



GSG ASSOCIATES INC. UTILIZATION REVIEW PLAN

46 W. DAYTON ST.
PASADENA, CA 91105

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INTRODUCTION

GSG's Mission Statement

- To assure that the injured or ill employee received the appropriate care from the appropriate provider in an expeditious fashion.
- GSG Associates, Inc. strives to be a leader in medical/ disability cost containment solutions for our clients by providing flexible services to adapt to THEIR needs, not OURS.
- Our Goal is to excel in regulatory compliance, exceed best-practice standards and continue to choose the RIGHT people for the job.
- Our passion and integrity remain at the core of servicing our clients and remains the golden thread and the golden rule in our business practice.

The purpose of this utilization review plan, as noted in Labor Code Section 4610 and CCR § 9792.6 et seq of title 8 of the California code of regulations is to provide a UR process compliant with these laws that will ensure appropriate medical care for injured workers and consistent with evidence based medicine.

GSG will amend this utilization review plan as appropriate with the changes that are adopted and incorporated in the regulations by the Administrative Director from time to time.

UTILIZATION REVIEW DEFINITIONS

“ACOEM Proactive Guidelines” means the American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines, Second Edition.

“Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on the Doctor’s First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “Primary Treating Physician’s Progress Report,” DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the DWC PR-2.

“Claims Administrator” is a self-administered workers’ compensation insurer, an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610. The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.

“Concurrent Review” is defined as the utilization review conducted during an inpatient stay.

“Course of treatment” means the course of medical treatment set forth in the treatment plan contained on the “Doctor’s First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “Primary Treating Physician’s Progress Report,” DWC Form PR-1, as contained in section 9785.2 or in narrative form contained the same information required in the DWC Form PR-2.

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

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

could jeopardize the injured workers' permanent ability to regain maximum function.

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

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

“Immediately” means within 24 hours after learning the circumstances that would require an extension of the timeframe for decisions specified in subdivisions (b) (1), (b) (2) or (c) and (g) (1) or section 9792.9

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

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

“Medical Management” for the purposes of this UR plan means contacting treating providers to negotiate and pre-authorize (prior authorization) appropriate treatment plans in order to expedite treatment for the injured worker and promote a safe and swift return to work.

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

“MTUS” means the Medical Treatment Utilization Schedule set forth in 8 CCR 9792.20 through 9792.23.

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

“Request for authorization” means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) or a written request for a specific course of proposed medical treatment. An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours. Both the written confirmation of an oral request and the written request must be set forth on the “Doctor’s First Report of Occupational Injury of Illness,” Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization.

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

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

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

“Utilization review process” means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. Utilization review does not include determination of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed.

“Written” includes a facsimile as well as communications in paper form.

Medical Necessity:

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

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

UR STANDARDS

Telephone Access:

Physicians may request authorization for health care services between the hours of 9AM and 5:30PM pacific standard time, through GSG's telephone and facsimile access numbers on normal business days as defined in LC 4600.4 and civil code section 9.

After business hours, the voicemail will direct them to leave their request in a dedicated voicemail mailbox, or to fax their request to the GSG fax number given in the voicemail directions.

GSG's written Policy and Procedures governing the UR process are consistent with URAC and the State of California Utilization Review Regulations.

GSG utilizes the recommended standards set forth in the MTUS. These guidelines shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker for the effects of his or her injury.

The UR plan is:

- Evaluated at least annually and updated when necessary.
- Includes involvement from actively practicing physicians in its development.
- May be disclosed by the employer to employees, physicians, and the public upon request. This plan is available to the general public on our web site: <http://www.gsga.net>.
- Disclosed to the physician and the injured employee and their representative if used as the basis of a decision to modify, delay or deny services,

The criteria shall be consistent with the MTUS adopted on an ongoing basis.

Dependant upon our individual client directives for each client either the GSG Nurse Consultant or the claims adjuster will be the first level of review on treatment requests. Any treatment request to be delayed, modified or denied will be transferred to a Reviewer or Expert Reviewer.

TREATMENT GUIDELINES

GSG will utilize the Medical Treatment Utilization Schedule as defined in the Utilization Review Definitions.

For all conditions or injuries not covered by the MTUS, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based.

- Evaluated annually
- Disclosed to the treating physician and the injured employee
- Publicly available.

GSG is utilizing other evidence based guidelines when appropriate or after the MTUS has been utilized as a first resource.

- Work Loss Data Official Disability Guidelines (ODG)
- Reed Groups The Medical Disability Advisor (MDA)
- We also provide access for our Reviewers to “M.D. Consult” – a research site.

PROGRAM CONFIGURATION

GSG's Medical Director:

Gracia Goade, M.D. California License # G40760

Telephone: 626-585-1808

Address: 46 W. Dayton St., Pasadena, Calif. 91105

Medical Director is responsible for the overall UR plan and ensures that the utilization review process is followed in accordance with this document. GSG's medical director is a licensed physician who holds an unrestricted license to practice in California and is competent by his licensure and scope of practice to evaluate the specific clinical issues involved in medical treatment services.

The medical Director oversees the Reviewers and Expert Reviewers and may be called upon for final UR decisions. He/She is ultimately responsible for the UR decisions.

He/She may also make the final decision when a request is to be transferred to a Specialty Panel Reviewer (Expert Reviewer).

GSG's Reviewers and Expert Reviewers:

Reviewers and Expert Reviewers are defined in the list of definitions.

Specialty Panel (Expert Reviewers)

GSG's specialty panel consists of Board Certified specialists in various disciplines. The Reviewer and/or the Medical Director will review a case before a case is referred to an Expert Reviewer for an appeal if deemed necessary or appropriate.

The Medical Director, Reviewers, Expert Reviewers are contracted health professionals that work off-site and provide UR services that are compliant with California law.

Nurse Consultant(s):

GSG's Nurse Consultants are Registered Nurses currently licensed in the state in which they are stationed to complete reviews.

Nurse Consultants work either on-site at GSG headquarters or off-site and provide first level utilization review and utilization management services dependant upon client directives.

This first level review will be completed within appropriate timeframes in the event that the case will need to be transferred to a Reviewer or Expert Reviewer. They will assess the medical information and request additional medical information as necessary within timeframes.

They may approve the request based on the clinical information given and appropriate guidelines.

Dependent upon client directives, the UR program may enhance its Utilization Review to include communication with providers of care and facilities along with specific client personnel to enhance the program for pro-active medical management (treatments monitored, agreed upon between all parties and performed without the UR process as defined) and return to work and transitional care alternatives consistent with guidelines and cost-efficiency and safety for the injured worker.

UTILIZATION REVIEW PROCESS

The GSG Nurse Consultant performs the initial first level assessment for utilization unless client directives state that the claims adjuster or technician will perform the first level of review. The nurse may recommend an approval based on their assessment of the medical information received or upon further discussion with the requesting provider when appropriate and guidelines are met. The Nurse Consultant may request additional information needed to make a decision within timeframes laid out by the regulations. The nurse does not delay, deny or modify treatment requests.

Referrals

Referrals for UR treatment review must be in written form and are accepted by fax, or by mail. Requests for treatment must be set forth on form DLSR 5021, or on the PR2, or in narrative form containing the same information as the PR2. However, if in narrative format, it must be clearly marked at the top that it is a request for authorization, however.

According to the individual client directives, the claims adjuster or UR technician may authorize limited procedures for common conditions and will review the initial medical information for incomplete records. If they feel that additional information is necessary to complete a UR review, they may request additional information and send decision letters keeping within regulatory timeframes and statutes.

Any request that cannot be authorized will be referred to GSG for review and potentially to a GSG Reviewer or Expert Reviewer if appropriate.

For those clients that have their own MPN, they will work within their contractual boundaries which may include that treatment requests do not have to be referred for authorization if they comply with the MTUS and/or that they may have limited

authority to provide specific services without the need to submit requests for pre-authorization through utilization review.

Initial review (for UR request referred to GSG)

The Nurse Consultant will perform the initial medical review of the information received (when attached with the treatment request); that should include an initial evaluation, diagnosis and treatment provided along with a treatment plan. The Nurse Consultant will assess if the reasonable information necessary to make a recommendation is missing and if so, send a request for information notice to the requesting physician defining what information is missing, keeping timeframes per regulations under consideration.

Documentation of Decisions:

Any Activity and decision undertaken by Nurse Consultants and Reviewers/ Expert Reviewers are always clearly documented in GSG's medical management software, the client's software program or hardcopy when the client does not possess a system.

Approvals:

Upon review of the available information the Nurse Consultant may approve the treatment request if clinically appropriate and guidelines are met. Approval notices will follow UR regulations.

Approval notification is given to the claim's payer so that the claim's payor may appropriately reimburse for the specified course of medical treatments that were approved by GSG.

Delay, Modify, Denials: (only made by a GSG Reviewer, Expert Reviewer or the Medical Director)

All delays, modifications and denials will include the Reviewer's or Expert Reviewer's license number, contact information and hours of availability. The notification will include:

- The date on which the decision is made.
- Description of the specific course of proposed medical treatment for which authorization was requested.
- A specific description of the medical treatment service approved, if any.
- A clear and concise explanation of the reasons for the claims administrators' decision.
- Clinical reasons regarding medical necessity.

Withdraws:

At the request of the claims adjuster or the requesting provider and when deemed appropriate for the particular circumstances, a treatment request may be withdrawn from the utilization review process. Regulatory compliance will be adhered to within the scope of a UR withdraw request.

DECISION TIMEFRAMES

Decisions are made timely after a receipt of the information necessary in order to make a recommendation. Timeframes are dependent upon the type of UR being performed (i.e. prospective, concurrent)

Request for Information:

When a request for treatment is received that requires additional information in order to make a determination, GSG will fax a “request for information letter” to the provider that will outline the additional information needed in order to complete the review. This letter will be faxed to the requesting provider within 5 days of the initial request for treatment and in no event shall the determination be made more than 14 days from the date of receipt of the original request for the authorization by the requesting physician.

If the requesting physician does not submit the requested information within 14 days of the date of the original written request, the GSG shall forward the referral to a Reviewer or Expert Reviewer who may deny the request for lack of information, and will note that the request will be reconsidered upon receipt of the information requested. The reconsideration will be completed within 5 days of receipt of that information.

Prospective and Concurrent Reviews:

Shall be made in a timely fashion that is appropriate for the nature of the injured workers condition, not to exceed five (5) working days from the date of receipt for the written request for authorization.

In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been

agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker.

Expedited Reviews:

Prospective or concurrent decisions related to an expedited review (as noted in the definitions) shall be made in a timely fashion appropriate to the injured workers condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician should indicate the need for an expedited review upon submission of the request.

Emergency healthcare services that have not requested authorization may be subject to retrospective review.

Retrospective Reviews:

If additional information is required in order to render a decision, it will be requested as soon as possible upon review of the retro request. Decisions will be communicated within 30 days of receipt of the information that is reasonably necessary to make the determination. These communications will be in compliance with the communications listed below and copied as below, i.e. approval, denial, etc.

Communication and Notification Requirements:

Approvals-

A decision to approve the treatment request will be phoned or faxed to the requesting physician within **24 hours** of the decision. When phoned, the decision will be followed by written notice to the requesting physician within 24 hours of the decision for concurrent reviews and two (2) business days for prospective review.

Approval notification is given to the claim's payer so that they may appropriately reimburse for the specified course of medical treatments that were approved.

Negotiated Treatment:

When the Nurse Consultant has a dialogue with the requesting physician and they agree upon a revised treatment plan, the requesting provider will submit a signed amended treatment request based upon their agreed upon plan. The new treatment request will then be treated as an "approval" following approval timeframes and communication policy as noted in this plan.

Modification:

When a Reviewer or Expert Reviewer makes a modification to a treatment request, the decision shall be communicated to the requesting physician initially by phone or fax. If by phone, a letter will be sent within 24 hours for concurrent and within two (2) business days of the decision for prospective.

The letter shall include:

- The procedure requested
- The modified procedure authorized
- A description of the criteria or guidelines used
- The clinical reasons for the decision.
- Will be copied to the injured worker and their attorney if applicable
- Please see "Denial" section below for all language that will be included in the letter pursuant to § 9792.9(j)(1-9) and § 9792.9(k).

The Non-physician provider of goods or services for whom contact information has been included, shall be notified in writing of any decision to modify the treatment request but shall not include the rational, criteria or guidelines used for the decision.

Delay:

The claims administrator may extend the regulatory timeframes under the following conditions A and B:

- A) Is not in receipt of all the necessary medical information reasonably requested,
- B) Needs a specialized consultation and review of medical information by an Expert Reviewer.

Or a Reviewer may delay the request under the condition that:

- A) The Reviewer has asked that an additional examination or test be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice.

For delays that meet the criteria of the above (A,B or C), a notice shall be sent immediately to the requesting physician, the injured worker and their attorney in writing that the decision cannot be made within the required timeframe, and list an anticipated date on which a decision will be rendered. It will specify the medical information requested but not received, the additional examinations or tests required or the specialty of the expert reviewer to be consulted.

The notice shall include a statement that if the injured worker believes that a bona fide dispute exists relating to his or her entitlement to medical treatment, the injured worker or the injured worker's attorney may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, in accordance with sections 10136 (b) (1), 10400, and 10408.

The non-physician provider of goods or services identified in the requested for authorization and for who contact information has been included, shall be notified in writing of the decision to extend the timeframe and the anticipated date on which the decision will be rendered in accordance with the subdivision. The

written notification shall not include the rationale, criteria or guidelines used for the decision.

Upon receipt of the information or the report by the expert reviewer, the claims administrator shall make the decision to approve, or refer it to GSG and/or the reviewer shall make a decision to modify, or deny the request within 5 working days of receipt of the information for prospective or concurrent review and within 30 days of retrospective review.

The decision shall be communicated to the requesting physician initially by phone or fax. If by phone, a letter will be sent within 24 hours for concurrent and within two (2) business days of the decision for prospective.

- The procedure requested
- A description of the criteria or guidelines used
- The clinical reasons for the delay.
- Will be copied to the injured worker and their attorney if applicable
- Please see "Denial" section below for all language that will be included in the letter pursuant to § 9792.9(j)(1-9) and § 9792.9(k).

Denial:

When a Reviewer or Expert Reviewer denies a treatment request, the decision shall be communicated to the requesting physician initially by phone or fax. If by phone, a letter will be sent within 24 hours for concurrent and within two (2) business days of the decision for prospective.

The letter shall include:

- The specific treatment requested that is being denied.
- A description of the criteria or guidelines used pursuant to section 9792.8, subdivision (a) (3).
- The clinical reasons for the decision.
- The denial letter will be sent to the injured work and their attorney if applicable

- The letter will also include language as set forth in the regulations:

“Any dispute shall be resolved in accordance with the provisions of Labor Code section 4062, and that an objection to the utilization review decision must be communicated by the injured worker or the injured workers attorney on behalf on the injured worker to the claims administer in writing within 20 days of receipt of the decision. It shall further state that the 20 day time limit may be extended for good cause or by mutual agreement of the parties. The letter shall further state that the injured worker may file an application for adjudication of claim and request for expedited hearing, DWC form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with sections 10136(b) (1), 10400, and 10408.

It will include the following mandatory language:

Either

“If you want further information, you may contact the local state information and assistance office by calling [either district I & An office telephone number closest to the injured worker] or you may receive recorded information by calling 1-800-736-7401.

Or

“If you want further information, you may contact the local state Information and Assistance office closest to you. Pleas see attached listing (attach a listing of I & A offices and telephone numbers) or you may receive recorded information b calling 1-800-736-7401.”

And

“You may also consult an attorney of you choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney’s fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.”

Details about the claims administrators' internal utilization review appeal process, if any, and a clear statement that the appeals process is on a voluntary basis, including the following mandatory statement:

“If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with LC section 4062. You must meet this deadline even if you are participating in the claims administrators internal utilization review appeal process.”

Non-physician provider of goods or services for whom contact information has been included, shall be notified in writing of any decision to modify the treatment request but shall not include the rationale, criteria or guidelines used for the decision.

In addition the QME Attachment forms and Local office form go with All Delay, Deny, or Modify Decisions. QME Form 105 is for a claim that is not represented and QME 106 is for claim that is represented

DISPUTE PROCESS

UR reconsiderations and Appeals:

Reconsiderations of a treatment request are considered a "reconsideration" when additional information which had been previously requested is received for review. This information may be reviewed by the Nurse Consultant and approved if it meets guidelines. If the additional information received does not meet guidelines it will be referred to the Reviewer (which may be the same physician who denied the original treatment request due to lack of information.)

An appeal is when an original treatment request was denied on something other than lack of information. An appeal will go to a Reviewer who did not deny the first request and may be an Expert Reviewer dependant upon the case and the medical director's discretion. This internal appeal process is voluntary.

An appeal may be requested by an injured worker, or their attorney, the requesting physician or the facility in writing within 20 days of receipt of the UR review decision. The 20 day time limit may be extended for good cause or by agreement of the parties.

If a previously appealed treatment request is still disputed after this voluntary internal appeal process, the dispute/objection will be referred to the claims adjuster for their claims processing that may include the provisions of Labor Code 4062 per statutory requirements. The injured worker and attorney (if applicable) will be notified that if they still object to the decision they must object through LC 4062 within 20 days of receipt of the decision.

Utilization Review Appeal Process:

An appeal must be in writing and received within 20 days of the receipt of the utilization review decision and should be prominently displayed “UR Appeal” and include a copy of the specific UR decision that is being appealed.

There will be documentation of peer to peer contact or attempts thereof.

If an appeal is received based on a prior denial for lack of information with no new information attached, a notice will be sent stating that “A Notice has previously been sent regarding to this request for authorization, no further notices shall be sent.”

Utilization Review Dispute Resolution:

A clear statement that any dispute shall be resolved in accordance with the provision of Labor Code Section 4062, and that an objection to the utilization review decision must be communicated by the injured worker or the injured worker’s attorney on behalf of the injured work to the claims administrator in writing within 20 days of receipt of the decision. It shall further state that the 20-day time limit may be extended for good cause or by mutual agreement of the parties. The letter shall further state that the injured worker may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance Section 10136(b)(1), 10400, and 10408.

Included will be the following mandatory language:

Either

If you want further information, you may contact the local state Information and Assistance office by calling [enter district I & A office telephone number closest to

the injured worker] or you may receive recorded information by calling 1-800-736-7401

Or

“If you want further information, you may contact the local state information and Assistance office closest to you. Please see attached listing (attach a listing of I & A offices and telephone number) or you may receive recorded information by calling 1-800-736-7401.”

And

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney’s fee will be deducted from any award you receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

Details about the claims administrator’s internal utilization review appeals process, if any, and a clear statement that the appeals process is on a voluntary basis, including the following mandatory statement:

If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with Labor Code section 4062. You

must meet this deadline even if you are participating in the claims administrator's internal utilization review appeals process

In addition the QME Attachment forms and Local office form go with All Delay, Deny, or Modify Decisions. QME Form 105 is for a claim that is not represented and QME 106 is for claim that is represented

The written decision to modify, delay or deny treatment authorization provided to the requesting physician shall also contain the name and specialty of the Reviewer or Expert Reviewer, and the telephone number in the United States of the Reviewer or Expert Reviewer. The written decision shall also disclose the hours of availability of either the Reviewer, the Expert Reviewer or the Medical Director for the treating physician to discuss the decision which shall be, at a minimum, four hours per week during normal business hours, 9:00Am to 5:30 PM, or an agreed upon scheduled time to discuss the decision with the requesting physician. In the event the Reviewer is unavailable, the requesting physician may discuss the written decision with another Reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

If authorization is denied on the basis of lack of information, there will be documentation reflecting an attempt to obtain the necessary information from the requesting provider or from the provider of goods or services identified in the request for authorization either by facsimile or mail.

Within a client's MPN if the employee disputes the diagnosis or treatment of the treating physician, the dispute will be resolved in accordance with Labor code 4616.3 (c). These disputes are not considered UR disputes.

DISCLOSURE

GSG hereby certifies that the information and material contained in this utilization management plan is true and accurate to the best of their knowledge pursuant to Labor Code section 4610 and 8 CCR § 9792.6.

The utilization management plan is subject to amendments, and it will be disclosed to the public upon request to the claim's administrator. GSG may charge members of the public reasonable copying and postage expenses related to disclosing the complete utilization plan.

A. Hausel CEO

Signature of authorized GSG Representative

Date 10/20/2009

Gracia Goode, MD, MS

Signature of Medical Director (GSG)

Date 10/20/2009

CA Medical License Number: **G40760**