message and any accompanying documents.

This decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Contact	Role	Delivery Method	Address

Physician Reviewer Determination

Date of Physician Determination:

Treatment Requested:

List of Medical Records Reviewed:

Clinical Summary:

Appeal:

Clinical Rationale:

EBM Citations:

California Medical Treatment Utilization Schedule (MTUS)/ACOEM Practice Guidelines

Peer to Peer Contact Information:

Contact Date	Peer To Peer Action	Phone Number	Spoke To	Comment

<Physician Advisor Signature>

Physician Advisor
License

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

A decision to modify or deny the treatment authorization on this claim has been made by the physician reviewer noted on the determination letter. You may reach the physician reviewer organization at tel: 888-920-4440 Monday through Friday, between the hours of 9:00 am and 5:30 pm Pacific Time.

careworks

8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123

<Date>

UTILIZATION REVIEW APPEAL RECOMMENDATION NON-CERTIFICATION

Referral Number –

Claimant Name:	Client:
Claim Number:	Adjuster:
Date of Injury:	

Date Request First Received:	
Physician Reviewer:	
UR Nurse:	
Additional Medicals Requested:	
Method of Request:	
Medicals Requested:	
Medicals Received Date:	
Decision Date:	

Requester:

Careworks has been asked to review the appeal of the treatment request listed below for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Reviewer made the following determination recommendation and is available to the provider at (800) 580-2273 between the hours of 8:00am to 5:30pm Pacific Time.

Services Requested	Determination	Qty Requested	Qty Authorized	Qty Denied

Diagnosis Codes/Descriptions:

The full clinical rationale for the determination follows in the Physician Reviewer Determination.

This evaluation has been conducted entirely on the basis of the medical information/documentation provided for review. If additional information becomes available, it may alter the conclusions contained in this report. Careworks's decisions are based on the recommendation of the CA MTUS. If it is "silent" on an issue, one or more of the following evidence-based guidelines may be consulted: ACOEM Guidelines, Official Disability Guidelines, guidelines from specialty societies or other national organizations.

These findings apply only to the specific treatment proposed by the treating physician or facility. A separate review will be necessary if the treating physician proposes additional types of treatment. The treating physician or facility should contact Careworks at (800) 580-2273 if additional types of treatment are proposed.

Careworks's utilization review findings are intended solely as clinical opinions to determine whether proposed treatment is medically reasonable and necessary, based on the information provided. Careworks expresses no legal opinion through these findings regarding the liability of any party to pay for any treatment that may be provided to a non-compensable area. Careworks's authorization or non-authorization of treatment or procedures is not intended in any way to relieve the treating physician's responsibility for patient care.

MPN preauthorization requests received from an out-of-network provider without approval from the claims examiner or network administrator will be processed based on medical necessity only. Authorization(s) and medical necessity approval(s) of a procedure or service do not guarantee payment of all or part of your charges. Out-of-network provider treatment for MPN claimants requires network approval.

In compliance with HIPAA regulations, this e-mail/telefax message and any documents accompanying this transmission is intended solely for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under the applicable law. If the receiver of this message is not the intended recipient or the agent responsible, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you are not the intended addressee/recipient, please reply to the sender advising of the error in transmission and immediately destroy/delete the message and any accompanying documents.

The ordering provider may contact our peer review department within two business days to discuss the adverse determination.

Contact	Role	Delivery Method	Address

Physician Reviewer Determination

<Referral Number>

Date of Physician Determination:

Treatment Requested:

List of Medical Records Reviewed:

Clinical Summary:

Decision:

<Service Requested>

Clinical Rationale:

EBM Citations:

Peer to Peer Contact Information:

Contact Date	Peer To Peer Action	Phone Number	Spoke To	Comment

A decision to modify, or deny the treatment authorization on this claim has been made by the physician reviewer noted on the determination letter. You may reach the physician reviewer organization at tel:888-920-4440 Monday through Friday, between the hours of 9:00 am-10:00 pm EST.

<Physician Advisor Signature>

Physician Advisor
License Number

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

8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123

Date

UTILIZATION REVIEW
INCOMPLETE RFA

Referral Number –

Notification Date:

Claimant Name:	Client:
Claim Number:	Adjuster:
Date of Injury:	

Requester:

Dear ,

This letter is to notify you that the Request for Authorization (RFA) received on (insert date) for the above referenced injured worker cannot be reviewed at this time because it does not meet the definition of a "completed" request for authorization under California Code of Regulations, Title 8, section 9792.6.1(u).

Pursuant to 8 CCR §9792.6.1(u), a request for authorization is considered completed only when it:

- Identifies both the injured employee and the requesting provider;
- Identifies with specificity all recommended medical treatment; and
- Is accompanied by documentation issued or created no earlier than 30 days prior to submission that substantiates the medical necessity of the requested treatment.

Based on our review, the following required element(s) were missing or incomplete:

Other
Medical submitted is dated (insert date) . Medical is over 30 days old.

Required Action
For utilization review to proceed, the entire Request for Authorization (RFA) must be resubmitted along with the missing information identified above.

Under California Code of Regulations, Title 8, section 9792.6.1(u), a request for authorization is deemed completed only when all required elements are submitted together. Accordingly, submission of partial documentation without a fully completed RFA does not constitute a completed request for authorization and cannot be reviewed.

The request will be deemed completed only upon receipt of a new, fully completed RFA accompanied by all required supporting documentation, at which time utilization review timeframes will begin pursuant to 8 CCR §9792.9.3.

To prevent further delay, please correct and resubmit the information by fax to 800-580-3123.

Important Notice
This correspondence does not constitute a utilization review approval, modification, or denial. No determination regarding medical necessity has been made at this time due to the incomplete nature of the request.

If you have questions regarding this notice or the information required to complete the request, please contact the claims administrator listed above or the Utilization Review department directly at 800-580-2273.

You have the right to file a complaint by contacting the Utilization Review Department toll-free at 800-580-2273, by fax at 800-580-3123, or mailing to the address on this notice. We will respond to your complaint as quickly as possible, but no longer than 30 days.

Sincerely,

Careworks UR 800-580-2273

Contact	Role	Delivery Method	Address

careworks

8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123

Date

Requester Name
Requester Address
Requester Telephone Number

UTILIZATION REVIEW REQUEST FOR ADDITIONAL INFORMATION LETTER

Referral Number:

Notification Date:

Claimant Name:	Client:
Claim Number:	Adjuster:
Date of Injury:	

Date Request First Received:	
Physician Reviewer:	
UR Nurse:	
Additional Medicals Requested:	
Method of Request:	
Medicals Requested:	
Medicals Received Date:	
Decision Date:	

Requester: (insert Requester Name)

Careworks has been asked to review the treatment request listed below for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Reviewer made the following modification determination recommendation and is available to the provider at (800) 580-2273 between the hours of 9:00 am and 5:30 pm Pacific Time.

Services Requested	Determination	Qty Requested	Qty Authorized	Qty Denied

Diagnosis Codes/Descriptions:

Services Approved From:

This evaluation has been conducted entirely on the basis of the medical records information/documentation provided for the review. If additional information becomes available, it may alter the conclusions contained in this report. Careworks' decisions are based on the recommendation of the CA MTUS. If it is "silent" on an issue, one or more of the following evidence-based guidelines may be consulted: ACOEM Guidelines, Official Disability Guidelines, guidelines from specialty societies or other national organizations.

These findings apply only to the specific treatment proposed by the treating physician or facility. A separate review will be necessary if the treating physician proposes additional types of treatment. The treating physician or facility should contact Careworks at (800) 580-2273, if any additional types of treatment are proposed.

Careworks' utilization review findings are intended solely as clinical opinions to determine whether proposed treatment is medically reasonable and necessary, based on the information provided. Careworks expresses no legal opinion through these findings regarding the liability of any party to pay for any treatment that may be provided to a non-compensable area. Careworks' authorization or non-authorization of treatment or procedures is not intended in any way to relieve the treating physician's responsibility for patient care.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured workers' attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, 10 calendar days from the mailing date of the utilization review decision to the employee for formulary disputes and within 30 calendar days from the mailing date of the utilization review decision to the employee for all other medical treatments. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, is included with this notice if you have not yet filed for IMR.

You have a right to disagree with decisions affecting your claim, which includes seeking IMR of the decision (see attached application). If you have questions about the information in this notice, please call me, (insert Adjuster name) at (insert Adjuster phone number). However, if you are represented by an attorney, please contact your attorney instead of me.

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

You may utilize our internal appeals process if you notify us within 10 days after the receipt of the utilization review decision. Please note that our internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but it may be pursued on an optional basis.

The ordering provider may contact our peer review department within two business days to discuss the adverse determination.

Careworks Voluntary Appeal Process

Careworks offers a voluntary internal appeal process in which a medical provider, claimant, or claimant's representative is entitle to appeal Careworks' findings. The requestor is expected to send any pertinent medical records and/or any additional documentation that might be helpful for the reviewer. Any internal utilization review appeals process will be completed within 30 calendar days of the date of utilization review decision. Please submit the appeal in writing, via USPO, tele/fax or electronic mail to the attention of the Appeals Department.

Careworks Managed Care Services
Utilization Review
8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123
Email: ur@careworks.com

In all correspondence, please refer to the Careworks Utilization Review Number: (insert claim specific UR number) and state "appeal"

MPN preauthorization requests received from an out-of-network provider without approval from the claims examiner or network administrator will be processed based on medical necessity only. Authorization(s) and medically necessity approval(s) of a procedure or service do not guarantee payment of all or part of your charges. Out-of-network provider treatment for MPN claimants requires network approval.

Contact	Role	Delivery Method	Address

In compliance with HIPAA regulations, this e-mail/telefax message and any documents accompanying this transmission is intended solely for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under the applicable law. If the receiver of this message is not the intended recipient or the agent responsible, you are hereby notified that nay dissemination, distribution, or copying of this communication is strictly prohibited. If you are not the intended addressee/recipient, please reply to the sender advising of the error in transmission and immediately destroy/delete the message and any accompanying documents.

Physician Reviewer Determination

Date of Physician Determination:

Treatment Requested:

List of Medical Records Reviewed:

Clinical Summary:

Decision:

Clinical Rationale:

EBM Citations:

Peer to Peer Contact Information

Contact Date	Peer to Peer Action	Phone Number	Spoke to	Comment

Physician Advisor
License Number:

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

careworks

8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123

Date

Adjuster Name

UTILIZATION REVIEW RECOMMENDATION MODIFICATION

Referral Number:

Notification Date:

Claimant Name:	Client:
Claim Number:	Adjuster:
Date of Injury:	

Date Request First Received:	
Physician Reviewer:	
UR Nurse:	
Additional Medicals Requested:	
Method of Request:	
Medicals Requested:	
Medicals Received Date:	
Decision Date:	

Requester: (insert Requester Name)

Careworks has been asked to review the treatment request listed below for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Reviewer made the following modification determination recommendation and is available to the provider at (800) 580-2273 between the hours of 9:00 am and 5:30 pm Pacific Time.

Services Requested	Determination	Qty Requested	Qty Authorized	Qty Denied

Diagnosis Codes/Descriptions:

Services Approved From:

This evaluation has been conducted entirely on the basis of the medical records information/documentation provided for the review. If additional information becomes available, it may alter the conclusions contained in this report. Careworks' decisions are based on the recommendation of the CA MTUS. If it is "silent" on an issue, one or more of the following evidence-based guidelines may be consulted: ACOEM Guidelines, Official Disability Guidelines, guidelines from specialty societies or other national organizations.

These findings apply only to the specific treatment proposed by the treating physician or facility. A separate review will be necessary if the treating physician proposes additional types of treatment. The treating physician or facility should contact Careworks at (800) 580-2273, if any additional types of treatment are proposed.

Careworks' utilization review findings are intended solely as clinical opinions to determine whether proposed treatment is medically reasonable and necessary, based on the information provided. Careworks expresses no legal opinion through these findings regarding the liability of any party to pay for any treatment that may be provided to a non-compensable area. Careworks' authorization or non-authorization of treatment or procedures is not intended in any way to relieve the treating physician's responsibility for patient care.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured workers' attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, 10 calendar days from the mailing date of the utilization review decision to the employee for formulary disputes and within 30 calendar days from the mailing date of the utilization review decision to the employee for all other medical treatments. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, is included with this notice if you have not yet filed for IMR.

You have a right to disagree with decisions affecting your claim, which includes seeking IMR of the decision (see attached application). If you have questions about the information in this notice, please call me, (insert Adjuster name) at (insert Adjuster phone number). However, if you are represented by an attorney, please contact your attorney instead of me.

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

You may utilize our internal appeals process if you notify us within 10 days after the receipt of the utilization review decision. Please note that our internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but it may be pursued on an optional basis.

The ordering provider may contact our peer review department within two business days to discuss the adverse determination.

Careworks Voluntary Appeal Process

Careworks offers a voluntary internal appeal process in which a medical provider, claimant, or claimant's representative is entitle to appeal Careworks' findings. The requestor is expected to send any pertinent medical records and/or any additional documentation that might be helpful for the reviewer. Any internal utilization review appeals process will be completed within 30 calendar days of the date of utilization review decision. Please submit the appeal in writing, via USPO, tele/fax or electronic mail to the attention of the Appeals Department.

Careworks Managed Care Services
Utilization Review
8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273

Fax: (800) 580-3123
Email: ur@careworks.com

In all correspondence, please refer to the Careworks Utilization Review Number: (insert claim specific UR number) and state "appeal"

MPN preauthorization requests received from an out-of-network provider without approval from the claims examiner or network administrator will be processed based on medical necessity only. Authorization(s) and medically necessity approval(s) of a procedure or service do not guarantee payment of all or part of your charges. Out-of-network provider treatment for MPN claimants requires network approval.

Contact	Role	Delivery Method	Address

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Physician Reviewer Determination

Date of Physician Determination:

Treatment Requested:

List of Medical Records Reviewed:

Clinical Summary:

Decision:

Clinical Rationale:

EBM Citations:

Peer to Peer Contact Information

Contact Date	Peer to Peer Action	Phone Number	Spoke to	Comment

Physician Advisor
License Number:

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

careworks

8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123

Date

Adjuster Name

UTILIZATION REVIEW RECOMMENDATION NON-CERTIFICATION

Referral Number:

Notification Date:

Claimant Name:	Client:
Claim Number:	Adjuster:
Date of Injury:	

Date Request First Received:	
Physician Reviewer:	
UR Nurse:	
Additional Medicals Requested:	
Method of Request:	
Medicals Requested:	
Medicals Received Date:	
Decision Date:	

Requester: (insert Requester Name)

Careworks has been asked to review the treatment request listed below for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Reviewer made the following modification determination recommendation and is available to the provider at (800) 580-2273 between the hours of 9:00am to 5:30pm Pacific Time.

Services Requested	Determination	Qty Requested	Qty Authorized	Qty Denied

Diagnosis Codes/Descriptions:

The full clinical rationale for the determination follows in the Physician Reviewer Determination.

This evaluation has been conducted entirely on the basis of the medical information/documentation provided for review. If additional information becomes available, it may alter the conclusions contained in this report. Careworks' decisions are based on CA MTUS. If it is "silent" on an issue, one or more of the evidence-based guidelines may be consulted" ACOEM Guidelines, Official Disability Guidelines, guidelines from specialty societies or other national organizations.

These findings apply only to the specific treatment proposed by the treating physician or facility. A separate review will be necessary if the treating physician proposes additional types of treatment. The treating physician or facility should contact Careworks at (800) 580-2273, if any additional types of treatment are proposed.

Careworks' utilization review findings are intended solely as clinical opinions to determine whether proposed treatment is medically reasonable and necessary, based on the information provided. Careworks expresses no legal opinion through these findings regarding the liability of any party to pay for any treatment that may be provided to a non-compensable area. Careworks' authorization or non-authorization of treatment or procedures is not intended in any way to relieve the treating physician's responsibility for patient care.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured workers' attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, 10 calendar days from the mailing date of the utilization review decision to the employee for formulary disputes and within 30 calendar days after the service of the utilization review decision to the employee for all other medical treatments. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, is included with this notice if you have not yet filed for IMR.

You have a right to disagree with decisions affecting your claim, which includes seeking IMR of the decision (see attached application). If you have questions about the information in this notice, please call me, (insert Adjuster name) at (insert Adjuster phone number). However, if you are represented by an attorney, please contact your attorney instead of me.

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

You may utilize our internal appeals process if you notify us within 10 days after the receipt of the utilization review decision. Please note that our internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but it may be pursued on an optional basis.

The ordering provider may contact our peer review department within two business days to discuss the adverse determination.

Careworks Voluntary Appeal Process

Careworks offers a voluntary internal appeal process in which a medical provider, claimant, or claimant's representative is entitle to appeal Careworks' findings. The requestor is expected to send any pertinent medical records and/or any additional documentation that might be helpful for the reviewer. Any internal utilization review appeals process will be completed within 30 calendar days of the date of utilization review decision. Please submit the appeal in writing, via USPO, tele/fax or electronic mail to the attention of the Appeals Department.

Careworks Managed Care Services
Utilization Review
8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123
Email: ur@careworks.com

In all correspondence, please refer to the Careworks Utilization Review Number: (insert claim specific UR number) and state "appeal"

MPN preauthorization requests received from an out-of-network provider without approval from the claims examiner or network administrator will be processed based on medical necessity only. Authorization(s) and medically necessity approval(s) of a procedure or service do not guarantee payment of all or part of your charges. Out-of-network provider treatment for MPN claimants requires network approval.

In compliance with HIPAA regulations, this e-mail/telefax message and any documents accompanying this transmission is intended solely for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under the applicable law. If the receiver of this message is not the intended recipient or the agent responsible, you are hereby notified that nay dissemination, distribution, or copying of this communication is strictly prohibited. If you are not the intended addressee/recipient, please reply to the sender advising of the error in transmission and immediately destroy/delete the message and any accompanying documents.

Contact	Role	Delivery Method	Address

Physician Reviewer Determination

(insert specific claim UR number)

Date of Physician Determination:

Treatment Requested:

List of Medical Records Reviewed:

Clinical Summary:

Decision:

Clinical Rationale:

EBM Citations:

Peer to Peer Contact Information

Contact Date	Peer to Peer Action	Phone Number	Spoke to	Comment

A decision to modify, or deny the treatment authorization of this claim has been made by the physician reviewer noted on the determination letter. If you would like to discuss the determination with the physician reviewer, please call Careworks at 800-580-2273, within 48 hours or receipt of determination, Monday-Friday 9:00am to 5:30pm Pacific Time to schedule.

Physician Advisor/Reviewer
License Number:

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

careworks

8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123

Date

Adjuster Name

UTILIZATION REVIEW RECOMMENDATION
CERTIFIED

Referral Number:

Claimant Name:	Client:
Claim Number:	Adjuster:
Date of Injury:	

Date Request First Received:	
Physician Reviewer:	
UR Nurse:	
Additional Medicals Requested:	
Method of Request:	
Medicals Requested:	
Medicals Received Date:	
Decision Date:	

Requester:

Services Requested	Determination	Qty Requested	Qty Authorized	Qty Denied

Services Approved From:

Diagnosis Codes/Descriptions:

Clinical Rationale:

EBM Citations:

This evaluation has been conducted entirely on the basis of the medical information/documentation provided for review. Careworks's decisions are based on the recommendation of the CA MTUS. If it is "silent" on an issue, one or more of the following evidence-based guidelines may be consulted: ACOEM Guidelines, Official Disability Guidelines, guidelines from specialty societies or other national organizations.

These findings apply only to the specific treatment proposed by the treating physician or facility. A separate review will be necessary if the treating physician proposes additional types of treatment. The treating physician or facility should contact Careworks at (800) 580-2273 if additional types of treatment are proposed.

Careworks's utilization review findings are intended solely as clinical opinions to determine whether proposed treatment is medically reasonable and necessary, based on the information provided. Careworks expresses no legal opinion through these findings regarding the liability of any party to pay for any treatment that may be provided to a non-compensable area. Careworks's authorization or non-authorization of treatment or procedures is not intended in any way to relieve the treating physician's responsibility for patient care. Any dispute shall be resolved in accordance with Labor Code Section 4610.5 and 4610.6.

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.

MPN preauthorization requests received from an out-of-network provider without approval from the claims examiner or network administrator will be processed based on medical necessity only. Authorization(s) and medical necessity approval(s) of a procedure or service do not guarantee payment of all or part of your charges. Out-of-network provider treatment for MPN claimants requires network approval.

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Contact	Role	Delivery Method	Address

careworks

8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123

Date

Adjuster Name

UTILIZATION REVIEW RECOMMENDATION- NO DECISION RENDERED

Referral Number:

Claimant Name:	Client:
Claim Number:	Adjuster:
Date of Injury:	

Date RFA First Received:	UR Nurse:
Decision Date:	

Requester:

Services Requested	Determination

The requested medication, medical services, goods, or items are a duplicate request and therefore no decision was rendered.

MPN preauthorization requests received from an out-of-network provider without approval from the claims examiner or network administrator will be processed based on medical necessity only. Authorization(s) and medical necessity approval(s) of a procedure or service do not guarantee payment of all or part of your charges. Out-of-network provider treatment for MPN claimants requires network approval.

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or the agent responsible, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you are not the intended addressee/recipient, please reply to the sender advising of the error in transmission and immediately destroy/delete the message and any accompanying documents.

Distribution:

8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123

Date

Adjuster Name

UTILIZATION REVIEW RECOMMENDATION- PROSEPECTIVE REVIEW NOT REQUIRED EXEMPT MEDICINE

Referral Number:

Claimant Name:	Client:
Claim Number:	Adjuster:
Date of Injury:	

Date RFA First Received:	UR Nurse:
Date Completed Medical Received:	Decision Date:

Requester:

Services Requested	Determination

The drug requested is exempt in its generic form and does not require authorization through prospective review prior to dispensing the drug. The physician did not document "Do Not Substitute" or "Dispense as Written" on the request therefore the generic equivalent does not require prospective review. The MTUS Drug List is set forth by active drug ingredient(s). Therefore, no further action was taken.

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

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.

MPN preauthorization requests received from an out-of-network provider without approval from the claims examiner or network administrator will be processed based on medical necessity only. Authorization(s) and medical necessity approval(s) of a procedure or service do not guarantee payment of all or part of your charges. Out-of-network provider treatment for MPN claimants requires network approval.

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Contact	Role	Delivery Method	Address

careworks

8125 Sedgwick Way
Memphis, TN 38125
Phone: (800) 580-2273
Fax: (800) 580-3123

Date

Adjuster Name

UTILIZATION REVIEW RECOMMENDATION- UTILIZATION REVIEW DEFERRED

Referral Number:

Claimant Name:	Client:
Claim Number:	Adjuster:
Date of Injury:	

Date RFA First Received:	UR Nurse:
Decision of Prior Denial Decision:	
Date of this Written Decision:	

Requester:

Services Requested	Determination

The request for authorization received on the date identified above seeks the same specific course of proposed medical treatment that was previously denied by utilization review on the prior denial decision date identified above. Pursuant to Labor Code section 4610(k) and California Code of Regulations, title 8, section 9792.9.2, utilization review of this request is deferred because the prior denial remains effective and the request does not expressly and unequivocally identify or document a change in facts material to the basis of the prior denial.

Reason for dispute of liability: The claims administrator disputes liability for the recommended treatment because the same treatment was previously denied, and the current request does not include documentation showing a material change in the facts supporting the prior denial. If the requesting physician expressly and unequivocally identifies a material change in facts and submits documentation supporting that change, the request will be reviewed by a physician reviewer in accordance with applicable utilization review requirements.

Any dispute regarding this decision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

You have a right to disagree with decisions affecting your claim. 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.

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

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Distribution:

Appendix C – Clients and Delegated Utilization Review Vendors

Careworks performs utilization review and utilization management services for employers, insurers, self-insured employers, third-party administrators, public entities, joint powers authorities, and other clients identified in this appendix or maintained in Careworks' records.

Careworks may utilize delegated Utilization Review Organizations (UROs), physician review organizations, pharmacy benefit managers, specialty review vendors, and other qualified entities to perform certain utilization review-related functions. Delegated entities shall comply with all applicable California workers' compensation laws and regulations, URAC accreditation requirements, contractual obligations, and Careworks oversight requirements.

Careworks retains responsibility for oversight and monitoring of all delegated utilization review activities.

The Client List and Delegated Vendor List may be updated periodically to reflect additions, removals, mergers, acquisitions, or other organizational changes and shall be maintained by Careworks in accordance with applicable California utilization review filing requirements.

CLIENT LIST

Alpine County	Kings County Area Public Transit Agency
Amador County	Lake County
Amador Regional Transit System	Lassen County
Ameritrust Insurance Corporation	Meadowbrook/ TPA Associates
Berkley Oil & Gas	Mendocino County
Butte County	ProCentury Insurance Company
Calaveras County	San Benito County
Cincinnati Insurance Company	San Joaquin County
City of Belmont	Santa Cruz Fire Agencies Insurance Group
City of El Cajon	SIRMA
City of Hemet	Siskiyou County
City of Lancaster	Solano County
City of Rancho Cordova	Star Insurance Company
City of South Pasadena	State of Florida Division of Risk Management
Colusa County	Tehama County
CSRM	Transguard Insurance Company
El Dorado County	Walmart
First Five Contra Costa Children and Families Commission	West Bend Mutual Insurance Company
Gold Coast Transit	Williamsburg National Insurance Company
Huntington Beach Union High School District	Yuba County
Inyo County	(intentionally blank)

DELEGATED UTILIZATION REVIEW VENDORS

- Dane Street, LLC
- MES Solution, Inc.
- Network Medical Review Company, Ltd. (NMR)