

California Utilization Review Plan Template – Effective April 1, 2026

I. UR-01 Form (Filled and Signed)

II. Cover Page

- Organization Name – ezURs.com Inc
- DWC Plan ID (if existing) - 113
- Date of Submission – 06/02/2026

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IV. Purpose and Scope

ezURs, Inc. (“ezURs”) maintains this Utilization Review (“UR”) Plan to ensure that all requests for medical treatment are reviewed in accordance with California Labor Code §4610 and applicable regulations contained in Title 8 California Code of Regulations Sections 9792.6 through 9792.12.

The purpose of this plan is to provide a systematic process for evaluating the medical necessity of treatment recommendations for injured workers and to ensure timely, fair, evidence-based determinations regarding requested medical services.

V. Definitions

For purposes of this Utilization Review Plan, the following definitions apply:

Authorization

“Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed “Request for Authorization,” as defined in this section, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, sections 9792.9.1 through 9792.12.

Claims Administrator

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

Concurrent review

“Concurrent review” means utilization review conducted during an inpatient stay.

Course of treatment

“Course of treatment” means the course of medical treatment set forth in the treatment plan contained on the “Doctor's First Report of Occupational Injury or Illness,” DIR Form 5021, found at California Code of Regulations, title 8, section 14006.1, or on the applicable physician reporting forms authorized by section 9785.

Denial

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

Dispute liability

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

Disputed medical treatment

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

Emergency health care services

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

Expedited review

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

Expert reviewer

“Expert reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, whose consultation for a specialized review has been requested by the claims administrator or utilization review organization, necessitating an extension of time, under section 9792.9.6, prior to the determination of medical necessity.

Health care provider

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

Immediately

“Immediately” means within one business day.

Material modification

“Material modification” is when the claims administrator changes utilization review vendor(s); makes a change to the utilization review standards as specified in section 9792.7; or changes its medical director, address, company name or corporate structure.

Medical director

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

Medical services

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

Medical Treatment Utilization Schedule (MTUS)

“Medical Treatment Utilization Schedule” means the standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20.

Modification

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

MTUS Drug Formulary

“MTUS Drug Formulary” means the drug formulary adopted by the Administrative Director under Labor Code section 5307.27 and defined in section 9792.27.1(m). The MTUS Drug Formulary contains the MTUS Drug List, which is set forth in section 9792.27.15.

Prospective review

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

Request for authorization

“Request for authorization” means a written request for a specific course of proposed medical treatment that meets all of the following criteria: (1) Unless accepted by a claims administrator under section 9792.9.1(b), a request for authorization must be set forth on a “Request for Authorization (DWC Form RFA)” as contained in California Code of Regulations (CCR), title 8, section 9785.5, completed by a treating physician and as further outlined in this subdivision and in section 9785(h).

Completed

“Completed,” for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization identifies both the employee and the requesting provider;

identifies with specificity all the recommended treatments in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used; and is accompanied by documentation, issued or created no earlier than 30 days before the date of submission of the request for authorization, that substantiates the need for the requested treatment. A request for authorization shall be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.6. (3) The request for authorization must be signed by the treating physician and may be mailed, faxed, or, if available, sent electronically through the use of an encrypted email system or via electronic data interchange (EDI) to the address, fax number, e-mail address, or clearinghouse designated by the claims administrator under section 9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

Retrospective review

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

Reviewer or Physician Reviewer

“Reviewer” or “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 these services are within the scope of the reviewer's or physician reviewer's practice.

Non-physician reviewer

“Non-physician reviewer” means an individual designated by the claims administrator or utilization review organization to assist in determining the medical necessity of the requested treatment. A non-physician reviewer may not modify or deny a treatment request.

Treating Physician

"Treating Physician" means the physician primarily responsible for managing the medical care of the injured worker and submitting requests for authorization for medical treatment.

URAC

“URAC” is the non-profit organization, located at 1220 L Street, NW, Suite 900, Washington, D.C., 20005, or as indicated online at www.urac.org, that provides accreditation for workers' compensation utilization review programs.

Utilization review decision

“Utilization review decision” means a decision pursuant to Labor Code section 4610 to approve, modify, or deny, a treatment recommendation or recommendations by a physician prior to,

retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code sections 4600 or 5402(c).

Utilization review plan

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

Utilization review process

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

Voluntary Internal Appeal

“Voluntary Internal Appeal” means a utilization review to reconsider a prior adverse determination.

Written

“Written” includes a communication transmitted by facsimile or in paper form. Electronic mail or electronic data interchange (EDI) may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail or by EDI, unless sent through the use of an encrypted electronic mail or EDI system.

Normal business day or Business day

“Normal business day” or “business day” does not include Saturday, Sunday, or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website.

Working day

“Working day” as used in this plan is the same as “business day” or “normal business day.”

VI. Utilization Review Process

- **General Procedures & Intake Process**

1. Submission of Requests for Authorization

Requests for Authorization may be submitted by:

- Electronic mail to utilizationreview@ezurs.com
- Facsimile to 888-970-2954
- Phone at 800-773-3413
- Electronic data interchange
- US Postal Service Mail:
ezURs.com Inc.
2435 N Central Expy, Ste 1350
Richardson TX 75080
- Other approved transmission methods.

ezURs maintains telephone, fax, and electronic communication capabilities to receive requests from treating physicians during and after business hours. Representatives are personally available by telephone from 9:00 AM to 5:30 PM Pacific Time, on business days.

Upon receipt each Request for Authorization will be reviewed and either:

- Accepted as complete; or
- A request for authorization that does not meet the definition of a complete request will be marked as "not complete" by a non-physician reviewer and returned to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt of the request for authorization.

2. Acknowledgment of Receipt

- A complete Request for Authorization submitted to ezURs by the carrier/adjuster will be acknowledged via email or fax to the carrier/adjuster which identifies the receipt date as defined in CA DWC rule 9792.9.1, the date the complete request was received at ezURs and the applicable regulatory timeframe as defined in DWC rule 9792.9.3.

3. Tracking and Logging

- ezURs internal software system will be used for logging and tracking timelines for all complete RFAs. All RFAs will be date-stamped upon receipt and logged into ezReviews to track regulatory timeframes and outcomes.
- **Dispute of Liability; Deferral**
 - Utilization review of a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

- A claims administrator who determines that Labor Code section 4610(k) precludes the need for utilization review must comply with the requirements under this section.
 - A request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of such change. Such a request must be reviewed by a physician reviewer and any modification or denial of the request must comply with applicable requirements as set forth at section 9792.9.5.
- If the claims administrator disputes liability as allowed under subdivision (a), it may, no later than five (5) business days from receipt of the request for authorization, issue a written decision deferring utilization review of the requested treatment unless the requesting physician has been previously notified under this subdivision of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall contain the following information specific to the request:
 - The date on which the request for authorization was first received.
 - A description of the specific course of proposed medical treatment for which authorization was requested.
 - A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment.
 - A plain language statement advising the injured employee that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.
 - The following mandatory language advising the injured employee:

"You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me." AND "For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

- (c) If utilization review is deferred pursuant to this subdivision, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, the time for the claims administrator to conduct retrospective utilization review in accordance with this section shall begin on the date the determination of the claims administrator's liability becomes final. The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a request for authorization after the final determination of liability.
- After a UR decision has been made to certify treatment, the insurer has one opportunity to dispute a condition or body part. For the RFA immediately following the initial UR certification for the condition or body part intended to be disputed, the adjuster MUST specifically request the UR reviewer to comment on causation (no matter the resulting determination). If the UR review comments on causation in a way that questions compensability of the condition/body part to be treated, the insurer can then request a QME. If QME determines the condition is not related to the injury, the insurer can defer all future treatment requests related to the condition/body part. A non-physician reviewer may issue subsequent deferral due to liability.
- If the physician documents a material change in facts for previously denied treatment, the request cannot be deferred and must undergo physician review. A Physician Reviewer will review the information to determine and document whether there has been a material change in facts that is supported by the available documentation.

- **Timeframe for Decision Making**

- 1. **Prospective, Concurrent, and Retrospective Reviews**

- Prospective - A decision shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed request for authorization. For prospective review, a decision to approve, modify, or deny a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. If the initial communication is by telephone, written communication shall be issued to the requesting physician, injured worker, and, if applicable, to the injured worker's representative within two (2) business days for prospective review.
- Concurrent - A decision shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed request for authorization. For concurrent review, a decision to approve, modify, or deny a request for authorization of treatment shall be initially communicated to the requesting

physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. If the initial communication is by telephone, written communication shall be issued to the requesting physician, injured worker, and, if applicable, to the injured worker's representative within 24 hours of the decision for concurrent review.

- Retrospective – A decision to approve, modify, or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and information regarding rendered medical treatment that is sufficient for a reviewer to make a determination. 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 within 30 days of the receipt of the request for authorization and information that is sufficient for a reviewer to make a determination .

2. Concurrent Review:

- Prior to a concurrent review decision to deny authorization for medical treatment the reviewer will notify the requesting physician of the decision and discuss a care plan, agreed upon by the requesting physician, that is appropriate for the medical needs of the employee and document that the medical care provided during a concurrent review is treatment that is medically necessary to cure or relieve from the effects of the industrial injury. Written communication of the decision shall be issued to the injured worker, and, if applicable, to the injured worker's representative within 24 hours of the decision for concurrent review. Failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request

3. Expedited Review

- Requests meeting expedited review criteria shall be reviewed as soon as medically necessary and no later than seventy-two (72) hours after receipt of information reasonably necessary to make the determination. 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 prospective or concurrent decisions would be detrimental to the injured worker's condition, shall be reviewed under the timeframe applicable to prospective or concurrent decisions. For expedited review, a decision to approve, modify or deny a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. Written communication of the decision shall be

issued to the requesting physician, injured worker, and, if applicable, to the injured worker's representative within 72 hours of receipt of the request.

VII. Notices for Initial Decisions

1. Written Decision Content Requirements

All utilization review determinations shall be communicated in writing and issued within the timeframes established by California Labor Code §4610 and Title 8 California Code of Regulations.

Approval Notices

Written approval notices shall include:

- Identification of the injured worker;
- Date of the complete Request for Authorization (RFA) was first received;
- Description of the treatment, service, or medication requested;
- Description of the treatment, service, or medication approved;
- Date of approval determination;
- Any approved duration, frequency, quantity, or limitations applicable to the authorization;
- Contact information for questions regarding the authorization;
- Any additional information required by applicable law or regulation.

If applicable, the written decision shall also include the date the request for information, exam, or consultation under section 9792.9.6, subdivision (a)(1)(A), (B), or (C) was requested, and the date the information was received.

Approvals may be communicated by US Mail, telephone, facsimile, electronic transmission, or other means, provided written confirmation is maintained in the claim record.

Modification and Denial Notices

Any decision to modify, or deny a treatment request based in whole or in part upon medical necessity shall be made by a physician reviewer competent to evaluate the specific clinical issues involved.

Written modification or denial notices shall include:

- Identification of the injured worker;
- Date of the complete Request for Authorization (RFA) was first received;
- Date on which the determination is made;
- The specific treatment, service, or medication requested;
- A specific description of the medical treatment or service approved, if any.
- A list of all medical records reviewed;

- Determination rendered (modification, delay, or denial);
- Clear and complete clinical rationale, in plain language where possible, of the reasons for the reviewing physician's decision;
- Description of the medical criteria, guidelines, or standards relied upon in making the determination;
- Identification of the applicable Medical Treatment Utilization Schedule (MTUS) guideline, MTUS Drug Formulary provision, or other evidence-based criteria utilized;
- Qualifications and specialty of the physician reviewer;
- The hours of availability of either the physician reviewer, the expert reviewer, or the medical director for the treating physician to discuss the decision;
- Identification of the URAC accredited entity
- A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application.
- Details about the claims administrator's internal utilization review appeals process, if any;
- The Application for Independent Medical Review, DWC Form IMR, with all fields of the form completed and an addressed envelope for mailing to the Administrative Director or their designee;
- The following mandatory language advising the injured employee:
 "You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me."
 and
 "For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."
- Any additional information required under California Labor Code §4610 and applicable regulations.

If the timeframe for decision was extended under section 9792.9.6, a specific description of the information needed to make a medical necessity determination of the treatment request; the date(s) and time(s) the request(s) for information, exam, or consultation under subdivision (a)(1)(A), (B), or (C) of section 9792.9.6 were requested; the manner in which the requests were made; and the date the information was first received.

The clinical rationale shall be sufficiently detailed to permit the requesting physician, injured worker, and claims administrator to understand the basis of the determination.

2. Extension of Timeframe for Decision

Review timeframes may be extended when additional information, testing, or consultation is reasonably necessary to make a determination. Requests for additional information shall comply with California regulatory requirements.

The reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization.

Upon receipt of the information requested the reviewer, for prospective or concurrent review, shall make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information. For prospective or concurrent decisions related to an expedited review, shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information.

If the information reasonably necessary to make a determination under subdivision (a) (1)(A) that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed or accepted request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, a physician reviewer shall deny the request in accordance with applicable rules in section 9792.9.5(e)

If the results of the additional examination or test required under subdivision or the specialized consultation that is requested by the physician reviewer under this subdivision is not received within thirty (30) days from the date of the request for authorization, the reviewer shall deny the request.

Requests for Authorization that include only medications require a determination within 5 business days, with no timeframe extension.

When an extension is required:

- The reviewer shall request only information reasonably necessary to make the determination;
- The request for additional information shall be documented in the utilization review file;
- The requesting physician shall be notified of the information needed;
- The injured worker and claims administrator shall be notified when required by regulation;
- The final determination shall be issued within the extended timeframe authorized by §9792.9.6.

All extension notices shall clearly identify the information required and the reason such information is necessary to complete the review.

If the timeframe for decision was extended a specific description of the information needed to make a medical necessity determination of the treatment request; the date(s) and time(s) the request(s) for information, exam, or consultation under subdivision (a)(1)(A), (B), or (C) of section 9792.9.6 were requested; the manner in which the requests were made; and the date the information was first received will be included in the written notice of determination.

3. MTUS Drug Formulary Determinations

Utilization review determinations involving prescription medications shall comply with the MTUS Drug Formulary requirements.

When approving a request for a generic or exempt drug that may be dispensed without prospective utilization review under the MTUS Drug Formulary:

- The determination shall clearly identify the medication approved;
- The notice shall indicate that the approval is based upon the MTUS Drug Formulary provisions, where applicable;
- Any restrictions regarding quantity, duration, dosage, or refills shall be identified.
- For medication requests that are listed as Exempt on the Formulary, "- Exempt per MTUS Drug Formulary" will be added to the end of the treatment line or words to that effect and meaning. Reviewers will proceed to review for medical necessity.
- For authorization of a drug where the request for authorization did not indicate "Do Not Substitute" or "Dispense as Written," the written decision approving the request in generic form shall indicate, "generic substitute authorized" or words to that effect and meaning.

Requests for non-exempt medications or formulary exceptions shall be reviewed in accordance with applicable MTUS Drug Formulary regulations and medical necessity standards.

4. Duplicate Treatment Requests – Twelve-Month Rule

Pursuant to §9792.9.5(g), utilization review is not required for a treatment request that is of the same treatment requested by the same provider, or a provider working in the same practice group as the prior requesting provider to a request previously denied or modified on the basis of medical necessity within the preceding twelve (12) months, unless an exception applies.

The claims administrator or utilization review organization may issue a notice indicating that the request constitutes a duplicate request previously reviewed within the prior twelve-month period.

Exception to the Twelve-Month Rule (§9792.9.2(a))

The twelve-month duplicate request limitation shall not apply when the repeat treatment request includes:

1. An express or unequivocal statement by the requesting physician indicating or opining that there has been a change in facts material to the basis of the prior denial, modification, or delay; and
2. Documentation supporting the material change in circumstances.

Examples of material changes may include, but are not limited to:

- Significant worsening of the injured worker's condition;
- New diagnostic findings;
- Failure of previously authorized treatment;

- New clinical information relevant to medical necessity;
- Changes in functional status.

When sufficient documentation of a material change is submitted, the request shall be treated as a new request for authorization and shall undergo utilization review in accordance with all applicable statutory and regulatory requirements.

VIII. Utilization Review Criteria

1. Medical Necessity

All utilization review determinations shall be based upon medical necessity as required by California Labor Code §4610 and applicable regulations.

Medical necessity determinations shall be made using the hierarchy of evidence established by California law and shall be based primarily upon the Medical Treatment Utilization Schedule (MTUS), including all applicable treatment guidelines, treatment recommendations, and the MTUS Drug Formulary.

When evaluating a treatment request, reviewers shall consider:

- The nature and extent of the industrial injury or illness;
- The injured worker's clinical presentation;
- Objective medical findings;
- Functional status and treatment goals;
- Prior treatment history and response;
- Applicable MTUS recommendations;
- Other evidence-based medical literature where permitted by law;
- The medical necessity of the requested treatment to cure or relieve the effects of the industrial injury.

Medical necessity determinations shall be made on an individualized basis and shall consider the specific clinical circumstances of the injured worker.

2. Authorized Treatment

Treatment requests shall be reviewed and determined in accordance with evidence-based medical treatment guidelines and applicable California workers' compensation laws and regulations. The criteria for a physician reviewer to determine the medical necessity of requested treatment shall be consistent with the adopted medical treatment utilization schedule. Authorization of medical treatment beyond what is covered in the medical treatment utilization schedule or supported by the best available medical evidence in order to account for medical circumstances warranting an exception may be indicated.

Following review, a treatment request may be:

Approved

A request shall be approved when the requested treatment is medically necessary and supported by applicable evidence-based criteria or medical circumstances warranting an exception.

Modified

A request may be modified when:

- The requested treatment is partially supported by applicable medical evidence;
- An alternative treatment is medically appropriate;
- Adjustments to frequency, duration, quantity, dosage, or level of care are medically warranted.

Any modification based upon medical necessity shall be made by a physician reviewer competent to evaluate the clinical issues involved.

Denied

A request may be denied when:

- The treatment is not medically necessary;
- The treatment is not supported by applicable evidence-based guidelines;
- The requested treatment exceeds guideline recommendations without sufficient clinical justification; or
- The treatment is otherwise not reasonably required to cure or relieve the effects of the industrial injury.

All modification and denial determinations shall include a written clinical rationale and identification of the medical criteria relied upon in reaching the determination.

3. First Thirty-Day Treatment Authorization Exemption

ezURs recognizes that, pursuant to California Labor Code §5402(c) and Title 8 California Code of Regulations §9792.9.7, medically necessary treatment consistent with the Medical Treatment Utilization Schedule (MTUS) may be provided during the first thirty (30) days following the date the injury is reported under circumstances specified by California law.

During this period:

- Prospective utilization review may not be required for treatment that qualifies under the statutory and regulatory exemption;
- Treatment must remain consistent with the MTUS and applicable workers' compensation requirements;
- The exemption does not apply when a claims administrator has lawfully denied liability for the claim or when otherwise permitted by statute or regulation;

- Treatment requests falling outside the exemption remain subject to utilization review requirements.

Medically necessary care consistent with the adopted MTUS may be provided without prospective authorization in the first 30 days after the date of injury, under conditions set in § 9792.9.7. Approvals of a request for authorization of non-drug treatment that are exempt under the 30-day exemption (9792.9.7), the written decision approving the request shall identify the exempt treatment as, "30-day exemption" or words to that effect and meaning.

The following medical treatment services, unless previously authorized by the claims administrator or rendered as emergency medical treatment, cannot be provided under subdivision (a) and shall require prospective utilization review under section 9792.9.1 or 9792.9.3:

(1) Pharmaceuticals, to the extent they are not expressly exempt from prospective review under the MTUS Drug Formulary.

(2) Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician's office. This includes all necessary and routine pre-operative, intra-operative, and post-operative services performed for the purpose of surgery including, but not limited to, related diagnostic tests or procedures, rehabilitation services, durable medical equipment or supplies, and routine post-surgical pain management treatment or services. For the purpose of this section, "surgery" means: 1) any procedure set forth in the Surgery section of the American Medical Association's Current Procedural Terminology (CPT®) which is incorporated by reference at section 9789.31(h), and any updates pursuant to section 9789.36; or 2) any procedure code defined as "surgery" in the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule found in the Healthcare Common Procedure Coding System (HCPCS), which is incorporated by reference at section 9789.31(i), and any updates pursuant to section 9789.36.

(3) Psychological or psychiatric treatment services, which includes diagnostic services, psychotherapy, and other services or procedures to an individual or group in all care settings provided by a physician or other qualified health care provider, and including psychiatric pharmaceuticals, to the extent they are not expressly exempt from prospective utilization review under the MTUS Drug Formulary.

(4) Home health care services, including health care and other medically necessary services provided to the injured worker in the residential setting.

(5) Imaging and radiology services, excluding X-rays.

(6) All durable medical equipment, prosthetics, orthotics, and supplies where the purchase or rental cost of the item with necessary supplies, if any, for the expected course of treatment is greater than \$250.00 as determined by the DWC Official Medical Fee Schedule (OMFS), or, for an unlisted item, where the billed amount will be greater than \$250.00.

(7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies. For the purpose of the subdivision, electrodiagnostic medicine is a

medical specialty where the physician uses neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic, neuromuscular, and/or muscular systems. This includes, but is not limited to, procedures set forth in the American Medical Association's Current Procedural Terminology (CPT®) Medicine section, under the subheading "Neurology and Neuromuscular Procedures," and any test that measures the speed and degree of electrical activity in the muscles and nerves in order to make a diagnosis.

(8) Spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections.

Nothing in this section shall be interpreted to limit the claims administrator's rights and obligations under California Labor Code §5402 or other applicable provisions of law.

4. Drug Authorization

For all medication requests, the adopted drug formulary consistent with California's MTUS will be referenced to identify inclusion and/or exemption status related to the medication and condition.

Prescription drug requests shall be reviewed in accordance with:

- The MTUS Drug Formulary;
- Applicable MTUS treatment guidelines;
- California workers' compensation regulations;
- Evidence-based medical necessity standards.

Exempt Drugs

Drugs designated as exempt under the MTUS Drug Formulary may be dispensed without prospective utilization review when all applicable formulary requirements are satisfied.

The reviewer shall verify that:

- The medication is identified as exempt within the MTUS Drug Formulary;
- The requested use complies with formulary requirements;
- The prescription is consistent with applicable MTUS treatment recommendations;
- No formulary restriction, limitation, or contraindication applies.

Non-Exempt Drugs

Requests for non-exempt medications shall be subject to prospective utilization review.

Review shall consider:

- Diagnosis and clinical indication;
- Medical necessity;
- Duration of therapy;
- Dosage and quantity;
- Prior treatment history;

- Safety considerations;
- MTUS Drug Formulary recommendations;
- Evidence supporting the requested medication.

Formulary Exceptions

Requests for medications outside formulary recommendations may be approved when sufficient clinical documentation demonstrates medical necessity and supports a departure from standard formulary recommendations.

Any modification or denial of a medication request based upon medical necessity shall be rendered by a qualified physician reviewer and communicated in accordance with applicable California notice requirements.

5. Consistency of Review Criteria

ezURs shall apply utilization review criteria consistently and uniformly to similarly situated treatment requests while maintaining consideration of the individual clinical circumstances of each injured worker.

All utilization review criteria shall be reviewed periodically and updated as necessary to ensure compliance with:

- California Labor Code §4610;
- The Medical Treatment Utilization Schedule (MTUS);
- The MTUS Drug Formulary;
- Applicable regulations of the Administrative Director;
- Current evidence-based medical standards.

IX. Appeal and Independent Review

Voluntary Internal Appeal

- A voluntary internal appeal may be requested within ten (10) calendar days after the service of the utilization review decision to the employee. Voluntary internal utilization review appeal decisions will be completed no later than ten (10) business days from the date of the receipt of the request. Following an internal utilization review appeal that results in a modification of the requested medical treatment shall be communicated to the requesting physician and the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney according to the requirements set forth in section 9792.9.5(e). The Application for Independent Medical

Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.5(e)(7), must indicate that the decision is a modification after appeal.

Independent Medical Review

- A request for independent medical review of a utilization review decision that denies or modifies a medical treatment request must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days after the mailing date of the written utilization review determination. For a utilization review decision that only denies or modifies a request for a drug listed on the MTUS Drug List, the request for independent medical review must be filed by the eligible party within 10 days after the mailing date of the written utilization review decision.
- Failure of the Injured Employee to request an independent medical review timely will result in the loss of the right. Written decisions that modify or deny a treatment will include the following directives to facilitate dispute resolution: The Injured Employee has a right to disagree with decisions affecting their claim. If the Injured Employee has questions about the information in this notice, the Injured Employee should call ezURs at 800-773-3413. However, if the injured employee is represented by an attorney, the Injured Employee should contact their attorney.

For information about the workers' compensation claims process and Injured Employees' 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.

X. Personnel and Qualifications

1. Medical Director

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Physical Medicine & Rehabilitation
Brain Injury Medicine - Subspecialty
C184344

- The medical director shall ensure that the process by which the claims administrator reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical services, complies with Labor Code section 4610

2. Physician Reviewers

- A reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the reviewer's scope of practice, may, except as indicated below, modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury. Physician Reviewers will hold unrestricted

license in a US state and conduct all review activities within the United States and US territories.

3. Non-Physician Reviewers

- A non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. A non-physician reviewer may approve requests for authorization of medical services. A non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization. Additionally, a non-physician reviewer may reasonably request appropriate additional information that is necessary to render a decision.

4. Expert Review Consultants

- An expert reviewer may provide specialized consultation and review of medical information when the physician reviewer determines specialized consultation is needed to make a medical necessity decision and identifies the specialty of the expert reviewer to be consulted. An expert reviewer is a physician, or other licensed health practitioner, competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the reviewer's scope of practice with a minimum of 5 years of experience in utilization review services.

XI. Plan Submission and Modifications

1. Initial Submission

- This UR Plan is submitted to the DWC in a searchable electronic format with required attachments.

2. Material Modifications

- ☐ Ownership changes
- ☒ Medical Director changes
- ☐ Corporate structure
- ☒ Process changes affecting compliance
- ☐ Other

XII. Quality Assurance & Compliance Monitoring

1. Internal Audits

- ezURs.com Inc. maintains a Quality Management (QM) Program that systematically measures, evaluates, and improves the quality of care and services provided. Routine checks for adherence to timelines and criteria. The Medical Director (or equivalent designate) will perform a quality check on the first two (2) reports completed by each new reviewer prior to distribution. Reviews are randomly audited quarterly to monitor quality and compliance.

2. Accreditation Requirements

- ezURs maintains URAC Workers' Compensation Utilization Management (WCUM) Accreditation.

3. Delegated UR Functions

- ezURs.com does not delegate utilization review functions.

4. Financial incentive policy

- Per policy Consumer Protection and Empowerment 2.0 ezURs.com prohibits financial incentives that may compromise consumer protection, fairness, or quality of care and will monitor all financial arrangements to ensure decisions are made solely on clinical appropriateness. No financial incentives to doctors and other providers based on the utilization review decision will be allowed.

XIV. Documentation & Recordkeeping

1. Records Retention

All HIPAA-related documentation will be retained according to the Health Insurance Portability and Accountability Act of 1996: 45 C.F.R. Section 164.501, its successor laws such as the HITECH Act, and State regulations. The period of retention is seven (7) years from the date of the document's creation or modification. Non-HIPAA-related documents are retained per State law governing medical records and business records for at least a minimum of five (5) years. When laws and regulations conflict, records will be retained for the longest period of time required.

2. Confidentiality

ezURs will maintain compliance with all State and Federal laws pertaining to the disclosure of individually-identifiable health information. Access to PHI is strictly limited to those

personnel who need information containing PHI to carry out their assigned job responsibilities.

3. Provider & Patient Communications

All provider & patient communications will adhere to ezURs code of ethics and business conduct and will be documented within the affiliated case communications for documentation and recordkeeping.

XV. Appendices

- UR-01 Form
- Appendix A: Sample Decision Letter Templates
- Appendix B: Client or UR Vendor list