Berkshire Hathaway
HOMESTATE COMPANIES

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California Utilization Review Plan

January 3, 2025

The Berkshire Hathaway Homestate Companies include the following companies that are admitted to write workers' compensation insurance in California:

- Berkshire Hathaway Homestate Insurance Company
- Cypress Insurance Company
- Oak River Insurance Company
- Redwood Fire and Casualty Insurance Company

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This Utilization Review Plan has been filed with the Administrative Director pursuant to LC § 4610. It sets forth BHHC's policies and procedures and a description of its Utilization Review Process. BHHC has established and maintains this Utilization Review Plan and its Utilization Review Process in compliance with applicable law.

Definitions

Capitalized terms used in this Utilization Review Plan have the following meanings:

1. "Administrative Director" means the Director of the California Division of Workers' Compensation.

2. "Approval," and "Approve" mean a decision that the requested treatment or service is Authorized as medically appropriate.

3. "Authorization" and "Authorized" 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 LC § 4600, subject to the provisions of LC § 5402, based on either a Complete "Request for Authorization", DWC Form RFA, as contained in the CCR § 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section § 9792.9.1(c)(2), that has been transmitted by the treating physician to BHHC. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of CCR § 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Authorization", DWC Form RFA if that form was initially submitted by the treating physician.

   *All authorizations given are provided on authorization letters.

4. "BHHC" means the following affiliated companies admitted to write workers' compensation insurance in California and doing business as the Berkshire Hathaway Homestate Companies:

   Berkshire Hathaway Homestate Insurance Company
   Cypress Insurance Company
   Oak River Insurance Company
   Redwood Fire and Casualty Insurance Company

5. "BHHC Medical Provider Network" means an entity or a group of providers approved as a medical provider network by the Administrative Director pursuant to LC §§ 4616 to 4616.7.

6. "CCR" means Title 8 of the California Code of Regulations.

7. "Complete," with respect to a Request for Authorization, means (a) that the Request for Authorization is set forth on DWC Form RFA, identifies both the employee and the provider, identifies with specificity a recommended treatment or treatments, is accompanied by documentation substantiating the need for the requested treatment, and is signed by the treating physician; or (b) that the Request for Authorization has been accepted as complete by BHHC pursuant to CCR § 9792.9.1(c)(2).

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

9. “Denial” and “Deny” mean a decision by a Physician Reviewer that the requested treatment or service is not Authorized.

10. “Disputed Medical Treatment” means medical treatment that has been Modified or Denied by a Utilization Review Decision on the basis of Medical Necessity.

11. “DWC Form RFA” means the form contained in CCR § 9785.5.

12. “Drug Formulary” means the Drug List and the formulary rules set forth in CCR §§ 9792.27.1 to 9792.27.23.

13. “Drug List” means the drug list and related information set forth in CCR § 9792.27.15.

14. “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.

15. “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the patient’s health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

16. “Emergency Treatment Services” means treatment for an Emergency Medical Condition and provided in a licensed “general acute care hospital,” as defined in California Health and Safety Code § 1250.

17. “Exempt” and “Exempt Drug” means a drug on the Drug List which is designated as being a drug that does not require Authorization through Prospective Review or Concurrent Review prior to dispensing the drug, provided that the drug is prescribed in accordance with the Medical Treatment Utilization Schedule.

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

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

20. “Immediately” means within on business day.

21. “LC” means the California Labor Code.

22. “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.

23. “Medical Director” is a physician and surgeon employed or designated by BHHC who is licensed by the Medical Board of California or the Osteopathic Board of California and holds an unrestricted license to practice medicine in the State of California.

24. “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.

25. “Medical Treatment Utilization Schedule” means the standards of care adopted by the Administrative Director pursuant to LC § 5307.27 and set forth in Division 1, Chapter 4.5, Subchapter 1, Article 5.5.2 of the CCR.

26. “Medically Necessary” and “Medical Necessity” mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the standards set forth in LC § 4610.5(c)(2).

27. “Modification” and “Modify” mean a decision by a Physician Reviewer that part of the requested treatment or service is not Medically Necessary.

28. “Non-Exempt Drug” means a drug on the Drug List which is designated as requiring Authorization through Prospective Review or Concurrent Review prior to dispensing the drug.

29. “Perioperative Fill Drug” means a Non-Exempt Drug designated as a perioperative fill drug on the Drug List.

30. “Perioperative Period” means the period from 4 days prior to surgery to 4 days after surgery.

31. “Physician 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 the services are within the individual’s scope of practice.

32. “Prior Authorization” means prior approval from the claims administrator to provide a limited course of proposed medical treatment as outlined within the UR plan without submitting a Request for Authorization.

33. “Predesignated Physician” means a physician predesigned by the injured worker pursuant to LC § 4600(d).

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

35. “Request for Authorization” means a Written request for a specific course of proposed medical treatment.

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

37. “Special Fill Drug” means a Non-Exempt Drug designated as a special fill drug on the Drug List.

38. “Utilization Review Decision” means a decision pursuant to LC § 4610 to Approve, Modify or Deny, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to LC §§ 4600 or 5402(c). “Utilization Review Decision” may also mean a determination, occurring on or after January 1, 2018, regarding medication prescribed pursuant to the Drug Formulary.

39. “Utilization Review Process” means utilization management functions that prospectively, retrospectively, or concurrently review and Approve, Modify, or Deny, based in whole or in part on Medical Necessity to cure or relieve, treatment recommendations by physicians (as defined in LC § 3209.3), prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to LC § 4600.

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

Utilization Review Policies & Procedures

Deferral of Utilization Review

Utilization review of a Request for Authorization may be deferred if BHHC disputes liability for either the occupational injury for which treatment is recommended or the recommended treatment itself on grounds other than Medical Necessity.

If BHHC disputes liability for the requested medical treatment, it may, not later than 5 business days from receipt of the Complete Request for Authorization, issue a Written decision deferring utilization review of the requested treatment unless the requesting physician has been previously notified of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment. The Written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker’s attorney.

The Written decision shall contain the following information specific to the request:

1. The date on which the Complete 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 BHHC’s dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.
4. A plain language statement advising the injured employee that any dispute under CCR § 9792.9.1(b) shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers’ Compensation Appeals Board.
5. The mandatory language set forth in CCR § 9792.9.1(b)(1)(E).

If utilization review is deferred, and it is finally determined that BHHC is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers’

Compensation Appeals Board or by agreement between the parties, the time for BHHC to conduct Retrospective Review, shall begin on the date the determination of BHHC's liability becomes final. The time for BHHC to conduct Prospective Review shall commence from the date of BHHC's receipt of a Complete Request for Authorization after the final determination of liability.

Medical Director

BHHC has designated a Medical Director to oversee the Utilization Review Process in compliance with LC § 4610(g)(2). The Medical Director is responsible for all decisions made in the Utilization Review Process. The Medical Director shall ensure that the processes by which BHHC reviews and Approves, Modifies, or Denies Requests for Authorization by physicians prior to, retrospectively, or concurrent with the provision of medical services complies with the requirements of LC § 4610 and Division 1, Chapter 4.5, Subchapter 1, Article 5.5.1 of the CCR. The designated Medical Director's name, address, telephone number, and medical license number are set forth in Attachment A.

Medical Management Personnel

Medical Management Assistants

Medical Management Assistants (Assistants) are non-clinical support staff. Assistants validate RFA information for completeness to include identification of Employee Information, Requesting Physician Information, Requested Treatment and Requesting Physician Signature. Assistants issue provider letters for Treatment Rendered within 30 Days of Initial Date of Injury and record Express Care notifications. An Assistant will also submit Independent Medical Review records to the independent review organization and forward to the employee or the employee's representative a notification that lists all the documents submitted to the independent review organization.

Medical Management Specialists

Medical Management Specialists (Specialists) are non-clinical support staff who hold at least a high school diploma or equivalent and undergo several internal clinical medical training courses. Specialists review Requests for Authorization, answer telephone calls, obtain demographic information, and facilitate workflow within the utilization review department.

A Specialist may Approve Requests for Authorization for medical services that do not require a Medical Necessity determination by applying administrative decisions or specified criteria set forth in Attachment C. A Specialist may discuss applicable criteria with the requesting physician, should the treatment for which Authorization is sought appear to be inconsistent with the Medical Treatment Utilization Schedule. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended Request for Authorization, and the Specialist may approve the amended Request for Authorization. Additionally, a Specialist may reasonably request appropriate additional information that is necessary to render a decision. If a Specialist cannot Approve a Request for Authorization due to Medical Necessity, or if requested information is not timely received, the Specialist refers the Request for Authorization to a Nurse. A Specialist cannot Modify or Deny a Request for Authorization.

Medical Management Nurses

Medical Management Nurses (Nurses) are nurses who maintain an active current California registered nursing licensure or vocational nursing licensure and have at least 3 years of clinical experience.

A Nurse may Approve Requests for Authorization for medical services that are consistent with the Medical Treatment Utilization Schedule. A Nurse may discuss applicable criteria with the requesting physician, should the treatment for which Authorization is sought appear to be inconsistent with the Medical Treatment Utilization Schedule. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended Request for Authorization, and the Nurse may approve the amended Request for Authorization. Additionally, a Nurse may reasonably request appropriate additional information that is necessary to render a decision. If a Nurse cannot Approve a Request for Authorization, or if requested information is not timely received, the Nurse refers the Request for Authorization to a Physician Reviewer. A Nurse cannot Modify or Deny a Request for Authorization.

Medical Management Supervisors

Medical Management Supervisors (Supervisors) have at least 3 years of clinical experience.

A Supervisor may Approve Requests for Authorization for medical services that are consistent with the Medical Treatment Utilization Schedule. If a Supervisor cannot Approve a Request for Authorization, or if requested information is not timely received, the Supervisor refers the Request for Authorization to a Physician Reviewer. A Supervisor cannot Modify or Deny a Request for Authorization.

Medical Management Manager

Medical Management Manager (Manager) is a nurse who maintains an active current California registered nursing licensure.

A Manager may Approve Requests for Authorization for medical services that are consistent with the Medical Treatment Utilization Schedule. If a Manager cannot Approve a Request for Authorization, or if requested information is not timely received, the Manager refers the Request for Authorization to a Physician Reviewer. A Manager cannot Modify or Deny a Request for Authorization.

Physician Reviewers

Physician Reviewers are medical doctors, doctors of osteopathy, psychologists, acupuncturists, optometrists, dentists, podiatrists, or chiropractic practitioners licensed by any state or the District of Columbia. BHHC has designated a URAC-accredited third-party independent review organization to coordinate review of Requests for Authorization by Physician Reviewers when internal staff is unable to Approve a Request for Authorization. All Physician Reviewers are selected by the independent review organization. The independent review organization is required to comply with all state and federal statutory and regulatory requirements. The designated independent review organization's name, address, and telephone number are set forth in Attachment B.

A Physician Reviewer may Approve, Modify or Deny Requests for Authorization. A Physician Reviewer may reasonably request appropriate additional information that is necessary to render a

decision. Only a Physician Reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment, where these services are within the Physician Reviewer's scope of practice, may Modify or Deny Requests for Authorization for reasons of Medical Necessity to cure or relieve the effects of the industrial injury or due to incomplete or insufficient information. Financial incentives to doctors for utilization review decisions is prohibited.

Physician Reviewers or the Medical Director are available for the treating physician to discuss utilization review decisions at least four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM Pacific Time, or an agreed upon scheduled time.

Medically Based Criteria

The Medical Treatment Utilization Schedule is the primary source of guidance for the evaluation and treatment of injured workers. Treatment shall not be denied on the sole basis that the condition or injury is not addressed by the Medical Treatment Utilization Schedule.

If a medical condition or injury is not addressed by the Medical Treatment Utilization Schedule, medical care shall be in accordance with other medical treatment guidelines or peer-reviewed studies found by applying the following medical evidence search sequence for the evaluation and treatment of injured workers:

1. The Physician Reviewer searches the recommended guidelines set forth in the Medical Treatment Utilization Schedule to find a recommendation applicable to the injured worker's medical condition or injury.
2. In the limited situation where a medical condition or injury is not addressed by the Medical Treatment Utilization Schedule or if the Medical Treatment Utilization Schedule's presumption of correctness is being challenged:
    a. The Physician Reviewer searches the most current version of the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines or the Official Disability Guidelines to find a recommendation applicable to the injured worker's medical condition or injury. The Physician Reviewer chooses the recommendation that is supported with the best available evidence according to the Methodology for Evaluating Medical Evidence set forth in CCR § 9792.25.1.
    b. If no applicable recommendation is found, or if the Physician Reviewer believes there is another recommendation supported by a higher quality and strength of evidence, the Physician Reviewer searches the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury. The Physician Reviewer chooses the recommendation that is supported with the best available evidence according to the Methodology for Evaluating Medical Evidence set forth in CCR § 9792.25.1.
    c. If no applicable recommendation is found, or if the Physician Reviewer believes there is another recommendation supported by a higher quality and strength of evidence, the Physician Reviewer searches for current studies that are scientifically based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury. The Physician Reviewer chooses the recommendation that is

supported with the best available evidence according to the Methodology for Evaluating Medical Evidence set forth in CCR § 9792.25.1.

All criteria used in the utilization review process are consistent with the requirements of Labor Code §4604.5 and §5307.27. At least annually, or as otherwise appropriate, the Medical Director evaluates all criteria, guidelines and protocols used in the utilization review decision-making process to ensure these are consistent with the Medical Treatment Utilization Schedule and/or principles of evidenced based medicine. The Medical Director maintains current knowledge and familiarity with evidence-based peer-reviewed guidelines and updates the criteria as appropriate pursuant to CCR §9792.7(b)(1).

Request for Authorization

The Utilization Review Process begins when the Complete Request for Authorization is first received by BHHC.

The Request for Authorization for a course of treatment must be in Written form set forth on DWC Form RFA. The Request for Authorization must be signed by the treating physician and may be mailed or faxed to the address or fax number designated below. The treating physician may submit the Request for Authorization with an electronic signature.

Upon receipt of a Request for Authorization that is not Complete, in which it does not identify the employee or provider, does not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity for the requested treatment, or is not signed by the requesting physician BHHC may return it to the requesting physician marked "NOT COMPLETE," specifying the reasons for the return of the Request for Authorization, no later than 5 business days from receipt. The timeframe for a decision on a returned Request for Authorization shall begin anew upon receipt of a Complete Request for Authorization.

BHHC may, in its sole discretion, accept a Request for Authorization that does not utilize the DWC Form RFA, provided that: (1) "Request for Authorization" is clearly written at the top of the first page of the document; (2) all requested medical services, goods, or items are listed on the first page; and (3) the request is accompanied by documentation substantiating the Medical Necessity of the requested treatment.

Health care providers may mail Requests for Authorization to following address:

BHHC
PO Box 881716
San Francisco, CA 94188

Health care providers may fax Requests for Authorization to the dedicated fax number (415) 675-4230.

Health care providers may call (888) 495-8949 to request Authorization for medical services or to conduct peer-to-peer discussions regarding issues, including the appropriateness of the requested treatment, modification of a treatment request, or obtaining additional information needed to make a Medical Necessity decision. A representative is personally available at this number from

9:00 a.m. to 5:30 p.m. Pacific Time on business days. A voice mail system is available to receive communications from health care providers requesting Authorization for medical services after business hours.

Misdirected Requests for Authorization

Any Request for Authorization that has not been faxed to the dedicated UR fax number or mailed to BHHC is considered misdirected. This includes all Request for Authorization emailed, sent to general BHHC fax numbers, received by Attorneys, Field Nurses, or anyone working on behalf of BHHC.

Upon identification of a Misdirected Request for Authorization, the Misdirected Request for Authorization will be forwarded to the BHHC dedicated UR fax number. Receipt of a Request for Authorization to the dedicated UR fax number will begin the UR process.

Mail Receipt

When a Request for Authorization is sent by mail, the date of receipt will be determined by the date stamped on it by BHHC's mailroom. In the absence of documentation of receipt, the Request for Authorization shall be deemed to have been received by BHHC 5 business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service (as evidenced by the postmark date), unless the Request for Authorization is delivered via certified mail, with return receipt mail, absent documentation of receipt, in which case it shall be deemed to have been received by BHHC on the receipt date entered on the return receipt. In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the Request for Authorization shall be deemed to have been received by BHHC 5 days after the latest date the sender wrote on the document.

Facsimile Receipt

The Request for Authorization shall be deemed to have been received by BHHC by facsimile on the date the Request for Authorization was received if the receiving facsimile electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the Request for Authorization was transmitted shall be deemed to be the date the form was received by BHHC.

The Request for Authorization or the cover sheet accompanying the Request for Authorization, shall bear a notation of the date, time and place of transmission and the facsimile number to which the Request for Authorization was transmitted, or the Request for Authorization shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax transmission report, which shall display the facsimile number to which the Request for Authorization was transmitted.

A Request for Authorization transmitted by facsimile on a weekend, on a holiday, or after 5:30 PM Pacific Time on a weekday shall be deemed to have been received by BHHC on the following business day, except in case of an Expedited Review or Concurrent Review. The requesting physician must indicate if there is a need for an Expedited Review on the Request for Authorization.

Prior Authorization

BHHC may allow select providers within the BHHC Medical Provider Network, based on provider performance in accordance with the BHHC Medical Provider Network Quality of Care and Performance policy, to participate in BHHC Express Care, which is the ability to provide specified medical care to injured workers without the prior submission of a Request for Authorization as outlined in Attachment D. Providers must submit a notification of Express Care treatment within five business days of the date of service.

Emergency Health Care Services

BHHC does not require Prospective Review or Concurrent Review of Emergency Health Care Services. Failure to obtain authorization prior to providing Emergency Health Care Services shall not be used as a basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for Emergency Health Care Services. Emergency Health Care Services may be subjected to Retrospective Review. Documentation for Emergency Health Care Services shall be made available to BHHC upon request.

Treatment Rendered within 30 Days of Initial Date of Injury

Treatment Approved Without Utilization Review

For all dates of injury occurring on or after January 1, 2018, a member of the BHHC Medical Provider Network or a Predesignated Physician may render medical treatment within 30 days following the initial date of injury without Prospective Review or Concurrent Review, provided the treatment is rendered for a body part or condition that is accepted as compensable by BHHC and is addressed in the Medical Treatment Utilization Schedule. In the event that the employee is not subject to treatment with the BHHC Medical Provider Network or Predesignated Physician, treatment rendered by a physician or facility selected by BHHC within 30 days following the initial date of injury shall not be subject to Prospective Review or Concurrent Review, provided the treatment is rendered for a body part or condition that is accepted as compensable by BHHC and is addressed in the Medical Treatment Utilization Schedule. The services rendered shall be consistent with the Medical Treatment Utilization Schedule. For treatment rendered by a BHHC Medical Provider Network physician, a Predesignated Physician, or a BHHC-selected physician, the Doctor's First Report of Occupational Injury or Illness (DLSR Form 5021) and a Complete Request for Authorization shall be submitted by the physician within 5 days following the employee's initial visit and evaluation may be faxed to 415-675-4230.

A request for payment for Emergency Treatment Services provided within 30 days following the initial date of injury without Prospective Review shall be submitted to BHHC within 180 days of the date the service was provided. A request for payment for any other treatment provided within 30 days following the initial date of injury without Prospective Review shall be submitted to BHHC within 30 days of the date the service was provided.

Exceptions

Unless rendered as Emergency Health Care Services, the following medical treatment services provided within the 30 days following the initial date of injury shall be subject to Prospective Review or Concurrent Review:

1. Pharmaceuticals, to the extent they are neither expressly exempted from Prospective Review or Concurrent Review nor authorized by the Drug Formulary.
2. Nonemergency inpatient and outpatient surgery, including all pre-surgical and post-surgical services.
3. Psychological treatment services.
4. Home health care services.
5. Imaging and radiology services, excluding x-rays.
6. All durable medical equipment, whose combined total value exceeds $250, as determined by the Official Medical Fee Schedule.
7. Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
8. Any other service designated and defined through rules adopted by the Administrative Director.

Medical treatment that is not addressed in the Medical Treatment Utilization Schedule is subject to Prospective Review or Concurrent Review, even if rendered within 30 days following the initial date of injury.

Medical treatment rendered by a provider or physician who is not a member of the BHHC Medical Provider Network, or a Predesignated Physician is subject to Prospective Review or Concurrent Review, even if rendered within 30 days following the date of injury.

If a physician fails to submit a Doctor's First Report of Occupational Injury or Illness and a Complete Request for Authorization within 5 days following the employee's initial visit and evaluation, BHHC may remove the physician's ability to provide further medical treatment to the employee that is exempt from Prospective Review or Concurrent Review.

BHHC may perform Retrospective Review for any treatment provided without Prospective Review or Concurrent Review during the first 30 days following the initial date of injury solely for the purpose of determining if the physician or provider is prescribing treatment consistent with the Medical Treatment Utilization Schedule, including the Drug Formulary. If it is found after Retrospective Review that there is a pattern and practice of the physician or provider failing to render treatment consistent with the Medical Treatment Utilization Schedule, including the Drug Formulary, BHHC may prohibit the physician or provider from providing further medical treatment to any employee without Prospective Review or Concurrent Review. BHHC shall notify the physician or provider of the results of the Retrospective Review and the requirement for Prospective Review or Concurrent Review for all subsequent medical treatment. The results of the Retrospective Review may constitute a showing of good cause for a petition requesting a change of physician or provider by BHHC pursuant to LC § 4603 and may service as grounds for termination of the physician or provider from the BHHC Medical Provider Network.

If a provider performs a medical service, which is Authorized, but performs services beyond the scope of the Authorized services, the services beyond the scope of the Authorization may be Denied if the services are not Medically Necessary as determined by a Physician Reviewer. Such services are subject to Retrospective Review. The treating physician performing the service must provide documentation showing that treatment was for:

1. An Emergency Health Care Service;
2. A medical condition discovered during the course of providing the Authorized treatment and it was Medically Necessary to treat the newly discovered condition; or
3. A medical service or durable medical equipment identified as Medically Necessary during a medical examination and the treatment is rendered during the same office visit as the medical examination.

Providers must submit medical documentation to support the Medical Necessity of any services rendered outside the scope of Authorized services. Those services will be reviewed for Medical Necessity through Retrospective Review. Failure to provide appropriate documentation of Medical Necessity may result in Denial of reimbursement for the services.

Medications

Medications prescribed or dispensed to treat a work-related injury or illness are subject to the Medical Treatment Utilization Schedule, including the Drug Formulary.

Exempt Drugs

Except as indicated below, an Exempt Drug may be dispensed to the injured worker without obtaining Authorization through Prospective Review, Concurrent Review or Expedited Review if the drug treatment is in accordance with the Medical Treatment Utilization Schedule.

Brand Name Drugs

Prospective Review or Concurrent Review is required before an Exempt brand name drug is dispensed when a less costly therapeutically equivalent generic drug exists.

Physician-Dispensed Drugs

Exempt Drugs dispensed by a physician must be Authorized through Prospective Review or Concurrent Review prior to being dispensed, except a physician may dispense up to a 7-day supply of one or more Exempt Drugs at the time of an initial visit without obtaining Authorization through Prospective Review or Concurrent Review, if the drug treatment is in accordance with the Medical Treatment Utilization Schedule and the initial visit occurs with 7 days of the date of injury.

Compounded Drugs

Compounded drugs must be Authorized through Prospective Review or Concurrent Review prior to being dispensed.

Non-Exempt & Unlisted Drugs

Except as indicated below, Authorization through Prospective Review or Concurrent Review must be obtained prior to the time a Non-Exempt Drug or a drug that is not listed on the Drug List is dispensed.

Special Fill Drugs

A Special Fill Drug may be dispensed to the injured worker without seeking Prospective Review or Concurrent Review provided (a) the Special Fill Drug is prescribed at the single initial treatment visit following a workplace injury; (b) the initial visit is within 7

days of the date of injury; (c) the prescription is for a supply for the Special Fill Drug not to exceed the limit set forth in the Drug List; (d) the Special Fill Drug is prescribed in accordance with the Medical Treatment Utilization Schedule; and (e) the prescription for the Special Fill Drug is for (1) a generic drug or a single source brand name drug; or (2) a brand name drug where the physician documents and substantiates the medical need for the brand name drug rather than the generic drug.

Perioperative Fill Drug

A Perioperative Fill Drug may be dispensed to the injured worker without seeking Prospective Review or Concurrent Review provided (a) the Perioperative Fill Drug is prescribed during the Perioperative Period; (b) the prescription is for a supply of the Perioperative Fill Drug not to exceed the limit set forth in the Drug List; (c) the Perioperative Fill Drug is prescribed in accordance with the Medical Treatment Utilization Schedule; and (d) the prescription for the Perioperative Fill Drug is for (1) a generic drug or a single source brand name drug; or (2) a brand name drug where the physician documents and substantiates the medical need for the brand name drug rather than the generic drug.

Additional Documentation

For certain drugs, additional documentation must accompany the Request for Authorization.

Brand Name Drugs

If a physician prescribes a brand name drug when a less costly therapeutically equivalent generic drug exists, and writes “Do Not Substitute” or “Dispense as Written” on the prescription, the physician must document the Medical Necessity for prescribing the brand name drug in the patient’s medical chart and in the Doctor’s First Report of Occupational Injury or Illness (DLSR Form 5021) or the Primary Treating Physician’s Progress Report (DWC Form PR-2). The documentation must include the patient-specific factors that support the physician’s determination that the brand name drug is Medically Necessary.

Compounded Drugs

When it is necessary for medical reasons to prescribe or dispense a Compounded Drug instead of another drug, the physician must document the Medical Necessity in the patient’s medical chart and in the Doctor’s First Report of Occupational Injury or Illness (DLSR Form 5021) or the Primary Treating Physician’s Progress Report (DWC Form PR-2). The documentation must include the patient-specific factors that support the physician’s determination that the compounded drug is Medically Necessary.

Types of Utilization Review

The first day in counting any timeframe requirement is the date after receipt of the Complete Request for Authorization, except when the timeline is measured in hours. Whenever the timeframe requirement is measured in hours, the time for compliance is counted in hours from the time of receipt of the Complete Request for Authorization.

Expedited Review

Decisions to Approve, Modify or Deny a Request for Authorization related to an Expedited Review shall be made in a timely fashion appropriate to the injured worker’s condition, not to

exceed 72 hours after the receipt of the Written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for an Expedited Review upon submission of the request. A request for Expedited Review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for non-expedited utilization review would be detrimental to the injured worker's condition, shall be reviewed by BHHC in a timeframe that is appropriate for the nature of the injured worker's condition, not to exceed 5 business days from the date of receipt of the Complete Request for Authorization.

Prospective Review

Except for Requests for Authorization made pursuant to the Drug Formulary, prospective decisions to Approve, Modify or Deny a Request for Authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed 5 business days from the date of receipt of the Complete Request for Authorization and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

Prospective decisions regarding Requests for Authorization covered by the Drug Formulary shall be made no more than 5 business days from the date of receipt of the Complete Request for Authorization.

Concurrent Review

Except for Requests for Authorization made pursuant to the Drug Formulary, concurrent decisions to Approve, Modify or Deny a Request for Authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed 5 business days from the date of receipt of the Complete Request for Authorization and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

Concurrent decisions regarding Requests for Authorization covered by the Drug Formulary shall be no more than 5 business days from the date of receipt of the Complete Request for Authorization.

Medical care provided during a Concurrent Review shall be treatment that is Medically Necessary to cure or relieve the effects of the industrial injury. Medical care shall not be discontinued until the requesting physician has been notified of the decision and the care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee.

If BHHC disputes whether or not one or more services offered concurrently with a utilization review were Medically Necessary to cure and relieve, the dispute shall be resolved pursuant to independent bill review, if applicable, or otherwise pursuant to LC § 4062. A compromise between the parties that BHHC believes may result in payment for services that were not Medically Necessary to cure and relieve shall be reported by BHHC to the licensing board of the provider or providers who received payments for evaluation as to possible violations of the statutes governing appropriate professional practices.

Retrospective Review

Retrospective decisions to Approve, Modify or Deny a Request for Authorization shall be made within 30 days of receipt of the Complete Request for Authorization and medical information that is reasonably necessary to make a determination.

Request for Additional Information

If BHHC is not in receipt of all information reasonably necessary to make a determination on a Complete Request for Authorization (other than a Request for Authorization made pursuant to the Drug Formulary), a Physician Reviewer, Nurse or Specialist shall request in Writing the information from the treating physician within 5 business days from the date of receipt of the Complete Request for Authorization.

If the information reasonably necessary to make a determination that is requested by the Physician Reviewer, Nurse or Specialist is not received within 14 days from receipt of the Complete Request for Authorization for Prospective Review or Concurrent Review, or within 30 days of receipt of the Complete Request for Authorization for Retrospective Review, the Physician Reviewer shall Deny the Request for Authorization with the stated condition that the Request for Authorization will be reconsidered upon receipt of the information. BHHC's file shall document the attempt(s) by the Physician Reviewer, Nurse or Specialist to obtain the necessary medical information from the physician either by facsimile, mail or e-mail.

Upon receipt of the information requested, for Prospective Review or Concurrent Review, the Physician Reviewer, Nurse or Specialist shall make the decision to Approve, or the Physician Reviewer shall make the decision to Modify or Deny, the Request for Authorization within 5 business days of receipt of the information.

Upon receipt of the information requested, for Expedited Review, the Physician Reviewer, Nurse or Specialist shall make the decision to Approve, or the Physician Reviewer shall make the decision to Modify or Deny, the Request for Authorization within 72 hours of receipt of the information.

Upon receipt of the information requested, for Retrospective Review, the Physician Reviewer, Nurse or Specialist shall make the decision to Approve, or the Physician Reviewer shall make the decision to Modify or Deny, the Request for Authorization within 30 calendar days of receipt of the information requested.

Notification of Utilization Review Determinations

Approvals

A decision to Approve a Request for Authorization shall specify the specific date the Complete Request for Authorization was received, the specific medical treatment service requested, the specific medical treatment service Approved, and the date of the decision.

For Prospective Review, Concurrent Review, or Expedited Review, Approvals shall be communicated to the requesting physician within 24 hours of the decision and shall be communicated to the requesting physician initially by telephone, facsimile or electronic mail. The communication by telephone shall be followed by Written notice to the requesting physician

within 24 hours of the decision for Concurrent Review and within 2 business days for Prospective Review.

For Retrospective Review, a Written decision to Approve shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.

Payment, or partial payment, of a medical bill for services requested on the Request for Authorization, within the 30-day timeframe for Retrospective Review, shall be deemed a retrospective Approval, even if a portion of the medical bill for the requested services is contested, Denied, or considered incomplete. A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured employee who received the medical services, and his or her attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective Approval.

Modifications & Denials

For Prospective Review, Concurrent Review, or Expedited Review, a decision to Modify or Deny shall be communicated to the requesting physician within 24 hours of the decision and shall be communicated to the requesting physician initially by telephone, facsimile or electronic mail. The communication by telephone shall be followed by Written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, within 24 hours of the decision for Concurrent Review and within 2 business days for Prospective Review and for Expedited Review within 72 hours of receipt of the Complete Request for Authorization.

For Retrospective Review, a Written decision to Deny part or all of the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of Complete Request for Authorization and medical information that is reasonably necessary to make a determination.

The Written decision Modifying or Denying treatment Authorization shall be provided to the requesting physician, the injured worker, the injured worker's representative, and if the injured worker is represented by an attorney, the injured worker's attorney. The Written decision shall be signed by the Physician Reviewer, and shall contain the following information specific to the request:

1. The date on which the Complete Request for Authorization was first received.
2. If applicable, the date on which information requested pursuant to CCR § 9792.9.1(f) was received.
3. The date on which the decision is made.
4. A description of the specific course of proposed medical treatment for which Authorization was requested.
5. A list of all medical records reviewed.
6. A specific description of the medical treatment service Approved, if any.

7. A clear, concise, and appropriate explanation of the reason for the Physician Reviewer's decision, including the clinical reasons regarding Medical Necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to CCR § 9792.8.
8. If a Utilization Review Decision to Modify or Deny a Medical Service is due to incomplete or insufficient information, the decision shall specify the reason for the decision, a specific description of the information that is needed, the date(s) and time(s) of attempts made to contact the physician to obtain the necessary information, and a description of the manner in which the request was communicated. The decision shall include the stated condition that the Request for Authorization will be reconsidered upon receipt of the information
9. Enclose an Application for Independent Medical Review (DWC Form IMR). All fields of the form, except the signature of the employee, must be completed by BHHC. The Written decision provided to the injured worker shall include an addressed envelope for mailing to the Administrative Director or his or her designee.
10. A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of LC §§ 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 10 days of receipt of the utilization review decision for formulary requests and within 30 calendar days after service of the decision for all other medical treatment disputes.
11. Include the mandatory language set forth in CCR § 9792.9.1(e)(5)(I): "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, (adjustername), at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster."

    and

    "For information about the workers' compensation 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."
12. The Written decision Modifying or Denying treatment Authorization provided to the requesting physician shall also contain the name and specialty of the Physician Reviewer, and the telephone number in the United States of the Physician Reviewer. The Written decision shall also disclose the hours of availability of either the Physician Reviewer or the Medical Director for the requesting physician to discuss the decision, which shall be, at a minimum, 4 hours per week during normal business hours, 9:00 AM to 5:30 PM, Pacific Time or an agreed upon scheduled time to discuss the decision with the requesting physician. In the event the Physician Reviewer is unavailable, the requesting physician may discuss the Written decision with another Physician Reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.
13. If the injured worker's condition or injury is not addressed by the Medical Treatment Utilization Schedule or the Medical Treatment Utilization Schedule's presumption of

correctness is being challenged, the Physician Reviewer shall provide in the Written decision Modifying or Denying treatment Authorization a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury. The citation provided by the Physician Reviewer shall be the primary source relied upon which he or she believes contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury. If the Physician Reviewer provides more than one citation, a narrative shall be included by the Physician Reviewer in the Utilization Review Decision explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

Duration of Utilization Review Decision

A Utilization Review Decision to Modify or Deny a Request for Authorization shall remain effective for 12 months from the date of the decision without further action by BHHC with regard to a further recommendation by the same physician, or another physician within the physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the Utilization Review Decision.

Dispute Resolution

Voluntary Internal Appeal Process

BHHC does not offer a voluntary internal appeal process.

Independent Medical Review

If the Request for Authorization of medical treatment is Modified or Denied based on Medical Necessity, any dispute shall be resolved in accordance with LC §§ 4610.5 and 4610.6. BHHC shall have no liability for medical treatment furnished without the Authorization of BHHC if the treatment is Modified or Denied by a Utilization Review Decision unless the Utilization Review Decision is overturned by independent medical review or the Workers' Compensation Appeals Board.

A request for independent medical review must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, no later than 10 days after service of the Written Utilization Review Decision for Drug Formulary disputes and no later than 30 days after service of the Written Utilization Review Decision for all other medical treatment disputes. If at the time of a Utilization Review Decision BHHC is also disputing liability for the treatment for any reason besides Medical Necessity, the time for the employee to submit an application for independent medical review is extended to 30 days after service of a notice to the employee showing that the dispute of liability has been resolved.

If the Administrative Director reasonably requests additional appropriate information from BHHC in order to make a determination that a Disputed Medical Treatment is eligible for independent

medical review, BHHC shall respond to any reasonable request within 5 business days following receipt of the request.

Independent Medical Review Records Submission

Within 15 days following the mailing of the notification from the independent review organization that the Disputed Medical Treatment has been assigned for independent medical review, or within 12 days if the notification was sent electronically, or for Expedited Review within 24 hours following receipt of the notification, the independent review organization will receive from BHHC all of the following documents:

1. A copy of all reports of the physician relevant to the employee's current medical condition produced within 6 months prior to the date of the Request for Authorization, including those that are specifically identified in the Request for Authorization or in the Utilization Review Decision. If the requesting physician has treated the employee for less than 6 months prior to the date of the Request for Authorization, BHHC shall provide a copy of all reports relevant to the employee's current medical condition produced within the described 6 month period by any prior treating or referring physician.
2. A copy of the Application for Independent Medical Review (DWC Form IMR) that was included with the Utilization Review Decision, which notified the employee that the Disputed Medical Treatment was Denied or Modified.
3. A copy of all information, including correspondence, provided to the employee by BHHC concerning the Utilization Review Decision regarding the Disputed Medical Treatment.
4. A copy of any materials the employee or the employee's provider submitted to BHHC in support of the request for the Disputed Medical Treatment.
5. A copy of any other relevant documents or information used by BHHC in determining whether the Disputed Medical Treatment should have been provided, and any statements by BHHC explaining the reasons for the decision to Deny or Modify the recommended treatment on the basis of Medical Necessity.
6. BHHC’s response to any additional issues raised in the employee's application for independent medical review.

BHHC shall, concurrent with providing documents to the independent review organization, forward to the employee or the employee’s representative a notification that lists all of the documents submitted to the independent review organization. BHHC shall provide with the notification a copy of all documents that were not previously provided to the employee or the employee’s representative excluding mental health records withheld from the employee pursuant to California Health and Safety Code § 123115(b).

Any newly developed or discovered relevant medical records in the possession of BHHC after the documents are provided to the independent review organization shall be forwarded to the independent review organization within 1 business day. BHHC shall concurrently provide a copy of the newly developed or discovered relevant medical records to the employee, or the employee’s representative, unless the offer of medical records is declined or otherwise prohibited by law.

If the independent review organization requests additional documentation or information from BHHC, the additional documentation or other information shall be sent by BHHC to the independent review organization, with a copy forwarded to all other parties, within 5 business days after the request is received in routine cases or 1 calendar day after the request is received in expedited cases.

Termination of Independent Medical Review

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

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

Implementation of Determination After Independent Medical Review

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

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

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

Quality Assurance Program

BHHC maintains a quality assurance program. On a monthly basis, a sample of medical treatment requests is audited to ensure regulatory compliance, proper application of medical treatment guidelines and determination, as well as adherence to company procedures.

Privacy Policy

BHHC does not disclose personal information, except as required or allowed by law. We authorize our workers, agents, outside vendors and others to access personal information only when they have a business reason to do so. We have physical, electronic, and procedural safeguards to protect personal information from unauthorized access.

Public Availability

A copy of this Utilization Review Plan is available to the public by posting it on www.bhhc.com. A hard copy of this Utilization Review Plan is available upon request and upon payment of reasonable copying and postage expenses that shall not exceed $0.25 per page plus actual postage costs.

Attachment A

AVROM GART, M.D.
CA License No. G59372
Board Certified
Physical Medicine and Rehabilitation
Electrodiagnostic Medicine
Pain Management

Physical Medicine & Rehabilitation
Cedars-Sinai Spine Center
444 S. San Vicente Blvd., Ste. 800
Los Angeles, CA 90048
P: (310) 423-9960
F: (310) 423-9965
E-Mail: garta@cshs.org

Attachment B

The P&S Network, Inc.
8447 Wilshire Blvd., Suite 202
Beverly Hills, CA 90211
P: (323)556-0555
F: (323)556-0556

Attachment C

Medical Management Specialist Specified Criteria:

- Physical Therapy, Occupational Therapy, Massage Therapy, Aquatic Therapy, Chiropractic, Acupuncture
- Initial Post-Operative Therapies
- Specialist Evaluations
- Durable Medical Equipment not to exceed $500 per item
- Diagnostic imaging/testing for traumatic injuries to include MRI, CT, MR Arthrogram, EMG/NCS, Ultrasound
- Diagnostic imaging/testing for strains, sprains injuries > 2 months to include MRI, CT, MR Arthrogram, EMG/NCS, Ultrasound
- Carpel Tunnel, Shoulder and Knee steroid injections – No more than 3

Attachment D

BHHC Express Care - Treatment Eligible:

All treatments must be for the accepted injury, are expected to comply with the MTUS guidelines, and performed within BHHC Medical Provider Network.

- Providers can be found via www.talispoint.com/bhhc/campn

Conservative Treatment:

- PT/OT visits: up to 24 visits
- Chiro visits: up to 24 visits
- Acupuncture: up to 12 visits
- DME for combined total value up to $250 (Authorization is required prior to dispensing duplicate of previously dispensed DME)
- Diagnostic Ultrasound – Shoulder and/or abdominal wall
- X-Rays

Imaging/Diagnostics – (Not X-rays)

- CT Scan
- MR Arthrogram – Shoulder *
- MRI – Joint/Non-Spine *
- MRI – Spine (Cervical, Thoracic, Lumbar) **
- EMG/NCS *

* After 30 days with no improvement following conservative care, x-rays are negative or inconclusive
**After 60 days with no improvement following conservative care, x-rays are negative or inconclusive

Injections:

- Steroid Injection to Joint: Up to two injections
    - Shoulder
    - Wrist
    - Knee

Initial Specialty Consults: (Specialist referral must be within BHHC Medical Provider Network)

- Initial Audiology Evaluation
- Initial ENT Evaluation
- Initial General Surgery Evaluation
- Initial Ophthalmology Evaluation
- Initial Optometry Evaluation
- Initial Orthopedic Consultation
- Initial Pain Management Evaluation
- Initial PMR Evaluation
- Initial Podiatry Evaluation

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (888) 495-8949 • FAX: (415) 675-4230

December 10, 2024

Request for Information – NOT AN AUTHORIZATION

Telephone:
Fax:

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom It May Concern:

You have submitted a Request for Authorization dated [ ], which was first received by of on for the services listed below.

Unfortunately, based on the information submitted we cannot determine if the requested treatment plan/services is consistent with State mandated medical treatment guidelines for reasonable and necessary medical care as required by Labor Code.

Procedure and/or services requested:
Information required to render a determination:

When submitting the requested information, reference the Claim Number listed above on all written documentation relating to this request.

Fax the requested information to 1-415-675-2075. **Please note, this fax number is to be used for this response only.**

Should the requested information not be received by [12/24/2024], this request for authorization shall be denied pursuant to CCR §9792.9.1(f)(3)(A-B).

If you have any questions regarding this Request for Information, please contact me at 1-888-495-8949.

Sincerely,

Enclosures:

Berkshire Hathaway HOMESTATE COMPANIES

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: 888-495-8949 • FAX: 415-675-4230

December 04, 2024 **Notice of Administrative Authorization**

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by of on for the services listed below.

Based upon the information provided the following determination has been made:

Procedure and/or services requested:

Determination:	**Authorized**
Date of Determination:	December 04, 2024
Determination Number:	

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 888-495-8949.

Sincerely,

Signature Date: December 04, 2024

Berkshire Hathaway HOMESTATE COMPANIES

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: 888-495-8949 • FAX: 415-675-4230

December 04, 2024 **Notice of Administrative Authorization - IMR Overturn**

Telephone:
Fax:

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom It May Concern:

We are in receipt of an Independent Medical Review Final Determination Letter dated , which was received by of on for the services listed below. The original UR Determination was in part or fully Overturned by Independent Medical Review as outlined below.

IMR Determination: **Overturn**
Date of IMR Determination:
IMR Case #:

Authorization is limited to the procedure and services listed above. For extension or changes to the authorized treatment plan fax request to BHHC at 415-675-4230.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 888-495-8949.

Sincerely,

,
Signature Date: December 04, 2024

Berkshire Hathaway HOMESTATE COMPANIES

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (888) 495-8949 • FAX: (415) 675-4230

December 04, 2024 **Notice of Authorization**

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom It May Concern:

You have submitted a Request for Authorization dated , which was first received by on for the services listed below.

Procedure and/or services requested:
Based upon the information provided the following determination has been made.

Determination:	**Authorized**
Date of Determination:	December 04, 2024
Determination Number:	

The requested treatment is in accordance with the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines to include American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM).

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 888-495-8949.
Sincerely,

Signature Date: December 04, 2024

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: • FAX:

December 04, 2024 **Notice of Inpatient Rehabilitation Authorization**

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom It May Concern:

You have submitted a Request for Authorization dated , which was first received by on for the services listed below.

Procedure and/or services requested:

Based upon the information provided the following determination has been made.

Determination: **Authorized**
Date of Determination: December 04, 2024
Determination Number:

Authorization is limited to the rehabilitation duration and services listed above. For extension or changes to the authorized treatment plan fax request to BHHC at 415-675-4230.

The requested treatment is in accordance with the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines to include American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM).

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 888-495-8949.

Sincerely,
Signature Date: December 04, 2024

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: • FAX:

December 04, 2024

Notice of Surgical Authorization
Valid for 90 Days

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom It May Concern:

You have submitted a Request for Authorization dated , which was first received by on for the services listed below.

Procedure and/or services requested:
Based upon the information provided the following determination has been made.

Determination:	**Authorized**
Date of Determination:	December 04, 2024
Determination Number:	

The requested treatment is in accordance with the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines to include American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM).

Authorization is limited to the procedure and services listed above. For extension or changes to the authorized treatment plan fax request to BHHC at 415-675-4230.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 888-495-8949.
Sincerely,

Signature Date: December 04, 2024

Berkshire Hathaway HOMESTATE COMPANIES

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (888) 495-8949 • FAX: 415-675-4230

December 04, 2024 **Notice of UR Determination**

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated which was first received by of on for the services listed below.

Procedure and/or services requested:
One or more of the treatment/services requested identified above were previously reviewed by Utilization Review for consistency with state mandated medical treatment guidelines for reasonable and necessary medical care as required by the California Labor Code. The UR determination was appealed through Independent Medical Review (IMR). There has been no documented change in the facts material to the basis of the utilization review decision submitted.

Based upon the information provided the following determination has been made:

Date of Determination: December 04, 2024
Determination Number:
Previous UR Determination:
Previous IMR Uphold Date:

Determination:

Only Physician Reviewers can recommend that services be denied or modified. For UR Modification or Denial determinations, please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guidelines utilized in reaching the determination. The California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines to include American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) are referenced in reaching a determination.

Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 888-495-8949.

Sincerely,

Signature Date: December 04, 2024

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, , at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: 888-495-8949 • FAX: 415-675-4230

December 04, 2024

Notice of Modified Physician Determination

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by of on for the services listed below.

Procedure and/or services requested:
Based upon the information provided, P&S Network, Inc. has made the following determination on behalf of . Please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guideline utilized in reaching this determination.

Date of Determination: December 04, 2024
Determination Number:

Determination:

Only Physician Reviewers can recommend that services be modified, and this determination was made by peer review physician Dr. . The Physician Reviewer references the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines, to include the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) in reaching a determination.

Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 1-888-495-8949.

Sincerely,

Signature Date: December 04, 2024

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, , at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: 888-495-8949 • FAX: 415-675-4230

December 04, 2024 **Notice of Modified Physician Inpatient Rehabilitation Determination**

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by on for the services listed below.

Procedure and/or services requested:

Based upon the information provided, P&S Network, Inc. has made the following determination on behalf of. Please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guideline utilized in reaching this determination.

Date of Determination: December 04, 2024
Determination Number:

Determination:

Only Physician Reviewers can recommend that services be modified, and this determination was made by peer review physician Dr. . The Physician Reviewer references the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines, to include the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) in reaching a determination.

Authorization is limited to the procedure and services listed above. For extension or changes to the authorized treatment plan fax request to BHHC at 415-675-4230.

Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 1-888-495-8949.

Sincerely,

Signature Date: December 04, 2024

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, AdminCP San Diego, at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: 888-495-8949 • FAX: 415-675-4230

December 04, 2024

Notice of Modified Physician Surgical Determination
Valid for 90 Days

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by onfor the services listed below.
Procedure and/or services requested:

Based upon the information provided, P&S Network, Inc. has made the following determination on behalf of. Please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guideline utilized in reaching this determination.

Date of Determination: December 04, 2024
Determination Number:

Determination:

Only Physician Reviewers can recommend that services be modified, and this determination was made by peer review physician Dr. . The Physician Reviewer references the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines, to include the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) in reaching a determination.

Authorization is limited to the procedure and services listed above. For extension or changes to the authorized treatment plan fax request to BHHC at 415-675-4230.Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 1-888-495-8949.

Sincerely,

Signature Date: December 04, 2024

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, AdminCP San Diego, at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (888) 495-8949 • FAX: (415) 675-4230

December 04, 2024 **Notice of Physician Non-Authorization**

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by of on for the services listed below.

Procedure and/or services requested:
Based upon the information provided, P&S Network, Inc. has made the following determination on behalf of . Please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guideline utilized in reaching this determination.

Date of Determination: December 04, 2024
Determination Number:

Determination:

Only physician reviewers can recommend that services be denied, and this determination was made by Dr. . The physician reviewer references the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines, to include the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) in reaching a determination.

Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

All written documentation relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 888-495-8949.

Sincerely,

Signature Date: December 04, 2024

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, , at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

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P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (888) 495-8949 • FAX: (415) 675-4230

December 04, 2024 **Resubmission of RFA within 12 Months**

Date of Injury:

Claim Number:

Employee:

Employer:

To Whom It May Concern:

You have submitted a Request for Authorization dated, which was first received by of on for the services listed below.

Procedure and/or services requested:

Please be advised your request for treatment authorization was previously addressed by URD # dated . The new request is not supported by a documented change in the facts material to the basis of the utilization review decision.

Pursuant to California Labor Code § 4610(k), a utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Sincerely,

Signature Date: December 04, 2024

P&S Network

ACCREDITED
Independent Review Organization: Internal & External
Expires 12/01/2024

Physician Peer Review on Behalf of BHHC

Account No: ${account_no}
Determination No: ${location}

Requesting Physician:
${requesting_name}

Reviewing Physician:

Signature Not Found

${reviewing_name}
${reviewing_specialty}
${reviewing_license}

Patient Name:
${patient_name}

DOS: ${dos}
DOI: ${doi}
DOB: ${dob}
Claim No: ${claim_no}

NCM: ${ncm_name}

${a}

REQUESTED PROCEDURE/SERVICE

${id} ${request}

DETERMINATION

${determination}

${call_block}**TELEPHONE COMMUNICATIONS**

${date} ${time} ${memo}
${/call_block}

${backwards_compatible}${records_block}**MEDICAL RECORDS AND DATA REVIEWED**

${records}
${/records_block}
${p2p_block}**PEER-TO-PEER CONTACT**

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${recommendation_block}**RECOMMENDATIONS**

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${/recommendation_block}
${guidelines_block}**GUIDELINES / REFERENCES**

${guidelines}
${/guidelines_block}
${/backwards_compatible}
${backwards}

PHYSICIAN ATTESTATION:

- This report has been dictated using Dragon Medical voice recognition software and is therefore subject to transcription variance.
- I attest that I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review, and have current relevant experience and/or knowledge to render a determination on this case under review. My license or certification is current and unrestricted. I have at least five years of accumulative full-time equivalent experience providing direct clinical care to patients over the length of my career.
- The opinions expressed in this report are those of this evaluator and were rendered on the basis of documentation provided (outlined above) and are assumed as true and correct to the best of my knowledge except that as indicated was received from others.
- I certify that I have no material, professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the healthcare provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is subject of the review; the facility at which the recommended health care service or treatment would be provided; the developer or manufacture of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is under review, or the alternative therapy, if any, recommended by the employer; the employee or the employee's immediate family, or the employee's attorney. I do not accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.
- In the case of an appeal or re-review, I certify that I have identified the name of the physician who conducted the initial review, and that I have no subordinate relationship with that individual.

- *FOR CALIFORNIA ONLY*: To request a peer to peer discussion regarding this determination, please contact the P&S Network, Inc. The hours of availability for P&S Network Inc. are Monday - Friday 9am - 5:30pm P.S.T and the hours of availability for the BHHC Medical Director are Monday-Friday 10am-4:00pm (pacific standard time) Our phone number is (323) 556-0555.*

${disclaimer}

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: 888-495-8949 • FAX: 415-675-4230

January 02, 2025

Notice of Modified Physician Determination

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by of on for the services listed below.

Request for Information letter issued 12/31/24

Procedure and/or services requested:

Based upon the information provided, P&S Network, Inc. has made the following determination on behalf of . Please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guideline utilized in reaching this determination.

Date of Determination: January 02, 2025
Determination Number:

Determination:

Only Physician Reviewers can recommend that services be modified, and this determination was made by peer review physician Dr. . The Physician Reviewer references the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines, to include the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) in reaching a determination.

Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 1-888-495-8949.

Sincerely,

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, , at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: 888-495-8949 • FAX: 415-675-4230

January 02, 2025

Notice of Modified Physician Determination

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by of on for the services listed below.

Request for Information letter issued 12/31/24
Response to Request for Information received on 12/31/24

Procedure and/or services requested:

Based upon the information provided, P&S Network, Inc. has made the following determination on behalf of Cypress Insurance Company. Please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guideline utilized in reaching this determination.

Date of Determination: January 02, 2025
Determination Number:

Determination:

Only Physician Reviewers can recommend that services be modified, and this determination was made by peer review physician Dr. . The Physician Reviewer references the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines, to include the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) in reaching a determination.

Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 1-888-495-8949.

Sincerely,

Notice to Injured Worker

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If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, , at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: 888-495-8949 • FAX: 415-675-4230

January 02, 2025 **Notice of Modified Physician Inpatient Rehabilitation Determination**

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by on for the services listed below.

Request for Information letter issued 12/31/24

Procedure and/or services requested:

Based upon the information provided, P&S Network, Inc. has made the following determination on behalf of. Please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guideline utilized in reaching this determination.

Date of Determination: January 02, 2025
Determination Number:

Determination:

Only Physician Reviewers can recommend that services be modified, and this determination was made by peer review physician Dr. . The Physician Reviewer references the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines, to include the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) in reaching a determination.

Authorization is limited to the procedure and services listed above. For extension or changes to the authorized treatment plan fax request to BHHC at 415-675-4230.

Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 1-888-495-8949.

Sincerely,

Signature Date: January 02, 2025

Notice to Injured Worker

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Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: 888-495-8949 • FAX: 415-675-4230

January 02, 2025 **Notice of Modified Physician Inpatient Rehabilitation Determination**

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by on for the services listed below.

Request for Information letter issued 12/31/24
Response to Request for Information received on 12/31/24

Procedure and/or services requested:

Based upon the information provided, P&S Network, Inc. has made the following determination on behalf of . Please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guideline utilized in reaching this determination.

Date of Determination: January 02, 2025
Determination Number:

Determination:

Only Physician Reviewers can recommend that services be modified, and this determination was made by peer review physician Dr. . The Physician Reviewer references the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines, to include the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) in reaching a determination.

Authorization is limited to the procedure and services listed above. For extension or changes to the authorized treatment plan fax request to BHHC at 415-675-4230.

Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 1-888-495-8949.

Sincerely,

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, , at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: 888-495-8949 • FAX: 415-675-4230

January 02, 2025

Notice of Modified Physician Surgical Determination
Valid for 90 Days

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by of on for the services listed below.

Request for Information letter issued 12/31/24

Procedure and/or services requested:

Based upon the information provided, P&S Network, Inc. has made the following determination on behalf of . Please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guideline utilized in reaching this determination.

Date of Determination: January 02, 2025
Determination Number:

Determination:

Only Physician Reviewers can recommend that services be modified, and this determination was made by peer review physician Dr. . The Physician Reviewer references the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines, to include the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) in reaching a determination.

Authorization is limited to the procedure and services listed above. For extension or changes to the authorized treatment plan fax request to BHHC at 415-675-4230.Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 1-888-495-8949.

Sincerely,

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, , at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: 888-495-8949 • FAX: 415-675-4230

January 02, 2025

Notice of Modified Physician Surgical Determination
Valid for 90 Days

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by of on for the services listed below.

Request for Information letter issued 12/31/24
Response to Request for Information received on 12/31/24

Procedure and/or services requested:

Based upon the information provided, P&S Network, Inc. has made the following determination on behalf of . Please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guideline utilized in reaching this determination.

Date of Determination: January 02, 2025
Determination Number:

Determination:

Only Physician Reviewers can recommend that services be modified, and this determination was made by peer review physician Dr. . The Physician Reviewer references the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines, to include the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) in reaching a determination.

Authorization is limited to the procedure and services listed above. For extension or changes to the authorized treatment plan fax request to BHHC at 415-675-4230.Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 1-888-495-8949.

Sincerely,

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, , at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (888) 495-8949 • FAX: (415) 675-4230

January 02, 2025 **Notice of Physician Non-Authorization**

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by of on for the services listed below.

Request for Information letter issued 12/31/24

Procedure and/or services requested:

Based upon the information provided, P&S Network, Inc. has made the following determination on behalf of . Please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guideline utilized in reaching this determination.

Date of Determination: January 02, 2025
Determination Number:

Determination:

Only physician reviewers can recommend that services be denied, and this determination was made by Dr. . The physician reviewer references the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines, to include the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) in reaching a determination.

Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

All written documentation relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 888-495-8949.

Sincerely,

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, , at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (888) 495-8949 • FAX: (415) 675-4230

January 02, 2025 **Notice of Physician Non-Authorization**

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated , which was first received by of on for the services listed below.

Request for Information letter issued 12/31/24
Response to Request for Information received on 12/31/24

Procedure and/or services requested:

Based upon the information provided, P&S Network, Inc. has made the following determination on behalf of Cypress Insurance Company. Please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guideline utilized in reaching this determination.

Date of Determination: January 02, 2025
Determination Number:

Determination:

Only physician reviewers can recommend that services be denied, and this determination was made by Dr. . The physician reviewer references the California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines, to include the American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) in reaching a determination.

Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

All written documentation relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 888-495-8949.

Sincerely,

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, , at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

Berkshire Hathaway HOMESTATE COMPANIES

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (888) 495-8949 • FAX: 415-675-4230

January 02, 2025 **Notice of UR Determination**

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated which was first received by of on for the services listed below.

Request for Information letter issued 12/31/24

Procedure and/or services requested:
One or more of the treatment/services requested identified above were previously reviewed by Utilization Review for consistency with state mandated medical treatment guidelines for reasonable and necessary medical care as required by the California Labor Code. The UR determination was appealed through Independent Medical Review (IMR). There has been no documented change in the facts material to the basis of the utilization review decision submitted.

Based upon the information provided the following determination has been made:

Date of Determination: January 02, 2025
Determination Number:
Previous UR Determination:
Previous IMR Uphold Date:

Determination:

Only Physician Reviewers can recommend that services be denied or modified. For UR Modification or Denial determinations, please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guidelines utilized in reaching the determination. The California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines to include American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) are referenced in reaching a determination.

Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination Number listed above. If you have any questions regarding this determination, please contact me at 888-495-8949.

Sincerely,

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, , at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

P.O. BOX 881716 • SAN FRANCISCO CA 94188 • TOLL FREE: (888) 495-8949 • FAX: 415-675-4230

January 02, 2025 **Notice of UR Determination**

Date of Injury:
Claim Number:
Employee:
Employer:

To Whom it May Concern:

You have submitted a Request for Authorization dated which was first received by of on for the services listed below.

Request for Information letter issued 12/31/24
Response to Request for Information received on 12/31/24

Procedure and/or services requested:

One or more of the treatment/services requested identified above were previously reviewed by Utilization Review for consistency with state mandated medical treatment guidelines for reasonable and necessary medical care as required by the California Labor Code. The UR determination was appealed through Independent Medical Review (IMR). There has been no documented change in the facts material to the basis of the utilization review decision submitted.

Based upon the information provided the following determination has been made:

Date of Determination: January 02, 2025
Determination Number:
Previous UR Determination:
Previous IMR Uphold Date:

Determination:

Only Physician Reviewers can recommend that services be denied or modified. For UR Modification or Denial determinations, please reference the attached P&S Network, Inc. Physician Peer Review report for a description of the rationale and criteria/guidelines utilized in reaching the determination. The California Medical Treatment Utilization Schedule (MTUS) as well as other nationally recognized evidence based treatment guidelines to include American College of Occupational and Environmental Medicine Practice Guidelines (ACOEM) are referenced in reaching a determination.

Any dispute related to this determination shall be resolved as referenced in the included Notice unless the Claim is subject to an alternative dispute resolution process.

Where treatment is governed by the provisions of the Berkshire Hathaway Homestate Companies Medical Provider Network (MPN), the authorized treatment must be provided within this network. A directory of the BHHC MPN network can be accessed by logging on to www.bhhc.com.

Please note, this authorization does not constitute an agreement to any fees indicated within the submitted treatment request nor does the authorization guarantee a payment amount as billed. All bills to pertaining to the authorized medical treatment and/or service are subject to review by the claims administrator pursuant to the CA Workers' Compensation Rules and Regulations as well as any applicable PPO contract rates.

All written documentation, including medical bills relating to this determination should include the Claim Number and Determination

Number listed above. If you have any questions regarding this determination, please contact me at 888-495-8949.

Sincerely,

Notice to Injured Worker

The State of California requires that you be provided with the following information:

If you disagree with the utilization review decision, it 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 you, your representative or attorney on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 10 days of receipt of the utilization review decision for formulary requests and within thirty calendar days of receipt of the decision for all other medical treatment disputes.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster, , at 1-800-661-6029. However, if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation 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.

Notice to Requesting Physician

Berkshire Hathaway Homestate Companies (BHHC) will make available a medical reviewer from 9:00 a.m. to 5:30 p.m. on business days. If you have any questions or need clarification, please call Utilization Review at 1-888-495-8949.

Berkshire Hathaway Homestate Companies (BHHC) does not offer a voluntary internal appeal process.

If the Injured Worker disagrees with the utilization review decision and wishes to dispute it, the Injured Worker has the right to request an Independent Medical Review. All utilization review disputes will be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.