

AGREEMENT NUMBER 41430056
REGISTRATION NUMBER

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME

DEPARTMENT OF INDUSTRIAL RELATIONS

CONTRACTOR'S NAME

MAXIMUS FEDERAL SERVICES, INC.

2. The term of this Agreement is: **January 1, 2015 through December 31, 2017**

3. The maximum amount of this Agreement is: **\$0.00**
Zero Dollars and No Cents

4. The parties agree to comply with the terms and conditions of the following exhibits which are by this reference made a part of the Agreement.

Exhibit A - Scope of Work	16	page(s)
Exhibit A, Attachment 1	2	page(s)
Exhibit A, Attachment 2	1	page(s)
Exhibit A, Attachment 3 (3.1-3.4)	4	page(s)
Exhibit A, Attachment 4	1	page(s)
Exhibit A-1 - Maximus Response to DIR DWC RFP 14-001	352	page(s)
Exhibit B - Budget Detail and Payment Provisions	1	page(s)
Exhibit C - General Terms and Conditions	GTC-610	
Exhibit D - Special Terms and Conditions (Attached hereto as part of this agreement)	8	page(s)
Exhibit E - Additional Provisions	3	page(s)
Attachment I - Labor Code Excerpts	13	page(s)

Items shown with an Asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto.
These documents can be viewed at www.ols.dgs.ca.gov/Standard+Language

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME (If other than an individual, state whether a corporation, partnership, etc.)

MAXIMUS FEDERAL SERVICES, INC.

BY (Authorized Signature)

DATE SIGNED (Do not type)

[Signature]

12/31/14

PRINTED NAME AND TITLE OF PERSON SIGNING

Peter Vaeth, Director of Compliance and Contracts

ADDRESS

7950 Jones Branch Drive
McLean VA 22107

STATE OF CALIFORNIA

AGENCY NAME

DEPARTMENT OF INDUSTRIAL RELATIONS

BY (Authorized Signature)

DATE SIGNED (Do not type)

[Signature]

1/7/2015

PRINTED NAME AND TITLE OF PERSON SIGNING

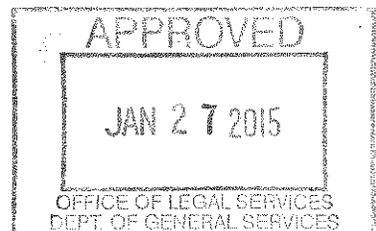
Matthew Shiroma, Contract and Procurement Manager

ADDRESS

Division of Administration/Contracts Unit
1515 Clay Street, 3rd Floor, Suite 301, Oakland, CA 94612

California Department of General Services Use Only

[Signature]



Exempt per:

[Signature]

EXHIBIT A SCOPE OF WORK

Contractor MAXIMUS Federal Services, Inc. ("Contractor") agrees to provide independent medical review ("IMR") services to the Department of Industrial Relations ("DIR") and the Division of Workers' Compensation ("DWC") ("DIR/DWC") as described herein.

I. PROJECT REPRESENTATIVES

The Project Representatives during the term of this agreement are:

Department of Industrial Relations	MAXIMUS Federal Services, Inc.
Contract Manager: Matthew Shiroma	Project Director: Thomas C. Naughton, JD, LLM
Address: Department of Industrial Relations 1515 Clay Street, Ste. 301 Oakland, CA 94612	Address: 625 Coolidge Drive, Suite 100 Folsom, CA 95630
Phone: (510) 286-6844	Phone: (703) 251-8545
Fax: (510) 286-6863	Fax: (703) 251-8240

Direct all inquiries to:

Department of Industrial Relations	MAXIMUS Federal Services, Inc.
Division of Workers' Compensation	Center for Health Dispute Resolution
Project Manager: Rupali Das, MD, MPH Executive Medical Director	Project Manager: Lou Shields
Address: 1515 Clay St., 18th Floor Oakland, CA 94612	Address: 625 Coolidge Drive, Suite 100 Folsom, CA 95630
Phone: (510) 286-3700	Phone: (916) 503-4998
Fax: (510) 622-3467	Fax: (916) 364-8134

The Parties may change their project representatives upon providing ten (10) days written notice to the other Party. Unless provided notice of otherwise, DIR/DWC Project Manager as used herein refers to Dr. Das or an appointed designee of Dr. Das.

II. TERM OF AGREEMENT

The Agreement shall begin on January 1, 2015 and end on December 31, 2017 unless DIR/DWC elects to extend the Agreement for an additional two year period such that it ends on December 31, 2019. By no later than October 1, 2017, DIR/DWC shall provide written notice to Contractor of its decision either to extend the agreement for an additional two (2) years, or to confirm the Agreement's expiration on December 31, 2017.

III. DEFINITIONS

DIR/DWC and Contractor agree that, for purposes of interpreting and enforcing this agreement, the following words shall have the meanings set forth below:

“Administrative Director” means the individual appointed by the Governor of the State of California to act as the head of the Division of Workers’ Compensation within the Department of Industrial Relations, or the individual acting in that capacity.

“Claims Administrator” means 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.

“Case Management System” or “CMS” is the case workflow tracking and management system to be established by Contractor that conforms with, at a minimum, the requirements set forth herein, and remains operational throughout the duration of this Agreement. Contractor’s Response to DIR/DWC’s 2014 Independent Medical Review RFP, incorporated as noted by reference herein, may also refer to this system as “case workflow tracking system”.

“Contractor” means MAXIMUS Federal Services, Inc., also referred to as MAXIMUS Federal, which is a wholly owned subsidiary of MAXIMUS, Inc. The terms Contractor, MAXIMUS Federal and MAXIMUS shall refer to the same entity.

“DIR” means the Department of Industrial Relations.

“DWC” means the Division of Workers’ Compensation within the Department of industrial Relations.

“Enhancements” mean changes that are requested by DIR/DWC or offered by Contractor that increase one or more capabilities of the case management workflow system.

“IMR” means independent medical review, and specifically, the independent medical review of a Utilization Review decision that is authorized by Labor Code sections 4610.5 and 139.5 (as added by Stats. 2012, Ch. 363 (Senate Bill 863)) and their implementing regulations, including 8 C.C.R. section 9792.10.1, et seq.

“Interested IMR Parties” means those individuals or entities that have an interest in the matter of the Independent Medical Review. Examples of Interested IMR Parties include the injured worker, injured worker’s physician, injured worker’s attorney or other representative, and claims administrators of the injured worker’s workers’ compensation insurance.

“Party” and “Parties” Party refers to either the Department of Industrial Relations Division of Workers’ Compensation or MAXIMUS Federal. Parties refer to both the Department of Industrial Relations Division of Workers’ Compensation and MAXIMUS Federal.

“Physician” Unless the express language or context indicates otherwise, “physician” shall have the same meaning in this agreement as in Labor Code section 3209.3 and includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners.

“Project Manager” shall mean either the individual identified by a Party as the Project Manager, or that individual’s designee.

“Provider” means the injured worker’s treating physician, whose recommendation for medical treatment is the subject of an IMR sought to resolve a dispute over the medical necessity for such treatment.

“Severity 1” means that essential system functions and functionality essential to the business process at hand are halted and daily activities cannot continue

“Support” means repair or user administration by Contractor necessary to continue or maintain the functionality of the CMS as currently designed.

“Upgrade” means a replacement of the hardware or software components of the case management system in order to maintain the system at or above the level of functionality required by the Agreement.

“User Administration” means the addition, deletion or revision of user permissions and access with respect to the system.

“Utilization Review” means the Claims Administrator’s review under Labor Code section 4610 and its implementing regulations of a medical treatment recommendation by an injured worker’s treating physician that may result in the approval, modification, delay or denial of such treatment recommendation. The abbreviation UR when used herein has the same meaning as Utilization Review.

IV. DIR/DWC’S ROLE AND RESPONSIBILITIES

DIR/DWC and Contractor agree that, with respect to the services to be performed by Contractor under this agreement, DIR/DWC shall be responsible for:

- A. Monitoring Contractor’s performance of the Agreement. The DIR/DWC Project Manager shall have the overall responsibility to monitor and evaluate the performance of Contractor with respect to the Independent Medical Reviews for DIR/DWC. The DIR/DWC Project Manager shall be able to review all reports for technical quality and compliance with the terms of the Agreement. For purposes of this clause, “reports” refer to individual Independent Medical Review determinations, performance reports, and any other report required to be prepared by Contractor under this agreement. In its discretion, DIR/DWC may specify revisions necessary to remove discrepancies in any report. The DIR/DWC Project Manager shall set forth such requested revisions in writing, and Contractor shall be bound to make those revisions so long as they do not exceed the scope of the work required in the Agreement.
- B. Overseeing the entire Independent Medical Review process, including oversight for Contractor’s compliance with all applicable statutes, regulations, and procedures. DIR/DWC will also be responsible for overseeing the implementation and execution of all applicable statutes, regulations and procedures.

- C. Reviewing any case in which Contractor notifies DIR/DWC that it appears the case may be ineligible for Independent Medical Review, or the information submitted with the application is insufficient to begin the IMR process, and making an independent determination as to whether the case is eligible for IMR.
- D. Ensuring that Contractor is in compliance with applicable deadlines.
- E. Ensuring that Contractor conducts reviews, and issues final determinations in a professional, appropriate, and timely manner.
- F. Ensuring that Contractor is responding to complaints and requests for information about specific cases, and the IMR process overall. Contractor shall maintain a record of all complaints it receives, and its response to all complaints. DIR/DWC may also respond to complaints and requests for information about specific cases, and the IMR process overall.

V. SERVICES TO BE PERFORMED

Except as noted below, the services that shall be performed by Contractor are those set forth in the May 12, 2014 Response to DIR RFP Number 14-001, "Independent Medical Review", submitted by MAXIMUS Federal Services, Inc. ("the Response") and incorporated herein. DIR/DWC and Contractor agree that:

A. In the Response on page 2-4 at section "Scalable Case Workflow Tracking System and Supporting Tools," the following sentence at the end of the first paragraph which reads,

We continue to work closely with DWC to improve and upgrade *entellitrak* through regular system releases, including the online IMR Application which will be fully implemented in July 1, 2014.

Is revised so it shall read:

We continue to work closely with DIR/DWC to improve and upgrade *entellitrak* through regular system releases, including an online IMR Application. No later than January 15, 2015, Maximus shall provide DIR/DWC with a written plan that details what mode of online IMR Application processing Maximus will implement, and gives an overview, with benchmarks, of how Maximus will build that functionality into *entellitrak*. As soon as possible, DIR/DWC will review the proposed plan and respond in writing to Maximus with either its approval, or any questions or concerns about the plan that must be addressed by Maximus before DIR/DWC gives its approval. Once DIR/DWC gives its written approval of the plan Maximus proposes, Maximus shall have ninety (90) days within which to build out the functionality of *entellitrak* such that the approved mode of online IMR Application processing is fully functional.

B. In the Response on page 2-6 at section, "Data Reporting and Analysis," after the sentence that reads, 'MAXDat will allow DWC users to create customized reports on any data elements that are captured in *entellitrak*,' the following sentence ***is inserted:***

This complete access will be fully functional as of January 1, 2015.

C. In the Response on page 4-6 at section, "4.1 Conduct IMR", at the entry for "Disclose financial interests of employees," in the "MAXIMUS Federal Approach" column, the following sentence **is inserted**:

During the term of the IMR agreement, MAXIMUS Federal shall disclose the financial interests of its employees as required by Labor Code section 139.5 and its corresponding regulations, and shall adhere to the protocol referenced at section 4.4.11.7, *infra*.

D. In the Response on page 4-11 at section 4.2.2, "Redacted Final Determination Forms," the next to last sentence of the paragraph which reads,

These reports will be suitable for posting to the DWC website.

Is revised so it shall read:

Contractor shall issue reports that it has reviewed for, and do not contain PII or PHI, and that are suitable for direct posting by Contractor to the DWC website.

E. In the Response on page 4-13 at section 4.2.6., "System Load and Accessibility," the first sentence of the first paragraph which reads,

All public-facing websites controlled by MAXIMUS Federal meet government web accessibility standards.

Is revised so it shall read:

All public-facing websites controlled by MAXIMUS Federal meet federal and State of California web accessibility standards.

F. In the Response on page 4-15 at section 4.2.8, "Case Tracking Reports," the first paragraph which reads,

Reporting is one of the most important elements of the relationship between MAXIMUS Federal and our clients. DWC needs full transparency into the daily operations of the IMR project and we provide that transparency through multiple avenues, including both self-service and responsive assistance from MAXIMUS Federal project management. In addition to *entellitrak* system access, MAXIMUS Federal will continue to provide weekly, monthly, quarterly, and annual operational reports to DWC. We understand that the requirements include the reporting elements listed in RFP Appendix B, C, and D, as well as the required case data elements provided as part of the submitted determination letters listed in Appendix A.

Is revised and a table and language are inserted before the second paragraph so the section shall begin as follows:

Reporting is one of the most important elements of the relationship between MAXIMUS Federal and our clients. DWC needs full transparency into the daily operations of the IMR project and we provide that transparency through multiple avenues, including both self-service and responsive assistance from MAXIMUS Federal project management. In addition to *entellitrak* system access, MAXIMUS Federal shall continue to provide weekly, monthly, quarterly, and annual operational reports to DWC. Attachment 1 to Exhibit A sets forth the case data elements MAXIMUS shall cull from the submitted determination letters, maintain in the IMR database and thereby enable DIR/DWC to create customized reports. The table below notes minimal requirements MAXIMUS shall meet with respect to each of the reports specified therein. In addition, MAXIMUS shall ensure that each of the specified reports contains the data (or reporting elements) set forth in the corresponding attachment.

Corresponding Scope of Work Attachment	Report	Frequency	Description of Report Requirements
Attachment 2	IMR Weekly Executive Summary	Weekly	<ul style="list-style-type: none"> Cumulative program totals of received applications, closed cases Frequency distribution of statuses for all active cases at time of report Establishment of regularly-scheduled submission date to be determined
Attachment 3.1	IMR Monthly Application Status Report	Monthly	<ul style="list-style-type: none"> Resolution status totals of all applications received in calendar month to include gross number of applications and eventual case outcomes (i.e. totals of duplicates, final determinations, etc.) To be submitted on the 25th of each month, based on applications received two calendar months prior to the month in which report received (ex.: Status of applications received in January to be reported March 25th.)
Attachment 3.2	IMRO Monthly Production Report	Monthly	<ul style="list-style-type: none"> Resolution status totals of all IMRs completed in calendar month (in which decision issued) to include frequency distribution of decision outcomes, fee information, and details on complaints To be submitted on the 25th of each month, based on production in the previous calendar month (ex.: Final decisions, terminations, etc. occurring in January to be reported February 25th.)
Attachment 3.3	IMR Monthly Expert Reviewer Report	Monthly	<ul style="list-style-type: none"> Totals for all expert reviewers delineated by specialty and state(s) of license at time of reporting Number of reviews completed for each reviewer specialty To be submitted on the 25th of each month, based on production in the previous calendar month (ex.: Final decisions from January to be reported February 25th.)
Attachment 3.4	IMR Court-Ordered Remanded Reviews	Monthly	<ul style="list-style-type: none"> Listing of all court-ordered remanded IMR final determinations to include case, treatment and decision information of the original IMR; details of the WCAB remand; and determination of second review.
Attachment 4	IMR Annual Report	Yearly	<ul style="list-style-type: none"> Total number of received applications, closed cases for calendar year Subcategory percentage rates (ex.: % Upholds + % Overturns =100% of IMR case decisions) Establishment of regularly-scheduled submission date to be determined

Attachment 1: Data Element Specifications

Attachment 1 lists the minimum data elements for each IMR case that Contractor shall maintain in, and make available to DIR/DWC in the IMR project database. DIR/DWC shall have access to this data for purposes of analysis, research and reporting, with no restrictions to availability. The list contained in Attachment 3.4 is subject to change based on development and/or expansion of Contractor's database, as well as possible statutory changes to the IMR application process during the term of the Agreement.

Data related to DWC eligibility staff production shall be maintained by the Contractor, and available at all times for access by DWC for report generation. The data shall include (1) indicators of the number of cases routed to DWC and their status at time of reporting; (2) the number of cases in each Eligibility Reviewer's queue; and (3) daily production of individual DWC Eligibility Review.

G. In the Response on page 4-15, at section 4.2.8 at the subsection entitled, "Introducing the MAXDat Reporting Platform," the following language *is inserted*:

Contractor shall provide DIR/DWC staff with training on how to use the MAXDat reporting Platform no later than March 31, 2015. Such training shall include the provision of written instructions that may be retained by DIR/DWC.

H. In the Response at page 4-21 at section 4.3.1, "Case Tracking System Technical Support," after the last sentence of the last paragraph, which reads, "The support line will create all accounts within one business day of the user administration service and/or change request," the following language *is inserted*:

In addition to the foregoing support, in the event of locked passwords, MAXIMUS shall provide support that unlocks all user passwords in less than one business day of reporting the lockout, and/or shall provide DIR/DWC with the administration rights so that it may restore such accounts as soon as they are reported locked.

I. In the Response at page 4-22 at section 4.3.2, "Case Tracking User Training and Materials" the language of the first paragraph, which reads,

Since the IMR program's inception we have conducted numerous "train the trainer" seminars both in person and by webinar. As indicated in section 4.2, Case Workflow Tracking System, we have a number of system enhancements planned before the new contract start date. Our training team will prepare training materials on all enhancements, and deliver the training prior to the release date for all system enhancements. We will deliver the training either in person or by webinar depending on DWC's preference and the level of training required. Since we have already trained the primary DWC trainers the majority of our training will be focused on system enhancements and/or changes, and not full system training. In addition to the periodic system enhancement training, we will also deliver annual refresher training to the DWC trainers and provide them with updated materials. This approach will allow us to keep the DWC trainers updated on key system enhancements as well as keep the overall training materials up to date.

Is revised at the third, fifth and sixth sentences, and new language is inserted such that the paragraph shall read in its entirety:

Since the IMR program's inception we have conducted numerous "train the trainer" seminars both in person and by webinar. As indicated in section 4.2, Case Workflow Tracking System, we have a number of system enhancements planned before the new contract start date. Our training team will prepare training materials on all system enhancements, and deliver the training at least two weeks prior to the release date for all system enhancements. MAXIMUS shall deliver the training either in person or by webinar depending on DWC's preference and the level of training required. Since we have already trained the primary DWC trainers the majority of our training will be focused on system enhancements and/or changes, and not full system training. We shall provide full system training, however, when requested by DIR/DWC and warranted by changes in DIR/DWC staff. In addition to such as needed full system and periodic system enhancement training, we will also deliver annual refresher training to the DWC trainers and provide them with updated materials. This approach will allow us to keep the DWC trainers updated on key system enhancements as well as keep the overall training materials up to date.

J. In the Response on page 4-23 at section 4.3.3, "Case Workflow Tracking System Updates and Changes," the third and fourth sentences of the last paragraph that read,

We have incorporated the cost of reasonable future modifications into our per unit pricing rate. Reasonable future modifications will not be billed separately.

Are revised and language is added so that the last paragraph in its entirety shall read:

The system documentation that is provided to DWC will include both detailed system documentation and a non-technical summary of the upgrade. The non-technical summary will provide details of the upgrade in non-technical terms, and include a summary of the impact of the upgrade on process workflows. We have incorporated the cost of future modifications into our per unit pricing rate. Such modifications shall include those made regularly to address needs presented by DIR/DWC. Future modifications will not be billed separately. For additional information, please refer to our *Cost Proposal*. In addition to providing DIR/DWC with the system impact assessment and system documentation prior to implementation of a case workflow tracking system change, MAXIMUS shall provide DIR/DWC with training on the updates at least two weeks prior to implementation of an update.

K. In the Response on page 4-25 at section 4.3.4, Additional Functionality Requested," the following language **is inserted** as a new paragraph after the last paragraph and before section 4.4., "Deliverables:"

The foregoing change control process shall adhere to a maximum time frame as follows:

1. DIR/DWC requests change(s) in writing to MAXIMUS;
2. Within five (5) business days of receipt of the DIR/DWC requested change, MAXIMUS shall provide DIR/DWC with a written estimate of the time for implementation and the effect of the implementation on other IBR workflow processes;

3. Within five (5) business days of receipt of MAXIMUS's written estimate and effect notice specified above, DIR/DWC shall inform MAXIMUS of whether it wants to proceed with the requested change;
4. Within five (5) business days of receipt of DIR/DWC's notification of a decision to proceed with a requested change, MAXIMUS shall provide DIR/DWC with a written estimate of the implementation date.

L. In the Response on page 4-33 at section 4.4.3.3, "Claims Administrator and Additional Notice," the second paragraph that reads,

In the absence of information provided by the parties, our Case Assessment Team will dismiss the IMR application and notify DWC of the Claims Administrator's failure to provide documents. As noted above, we may contact the treating physician, as applicable, for additional information regarding the employee's condition and the need for the requested treatment. We can also consider documents submitted by the employee or treating physician in addition to those submitted by the Claims Administrator.

Is revised at the first and last sentences so the paragraph shall read:

In the absence of information provided by Interested IMR Parties, our Case Assessment Team will consult with DIR/DWC regarding disposition of the IMR application. As noted above, we may contact the Claims Administrator and/or the treating physician, as applicable, for additional information regarding the employee's condition and the need for the requested treatment. We will also consider documents submitted by the employee or treating physician in addition to those submitted by the Claims Administrator.

M. In the Response on page 4-34 at section 4.4.3.4, "Delivery of Cases Accepted for Expedited Review," the existing language is revised so ***the entire paragraph shall read:***

For expedited cases we will transmit notifications in the most expeditious manner possible. The expedited NOAFRI will include instructions that the parties in question have 24 hours to provide us with required or additional information. If the Claims Administrator fails to provide required documents to us within 24 hours, we can conduct IMR based solely on information provided by the employee or the treating physician. However, in the absence of information provided by those Interested IMR Parties, the Case Assessment Team will consult with DIR/DWC about the disposition of the IMR application. Similar to standard reviews, we have the ability to contact the treating physician for additional information regarding the employee's condition and need for the requested treatment. For expedited review requests that do not include required documentation within the timeframe required for expedited review, we will convert the request to a standard review to allow more time for submission of documents.

N. In the Response on page 4-35 at section 4.4.5.1, "Maintain a Case Workflow Tracking System," the first sentence of the second paragraph that begins,

DWC will continue to have direct access to the *entellitrak* system to review the status of any case using read-only, role based access that does not allow changes to the case.

Is revised and language is inserted after that sentence so the entire second paragraph shall read:

DWC shall have direct access to the *entellitrak* system by way of role-based access. MAXIMUS shall provide such role-based access to DWC users as directed and authorized by DWC. At the beginning of the Agreement term, and as needed throughout the term to update both authorized users and the rights assigned to each user, DWC shall provide MAXIMUS with a list of authorized DWC users in which DWC shall indicate each user's role, and the rights to be accorded him or her. MAXIMUS shall ensure that *entellitrak* is configured to afford DWC user rights that include, but are not limited to, reviewing case information, updating case status, and entering case information. DWC shall have the right to add or delete authorized users, and to expand or limit the rights of individual authorized DWC users throughout the term of the Agreement. DWC staff members receive a system-generated notification when requested to complete eligibility review of an IMR case. DWC can also view documents submitted in support of the appeal, and view the status of cases through use of the standard and advanced functions.

O. In the Response on page 4-37 at section, 4.4.5.3, "Enter All Information Collected in the IMR Application," the third sentence which reads,

DWC staff members have access to *entellitrak* and may access specific case data in real time.

Is revised so it shall read:

DWC staff members have access to *entellitrak* and may access case-specific data in real time.

P. In the Response on page 4-38 at section 4.4.5.6, "Database Allow Generation of Reports", the first sentence which reads,

As described in Section 4.2.8. Case Tracking Reports, we continue to generate and house all case tracking data in *entellitrak*, including the data elements listed in Appendix A.

Is revised so it shall read:

As described in Section 4.2.8. Case Tracking Reports, we continue to generate and house all case tracking data in *entellitrak*, including the data elements identified by DIR/DWC and subject to further modification by DIR/DWC during the term of the Agreement. As of January 1, 2015, those data elements shall be the elements identified in the Agreement at "Data Elements Specifications," Attachment 1 to Exhibit A, "Scope of Work".

Q. In the Response on page 4-43 at section, 4.4.6 "Number and Type of Reviewers," after the first sentence which reads,

In addition to the ongoing recruitment efforts of the Director of Professional Relations, MAXIMUS Federal has existing agreements with the University of Rochester School of Medicine and Dentistry Medical Faculty Group, Morehouse School of Medicine, and the

University of California at Davis School of Medicine to expedite treatment of needed specialists.

The following sentence is inserted:

DIR/DWC recommends that MAXIMUS Federal establish relationships with additional California-based medical schools toward that end.

R. In the Response on page 4-46 at section 4.4.8.2, "Final Determination," the following language ***is inserted*** as the last paragraph of the section:

MAXIMUS shall notify DIR/DWC of any and all decisions where MTUS was successfully rebutted. MAXIMUS shall provide notification by *entellitrak*.

S. In the Response on page 4-51 at section 4.4.10.2, "Records and Information Provided," the first sentence which reads,

In addition to the above, MAXIMUS Federal understands that no records and information provided to, obtained by, or prepared by MAXIMUS Federal in connection with any IMR performed are DWC records and cannot be used for any purpose not specified under this contract.

Is revised so it shall read:

In addition to the above, MAXIMUS Federal understands that all records and information provided to, obtained by, or prepared by MAXIMUS Federal in connection with any IMR performed are DWC records and cannot be used for any purpose not specified under this agreement. Further, all records and information provided to or obtained by MAXIMUS Federal in connection with any IMR performed shall be considered DIR designated "Confidential Information" under the Agreement.

T. In the Response on page 4-51 at section 4.4.10.4, "Information Designated Confidential by DIR or DWC", the first sentence which reads,

All financial, statistical, personal, technical, and other data and information relating to DWC's operations that are designated confidential by DWC and made available to MAXIMUS Federal in order to carry out this Agreement, or which become available to MAXIMUS Federal in carrying out this Agreement, will be protected by MAXIMUS Federal from unauthorized use and disclosure.

Is revised so it shall read:

All financial, statistical, personal, technical, and other data and information relating to DIR or DWC's operations and made available to MAXIMUS Federal in order to carry out this agreement, or which becomes available to MAXIMUS Federal in carrying out this agreement, shall be considered DIR Confidential Information, and shall be protected by MAXIMUS Federal from unauthorized use or disclosure.

U. In the Response on page 4-60, section 4.4.11.11, "Summary Report," which reads,

Our QA team will prepare a summary report of the reviews on a weekly basis to submit to DWC. Our report will be available MAXDat and will include data elements in a format specified by DWC listed in Appendix B of the RFP, and additional data elements to be specified by DWC.

Is revised so it shall read:

Our QA team will prepare a summary report of the reviews on a weekly basis to submit to DWC. Our report will be available in MAXDat and will include data elements in a format specified by DWC identified in the Agreement at Attachment 2, "IMR Weekly Executive Summary," to Exhibit A, "Scope of Work," and additional data elements that may be specified by DWC during the term of the Agreement. The report shall meet the requirements in the table set forth at section 4.2.8, "Case Tracking Reports," above.

V. In the Response on page 4-60, section 4.4.11.11, "Monthly Summary Report," which reads,

Within 15 days of each month-end, our QA team will prepare a summary report of the reviews completed during the previous month to submit to DIR/DWC. This report will include the following data listed in Appendix C of the RFP and additional data elements to be specified by DWC.

Is revised so it shall read:

Within the timeframe negotiated between DIR and MAXIMUS, MAXIMUS's QA team shall prepare and submit to DIR/DWC summary reports of the reviews completed during the previous month, including but not limited to: Monthly Application Status Reporting, Monthly IMRO Production Report, Monthly Expert Reviewer Report and IMR Court-Ordered Remanded Reviews. These reports shall meet the requirements set forth in the table at section 4.2.8, "Case Tracking Reports," above, and shall include the data identified in the Agreement at Attachments 3.1 through and including, 3.4 to Exhibit A, "Scope of Work," as well as additional data elements that may be specified by DWC during the term of the Agreement.

W. In the Response on page 4-60, section 4.4.11.12, "Year-end Summary Report," which reads,

Within 45 days of each year-end, our QA team will prepare a summary report of the work completed during the previous year to submit to DWC. The report will include the information contained in the monthly reports as per Appendix C in addition to the information contained in Appendix D in a format specified by DWC and additional data elements to be specified by DWC.

Is revised so it shall read:

Within 45 days of each year-end, our QA team will prepare a summary report of the work completed during the previous year to submit to DWC. The report shall: meet the requirements set forth in the table at section 4.2.8, "Case Tracking Reports," above; and include the information contained in the monthly reports as per Exhibit A, Attachment 3,

“Monthly Application Status Reporting,” the information identified in the Agreement at Attachment 4, “Annual Report,” to Exhibit A, “Scope of Work,” and additional data that may be specified by DWC during the term of the Agreement.

X. In the Response, language at the sections below ***is corrected*** as follows:

1) On page 4-55, at the last bullet of section 4.4.11.2, “Compliance with Labor Code 139.5 (d)(3),” the citation ***is revised so it shall read***: “pursuant to 139(5)(d)(5).”

2) On page 4-64 at section 4.4.17 “Prohibited Conflicts of Interest,” the last sentence of the second paragraph which reads, “Additionally, no MAXIMUS Federal board member, director, or officer of a workers’ compensation insurer or claims administrator or a trade association of workers’ compensation insurers or claims administrator serves as a MAXIMUS Federal board member, director, officer, or employee of Contractor,” ***is revised so it shall read***:

Additionally, no director or officer of a workers’ compensation insurer, claims administrator, or a trade association of workers’ compensation insurers or claims administrators also serves as a MAXIMUS Federal board member, director, officer or employee.

3) On page 4-64, at section 4.4.17 “Prohibited Conflicts of Interest,” at the third paragraph, which begins “As discussed earlier, MAXIMUS Federal and our designated reviewers do not have any material professional, material familial, or material financial affiliation with any of the following;” the second subparagraph ***is revised so it shall read***:

For our MPRs: They are screened throughout the IMR process to ensure that they do not have any material professional, material familial, or material financial affiliation with the injured worker’s employer, workers’ compensation insurer or claims administrator; or a medical provider network of the injured worker’s employer, insurer, or claims administrator that is an Interested IMR Party in any IMR application to which they have been assigned.

Y. In the Response on page 4-65 at section 4.4.19, “Monitoring of Contract Performance,” the last sentence which reads,

We agree to revise and deliver to the Department Project Manager any product deemed unacceptable by the Project Manager within 15 working days.

Is revised so it shall read:

MAXIMUS Federal shall revise and deliver to the DIR/DWC Project Manager within 15 working days any product of MAXIMUS created pursuant to this agreement (including the deliverables in section 4.4, above; the deliverables listed in Exhibit 1.4-1, “Intended Products,” on page 1-2 above; and the reports described in sections 4.2.8, “Case Tracking Reports,” and sections 4.4.11.10 -.12), the DIR/DWC Project Manager has deemed unacceptable.

Z. In the Response at section 5.1, “Staff Organization Plan” under “Project Management Roles,”

1) On page 5-6 under “Project Management Plan,” all text regarding Associate Medical Directors Bernice Stein, MD and A. David Matian, D.O. **is deleted**.

2) On pages 5-8 and 5-9 at Exhibit 5.1-1 “Dedicated Management Team Responsibilities,” the names Bernice Stein, MD and A. David Matian, D.O. from the Associate Medical Director I and II, respectively, fields **are deleted**.

3) After the biographical description of Director of Information Systems- Richard Brunner, the following language and table **are inserted**:

As of the date of execution of this agreement, this table identifies under “IMR” some of the key MAXIMUS staff who shall be responsible for performing authorized services. As soon as possible, Contractor shall notify DIR/DWC in writing of any further changes to the staff filling the roles identified below:

Team Member	California Operations	IMR		IBR	
	FTE Equivalency	Project Role	FTE Equivalency	Project Role	FTE Equivalency
Thomas Naughton	0.5	Client Executive	.25	Client Executive	.25
Lou Shields	1.0	Project Director	.80	Project Director	.20
Paul Manchester	1.0	Medical Director	.90	Medical Director	.10
Kevin Gregory	1.0	Director of Quality Assurance	.75	Director of Quality Assurance	.25
Jim Phillips	1.0	Director of Reporting	.75	Director of Reporting	.25
Richard Brunner	1.0	Director of Information Systems	.25	Director of Information Systems	.25
Robert Nydam	1.0	Project Manager	.90	Project Manager	.10
TBD	1.0	Associate Medical Director	.80	Associate Medical Director	.20
TBD	1.0	Associate Medical Director	.80	Associate Medical Director	.20
Dale Ramey	1.0	Senior Operations Manager	.66	Senior Operations Manager	.33
Eric Lian	1.0	Director of Training	1.0	Director of	.25

Team Member	California Operations	IMR		IBR	
	FTE Equivalency	Project Role	FTE Equivalency	Project Role	FTE Equivalency
				Training	
Kimberly Donselaar	1.0	Director of Professional Relations	1.0	N/A	N/A
Tricia Brantley	1.0	N/A	N/A	IBR Supervisor	1.0
Teresa Picard	1.0	N/A	N/A	Chief Coding Specialist	1.0
Dawn Ossont	1.0	N/A	N/A	Chief Coding Specialist	1.0
Karen Coulter	1.0	N/A	N/A	Chief Coding Specialist	1.0
Mollie Graves	1.0	N/A	N/A	Chief Coding Specialist	1.0
Launa Brinton	1.0	N/A	N/A	Chief Coding Specialist	1.0
Mary Radford	1.0	N/A	N/A	Coding Specialist	1.0
Donna Rugg	1.0	N/A	N/A	Coding Consultant	1.0

VI. PAYMENT

A. Because state budgeting restrictions prevent DIR/DWC from processing and submitting payments for reviews to Contractor, Contractor shall submit invoices directly to, and receive payments from, the Claims Administrators who are Interested Parties to the reviews. Direct payment is not intended to constitute a material affiliation between Contractor and Claims Administrators. Invoicing shall be for payment in arrears.

B. Invoicing and payment shall be based on the fees adopted by DIR/DWC as regulations. As of January 1, 2015, payment for IMR services by Contractor shall be as set forth below. The Parties agree that fees for Contractor's IMR services over the course of this agreement are subject to change, however, either to comply with applicable DIR regulations, or to reflect the Parties' future agreement to set different fees. For example, DIR/DWC and Contractor may agree to renegotiate the fees for 2015 based on the volume of cases in 2014. Contractor may charge reasonable interest on the fees to compensate for late fee payments.

IMR Service	Base Contract Period Fee*
Pharmaceutical-only Review	\$ 345.00
Non-Pharmaceutical Review	\$ 390.00
Withdraws IMR Application	\$ 123.00

* Base contract period is the 36 month period from January 1, 2015 through December 31, 2017

VII. LIMITATION OF LIABILITY

A. The Parties agree that Labor Code section 139.5(b) applies to the services authorized under this agreement. Pursuant to subdivision (b)(1), Contractor and its medical professional reviewers (“MAXIMUS MPRs”) shall be deemed to be consultants for the purposes of section 139.5. As such there and pursuant to Labor Code section 139.5(b)(2), there shall be no monetary liability on the part of, and no cause of action shall arise against any MAXIMUS MPR on account of any communication by that consultant of the DWC, or on account of any communication by that MAXIMUS MPR to any person when that communication is required by the terms of this agreement pursuant to section 139.5, and the MAXIMUS MPR does all of the following:

- (A) Acts without malice.
- (B) Makes a reasonable effort to determine the facts of the matter communicated.
- (C) Acts with a reasonable belief that the communication is warranted by the facts actually known to the consultant after a reasonable effort to determine the facts.

The Parties agree that the immunities afforded by Labor Code section 139.5(b) shall not affect the availability of any other privilege or immunity which may be afforded by law. Nothing in section 139.5 (b) shall be construed to alter the laws regarding the confidentiality of medical records.

Exhibit A – Scope of Work
Attachment 1
Data Element Specifications

Case Information

1. Unique identifier for each IMR, based on algorithm specified by DWC
2. Clinical case summary with no Personally Identifiable Information
3. Claim number
4. Claims Administrator information
 - a. Company Name
 - b. Name of Representative
 - c. Address, including City/State/Zip
 - d. Phone & Fax Number(s)
5. Attorney information (if represented)
 - a. Firm name
 - b. Name of Attorney
 - c. Address, including City/State/Zip
 - d. Phone & Fax Number(s)
6. Requesting Physician information
 - a. Practice name
 - b. Name of Requesting Physician
 - c. Address, including City/State/Zip
 - d. Phone & Fax Number(s)
 - e. Requesting Physician's specialty
7. Name of employer
8. Injured Worker's name
9. Injured Worker's workers' compensation information number (jurisdictional claim number, or JCN)
10. EAMS number
11. Date of IMR submission to Contractor
12. Date of UR decision
13. Date of Injury
14. Date Contractor referred case to DWC for preliminary review (if applicable)
 - a. Date DWC determined case eligible (if applicable)
15. Whether the Claims Administrator is disputing liability for the requested medical treatment for a reason other than medical necessity
16. Whether the dispute is based on original UR or on modification after the internal UR process is completed
17. Whether the review was withdrawn or terminated
 - a. Date of withdrawal or termination (if applicable)
18. Date case assigned for IMR
19. Date of IMR final determination issue
20. Whether the UR was prospective or retrospective
21. Whether the UR determination was standard or expedited
22. Disputed medical treatment(s)

23. Primary Diagnosis
24. International Classification of Disease (ICD) Code
25. Diagnosis description
26. Part(s) of body disputed
27. Number of disputed medical treatments per IMR request
28. Number and type(s) of reviewer(s) and reviewer(s) ID number(s)¹
29. Board certification and specialty of reviewer and, if applicable, subspecialty
30. Reviewer's state(s) of license
31. Whether the Claims Administrator's UR was upheld, partially overturned or overturned
32. Numbers of UR decisions overturned, by claims admin UAN
33. Percentage of completed IMR determinations involving UR decision being overturned, by claims admin UAN
34. Number and proportion completed IMR determinations upheld by attorney
35. Number and proportion completed IMR determination by individual provider
36. Proportion of cases reviewed by California and non-California reviewers

TREATMENT REQUEST INFORMATION (For each treatment disputed in the UR)

1. Name/Description of Treatment request
2. Whether the denial of treatment from the UR was upheld or overturned by the reviewer
3. Claims Administrator's supporting evidence detail (such as chapter name or guidelines)
4. Reviewer's medical treatment guidelines in supporting evidence (See Example 1)
5. Reviewer's supporting evidence detail (See Example 1)
6. Whether the Reviewer found the Claims Administrator's evidence to be relevant
7. Reviewer's decision rationale

Example 1 – Citation Requirements

Medical Treatment Guideline		Supporting Evidence
Medical Treatment Utilization Schedule (MTUS)	<ul style="list-style-type: none"> • Year of final regulation 	<ul style="list-style-type: none"> • Title of chapter (ex. Low Back Complains) • Section of chapter (ex. Surgical Considerations)
Other Guideline	<ul style="list-style-type: none"> • Name of publishing organization (ex. Official Disability Guidelines) • Year of publication 	<ul style="list-style-type: none"> • Title of chapter • Section of chapter
Journal	<ul style="list-style-type: none"> • Last name and first initial of first author • Article title 	<ul style="list-style-type: none"> • Journal title • Volume number • Year published

¹ Any association between an ID number and any other information, including but not limited to the association between an ID number and any IMR determination or determinations shall be confidential pursuant to Labor Code Section 4610.6(f) and shall be proprietary business information that is not subject to disclosure pursuant to Labor Code Section 139.5(e).

Exhibit A – Scope of Work
Attachment 2

IMR Weekly Executive Summary

The following items reflect minimum reporting. Additional data elements will be accepted.

1. Cumulative total number of IMR applications received
2. Cumulative total number of ineligible cases
3. Total number of open cases waiting for eligibility determinations
4. Total number of open cases in pipeline with information to proceed
5. Cumulative total number of closed cases (final determinations and terminations)

The following items are to be readily available if needed to supplement weekly reporting.

1. Total number of open cases with Preliminary Review completed
2. Total number of open cases referred to DWC
3. Total number of open cases awaiting medical records (after Notices of Assignment and Requests for Medical Records sent)
 - a. Total number of open cases that are past the deadline to submit medical records
4. Total number of open cases with referrals sent to medical panels
5. Total number of open cases with returned medical panel referrals
6. Week's total number of Final Determination Letters sent for reviewed cases
7. Week's total number of Ineligibility Determinations
 - a. Week's number of cases determined ineligible due to missing Utilization Review
 - b. Week's number of cases determined ineligible due to defective application (missing signature or other critical information)
 - c. Week's number of cases determined to be duplicates

Exhibit A – Scope of Work
Attachment 3.1

Monthly Application Status Reporting

The following items reflect minimum reporting. Additional data elements will be accepted.

1. Reporting month and year
2. Month's gross number of IMR applications received
 - a. Month's total number of duplicate IMR applications received
 - b. Month's total number of reporting month's unique IMR requests received
 - I. Total number of unique IMR requests that are eligible for IMR
3. Month's total number of open cases at time of reporting
4. Month's total number of termination letters sent

Exhibit A – Scope of Work
Attachment 3.2

Monthly IMRO Production Report

The following items reflect minimum reporting. Additional data elements will be accepted.

1. Reporting month and year
2. Total number of IMR determinations completed
 - a. Number of standard IMR determinations completed
 - I. Number of Standard pharmaceutical-only determinations completed
 - II. Number of standard IMR determinations completed within required timeframe
 - b. Average number of days to complete standard determination
 - c. Number of expedited IMR determinations completed
 - I. Number of expedited IMR determinations completed within required timeframe
 - d. Average number of days to complete expedited determination
3. Total number of IMR cases overturned
4. Total number of IMR cases partially overturned
5. Total number of IMR cases upheld
6. Total number of treatment requests overturned
7. Total number of treatment requests upheld
8. Number of completed determinations involving multiple reviewers
9. Total fees charged for IMR during reporting month
 - a. Fees charged for standard IMR determinations
 - b. Fees charged for standard pharmaceutical-only IMR determinations
 - c. Fees charged for expedited IMR determinations
 - d. Fees charged for terminated IMR cases
10. Average fee charged for IMR (total fees charged ÷ number of completed IMRs)
11. List of complaints received for reporting month
12. Number and type(s) of reviewer(s) and reviewer(s) ID number(s)¹

¹Any association between an ID number and any other information, including but not limited to the association between an ID number and any IMR determination or determinations shall be confidential pursuant to Labor Code Section 4610.6(f) and shall be proprietary business information that is not subject to disclosure pursuant to Labor Code Section 139.5(e).

Exhibit A – Scope of Work
Attachment 3.3

Monthly Expert Reviewer Report

The following items reflect minimum reporting. Additional data elements will be accepted.

1. Reporting month and year
2. Current number of expert reviewers for each medical specialty and state(s) of licensure
3. Month’s total number of IMR cases reviewed by reviewers with California credentials (can additionally be licensed in other states)
4. Month’s total number of IMR cases reviewed by reviewers with credentials solely outside of California
5. Frequency distribution of reviews conducted per medical specialty and credential (see Example 1)

Example 1 – Frequency Distribution

Expert Type	Total Count	CA License	Non-CA License
Occupational Medicine	12,226	6,161	6,065
PM&R	7,521	7,307	214
Pain Management	4,320	2,851	1,469
Orthopedic Surgery	3,151	2,151	1,000
Internal Medicine	1,146	210	936
Other	4,210	3,256	954
Total	32,574	21,936	10,638

Source: Fictitious data, for illustration purposes only

Exhibit A – Scope of Work
Attachment 3.4

IMR Court-Ordered Remanded Reviews

The following items reflect minimum reporting. Additional data elements may be reported based on mutual agreement.

For each court-ordered appeal:

1. IMR Case Number
2. Date of original Final Determination Letter (FDL)
3. Decision for each treatment in original FDL
4. Date of Workers' Compensation Appeals Board (WCAB) order
5. Date of Contractor receipt of WCAB order
6. Reason(s) for WCAB remand
7. Date second review sent to Reviewer
8. Date of second FDL
9. Final Disposition
10. Notes and/or Comments
11. Contractor objections, if applicable

Exhibit A – Scope of Work
Attachment 4

Annual Report

The following items reflect minimum reporting. Additional data elements will be accepted.

1. Reporting calendar year
2. Year's total number of IMR applications received
 - a. Percentage of total number of applications deemed duplicate IMR applications
 - b. Percentage of total number of applications deemed ineligible for IMR (for all reasons other than 'duplicate IMR application')
 - c. Percentage of total number of applications deemed eligible for IMR
3. Year's total number of IMR completed case decisions
 - a. Percentage of total number of IMR case decisions upheld
 - b. Percentage of total number of IMR case decisions partially overturned
 - c. Percentage of total number of IMR case decisions overturned
 - d. Percentage of total number of IMR case decisions from reviewer with California credentials
 - e. Percentage of total number of IMR case decisions from reviewer with credentials outside California
4. Year's total number of **standard** IMR completed case decisions
 - a. Percentage of total number of standard IMR case decisions completed within required timeframe
 - b. Percentage of total number of standard IMR case decisions completed outside required timeframe
5. Year's total number of **expedited** IMR completed case decisions
 - a. Percentage of total number of expedited IMR case decisions completed within required timeframe
 - b. Percentage of total number of expedited IMR case decisions completed outside required timeframe

Exhibit A-1 – Maximus Response to DIR DWC RFP 14-001

Independent Medical Review
 State of California, DIR, DWC



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1. Introduction

MAXIMUS Federal is the only independent medical review organization (IMRO) that can offer the Division of Workers' Compensation direct experience providing DWC IMR services and unique understanding and insight into the creation and context behind Senate Bill 863.

RFP Section C.4.a.2, Page 18

In this section we demonstrate our understanding of the context, purpose, objective, and intended products.

1.1 Context

On September 18, 2012, Governor Brown signed into law comprehensive workers' compensation reform legislation, Senate Bill (SB) 863, with the goal of improving access to medical care for injured workers, avoiding delays and disputes, and reducing costs to employers. A key provision of SB 863 affects how medical necessity determinations are made for medical care provided to injured workers. Effective January 1, 2013, for injuries occurring on or after that date, and effective July 1, 2013, for all dates of injury, IMR must be used to decide disputes between physicians and claims administrators involving necessary medical treatment for injured workers.

Shortly after the passing of the legislation MAXIMUS Federal began working in close collaboration with the Division of Workers' Compensation and the Department of Industrial Relations in the design and implementation of the IMR program. Throughout this process and the operation of IMR program over the last two years we developed an expert understanding of requirements of the program and to provide California's injured workers an equitable program that helps to ensure fairness, independence, and appropriate clinical expertise.

1.2 Purpose

We understand that the purpose of this Request for Proposal (RFP) is to contract with an independent medical review organization (IMRO) to conduct independent medical reviews submitted to DWC by injured workers under Labor Code section 4610.5 and California Code of Regulations, title 8 (8 C.C.R.), section 9792.10.1, et seq. Essential to fulfilling this purpose the IMRO must be absolutely independent and free from conflict of interest.

It is our belief and understanding that there is only one URAC accredited IRO that can fulfill this essential goal, MAXIMUS Federal. MAXIMUS Federal is the only URAC accredited IRO that exclusively provides IMR services on behalf of state and federal government agencies. Meaning we do not provide any IMR or related services to any claims administrator, state compensation insurance fund, workers' compensation, disability, or health insurer, hospitals, third party administrators, and medical provider networks in California or any other state. *Exhibit 1.2-1: MAXIMUS Federal Advantages* illustrates why MAXIMUS Federal is the best option to support DWC's stated purpose to provide unbiased, accurate, and timely IMRs to California injured workers.

? did you **KNOW**

MAXIMUS Federal is ...

- The only vendor with an in-depth working knowledge of Senate Bill 863, Labor Codes 139.5, 4610.5, and 8 CCR 9792.10.1
- The only URAC accredited IMRO that has California Government IMR experience
- The only IMRO that is absolutely conflict free and has no material relationships with any employer, claims administrator, workers' compensation, disability, or health insurer in California or the United States

Use or disclosure of data contained on this sheet is subject to the restrictions on the title page of this proposal

Independent Medical Review
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	IRO that exclusively provides government sponsored IMR services	Utilization Review Organization (URO)	IROs that provide commercial internal and external IMRs
Active Practice Requirement for all licensed Medical Professional Reviewers used to provide IMR	Yes	No	Sometimes
Organizational Independence	Yes	No	No
Specialty Match Requirements	Yes	Sometimes	Sometimes
URAC IRO Certification	Yes	No	Yes
Use of Evidence-based Clinical Guidelines	Yes	Sometimes	Sometimes
Experience providing 100,000 conflict free independent medical reviews a year (as opposed to utilization reviews)	Yes	No	No

Exhibit 1.2-1: MAXIMUS Federal Advantages. This table illustrates why MAXIMUS Federal is the best option to support DWC's stated purpose to provide unbiased, accurate, and timely IMRs to California injured workers.

1.3 Objective

As stated by DWC in their Initial Statement of Reasons in January 2013, the purpose of the DWC IMR program is to ensure that medical treatment decisions in workers' compensation cases will be made by a conflict-free medical expert applying sound medical decisions that are based on a hierarchy of evidence-based medicine standards. MAXIMUS Federal is the only URAC accredited IRO with California IMR experience and that can provide DWC with conflict-free opinions as evidenced in *Section: 1.2* above.

1.4 Intended Products

Please see *Exhibit 1.4-1: Intended Products* which provides a detailed list of the intended products to be completed for this effort. We also include the staff that will provide these products and estimated hours for completion.

Intended Products	Responsible Staff	Hours/Task
1. Preliminary Review of Cases	Preliminary Review Team	2 days
2. Assignment of Cases for IMR	Case Assessment Team	1 day
3. Information to Conduct IMR	Case Assessment Team	15 days
4. Timeframes for Completing Reviews	All Teams	30d for Standard 3d for Expedited
5. Case Information and Changes in Case Status	All Teams	30d for Standard 3d for Expedited
6. Number and Type of Reviewers	Medical Director and Recruitment Department	Ongoing
7. Content of Reviews	Case Closing Team	3-5 days
8. Distribution of Completed Reviews	Case Closing Team	1 day
9. Appeal and Review of Remanded Cases	Expedited Review Team	30 days
10. Confidentiality of Records and Information	All Staff	Ongoing

Exhibit 1.4-1: Intended Products. This exhibit provides a detailed list of the intended products to be completed for this effort, the staff responsible, and the expected timeframes.

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Intended Products	Responsible Staff	Hours/Task
11. Quality Assurance (QA)	Director of QA	Ongoing
12. Customer Service	Customer Service Representatives	Within 1 business day of contact
13. Timeliness	All Teams	Ongoing
14. Case Workflow Tracking System Availability Requirements	Director of Information Systems	Ongoing
15. Fraud and Quality of Care Reporting	QA Director	Ongoing
16. Certificate of Insurance	Corporate	10 days post contract award
17. Prohibited Conflicts of Interest	All Teams	Ongoing

Exhibit 1.4-1: Intended Products (continued). *This exhibit provides a detailed list of the intended products to be completed for this effort, the staff responsible, and the expected timeframes.*

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2. General Approach

MAXIMUS Federal's proposed solution is founded on lessons learned as DWC's IMR partner, a proven case workflow methodology, and features a medical professional reviewer (MPR) panel of 350 California-licensed practitioners in active practice. As a testament to our commitment to making the IMR program a success, in a 2013 Customer Survey, DWC rated MAXIMUS Federal's project staff as "very competent" and our quality of products as "high quality". Based on the foregoing MAXIMUS Federal Services is confident that we can provide DWC with a cost-effective, low-risk IMR service solution. We are positioned to implement this program immediately upon contract award, January 1, 2015, without any organizational conflicts of interests to mitigate.

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Set forth below, based upon our understanding of the RFP instructions, we outline our proposal design as well as our general approach to meeting DWC's requirements for the provision of IMR services.

Proposal Design

Exhibit 2-1: Proposed Design provides a brief overview our proposed design for our proposal. Our proposal carefully tracks the requirements set forth in DWC's Request for Proposal (RFP) 14-001: Independent Medical Review. Our proposed design is supported by the following elements, which are critical to our response:

- MAXIMUS Federal is the only IBRO that is completely free from conflicts of interest
- Our proposal design features a detailed and responsive approach to the technical requirements outlined in the RFP that is based on first-hand experience, and best practices and lessons learned that were developed in close collaboration with DWC since Project inception
- Established staff and medical professional reviewer resources with direct California IMR experience that are ready to support the DWC IMR Project come January 1, 2015.

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did you
KNOW

MAXIMUS Federal has ...

- A scalable workflow system, 100 Appeal Officers, and a combined panel of more than 350 California-licensed Medical Professional Reviewers
- Provided more than 55,000 California IMRs across all of our California IMR Projects and more than 800,000 IMRs in 2014
- More than 12 years of California IMR experience and currently operate more than 50 federal and state independent medical review programs
- No relationship with any claims administrator and/or disability insurer in California or any other state and as such is truly independent

Proposal Section	Proposal Title	Proposal Section Overview
1.	Introduction	Demonstrates our understanding of the context, purpose, objective, and intended products.
2.	General Approach	Provides an overview of our proposed design for the proposal and contains a focused discussion on

Exhibit 2-1: Proposed Design. This graphic provides a brief overview our proposed design for our proposal.

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Proposal Section	Proposal Title	Proposal Section Overview
3.	Overview	Presents the methods to be used in conducting the Independent Medical Review.
4.	Work Plan and Work Schedule Requirements	Describes in detail the specific methods, tasks, and activities that we propose to undertake in order to accomplish DWC objectives and produce the required deliverables.
5.	Management and Staffing	<p>Presents a plan for the internal management of the contract work that will ensure quality, orderly, and timely management of the tasks.</p> <p>We have included a staff organization plan which identifies proposed staff positions and provides for each one the percent of full-time equivalency and a brief job description.</p> <p>Our plan makes clear the relationship of each position and includes an organization chart.</p>
6.	Related Experience and References	<p>Describes our experience in conducting similar or comparable services and we identify the members of our proposed staff who have provided these services.</p> <p>A specific reference to the similar or comparable services has been included in this section.</p>
7.	Required Attachments	Contains all of the attachments required by this RFP

Exhibit 2-1: Proposed Design (continued). *This graphic provides a brief overview our proposed design for our proposal.*

Minimum Requirements

DWC has the opportunity to benefit from a contractor with unique expertise and experience to operate the California DWC Independent Medical Review Project (IMR Project). We are committed to applying our knowledge and experience of the existing IMR Project, California labor codes, statutes, and regulations, DWC processes, and the best practices to support DWC in deciding disputes between physicians and Claims Administrators about necessary medical treatment for injured workers.

MAXIMUS Federal’s California IMR program experience with DWC, DMHC, California Department of Insurance (CDI), and California Public Employees Retirement System (CalPERS), our extensive panel of California-licensed MPRs, our proven automated workflow process, and our ability to handle large case volumes makes us the ideal choice to continue serving as DWC’s Independent Medical Review Organization (IMRO) for the IMR Project. Our objective is to continue to operate the IMR Project in the most cost efficient manner while ensuring the highest quality of IMRs and continually striving to identify areas of innovation and improvement. MAXIMUS Federal is the only contractor who understands DWC, their IMR process and possesses practical experience in operating the IMR Project.

For the past 12 years, we have successfully provided IMR services to a variety of California agencies, including DWC, DMHC, CDI, CalPERS. MAXIMUS Federal is the only Utilization Review Accreditation Commission (URAC) accredited IRO that is completely free from conflicts of interest and

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can offers DWC a detailed and responsive approach to the technical requirements of the IMR Project based on first-hand experience, and best practices and lessons learned developed in close collaboration with DWC. This technical approach is supported by key personnel who are recognized as experts in their fields and who have proven themselves as trusted partners for the IMR Project. We look forward to continuing our collaborative partnership with the DWC on the new contract.

In *Exhibit 2-2: Key Features* we outline the highlights of our technical solution which will provide us with the capacity to perform 40,000 IMRs per month beginning on January 1, 2015.

Key Features	MAXIMUS Federal Qualifications
Capacity to perform more than 40,000 IMRs per month by January 1, 2015	<ul style="list-style-type: none"> ▪ Leverage our Panel of 950 California-licensed MPRs in active practice and staff of 100 Appeal Officers supported by <i>entellittrak</i>, our sophisticated case management tracking tool with allow us to process 40,000IMRs per month
Unmatched Panel of 950 California-licensed MPRs	<ul style="list-style-type: none"> ▪ All 950 reviewers are in active practice and board-certified or licensed of which 60 percent have significant California IMR experience ▪ Represent all ABMS specialties and subspecialties
Four-level Quality Assurance/Quality Control Process for IMR decisions	<ul style="list-style-type: none"> ▪ Level 1: Orientation and ongoing training for MPRs to ensure they understand program requirements. This onboarding process involves a direct interface with the Medical Director and experienced reviewers serving as MPRs ▪ Level 2: Prospective, initial assessment of all new reviewers with detailed feedback from the Medical Director until they are deemed ready to review on their own ▪ Level 3: Final decision letter quality assessment of MPR summary, rationale and outcome that involves a daily random sample covering 24 technical and substantive elements ▪ Level 4: Each final decision letter undergoes an audit performed by Appeal Officer to ensure legibility, completeness, and accuracy prior to distribution
Experienced Project Management Staff	<ul style="list-style-type: none"> ▪ Medical Director, Project Director, and Project Manager with experience managing 40,000 DWC IMRs to date ▪ 100 Appeal Officers with a combined 200 years of DWC IMR experience

Exhibit 2-2: Key Features. *The table above outlines key features and MAXIMUS Federal qualifications.*

We understand DWC is seeking a firm to conduct independent medical reviews submitted to them under California Labor Code Sections 139.5 and 4610.5, and California Code of Regulations, Title 8 (8 CCR), §9792.10.1, et seq. MAXIMUS Federal is the only firm with this experience and is prepared support this program immediately upon contract award.

Expert Administration of Complex Government Health Care Programs

As noted above we have a long history of collaborating with a number of California agencies providing IMR services for eligible California consumers and injured workers. This mutually beneficial relationship was established in January 2001, when MAXIMUS Federal began serving as DMHC’s IMRO. As a testament to our success, we are still the sole IMRO for the DWC, DMHC, CDI, and CalPERS IMR programs. In cooperation with DWC, CDI, DMHC, and CalPERS, MAXIMUS Federal has assisted in making these projects a commonly cited model for independent review. During this time period, we have completed more than 55,000 IMRs for the State of California.

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In addition to our work with DWC and the other California agencies, we have successfully implemented health care IMR programs and quality oversight programs for more than 50 federal and state agency clients, including the Centers for Medicare & Medicaid (CMS) and the Office of Personnel Management (OPM). Our overall experience in state and federal government independent review programs sets us far apart from the competition. In 2013 alone, we have rendered more than 800,000 independent medical review decisions addressing the full spectrum of health care claims including worker's compensation, Medicare, Medicaid, group health, medical necessity, experimental, cosmetic, and provider qualification disputes as well as issues of quality of care. With this experience, we can assure DWC that we have demonstrated success in handling at least 100,000 reviews per year of the type described in this RFP. In 2013, we processed more than 300,000 IMRs for our Medicare Part A project, more than 115,000 IMRs for our Part C project and more than 102,000 IMRs for our Medicare Part B project. References for these projects are contained in *Section 6.2.13* of our proposal.

In addition to the above, we have significant experience addressing large surges in case volumes and resolving backlogs which develop as result of such surges. During the initial term of the DWC IMR program it was thought by all stakeholders that the maximum number of cases received in a month would be 4,000 starting in July 2013. Based upon this analysis, we staffed and trained medical review panel to handle 4,000 cases a month starting in July 2013. In reality, in July 2013, we began receiving more than 12,000 cases a month, not including the submission of thousands of duplicate IMR applications. In order to address this unexpected surge in cases, we immediately began adding to our management and operations teams as well as increasing our MPR panel. Through these initiatives, we began to address this case volume that was three times greater than originally forecast and are currently completing more than 8,000 cases a month with a projection to be completing 20,000 cases per month by July 2014. Based upon this experience, and our belief that volumes will continue to increase, we are preparing for a volume of 40,000 cases a month starting in January 2015.

Commitment to California Based Operations

We are licensed to do business in the State of California (please see *Appendix L: California Business License*) and since January 2013, we have maintained a full-service, secure office in California. We will continue to house our Project operations in a full-service office in Folsom, California. Basing our offices within 90 minutes of DWC's Oakland offices will prove mutually beneficial for both MAXIMUS Federal and DWC. For example, it will allow in-person meetings between respective staff in Oakland within a day's or less notice. In addition, it provides DWC the opportunity to inspect and observe our operations on a regular and continual basis without inconveniencing either party.



Scalable Case Workflow Tracking System and Supporting Tools



Through the implementation of the *entellitrak* case flow tracking during the initial term of this program, we have provided DWC with first-hand evidence that we have the appropriate experience creating a case flow tracking system. If successful on this bid, we will continue to use *entellitrak* as our case workflow tracking system for the IMR Project. We believe our scalable system is the best solution to meet the ever increasing IMR volumes as evidenced throughout the life of this Project. We continue to work closely

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with DWC to improve and upgrade *entellitrak* through regular system releases, including the online IMR Application which will be fully implemented in July 1, 2014. To complement the *entellitrak* system and to enhance our ability to process IMRs in a timely and accurate manner we have added the following components:

- Our MAXIMUS Federal document management solution for scanning received case documentation to enable digital uploading to *entellitrak* and to facilitate case processing and help to ensure that all pertinent documents have been received and accounted for
- MOVE-IT, our HIPAA-compliant secure file transfer protocol (sFTP) tool, which helps to ensure case files are transferred quickly and securely with DWC
- Our credentialing database, which helps us to quickly identify qualified reviewers in same or similar specialty as required by the case and to mitigate any potential or actual conflicts of interest
- Through our highly optimized portal, Expert Gateway, we can securely make case and hearing documentation and related review materials available to our MPRs. This system utilizes data relating to capabilities, professional expertise, qualifications, program eligibility, geographic location, availability, and current workload

Our suite of tools offers DWC a low-risk, cost effective solution that will ensure all IMRs are completed on time and accurately. In addition, these tools will provide the foundation needed to support our capacity to process 40,000 IMRs a month and serve as the foundation to help efficiently eliminate the current backlog of cases.

Medical Professional Review Resources

MAXIMUS Federal has the MPR bandwidth to meet the anticipated IMR volumes as the DWC IMR Program continues to expand. MAXIMUS Federal can offer DWC access to more than 350 California-licensed physicians and other health care professionals available to complete IMRs. Many of our California-licensed reviewers are board certified in multiple specialties and can provide IMRs in these clinical areas. As such, we can offer the DWC more than 460 California certifications, which effectively increases our panel scope by 25 percent.

We have also entered into a number of subcontracting agreements with URAC accredited IROs and have added another 600 California licensed clinicians to our MPR Panel, bring the total number of MPR resources to 950 MPRs. With these commitments and resources we are confident we now have the capacity to process up to 40,000 IMRs a month. Lastly, we can also offer DWC access to more than 400 additional physicians and other health care professionals licensed in other states on as needed basis.

All of our MPRs to be used for this bid are currently in active practice at 24 hours (60 percent) per week, which exceeds DWC's 30 percent active requirement for at least two of the preceding four years. All of the reviewers to be used on this Project are credentialed, ABMS board certified and licensed. These resources will be available immediately upon contract award.

Experience and Familiarity with Evidenced-Based Medical Treatment Standards in the State of California

As set forth in *Section 6.2.3* of our proposal MAXIMUS Federal has extensive experience interpreting, understanding, and applying evidenced-based medical treatment standards in the State of California. At the inception of the DWC IMR program in 2012, we worked collaboratively with DWC to develop an

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agreed application of medical treatment standards. Through the receipt of more than 135,000 DWC IMR applications and the completion of more than 35,000 IMRs as well as extensive training our medical reviewers and staff are expert in the appropriate application of the California Medical Treatment Utilization Schedule (MTUS), the American College of Occupational and Environmental Medicine's Practice Guidelines (ACOEM – incorporated into MTUS), the Official Disability Guidelines (ODG) as well as scientifically based evidenced published in peer-reviewed, nationally recognized journals for conditions or injuries not addressed by MTUS, ACOEM and/or ODG. To ensure all our reviewers have ready access to the most recent peer-reviewed literature and scientific evidence we maintain a relationship with the ECRI Institute which provides us access all available peer-reviewed literature from nationally recognized journals and other recognized scientific sources. ECRI is designated as an Evidenced-Based Practice Center by the United States Agency for Healthcare Research and Quality (AHRQ).

Dedicated and Knowledgeable IMR Staff

We will leverage our current DWC IMR staff to manage this Project. These individuals have worked closely with DWC to implement and manage the program since its inception in January of 2012. Since the inception of the Project our staff resources have expanded to 100 Appeal Officers to meet case volume demands. These Appeal Officers, our version of case managers, to manage the day-to-day IMR process from case assignment through final determination. Our Appeal Officers work closely the MPRs to ensure the IMRs are completed on time and accurately.

In order to better facilitate the DWC IMR process we have divided our Appeal Officers into five specialized teams. We recently implemented this new process to help meet the increasing case volumes. We believe using specialized teams trained in each critical step in the review process and with the ability to resolved common issues and barriers will help expedite the IMR review process. Over the last several months using the process, we have seen a 25 percent increase in our capacity to process cases. In addition, to address the higher volumes and ensure we can provide the highest quality IMRs, we have recently added 30 experienced IMR nurses to serve as Appeal Officers, supervisors and quality reviewers, as well as two Associate Medical Directors and five Physician Quality Reviewers. With this staffing mix, we believe we have the staff in place to complete upwards of 40,000 IMRs a month as of January 2015.

Data Reporting and Analysis

Throughout the last two years, we have worked collaboratively with DWC to develop and provide the valuable data reports to assist with the analysis and tracking of the IMR program. We currently provide DWC weekly, monthly, quarterly, and annual operation reports and are prepared to provide the additional reports listed in the RFP. Furthermore, in order to provide DWC the greatest access to case tracking data, in September 2014 we will implement our MAXDat reporting platform which will allow DWC web-based access to our IMR reporting and dashboard tools. MAXDat will allow DWC users to create customized reports on any data elements that are captured in *entellitrak*. For example, DWC users will have the ability to access MAXDat and request a report detailing all cases involving a specific procedure in a given month or a specific medication involving an age and gender specific patient population. Examples of current reports provided to DWC may be found in *Appendix N: Current Reports* and examples reflecting the functionality of the upcoming dashboards are included in *Section 4.2: Case Flow Tracking System*.

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In addition, we will provide an expert consultant to assist with developing reports that meet the needs of DWC. Mr. Neuhauser is the Executive Director of the Center for the Study of Social Insurance at the University of California, Berkeley. Mr. Neuhauser has extensive experience with Workers' Compensation in California and has previously assisted the DWC on a series of initiatives to use data on injured workers to providing meaningful contributions to policies governing delivery of care to the injured worker population. In his capacity as a consultant, Mr. Neuhauser will bring his extensive experience with the Workers' Compensation program to bear on the design of data structures that support DWC. Complete information on reporting and MAXDat is found in *Section 4.2.8: Case Tracking Reports*.

Industry Best Conflict of Interest Standards

As a market leader in government sponsored independent medical review and health care consulting, we understand conflicts of interest. Based upon our business philosophy and the absolute need to maintain our independence and integrity, we do not provide any services to or contract with any claims administrator, workers' compensation, health/disability insurer, provider network or any other type of payor where it would create a conflict with a government program. Therefore, if a potential or actual conflict exists with a government program, we do not provide any services (for example, clinical review, technology assessment, consulting) or have any relationship with any of the aforementioned entities nor at any time in the future will we enter into any contractual agreements with these entities for the provision of any similar services. As such, we have no existing relationships of any kind with any workers' compensation, health/disability insurer, provider network or any other type of payor. Moreover, we have no relationship with any national health or disability insurer that is doing business in California (for example, Aetna, United, and Wellpoint).

Quality Management and URAC Accreditation

Our corporate policy emphasizes that quality is the most important aspect of all projects and it is never to be sacrificed for profitability. Throughout the existence of our company, we have evolved a highly effective approach to conducting management activities.

We implement and maintain a comprehensive Quality Management System (QMS) for every project we undertake. We consider Quality Management to encompass all activities our manager's conduct to achieve our quality-related objectives. These include quality assurance (QA), quality control (QC), and quality improvement (QI).

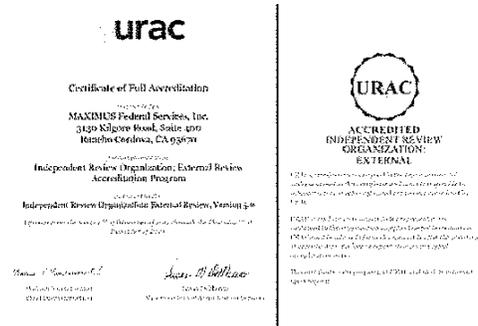
Our QMS:

- Enables us to demonstrate our success in meeting quality standards (we call this quality assurance)
- Ensures contract compliance and achievement of customer-defined performance standards (we call this quality control)
- Promotes discovery and awareness of best industry practices that enhance efficiency and ensure they are incorporated into our daily operations (we call this quality improvement.)

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In addition, our commitment to quality is evidenced by the fact that we have obtained full accreditation from URAC as an external review organization. Please see *Appendix A: URAC Certificate* for a copy of our URAC accreditation. URAC accreditation is the only nationally recognized external review organization accreditation program. We have been accredited by URAC since accreditation became available in 2000 and have received full re-accreditation five times with no areas for improvement noted. As a further demonstration of our commitment to quality, MAXIMUS Federal is committed to ISO 9001:2008 registration. We also have more than 30 ISO certified internal auditors within our organization responsible for continual and regular ISO audits of our projects. The advantages of this system are:



- A detailed and documented approach to defining all of the client's requirements
- Procedures and controls to ensure that client requirements are met
- Measures and documentation of client requirement attainment, including specification of any errors or deviations
- Errors or deviations require documented corrective action
- ISO demands a responsive client-focused approach to management and requires actions to continually improve process performance

Conclusion

We welcome the opportunity to continue to work with DWC in the operation of its IMR program. Based on the foregoing we can offer DWC a low risk, cost effective solution that features a seamless transition to the new contract and is designed to help to ensure a best-in-class program.

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3. Overview

Our methodology to conduct independent medical reviews on behalf of DWC is based upon on best practices and lessons learned as DWC's IMR partner since the program's inception. It is supported by a proven case management tool, *entellittrak*, and a medical professional reviewer (MPR) panel of 950 California-licensed practitioners. Our combined approach will allow us to process more than 40,000 IMRs a month. As a testament to our IMR methodology, in a 2013 Customer Survey, DWC rated MAXIMUS Federal's quality of products as "high quality". Based on the forgoing we are confident we can provide DWC with a cost-effective, low-risk IMR services solution. We are positioned to implement this program immediately upon contract award, January 1, 2015, without any organizational conflicts of interests to mitigate.

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In this section we provide an overview of our methods to conduct independent medical review. Please see *Section 4.2.8: Case Tracking Reporting* for a discussion of our analysis and reporting plans.

Having processed more than 55,000 California IMRs since 2001, MAXIMUS Federal and its staff have a full and complete understanding of the California IMR program for DWC, CDI, DMHC, and CalPERS. Our experience provides an expert understanding of the California workers' compensation and health insurance industry and the role of IMRs for injured workers and consumers. Since the implementation of the DWC IMR Program we have been able to continually leverage this unique experience and incorporate into our IMR methodology in the form of lessons learned and best practices.

All actions taken by MAXIMUS Federal during the review process are updated in *entrellittrak*, which is our case workflow tracking system that allows MAXIMUS Federal Project Staff to perform all actions required to assign and track a case through the various stages of the IMR process. This system was developed and customized specifically for DWC. We have been utilizing this tool since January 2013. We will implement all of the system enhancements included in the RFP prior to the January 1, 2015 contract start date. System and user testing will start well in advance of the contract start date to insure that the new system meets the requirements of DWC. It also allows DWC real-time access to case status and updates as we work side-by- side to ensure program success.

Through this process MAXIMUS Federal ensures that MPRs promptly review all pertinent medical records and other appropriate information submitted relevant to the IMR and that the determinations and analyses are conducted professionally, thoroughly, and in a timely manner. In addition, MAXIMUS Federal ensures that all reviews are written in plain English and will include the reviewers' reasons for supporting their analysis and decision, as well as applicable MTUS guidelines or other evidence-based resources. The purpose of the IMR is to decide disputes between physicians and Claims Administrators about necessary medical treatment for injured workers.

MAXIMUS Federal can offer ...

- Management staff, including 100 Appeal Officer to support our IMR methods
- A proven scalable case workflow methodology that will support new innovations, including the online IMR application and remote staff
- More than 950 California-licensed MPRs in active practice and representing every ABMS specialty and subspecialty that are available and prepared to support our IMR methodology

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3.1 Appeal Officer Resources

Below we describe the role of the Appeal Officers as it relates to the operation of this Project. Appeal Officers are our version of case managers who will manage the DWC IMR process from receipt of a case through final determination letters. Our more than 100 Appeal Officers slated to work on the Project bring us DWC IMR experience that cannot be duplicated. In order to better facilitate this IMR process we have divided our Appeal Officers into five specialized teams. We recently implemented this new process to help meet the increasing case volumes. We believe using specialized teams trained in each critical step in the review process will facilitate the ability to resolve common issues and barriers and ultimately help to expedite the IMR review process. Over the last several months using the process we have seen a 25 percent increase in our capacity to process cases. *Exhibit 3.1-1: Specialized Teams* describes these teams and the specific workflow roles and responsibilities. To ensure we have appropriate clinical support, each team will be led by a Nurse Reviewer, with a nursing degree and significant clinical experience.

Specialized Team	Role of Team
Preliminary Review Team	<ul style="list-style-type: none"> ■ Facilitate the processing of preliminary reviews to determine IMR eligibility. ■ Those reviews that are deemed eligible will be moved forward to the case assessment stage ■ Those found to ineligible are routed to DWC for an eligibility determination
Case Assessment Team	<ul style="list-style-type: none"> ■ Assess each IMR case file for legibility, completeness, relevance to the case ■ Data enter relevant case information into <i>entellittrak</i> and assign a unique internal case number for tracking and monitoring purposes ■ Request additional information from the Claims Administrator and other parties as necessary ■ Create a list of the case file materials and organize the case file for the MPR for ease of review ■ Recommend the rule(s) to applied for each treatment in dispute ■ Identify specialty and/or subspecialty required to perform the IMR
Panel Scheduling Team	<ul style="list-style-type: none"> ■ Determine the appropriate MPR to review the case ■ Ensure the MPR is qualified and available to review the case ■ Perform a MPR conflict of interest check to ensure the review is conflict free ■ Prepare the MPR Referral and Review Report for the reviewer to record his or her decision. ■ Upload Referral and Review Report and case file into Expert Gateway for MPR retrieval
Case Closing Team	<ul style="list-style-type: none"> ■ Perform a quality audit on the reviewer determination for accuracy and completeness ■ Contact MPR to remedy any deficiencies in conjunction with the Medical Director if necessary ■ Generate the final decision letter in <i>entrellittrak</i> for distribution to the injured worker or their representative, the treating provider, and the Claims Administrator
Expedited Review Team	<ul style="list-style-type: none"> ■ Process all expedited appeals within the three day window ■ Oversee all WCAB appeals and remands

Exhibit 3.1-1: Specialized Teams. *This table describes out team approach to completing IMRs in a timely and accurate fashion. By specializing in specific steps in the review process we have been able to improve our timeliness while increasing our monthly case resolution output.*

We are confident our specialized team approach will allow us to continue to complete standard IMRs within 30 days and expedited reviews within three calendar days after receipt of all documents need to complete the review.

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3.2 Proposed IMR Workflow Process

Please see *Exhibit 3.2-1: IMR Workflow Diagram*, which provides a graphic illustration of our DWC IMR workflow diagram.

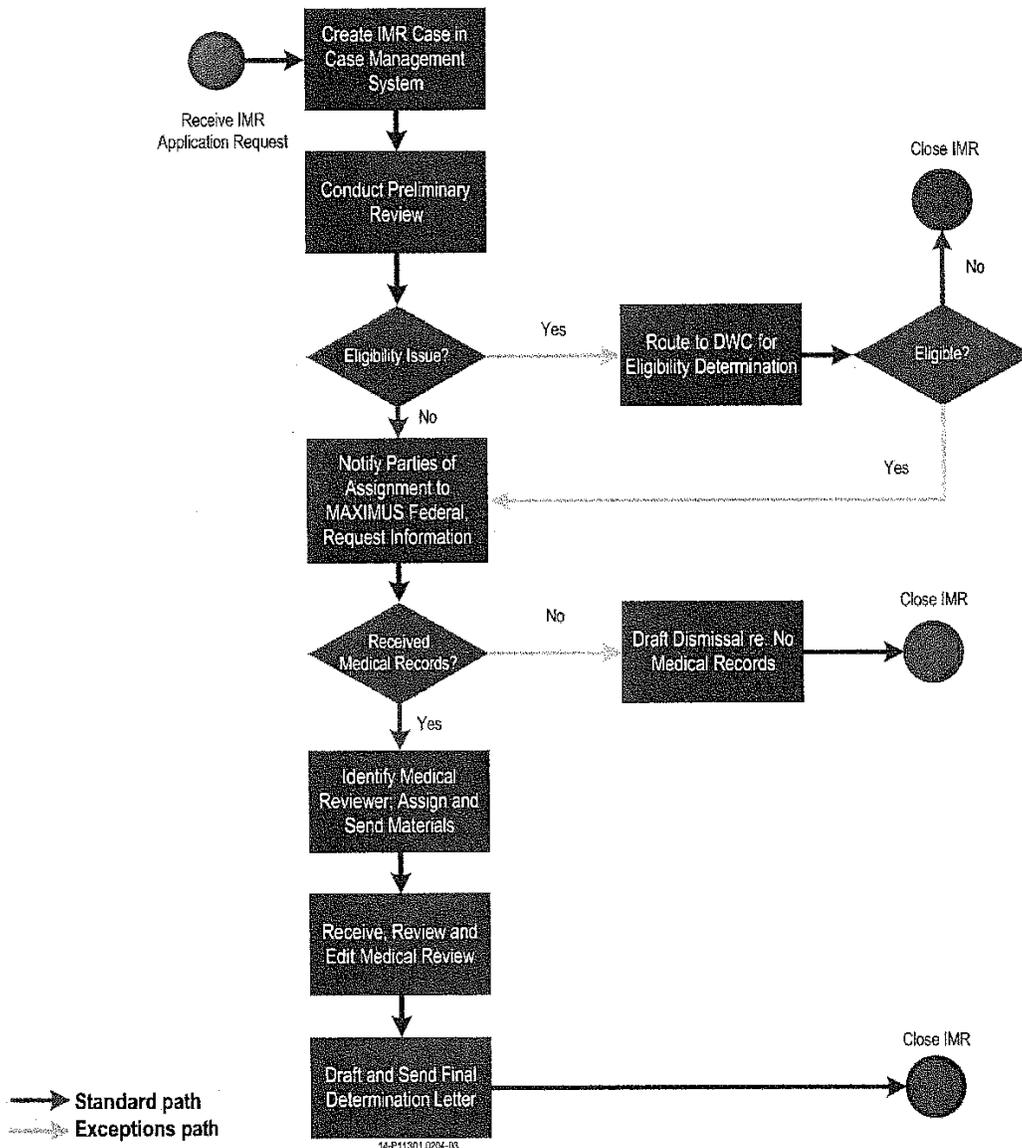


Exhibit 3.2-1: IMR Workflow Diagram. This flowchart depicts our process for completed DWC IMRs in a timely and accurate manner.

Our IMR process will include the following steps:

- Preliminary Review Process
- Case Assessment Process
- Case Assignment Process
- MPR Review Process
- Case Closing Process

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Preliminary Review

Upon receipt of an IMR request from an injured worker, our administrative staff will create a new IMR case in *entrellitrak*. Once the review data is captured, an IMR Tracking Number is assigned to the case. This is an internal number that includes the DWC IMR number that is used to monitor the progress of the IMR throughout the review process and to ensure that DWC's timeframes are met.

See *Exhibit 3.2-2: Preliminary Review Screen* for a screen shot of our preliminary review screen in *entrellitrak*. The IMR will be assigned to a member of our Preliminary Review Team. This team is responsible for validating the data included in the IMR application against information provided in the Utilization Review (UR) Denial letter and identifies claims administrative denial citations. The Preliminary Review Team will also identify other potential eligibility issues, such as reviews not being filed within 30 days of the UR Denial Letter being issued or for a conditional non-certification (lack of medical records).

The team also identifies the treatment(s) in dispute and enter this information into *entrellitrak*. If this process identifies potential eligibility issues with the IMR it is routed to DWC for an eligibility determination. If DWC determines the case is ineligible the IMR is terminated. If DWC determines the case is eligible, MAXIMUS Federal is notified and the case moves to Case Assessment process.

The screenshot shows the 'IMR Preliminary Review' screen. At the top is the State of California Department of Industrial Relations header with navigation links. The main content area contains the following fields:

- Preliminary Review** (Section Header)
- Preliminary Review Deadline Date**: 02/26/2014 (mm/dd/yyyy)
- MAXIMUS Federal Preliminary Review Date**: [Empty]
- Is there an unresolved liability issue?**: Yes No
- Date of injury**: 12/14/2013
- Is the date of injury prior to January 1, 2013?**: Yes No
- Is there sufficient information to begin the IMR process?**: Yes No
- Please select all information that has NOT been provided but is necessary to begin the IMR process**:
 - Application
 - Medical Records
 - Unsigned Application
 - Utilization Review
 - Other
- Claim Type**: Standard
- Is this an expedited request for IMR?**: Yes No
- Is there an apparent dispute over eligibility for IMR?**: Yes No
- Is the IMR request a duplicate of an existing IMR?**: Yes No
- Date Utilization Review Served**: 05/27/2013
- Date IMR Application Received by IMRO**: 02/04/2014
- Number of Days Between**: 253
- Was the IMR Application received past the deadline?**: Yes No
- Describe Any Other Issues**: [Text area]
- Save** button

Exhibit 3.2-2: Preliminary Review Screen. This graphic illustrates the Preliminary Review screen in *entrellitrak*.

Case Assessment

During the initial review the Appeal Officer then reviews all IMR file information submitted from the Claims Administrator, the injured worker, their representative or the treating provider and determines its legibility, completeness, and relevance to the case. If any information is determined to be illegible or

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incomplete, or if relevant information has not been submitted, the Appeal Officer will immediately contact the Claims Administrator and inform them what information is required for completion of the review.

The case assessment process also encompasses receipt of all IMR case file materials, abstraction of identifying information required for system entry, initial data entry, and establishing the priority of the review and case assignment. Receipt of IMR materials from DWC and Claims Administrators is logged in by administrative staff and scanned and uploaded into *entellitrak*. The information obtained from the assignment information will include:

- Verifying the IMR type (for example, standard or expedited)
- Verifying the parties related to the IMR (for example, injured worker, injured worker representative if applicable, treating provider, health care services plan, health care facility if applicable)
- Verifying the services in dispute (for example, request for continued physical therapy services)
- Verifying the injured worker's primary diagnosis
- Verifying the claims administrator's denial rationale (for example, services not considered medically necessary, services considered experimental and investigational)
- Determining the number of MPRs that may be required
- Identifying the specific questions presented by DWC and any other pertinent details provided by DWC

If an error has been made in entering of data, or data has not been entered, the Appeal Officer will inform the Administrative Assistant of the necessary corrections and/or provide new information for data entry.

For standard reviews the Claims Administrator has 15 calendar days of the date designated on the notification, if the notification was provided by mail, or within 12 calendar days of the date designated on the notification if the notification was provided electronically, to provide us with the following information in accordance with Section 9792.10.5:

- A copy of all reports of the employee's treating physician relevant to the employee's current medical condition for one year prior to the date of the request for authorization, including those that are specifically identified in the request for authorization or in the utilization review determination
- A copy of the adverse determination by the claims administrator notifying the employee and the employee's treating physician that the disputed medical treatment was denied, delayed, or modified
- A copy of all information, including correspondence, provided to the employee by the claims administrator concerning the utilization review decision regarding the disputed treatment
- A copy of any materials the employee or the employee's provider submitted to the claims administrator in support of the request for the disputed medical treatment
- A copy of any other relevant documents or information used by the claims administrator in determining whether the disputed treatment should have been provided, and any statements by the claims administrator explaining the reasons for the decision to deny, modify, or delay the recommended treatment on the basis of medical necessity
- The claims administrator's response to any additional issues raised in the employee's application for independent medical review

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For expedited IMRs, the Appeal Officer will request additional information within one business day from receipt of case file information.

Once all case file information is received, the Appeal Officer then determines the specialty or subspecialty needed to review the case. If necessary, we work in conjunction with the Medical Director to determine the medical specialty required to conduct medical review.

The Appeal Officer develops a detailed list of medical records to ensure we have all of the necessary documentation to proceed with the review. Once the records have been accounted we will organize the case file for the MPR to help facilitate the reviews as follows: IMR Application, Copy of the UR Denial Letter, Medical Records separated by provider and ordered by date. The Appeal Officer also provides guidance to the clinical reviewers regarding the clinical guidelines to be applied.

At the conclusion of the assessment process, assignments of all IMRs received have been made, and a task is automatically generated in *entellitrak* notifying the Panel Scheduling Team that IMR is ready to be assigned to a MPR. Panel scheduling assignments are captured in the tracking system, and open IMRs for each Panel Scheduler appear in his or her task queue.

After the IMR materials have been scanned and uploaded into *entellitrak* all hard copy records are shredded within 15 days pursuant a mutual agreement with DWC.

Panel Scheduling Team

This team will determine if appropriate MPR is available to conduct the IMR. We generally assign a single MPR to each case even if multiple issues are involved. We are able to do this because our MPRs are experienced in the California IMR process, are in active practice and are familiar with current standards of care, and have been trained to handle multiple case issues as required. The Appeal Officer will first determine if any of the California MPRs match the specialty that is required for the performance of the case. If MAXIMUS Federal has appropriate California MPRs on panel, staff will contact each appropriate California MPR to determine availability to review the case. In the unlikely event MAXIMUS Federal does not have an appropriate California MPR on panel, staff will contact non-California MPRs to determine availability.

If at any time, the Panel Scheduling Team is unclear as to what specialty should review the case, the Appeal Officer will contact the Medical Director or Director of Professional Relations for clarification. Once an appropriate MPR has been identified, the Appeal Officer enters assignment of the IMR in our tracking system.

Upon contacting an appropriate MPR, the Panel Scheduler will determine if the MPR is available to review the assigned case. This process involves the provision of specific case file information to the MPR. Upon initial contact, Panel Schedule staff will explain to the MPR that a case has been received from the injured worker and ask the MPR if the MPR can complete the review of the case within the specified timeframe. If the MPR indicates that the MPR is available to complete the case within the specified timeframe, staff will then explain the facts and circumstances surrounding the case to determine if the MPR is qualified to complete the review and absent of any material familial, financial, or professional affiliation with the parties to the case. As part of our ongoing quality control process, staff will ask the MPR the following questions to verify their qualifications provided in our credentialing database as it relates to the specific review:

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- Are you credentialed in the diagnosis and treatment of the medical condition defined in the case?
- Are you credentialed in the specific procedure or treatment in dispute in the case?
- Have you treated one or more patients with the injured worker's condition in this case in the past 12 months?
- If you have not treated a patient with such condition or provided the disputed procedure in the last 12 months, do you represent yourself as fully knowledgeable concerning the medical condition of the injured worker and treatment options for the Injured worker?
- Do you certify that aside from this case that you have not been involved in the diagnosis or treatment of the injured worker in this case?
- Do you certify that you do not have any relationship with any party to this case which would constitute a material familial, financial, or professional affiliation as defined in your contract with MAXIMUS Federal?
- Do you certify that you do not have a potential material familial, financial, or professional affiliation as defined in your contract with MAXIMUS Federal with any party to this case?

If in answering the above questions it is determined that the MPR is qualified to review the case and does not have a conflict of interest, staff will prepare a MPR Referral and Report Form for submission to the MPR. If in answering the above questions it is determined that the MPR is either not qualified to review the case or has a conflict of interest, staff will contact another MPR until another suitable candidate is assigned. *Exhibit 3.2-3: Expert Reviewer Screen* illustrates the MPR information that is captured in *entellitrak* once a reviewer has been selected.

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Exhibit 3.2-3: Expert Reviewer Screen. Illustrates the MPR information that is captured in entellitrak once a reviewer has been selected.

Once an appropriate MPR has been selected, staff will upload the MPR Referral Form, the organized case file and relevant MTUS or other guidelines on the Expert Gateway for the MPR.

The MPR Referral Form identifies the parties and provides a thorough summary of the facts and circumstances of the case, including a description of proposed care, the condition being treated, and so on. The MPR Referral Form will instruct the MPR to answer the exact questions submitted by DWC. In addition, the MPR Referral Form specifically instructs the assigned MPR to contact the Appeal Officer immediately if the MPR determines that additional information is necessary and/or if the MPR cannot complete the review of the case within the specified timeframes.

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Upon completion of the MPR Referral Form, the case file is prepared for submission to the MPR. The assigned MPR is contacted and informed that a copy of the case file will be delivered. At this time, the MPR is reminded of the facts and circumstances of the case, the date the review is due, and to immediately contact MAXIMUS Federal if additional information is required, if it is determined that a conflict of interest exists or if the review cannot be completed within timeframe.

As part of our ongoing quality measures, Appeal Officers forward MPR case assignments to the Director of Professional Relations and/or the Medical Director for review. If either the Director of Professional Relations or the Medical Director has any questions regarding case assignment, these questions are resolved prior to forwarding the cases to MPRs.

MPR Review Process

Upon receipt of the case file, the MPR also reviews all information for legibility, completeness, and relevance. If the MPR determines that additional information is necessary, the MPR immediately contacts the Appeal Officer and indicates what additional information is necessary. The Appeal Officer will then contact the Claims Administrator by facsimile or other acceptable means to obtain any additional information that is required to formulate an opinion in the case. In addition, the MPR reviews all case file information to ensure that the appropriate specialty has indeed been selected and that the MPR has no potential or actual conflicts of interest. If the MPR determines that appropriate specialty has not been selected or that the MPR is not qualified to review the case, the MPR immediately contacts the Appeal Officer so the reassignment may occur. DWC will be notified immediately if and when reassignment is necessary.

When all case file information has been received, the MPR reviews the case file and completes the MPR Referral Report. The MPR Referral Report will require the MPR to: (1) Draft a summary of the clinical facts; (2) Verify the treatments in dispute; (3) Select the rule to be applied for each treatment in dispute; and (4) applies rule to the relevant clinical facts; and (5) renders a decision and provides an opinion regarding the medical necessity of each treatment in dispute

The MPR will write all reviews in plain English to the extent practicable and will state the reasons supporting the answers to DWC's questions specifically referencing: (1) the injured worker's medical condition; (2) the relevant medical records and other records reviewed; and (3) the medical and scientific evidence considered, as applicable, that was relevant to the determination made.

The MPR Referral Report also requires the MPR to certify and attest that the MPR is qualified to review the case, that the MPR has no conflicts of interest, and that there has not been a change in the MPR's credentialing status since the MPR's submission of information to MAXIMUS Federal for credentialing.

Upon completion of the review, the MPR will forward the completed review to MAXIMUS Federal.

Case Closing Process

Upon return of the MPR review, the Case Closing Team audits each decision. The audit is to ensure that each decision specifically references the injured worker's medical condition, the medical records, and any relevant documents reviewed, explaining any facts that are significant to the analysis and that all questions posed by DWC have been answered and that the authorities cited are consistent with disputed treatments. Furthermore, each MPR report is reviewed to ensure the reviewer's reasons for the determination, specifically noting one or more of the medical and scientific evidence factors required to

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be considered under applicable California Labor Code 4610.5. The audit also goes through a formal editing process to safeguard against typographical errors or the inclusion of erroneous information. To ensure effectiveness editing is completed by administrative staff and an Appeal Officer other than the Appeal Officer managing the IMR.

The Appeal Officer will immediately contact the MPR for clarification of any issues. The Case Closing Team will contact the Project Manager and/or Medical Director as necessary for resolution of issues. Once any outstanding issues are resolved, the Appeal Officer will generate a final report through *entellitrak* to be distributed to the Interested Parties. The final decision letter will specifically answer the questions posed by DWC, the decision reached by the MPR and provide a summary of the medical condition at issue and the medical and scientific evidence considered, as applicable, that was relevant to the determination made accompanied by the biography of the MPR utilized. *Exhibit 3.2-4: IMR Decision Screen* illustrates how we capture information regarding IMR final decision letters.

Decision Date	02/14/2014	(mm/dd/yyyy)
Decision Letter Mailed Date	03/14/2014	(mm/dd/yyyy)
Decision	Upheld	
Review Type	Retrospective	
Decision Rationale		
IMR Fee		
Fee Date		(mm/dd/yyyy)

Exhibit 3.2-4: IMR Decision Screen. Illustrates IMR decision letter information is captured in entellitrak.

Case File Organization and Storage

MAXIMUS Federal IMR files are organized in a standard format. All information received from DWC, Claims Administrators, injured workers, injured worker representatives, and treating providers is scanned and then uploaded into *entellitrak*. The uploaded documentation is indexed by submitting party (for example, Claims Administrator, injured worker, and so on). This task is performed to safeguard and ensure that all information submitted is contained in the electronic case file. As IMRs are processed, further information is added to the electronic case file (for example, MPR packet, MPR report, final determination, additional information). Upon completion of the review process, the electronic version of the IMR documentation is retained in *entellitrak* and the hard copy documentation is destroyed in accordance with DWC directives.

The electronic case file includes the following information:

- Final Determination
- MPR Report
- Submitted Additional Information

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- Request for Additional Information
- Claims Administrator Submission
- DWC and Injured worker Submission

IMR electronic files are kept secure at all times. Project personnel are granted secure access to *entellitrak* and must log out of the system when they are not at their workstations. In addition, MPRs are required to keep files secure during the review process. To help ensure the confidentiality of files during the review process, all MPRs are required to sign a HIPAA Agreement.

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4. Work Plan and Work Schedule Requirements

MAXIMUS Federal's IMR methodology is supported by a proven case management tool, *entellitrak*, a medical professional reviewer (MPR) panel of 950 California-licensed practitioners, and a 137 member staff with direct experience supporting DWC IMR. Our proven approach and resources will allow us to meet all the deliverables required by DWC. As such, we are prepared to continue to seamlessly support this program immediately upon contract award, January 1, 2015, without any organizational conflicts of interests to mitigate.

RFP Section C.4.a.2, Page 18; C.2.b, Page 18

Exhibit 4-1: Work Plan provides an overview of all the task and work items identified in the Deliverables section of the RFP. The chart below identifies the staff responsible for each deliverable and the estimated hours, as applicable, that it will take to complete each deliverable. Please see *Section 4.4: Deliverables* for a detailed discussion of the specific elements and estimated response requirements for each deliverable. The last column in the table references the proposal sections in our response that identify the specific elements, response requirements, or portion of the deliverable products and services that each task or work item supports.

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MAXIMUS Federal provides ...

- A proven case management system that will support all of the deliverables for the DWC IMR Project
- 137 current staff members with direct California IMR experience to ensure full understanding of the program and accurate IMR deliverables
- A work plan to provide IMRs based on best practices and lessons developed in close collaboration with DWC since the program's inception in January 2013

Deliverables/Task	Responsible Party	Hours/ Task	Specific Elements/Response Requirements	Method Justification
1. Preliminary Review of Cases	Preliminary Review Team	2 days	See <i>Section 4.4.1</i> for the specific elements and related response requirements	This method is used to help determine the eligibility of injured workers for IMR
2. Assignment of Cases for IMR	Case Assessment Team	1 day	See <i>Section 4.4.2</i> for the specific elements and related response requirements	This method is used to assign IMRs to Appeal Officers for processing; a unique internal case number is assigned for tracking and monitoring purposes
3. Information to Conduct IMR	Case Assessment Team	15 days	See <i>Section 4.4.3</i> for the specific elements and related response requirements	This method ensures that each IMR file is complete; it is used to request additional information from Interested Parties as needed and determines the appropriate specialty needed for the IMR
4. Timeframes for Completing Reviews	All Teams	30d for Standard 3d for Expedited	See <i>Section 4.4.4</i> for the specific elements and related response requirements	This method includes our proposed IMR workflow and is used to ensure all cases are completed within the appropriate timeframes

Exhibit 4-1: Work Plan. Provides an overview of all the task and work items identified in the Deliverables section of the RFP

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Deliverables/Task	Responsible Party	Hours/ Task	Specific Elements/Response Requirements	Method Justification
5. Case Information and Changes in Case Status	All Teams	30d for Standard 3d for Expedited	See <i>Section 4.4.5</i> for the specific elements and related response requirements	This method involves the use of <i>entrellittrak</i> and is used to track case information and case status changes/updates
6. Number and Type of Reviewers	Medical Director and Recruitment Department	Ongoing	See <i>Section 4.4.6</i> for the specific elements and related response requirements	This method involves the composition of our panel, and ongoing recruitment of California-licensed reviewers to ensure we continue to have the appropriate resources to meet all review timeframes
7. Content of Reviews	Case Closing Team	3-5 days	See <i>Section 4.4.7</i> for the specific elements and related response requirements	This method is used to perform a quality audit on each reviewer determination to ensure accuracy and completeness
8. Distribution of Completed Reviews	Case Closing Team	1 day	See <i>Section 4.4.8</i> for the specific elements and related response requirements	This method is used to ensure final decision letters are distributed to the appropriate parties within the mandated timeframes
9. Appeal and Review of Remanded Cases	Expedited Review Team	30 days	See <i>Section 4.4.9</i> for the specific elements and related response requirements	This method is used to help process those reviews appealed to the WCAB in accordance with the mandated timeframes and pertinent rules and regulations
10. Confidentiality of Records and Information	All Staff	Ongoing	See <i>Section 4.4.10</i> for the specific elements and related response requirements	These methods are used to protect the confidentiality of records and related IMR information affiliated with DWC IMRs
11. Quality Assurance (QA)	Director of QA	Ongoing	See <i>Section 4.4.11</i> for the specific elements and related response requirements	These methods are used to meet all of the Quality Assurance requirements outlined in RFP Section A.11
12. Customer Service	Customer Service Representatives	Within 1 business day of contact	See <i>Section 4.4.12</i> for the specific elements and related response requirements	These methods are used to ensure Interested Parties can access customer service via a toll-free telephone number, fax, or e-mail for program complaints and questions
13. Timeliness	All Teams	Ongoing	See <i>Section 4.4.13</i> for the specific elements and related response requirements	These methods are used to ensure we are able to maintain 95% timeliness rating for all IMRs

Exhibit 4-1: Work Plan (continued). Provides an overview of all the task and work items identified in the Deliverables section of the RFP

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Deliverables/Task	Responsible Party	Hours/Task	Specific Elements/Response Requirements	Method Justification
14. Case Workflow Tracking System Availability Requirements	Director of Information Systems	Ongoing	See <i>Section 4.4.14</i> for the specific elements and related response requirements	These methods are used to ensure we have a viable case workflow tracking system to process IMRs pursuant to DWC rules and regulations
15. Fraud and Quality of Care Reporting	QA Director	Ongoing	See <i>Section 4.4.15</i> for the specific elements and related response requirements	These methods are used to ensure that we are able to identify and report any occurrences of suspected fraud or issues with the quality of care.
16. Certificate of Insurance	Corporate	10 days post contract award	See <i>Section 4.4.16</i> for the specific elements and related response requirements	This method is used to ensure that we have the necessary insurance coverages required by DWC
17. Prohibited Conflicts of Interest	All Teams	Ongoing	See <i>Section 4.4.17</i> for the specific elements and related response requirements	These methods are used to ensure that we have no organizational, reviewer, or staff conflicts of interest that would preclude us from providing independent and unbiased IMR review services

Exhibit 4-1: Work Plan (continued). Provides an overview of all the task and work items identified in the Deliverables section of the RFP

Facilities and Resources

MAXIMUS Federal will continue to operate this IMR Project out of our secure Folsom, California office. As the incumbent we have all the equipment and resources necessary to manage this contract upon contract award. Please see *Section 6.2.10: California Office Space* for additional information about our facilities and resources.

Anticipated Theoretical or Practical Problems

In *Exhibit 4-2: Potential Problems Risks* we assess potential theoretical or practical problems associated with the operation of larger IMR operations and our specific strategies for mitigating them.

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Potential Theoretical or Practical Problems	Solutions, Alternatives, or Contingency Plans	Deliverables/Tasks Affected
Ability to handle IMR volumes	<ul style="list-style-type: none"> ■ Scalable workflow process supported by <i>entrellittrak</i>, a proven case management system that has a long history of supporting large case volumes ■ Utilize existing combined panel of 950 board certified, California-licensed MPRs in active practice that are eligible to provide DWC IMRs ■ Leverage identified key personnel who have 200 combined years of DWC IMR management experience, including our 100 Appeal Officers ■ Combining these resources provides us with the capacity of 40,000 IMRs per month 	<ul style="list-style-type: none"> ■ Preliminary Review of Cases ■ Assignment of Cases for IMR ■ Information to Conduct IMR ■ Timeframes for Completing Reviews ■ Case Information and Changes in Case Status ■ Number and Type of Reviewers ■ Content of Reviews ■ Distribution of Completed Reviews ■ Appeal and Review of Remanded Cases ■ Confidentiality of Records and Information ■ Quality Assurance (QA) ■ Customer Service ■ Timeliness ■ Case Workflow Tracking System Availability Requirements ■ Fraud and Quality of Care Reporting ■ Prohibited Conflicts of Interest
Understanding of DWC IMR process and related rules and regulations	<ul style="list-style-type: none"> ■ Utilize our experience as the DWC incumbent where we provided more than 40,000 DWC IMRs ■ Leverage our more than 12 years of experience providing CA IMRs for DMHC, CDI, and CalPERS ■ Existing knowledge of California Labor Code Sections including 139.5, 4601.5, and California Code of Regulations, Title 8 (8 CCR), §9792.10.1, et seq. 	<ul style="list-style-type: none"> ■ Preliminary Review of Cases ■ Assignment of Cases for IMR ■ Information to Conduct IMR ■ Timeframes for Completing Reviews ■ Case Information and Changes in Case Status ■ Number and Type of Reviewers ■ Content of Reviews ■ Distribution of Completed Reviews ■ Appeal and Review of Remanded Cases ■ Confidentiality of Records and Information ■ Quality Assurance (QA) ■ Customer Service ■ Timeliness ■ Case Workflow Tracking System Availability Requirements ■ Fraud and Quality of Care Reporting ■ Prohibited Conflicts of Interest
Rapid implementation timeframe and system stability	<ul style="list-style-type: none"> ■ Employ our proven IMR expertise, workflows, infrastructure, and staff/reviewer resources to be ready to begin project operations on January 1, 2015 	<ul style="list-style-type: none"> ■ Case Information and Changes in Case Status ■ Number and Type of Reviewers ■ Confidentiality of Records and Information ■ Quality Assurance (QA) ■ Customer Service ■ Timeliness ■ Case Workflow Tracking System Availability Requirements

Exhibit 4-2: Potential Problems Risks. *This table describes potential theoretical or practical problems associated with the operation of larger IMRs and our specific strategies to mitigate these problems.*

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Potential Theoretical of Practical Problems	Solutions, Alternatives, or Contingency Plans	Deliverables/Tasks Affected
Sufficiency of MPR resources	<ul style="list-style-type: none"> Combined panel of 950 credentialed MPRs that are in active practice and eligible to perform DWC IMRs. Almost half of these MPRs possess existing DWC IMR experience and can serve as mentors for the new California-licensed MPRs Our Recruiting Department has launched a recruiting initiative to ensure we have sufficient California-licensed reviewers in all ABMS specialties and subspecialties, as well as reviewers for emerging new technologies 	<ul style="list-style-type: none"> Number and Type of Reviewers Appeal and Review of Remanded Cases Confidentiality of Records and Information Quality Assurance (QA)

Exhibit 4-2: Potential Problems Risks (continued). This table describes potential theoretical or practical problems associated with the operation of larger IMRs and our specific strategies to mitigate these problems.

4.1 Conduct IMR

RFP Section A.a (1-14), Pages 3-4

Exhibit 4.1-1: Conduct IMR provides a detailed overview of how we will conduct IMRs pursuant to DIR/DWC requirements delineated in RFP Section A.a(1-14).

IMR Requirements	MAXIMUS Federal Approach
<ul style="list-style-type: none"> Establish and provide sufficient administrative facilities and staff, organizational policies and procedures, information technology capacity, and available qualified physician reviewers free from conflicts of interest as set forth in Section (B) "Minimum Qualifications for Proposers" below, and to provide timely, complete, and professional case analyses and determinations as described in Labor Code sections 4610.5 and 4610.6, and 8 C.C.R. sections 9792.10.1 et seq. 	<ul style="list-style-type: none"> Utilize our existing secure Folsom, California office and staff to manage the DIR/DWC IMR Project. Utilize <i>entellitrak</i> and supporting suite of tools to process, monitor, and report on DIR/DWC IMRs. Utilize our existing panel of 950 California-licensed, board-certified MPRs in active practice. MAXIMUS Federal is completely conflict free and our reviewers undergo a rigorous conflict of interest assessment prior to case assignment. As part of their final determination each reviewer must attest to the fact that they are conflict free (See <i>Section 6.2.14: Freedom from Conflicts of Interest</i> for additional information).
<ul style="list-style-type: none"> Recruit and verify credentials of physician reviewers 	<ul style="list-style-type: none"> Our Recruiting Department has launched an ongoing recruiting initiative to increase our combined panel of more than 950 California-licensed MPRs. We have identified more than 80 new reviewer candidates in our application and credentialing pipeline. Please see <i>Section 4.4.6: Recruiting California Licensed MPRs</i> for additional information about our recruiting process. The MAXIMUS Federal credentialing program is extremely rigorous, and we are confident it exceeds the standards mandated by DIR/DWC and the relevant legislation. Our standards surpass the combined requirements of the NCQA and URAC. Please see <i>Section 4.4.12: Credentialing</i> for an overview of our credentialing program.

Exhibit 4.1-1: Conduct IMR. This table provides a detailed overview of how we will conduct IMRs pursuant to DIR/DWC requirements delineated in RFP Section A.a(1-14).

Use or disclosure of data contained on this sheet is subject to the restrictions on the title page of this proposal

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IMR Requirements	MAXIMUS Federal Approach
<ul style="list-style-type: none"> Perform conflicts of interest checks for physician reviewers 	<ul style="list-style-type: none"> Through a reviewer and staff conflict of interest process we are able to avoid actual and apparent conflicts via a rigorous screening of every IMR case file throughout the IMR process. The first conflict of interest assessment occurs during case receipt, another occurs once a reviewer has been selected, and the final assessment is done by the reviewer once all the case files have been received. At the end of the review process the MPR is required to sign an attestation that they are conflict free, which is included with the final decision. Please see <i>Section 6.2.14: Freedom from Conflicts of Interest</i> for additional information.
<ul style="list-style-type: none"> Disclose financial interests of its employees 	<ul style="list-style-type: none"> MAXIMUS Federal currently does not employ staff with financial interests as defined by DIR/DWC and the pertinent regulations.
<ul style="list-style-type: none"> Accept IMR applications via mail, fax, or online submission 	<ul style="list-style-type: none"> MAXIMUS Federal currently accepts IMR applications via mail and fax at our Folsom, California Mailroom, and online submissions through <i>entellitrak</i>.
<ul style="list-style-type: none"> Conduct the initial review of IMR applications for eligibility under guidelines determined by the DIR/DWC 	<ul style="list-style-type: none"> Our Preliminary Review team is comprised of Appeal Officers dedicated to performing eligibility review for IMR applications pursuant to DIR/DWC guidelines. Please see <i>Section 3: Overview</i> for additional information about our preliminary review process.
<ul style="list-style-type: none"> Notify the parties of IMR assignments and request mandatory information in a timely manner 	<ul style="list-style-type: none"> Our Case Assessment Team is comprised of Appeal Officers responsible for notifying the parties of IMR assignments and requesting mandatory information from the Claims Administrator and other parties as necessary. Please see <i>Section 3: Overview</i> for additional information about our case assessment process.
<ul style="list-style-type: none"> Manage the processing and drafting of reviews and the revision of written determinations 	<ul style="list-style-type: none"> Our Case Closing Team is comprised of Appeal Officers responsible for processing final determination letters and revising written determinations as applicable. Our MPRs are responsible for drafting reviews. Please see <i>Section 3: Overview</i> for additional information about these case-related actions.
<ul style="list-style-type: none"> Ensure the confidentiality of medical records and other data 	<ul style="list-style-type: none"> As a provider of California IMR services for the past 12 years we have established formal and exhaustive policies and procedures designed to protect confidentiality of medical records and other case-related data. These measures meet the requirements of URAC and applicable confidentiality and privacy protection laws, statutes, and regulations, including Labor Code 9792.10.5 (d). Please see <i>Section 4.4.10: Confidentiality of Records and Information</i> for additional information about these measures.
<ul style="list-style-type: none"> Have in place written policies and procedures to allow timely and effective referral of cases to qualified reviewers 	<ul style="list-style-type: none"> Please see <i>Appendix B: Case Referral Policies and Procedures</i> feature our Panel Scheduling Outgoing Cases document, which is designed to ensure qualified MPRs are assigned to IMRs. Please see <i>Section 3: Overview</i> for a detailed discussion of our case referral process.

Exhibit 4.1-1: Conduct IMR (continued). This table provides a detailed overview of how we will conduct IMRs pursuant to DIR/DWC requirements delineated in RFP Section A.a(1-14).

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IMR Requirements	MAXIMUS Federal Approach
<ul style="list-style-type: none"> Ensure that at all times it will have sufficient numbers of reviewers in a sufficient range of medical specialty available to satisfy the review time frames set forth in this RFP 	<ul style="list-style-type: none"> MAXIMUS Federal can offer DIR/DWC more than 950 California-licensed reviewers in active practice. Our MPR Panel represents every ABMS Specialty/Subspecialty. We also have an additional 80 qualified reviewer candidates in our application and credentialing pipeline. Please see <i>Section 4.4.6: Recruiting California Licensed MPRs</i> for additional information about our recruiting process.
<ul style="list-style-type: none"> Assign cases to reviewers who are matched by specialty to the medical issue(s) being considered in IMR applications and are free of conflicting interests in any parties to the case or their agents or representatives 	<ul style="list-style-type: none"> The scope and breadth of our MPR panel allows us to easily assign cases to reviewers who are matched by the same or similar medical issue considered in the IMR applications. Please see <i>Section 3: Overview</i> for a detailed discussion of our reviewer matching process.
<ul style="list-style-type: none"> Have in place protocols for providing appropriate training to reviewers in the proper methods of preparing IMR determinations using evidence-based medicine and according to the requirements of Labor Code section 4610.5(c)(2). Training protocols and documentation of training for reviewers shall be provided to DIR/DWC annually unless there are changes. 	<ul style="list-style-type: none"> Please see <i>Section 5: Management and Staffing</i> for a detailed discussion of MPR training protocols. All MPRs must successfully complete this training in order to perform IMRs on behalf of this Project. Our training protocols and documentation of MPR training will be provided to DIR/DWC annually unless there are changes.
<ul style="list-style-type: none"> Provide documentation of Quality Assurance/Quality Control (QA/QC) procedures to ensure that high-quality medical necessity determinations are made by reviewers. 	<ul style="list-style-type: none"> Please see <i>Section 4.4.11: Quality Assurance</i> for an overview of our QA/QC procedures designed to ensure that our MPRs create high-quality medical necessity determinations. Please see <i>Section 3: Overview</i> for a detailed discussion of our audit process of all final decision letters.

Exhibit 4.1-1: Conduct IMR (continued). This table provides a detailed overview of how we will conduct IMRs pursuant to DIR/DWC requirements delineated in RFP Section A.a(1-14).

4.2 Case Workflow Tracking System

RFP Section A.b (1-14), Pages 4-6; A14 (a-d), Page 13

The DWC requires a case workflow tracking system that meets the needs of the IMR program, offers a stable, low-risk solution that minimizes any interruption of services, and is responsive to your evolving needs.



Our case workflow tracking system, a uniquely customized version of the widely used commercial case management system *entellitrak*, is built and fully operational at the current time and will continue to be operational on January 1, 2015. The *entellitrak* system, created by MicroPact, is used by dozens of federal agencies including the Department of Labor, the General Services Administration, and the Internal Revenue Service.

As demonstrated by recent headlines regarding system implementation challenges, implementing a new system is sometimes a difficult and time-intensive process. We present the low-risk alternative of building on our proven infrastructure while diligently working toward constantly improving our service delivery. Both DWC and MAXIMUS Federal are fully committed to continuous improvement, particularly were it concerns critical project systems. Over the last few months, MAXIMUS Federal has begun a challenging yet rewarding process of working closely with DWC management to steadily improve the user satisfaction of our systems without compromising the continued effective workflow.

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We continuously improve and upgrade the system through regular system releases, including upgrades first suggested by DWC staff members. Significantly, before we reach January 1, 2015, improvements to our system will include additional online application functionality, the integration of our Expert Gateway tool, and continuing improvements to our customized version of *entellittrak*. These continuous updates are made possible as *entellittrak* is based on an open architecture platform developed using the common Java programming language.

DWC staff will continue to have access to *entellittrak* at all times with consideration to the planned and unplanned outage allowances described in this RFP and in *Section 4.2.9: System Availability* of our response. The *entellittrak* system is complimented by additional essential components of the overall case tracking solution. These components include a MAXIMUS Federal document management solution for scanning received case documentation to enable digital uploading to *entellittrak*; our HIPAA-compliant secure file transfer protocol (sFTP) tool MOVE-IT; our database of expert reviewer qualifications and credentials; our pending Expert Gateway; a new advanced reporting solution; and other basic office systems.

We also offer DWC our IMR application system currently in development. This web-based addition to the *entellittrak* system allows injured workers to file their claims electronically. The information from these forms is incorporated as an electronic file to the *entellittrak* system to create a pending case. For the injured worker, this is the only step they need to take to initiate their review request. This aligns the IMR Program with many common commercial applications that workers use every day from the comfort of their homes.

We also propose an additional reporting interface, our advanced business intelligence, and reporting platform, MAXDat. This system component will allow even greater flexibility to accurately assess the status of cases and generate reports at any given time. MAXDat is also a business intelligence tool that provides complex analysis of business process workflows and informs process improvement initiatives. In 2011, the MAXDat team was awarded the Gartner Business Process Management (BPM) Excellence Award for their BPM success. These same principles will be used to implement the MAXDat solution for the IMR Project, although the IMR solution will focus on transparency and the needs of DWC. More information regarding our proposed reporting solution is found in *subsection 4.2.8: Case Tracking Reports*.

In addition to the caseload tracking system and MAXDat, MAXIMUS Federal also intends to launch our proven Expert Gateway functionality well in advance of the January 1st, 2015 launch date for this refreshed contract. Our Expert Gateway system utilizes a relational database to record and store review qualifications, credentials, specialties, and current review assignments. The Expert Gateway portal provides a more efficient method for matching IMR requests with appropriately certified reviewers while streamlining scheduling, assignment, and completion of medical reviews by remote reviewers.

The Gateway securely delivers medical documentation and related review materials to the assigned reviewers, providing immediate access to all the information required for informed and accurate medical reviews. This proven system currently supports more than 80,000 clinical reviews each month for our national projects.

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Together, these system elements provide a solid, sophisticated solution for California's growing IMR program. *Exhibit 4.2-1: IMR System Connections* demonstrates the parties and connections that compose the IMR system environment.

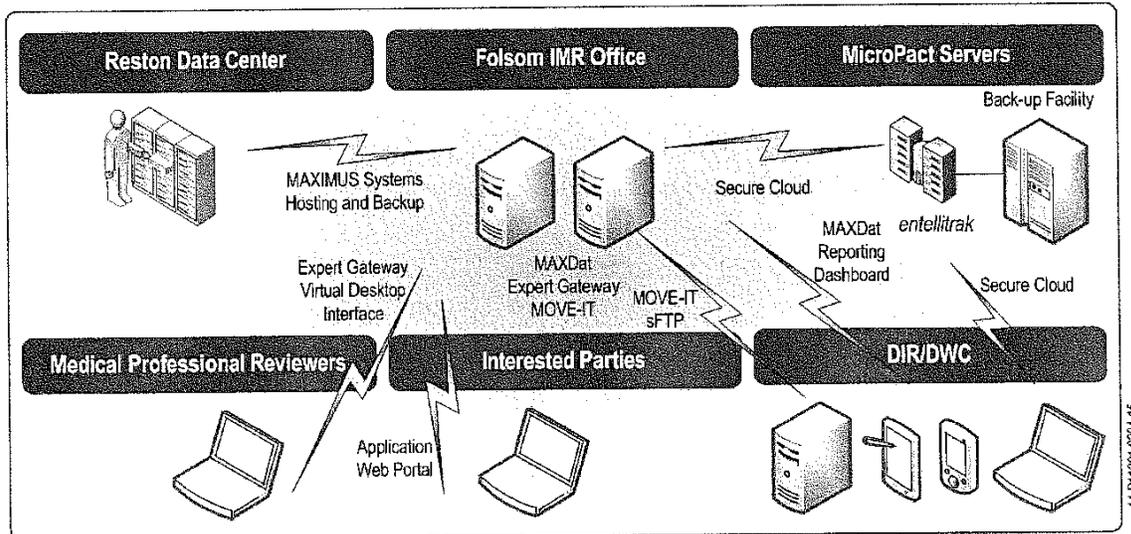


Exhibit 4.2-1: IMR System Connections. MAXIMUS Federal provides the solid infrastructure and connections to support increasing volumes of IMR work as and provide continuous system availability and advanced security.

Additional information on system security and availability is provided in the remainder of this section.

4.2.1 Case WorkFlow Tracking

The *entellitrak* system currently provides the functionality for DWC staff to update cases with eligibility determinations and other information as needed. DWC staff members have an assigned queue of potentially ineligible IMR cases ready for final eligibility determination, but may also search for specific cases to update them as required. The role-based security feature of the system provides the necessary confidentiality data protections to restrict case information to that permitted and required based on the type of user. For example, DWC staff members may see all information on a case with the exception of the current reviewer assigned to perform an IMR review.

We currently use *entellitrak* to manage workflow, routing, and assignment of cases throughout the lifecycle of a case. The system is equipped to facilitate the case lifecycle through discrete stages including intake, preliminary review, DWC eligibility review, acknowledgement, awaiting documentation or information, assignment to a medical reviewer, quality review of the received medical review, and appropriate submission. The system also features an expedited work queue to help ensure that expedited cases are handled with appropriate urgency, and a duplicate case feature to facilitate confirmation that there are no pending duplicate requests when a new review request is added to the system.

The *entellitrak* system tracks the receipt of applications by date as well as the applicable dates for changes in case status, such as when acknowledgement letters are sent and when cases are assigned for medical review. In addition, our document scanning system tracks the date that documents were scanned, and *entellitrak* includes the date the documents were added to the case tracking system.

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Exhibit 4.2.1-1: entellitrak Data Entry Screen demonstrates a view within the data entry system screen used by the Data Entry Specialist to enter a new application. The screen images in this section are complete with an example of a possible future frame design based on the DWC website and in alignment with the requirements of the RFP.

The screenshot displays a web-based data entry form for the State of California Department of Industrial Relations. The form is divided into two main sections: 'Medical Provider Information' and 'Employer & Claims Administrator Information'. The 'Medical Provider Information' section includes fields for Organization Name (Provider of Sacramento), Provider Specialty (Orthopedic Surgery), Provider Address 1 (123 Main St), Provider City (Sacramento), Provider State (California), Provider Zip Code (95660), Provider Phone (555-555-5555), and Provider Fax (555-555-5555). The 'Employer & Claims Administrator Information' section includes fields for Employer Name (Busy People Inc.), Claims Administrator Company Name (Claims Administration), Claims Examiner Prefix, Claims Examiner First Name (John), Claims Examiner Middle Initial (P), Claims Examiner Last Name (Doe), Claims Examiner Suffix, Claims Administrator Address 1 (1 Circle Drive), Claims Administrator City (Los Angeles), Claims Administrator State (California), Claims Administrator Zip Code (90044), Claims Administrator Phone (555-555-5555), Claims Administrator Fax (555-555-5555), Primary Diagnosis (xxxx), and Treatment Requested (MRI lumbar spine). There are also two radio button questions: 'Is the Claims Administrator Disputing Liability for the Requested Medical Treatment Besides the Question of Medical Necessity?' and 'IMR Form Signed?'. The form includes a 'Save' button at the bottom.

Exhibit 4.2.1-1: entellitrak Data Entry Screen.

The case tracking system also tracks the appropriate work queue assignment and whether a task in the workflow is unclaimed, in-process, or completed. For example, the system notes when an application for

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review is sent to a DWC staff member for an eligibility determination. If determined eligible, the system moves the case to the next step where it is evaluated for necessary documentation.

Exhibit 4.2.1-2: entellitrak Work Queue demonstrates a DWC view of cases to be reviewed for eligibility.

		DWL Case number	DWL Received Date	DWL Status	DWL Determination Review Issue
Assign to			2013-04-19	Pending Policy Question Response	Late
Assign to			2013-04-25	Pending Policy Question Response	Emp. Info.
Assign to			2013-04-24	Pending Policy Question Response	
Assign to			2013-04-24	Pending Policy Question Response	
Assign to			2013-04-24	Pending Policy Question Response	Emp. Info., LWD
Assign to			2013-04-24	Pending Policy Question Response	Emp. Info., LWD
Assign to			2013-04-24	Pending Policy Question Response	Emp. Info.
Assign to			2013-04-24	Pending Policy Question Response	Emp. Info.
Assign to			2013-04-24	Pending Policy Question Response	Emp. Info.
Assign to			2013-04-24	Pending Policy Question Response	Emp. Info.

Exhibit 4.2.1-2: entellitrak Work Queue.

All notices, acknowledgements, and requests to the reviewer are tracked in the system. For cases ready for review, the system automatically creates a referral notice to the selected reviewer to begin work. This reviewer is selected based on the process described in *Section 4.4.2: Assignment of Cases for Independent Medical Review* and this assignment is noted in the case tracking system. Our database of reviewers includes all information on the qualifications of reviewers and their current certification status.

During the lifecycle of a case, the system always lists the current case status. Once the review is complete, the system lists the outcome of the review. The system also tracks if a case has been remanded back to the project from the Workers' Compensation Appeals Board (WCAB) and documents the lifecycle of the new review provided by a different reviewer. We understand that DWC will identify the naming convention.

4.2.2 Redacted Final Determination Forms

In order to ensure public transparency while protecting personally identifiable information (PII) and personal health information (PHI), MAXIMUS proposes providing a final determination redacted case summary for each case that includes only fields that do not contain PII/PHI. The case summary will include outcomes as plain text, rather than codes, so that it will be assessable to the public, and we will include searchable terms as specified by DWC. These reports will be suitable for posting to the DWC website. An example of this form is provided in *Appendix L: Sample Redacted Case Summary Form*.

4.2.3 DWC System Access

Intuitive DWC system access is essential to a working case management process. We understand that DWC will identify the computer hardware and terminals for appropriate staff as well as establish and maintain secure lines of transmission between the Contractor and DWC. MAXIMUS Federal will provide

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access to the *entellitrak* system and associated MAXIMUS Federal system components, such as our MAXDat reporting dashboard over a web-based connection for DWC identified staff members.

4.2.4 Bulk Data Transmission

MAXIMUS Federal currently uses a proven, secure file transfer protocol (sFTP) tool, MOVE-IT, to transfer data from the *entellitrak* system to DWC. This tool is used on our projects through the country as a HIPAA-compliant solution that works across various system types. This secure, cost-effective solution will allow bulk transmission of data from the case workflow tracking system and associated document management components to DWC.

4.2.5 Web-Interface Design

The background presented when accessing the case workflow tracking system through the Internet and the DWC interface will be customized to use the same CSS style-sheet elements, logos, images, and matching cosmetic elements as required, presenting a uniform appearance with the Department of Industrial Relations (DIR) website. This background will be designed to blend seamlessly, from the user's viewpoint, into the viewable components of the case workflow tracking system and should not impact or interfere with the designed functionality of the system itself. The background page layout will work within HTML framework definitions defined by the DIR Web templates. We will employ URL domain masking as allowed by state and federal legal provisions and facilitate required cooperation with state domain administrator.

The *entellitrak* system is a web-based system and is 508-compliant. The web-based interface for the workflow tracking system can be viewed using a variety of browsers including Chrome, Firefox, Safari, Internet Explorer, Android Browser, and Mobile Safari. Although viewed through all of these potential browsers, full functionality may be limited by the company offering the browser and the settings determined by the local browser administrator. For example, Internet Explorer version 7 is no longer supported by Microsoft. This means that errors may occur that are outside of the control of the contractor or DIR personnel when using this browser.

In addition to the case workflow tracking system itself, MAXIMUS Federal offers a unique reporting dashboard as part of our respected MAXDat business intelligence solution. MAXDat provides full access to a wide variety of system data points, such as the number of cases awaiting assignment. MAXDat is available on all browsers and features a mobile-compatible version. MAXDat is the best solution for quickly viewing data for a snapshot on the current status of the IMR Project. *Exhibit 4.2.5-1: MAXDat MicroStrategy Mobile Interface* provides a visual representation of the types of display capabilities inherent with the MAXDat solution.

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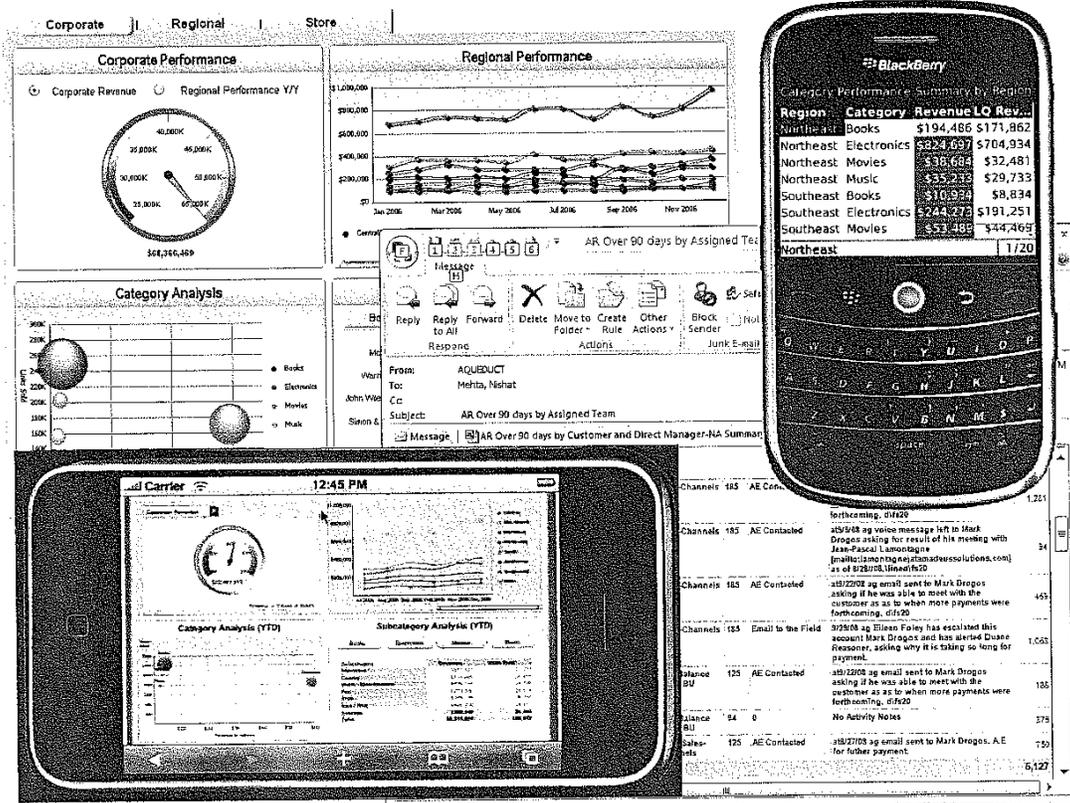


Exhibit 4.2.5-1: MAXDat MicroStrategy Mobile Interface. The mobile interface provides the DWC managers with the right information, in the best form, with minimal user effort.

MAXDat is discussed in more detail in Section 4.2.8: Case Tracking Reports.

4.2.6 System Load Time and Accessibility

All public-facing websites controlled by MAXIMUS Federal meet government web accessibility standards. Our websites are 508-compliant, and when providing important health educational materials to the public, we often review our material for readability by low-literacy audiences and utilize internal translation services as necessary. The *entellitrak* system is also built with government accessibility requirements in mind and is 508-compliant.

The page load time in the system will never be more than 7 seconds based on factors within our control, with the exception of complex queries, reports, and downloads. We cannot control factors such as the Internet speed of an individual accessing the system at home, or user system security or browser settings which may slow or block any website. Nonetheless, *entellitrak* internet connections incorporate multiple high-speed lines including DS3 and 100Mbps circuits. MicroPact, who hosts *entellitrak*, uses peering arrangements with their upstream carriers to help validate that no connection is over-utilized.

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4.2.7 System Security

The *entellitrak* system is federally accredited and secure with certification and accreditation based on NIST 800-53 (NIST Risk Management Framework (Categorize – Select – Implement – Assess – Authorize – Monitor), DIACAP and DCID 6/3 standards. The system uses role-based security that assigns a profile to all users, allowing that user to read, edit, add, or delete case elements based on their level of access. We use this important customization to limit access to PHI in alignment with HIPAA regulations. Our review staff does not use the *entellitrak* system directly, but will soon use our integrated Expert Gateway solution for seamless scheduling and submission of reviews once they authenticate over the secure portal. Reviewers only have access to case information distributed for their review during the review time period.

All software components of the MicroPact data center, where *entellitrak* is hosted, are configured to DISA Security Technical Implementation Guides (STIGs). All hosting systems are configured to meet the auditing requirements of FIPS-199 Moderate, MAC II/III, and PL2/PL3 systems. MicroPact guards *entellitrak* with Trend Micro™ enterprise protection including antivirus and patch management modules. MicroPact utilizes HP Fortify WebInspect Software to perform routine Web Vulnerability Scans against applications residing in both our Production and Development Environments. Production level scans are performed to maintain compliance with federal standards such as NIST 800-53. MicroPact also protects the physical site where the servers are stored with many features, including but not limited to motion detectors, an alarm system, a full security camera system with searchable archival footage, full redundant environmental monitoring, redundant HVAC systems, a clean agent fire suppression system, and multiple redundant telecommunications including 100 Mbps fiber-optic connection.

The Expert Gateway, a MAXIMUS Federal-developed system component, employs a secure Virtual Desktop Interface (VMWare View) that protects the confidentiality of the records and clinical opinion offered in response to an appeal request. The end user receives an email notification of an assignment and follows a link to a virtual session wherein he/she has access to the records for a case. The records may be reviewed online, but may not be printed, downloaded, saved to any external device, or even captured through a screen print. The MPR views the records and completes a web form where they address the specific issues raised in the appeal. No shred of information on the case is saved on the local device used by the reviewer, but the resulting clinical review is transferred to *entellitrak* for immediate use by the Appeals Officer constructing a decision letter.

MAXIMUS Federal also uses Federal Information Management Security Act and NIST 800-53 standards for overall monitoring of all system components integrated with *entellitrak*. Our approach conforms to Federal System Lifecycle Framework and will prepare us to cooperate with any system security audits. A continuous monitoring program is established to collect information in accordance with pre-established metrics, utilizing information readily available in part through implemented NIST 800-53 security controls.

For more information on operational project security and privacy procedures, including physical security, please see *Section 4.4.10. Confidentiality of Records and Information*.

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4.2.8 Case Tracking Reports

RFP Section A.b (8) Pages 5; A.5.f, page 9

Reporting is one of the most important elements of the relationship between MAXIMUS Federal and our clients. DWC needs full transparency into the daily operations of the IMR project and we provide that transparency through multiple avenues, including both self-service and responsive assistance from MAXIMUS Federal project management. In addition to *entellitrak* system access, MAXIMUS Federal will continue to provide weekly, monthly, quarterly, and annual operational reports to DWC. We understand that the requirements include the reporting elements listed in RFP Appendix B, C, and D, as well as the required case data elements provided as part of the submitted determination letters listed in Appendix A.

MAXIMUS Federal is also prepared to provide the following reports as listed in *RFP Section A.b.(8)*:

- i. Application Intake – to include all IMR requests and their operational process status
- ii. In Flight Cases – to include all cases in process
- iii. Workflow Reporting – to include individual and system process queues
- iv. Eligibility Decision - to include all cases for which eligibility has been determined
- v. Rejection Decision - to include all cases for which eligibility has been rejected
- vi. IMR Decision – to include all cases for which IMR decisions have been made

We understand and agree that these reports may not be sufficient to fully understand the complexities of the case tracking workflow. In the following sections, we describe how we will work with DWC to help ensure that they have all the necessary information to confidently assess the status of the project at all times. We meet the DWC's need for soft-copy, sortable reports with in innovative new solution described below.

Introducing the MAXDat Reporting Platform

To address DWC needs, our solution includes the latest generation of our MAXDat Reporting platform. This is the same platform used for some of our large health care call center eligibility support projects in Texas, New York, Colorado, and California. Similar to medical reviews, the system routinely tracks healthcare eligibility applications through a workflow process that cumulates in state review and decision.

We partner with the business intelligence industry leader MicroStrategy to offer user-friendly information dashboards and automated alerts. These dashboards allow DWC staff members to immediately access case tracking information from the reporting database over the Web through any Web browser. The user experience is intuitive and the tool buttons are immediately familiar to individuals with experience using Microsoft's Office applications.

Both MAXIMUS Federal and DWC staff will have web-based access to our reporting and data visualization tools in MAXDat, which allow users with little or no system experience to generate analytics and refine their reporting needs "on-the-fly," 24x7. Additional analysis can be generated as tabular, statistical, graphical, and online analytical processing (OLAP) style reporting. OLAP style reporting consists of three operations - aggregating data for trends (drill-up); being able to examine the details (drill-down); and extracting specific sets of data and then viewing the data from various

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viewpoints. As requested in the RFP, the information available in MAXDat will include available *entellitrak* system information on the status of cases and reviews such as the step in the process, if they have been assigned for IMR review, and the dates accepted and completed. The system will not include information on individual reviewers assigned.

MAXDat will also serve as a portal for receiving regularly scheduled reports. Designated DWC staff may subscribe to email alerts to inform them whenever new reports are available. In addition, the DWC will be able to re-print weekly, monthly, quarterly, and annually-submitted reports through this interface.

Exhibit 4.2.8-1: Sample MAXDat Dashboard provides a visual approximation of how case tracking information will be displayed for both MAXIMUS Federal and DWC users.

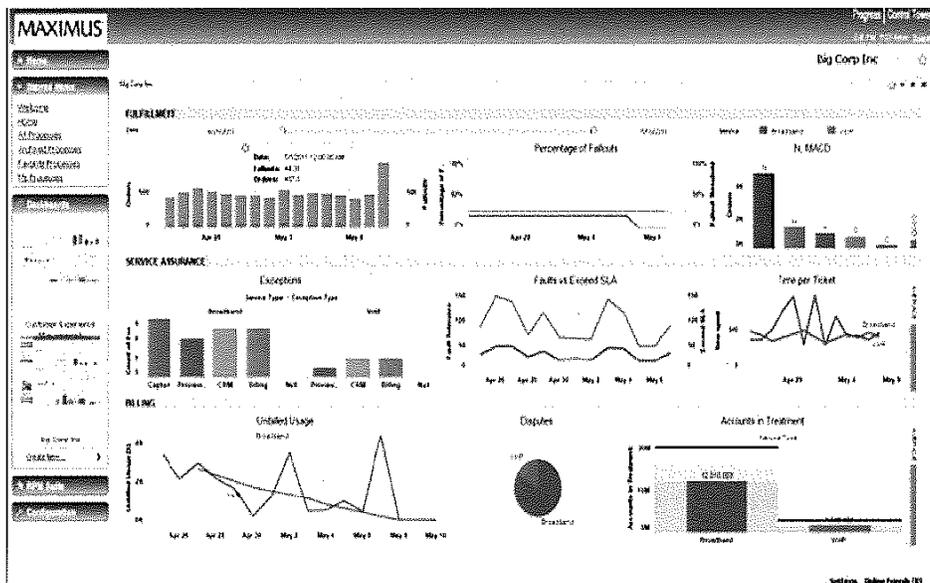


Exhibit 4.2.8-1: Sample MAXDat Dashboard. DWC users can display data in graphs and charts including the data elements listed in Appendix A.

As mentioned previously, the MAXDat dashboard is compatible with mobile devices, allowing DWC staff the ability to access IMR process data at on-the-go. *Exhibit 4.2.5-1: MAXDat MicroStrategy Mobile Interface*, earlier in this section, provides a visual representation of the types of display capabilities inherent with the MAXDat solution.

MAXIMUS Federal Nurse Supervisors and the Project Manager also use MAXDat to monitor the status of tasks in process and set alerts for tasks that are at risk of exceeding allocated timeframes. This is in addition to the alerts *entellitrak* issues for the project operations staff. Having these alerts in MAXDat allows the managers and DWC staff members to see an easy-to-read snapshot of all cases in process at a moment in time. This important view shows only cases that are not yet complete and is used to assist in the allocation and management of Appeals Officer team assignments.

Exhibit 4.2.8-2: Example of Potential Status Snapshot Dashboard shows an example of this type of dashboard but the actual data elements, time period, and layout will be determined by collaboration between the Director of Reporting and the DWC leadership.

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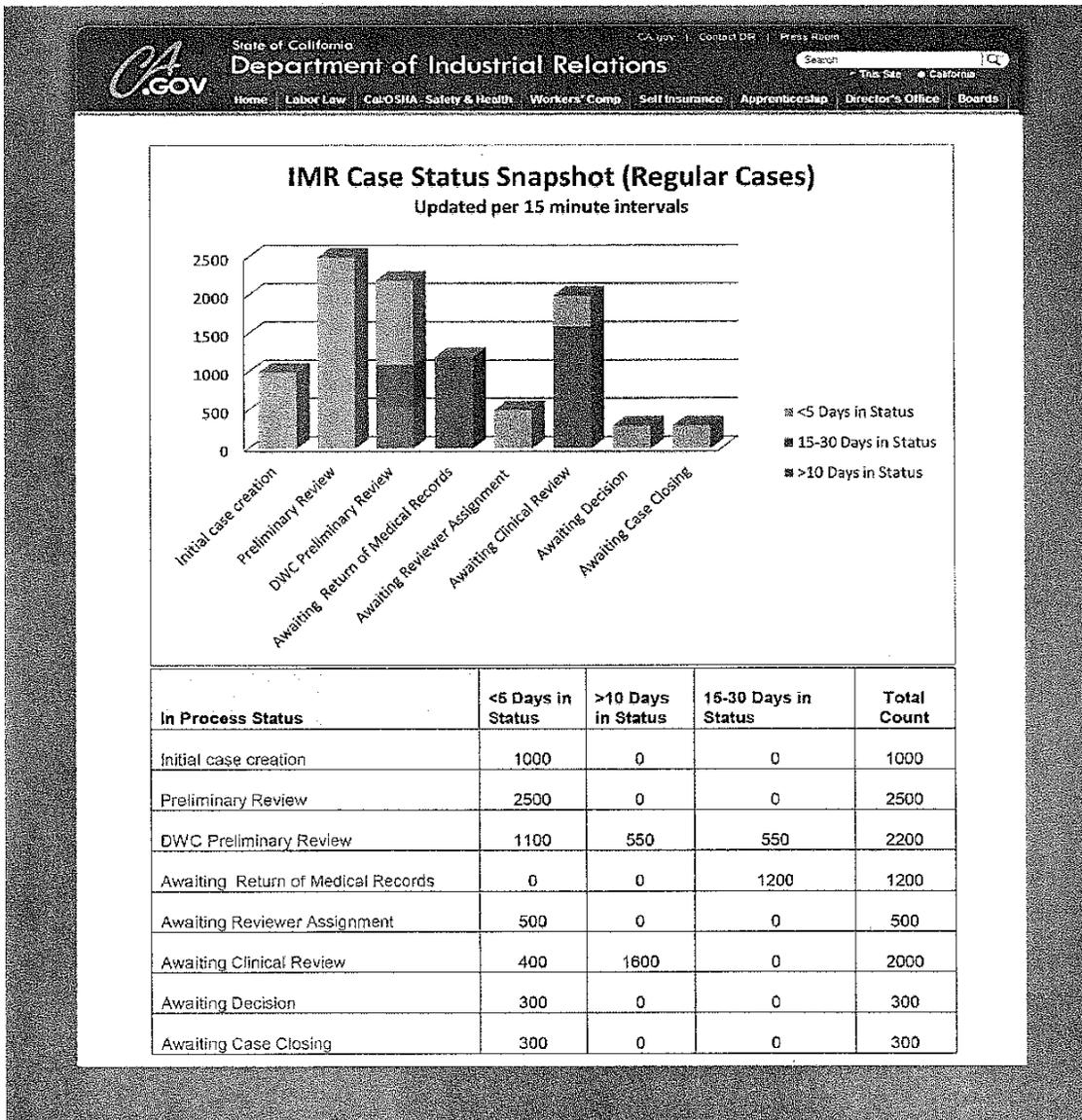


Exhibit 4.2.8-2: Example of Potential Status Snapshot Dashboard. MAXIMUS Federal provides DWC access to the same case tracking status data of the project used by the project supervisors to manage work.

Advanced Business Intelligence

MAXDat is not only a reporting solution, but also a powerful business intelligence and analysis tool. The MAXDat system is designed to be process-centric; data points are based on the workflow of the project rather than simply outcomes. This is combined with specialized technology that incorporates case tracking process metrics as well as appeal activities and statistics. By examining the correlation between business events and the context in which they occur, we achieve the complete, accurate, and immediate situational awareness necessary to reveal opportunities, threats, or inefficiencies and respond accordingly. The rich reporting environment can also be used to answer questions such as *What really happened in the past? Why did it happen? What is likely to happen in the future?*

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Exhibit 4.2.8-3: Business Intelligence Functions demonstrates the different functional capabilities of MAXDat.

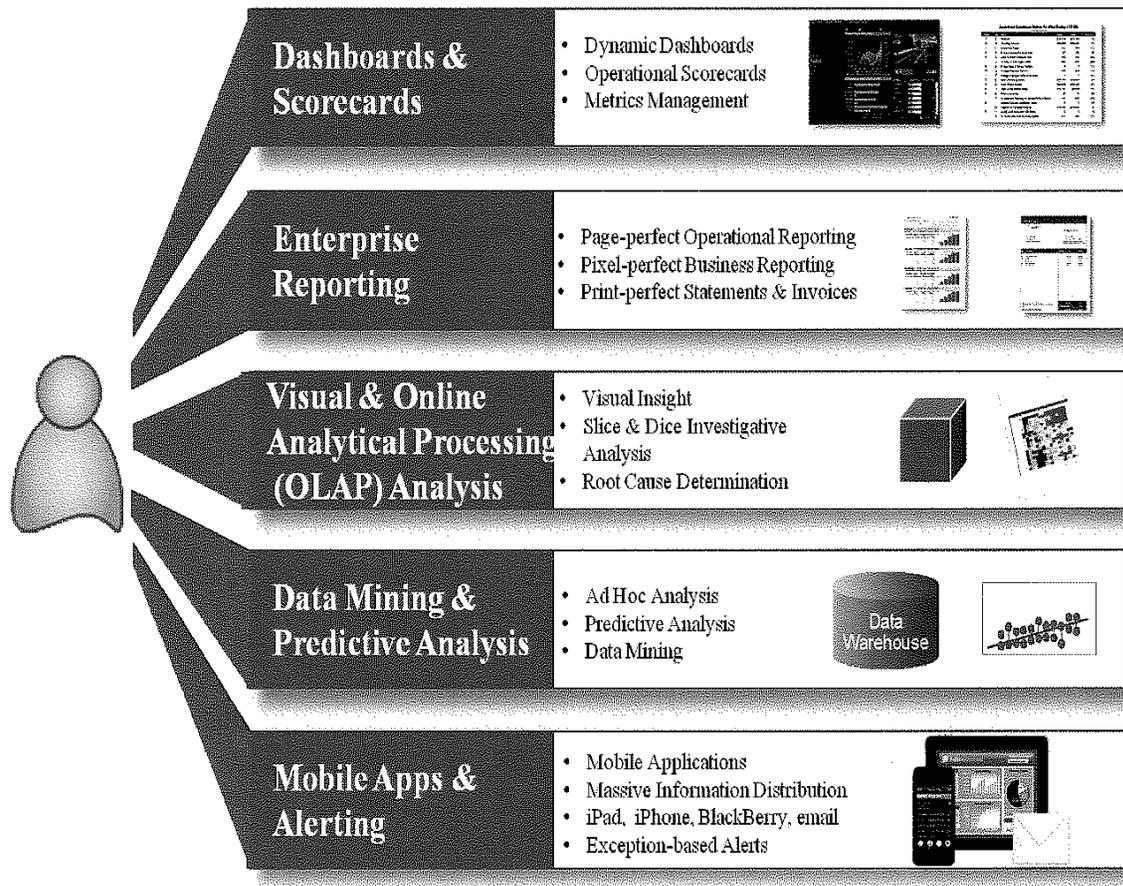


Exhibit 4.2.8-3: Business Intelligence Functions. MAXDat delivers five styles of data analytics and business intelligence.

New Reports and Report Modifications

With the introduction of the MAXDat reporting dashboards the DWC can immediately self-generate most types of case tracking information necessary to meet the State's needs. The MAXIMUS Federal reporting specialist and Director of Reporting are always available to help create and analyze these reports; explain our weekly, monthly, quarterly, and annual reports; and assist with designing and producing new types of reports using the existing data available from the system. We not only work with the DWC to modify reporting specifications for all necessary reports, but we may also proactively suggest additional reporting improvements. As mentioned previously, the State gains true visibility into the operational status of pending and completed reviews through the use of our proven MAXDat reporting solution.

In addition, MAXIMUS Federal brings the expertise of Frank Neuhauser, an expert public policy consultant who has previously assisted DWC with the UC DATA project where he assessed the data resources and needs for both administration and research purposes. Mr. Neuhauser is currently the Executive Director at the Center for the Study of Social Insurance. He will assist the IMR Project by

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working with IMR Project Management and DWC to identify their data and reporting needs and recommend additional reports as needed.

Reports Planning and Reports Specification Process

For new reports requiring information not previously collected, as requested by DWC, MAXIMUS Federal uses a formal reporting specification and change management process to make certain that all the changes requested will meet the needs of DWC and analyzes the impact of the changes on current operations. For example, if the report requires a change to data entry procedures, we analyze the impact of this change and include this information in our meetings with DWC.

Once it is determined that the new report will proceed, the reporting specification process includes a period of template creation, review, and testing prior to official inclusion in the set of regularly submitted reports. Our Director of Reporting, James Phillips, along with our expert consultant Frank Neuhauser, will work closely with DWC to create additional reporting templates for meet the needs of the IMR Project. These templates will follow a review process including submission to DWC, revision, and final approval of all parties.

4.2.9 System Availability

RFP Section A.b (14) Pages 5; 14 (a-d), Page 13

We understand that DWC requires access to *entellitrak* from 7AM – 7PM PST, Monday through Saturday at a minimum, except for planned outages with advance notice as described in *RFP Section A.b.14*. We also understand that the IMR application system must be available 24 hours per day, 7 days per week. If the *entellitrak* system is undergoing a planned outage, as with a periodic release of system upgrades, the information submitted through the IMR application will be stored temporarily as a secure data file until fully integrated into the system.

MicroPact, the developer and company hosting the *entellitrak* system, has a tailored Continuity of Operations (COOP) plan covering the *entellitrak* component of the IMR Project. MicroPact maintains both a primary and secondary processing center with replication between both sites. This allows the primary system to fail over to the secondary system in the event of a system outage without any loss of information. MicroPact currently hosts hardware and software for more than 200 government clients and the dedicated Cloud environment is compatible with several NIST-defined cloud computing service and deployment models. The company provides preventive maintenance for our unique version of *entellitrak*, such as providing virus scanning and automatic updating of virus definitions, validating that servers are kept up to date with the latest security patches, and reviewing event and error logs on the servers to facilitate optimal system performance. All server hardware and software are monitored 24 hours per day, 365 days per year.

MicroPact employs multiple upstream providers into the MicroPact data center utilizing a high-availability CISCO BGP4 multi-homed routing architecture to ensure continued system availability. MicroPact internet connections incorporate multiple high-speed lines including DS3 and 100Mbps circuits. MicroPact peering arrangements with their upstream carriers help validate that no connection is over-utilized and that MicroPact can increase circuit capacities in very short order. These technical allocations provide confidence that the *entellitrak* system will be available as required.

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MicroPact's servers maintain 24/7 availability except for scheduled downtimes. The servers will not shut down upon power failure due to a sophisticated power management system that includes the following features:

- Diesel generator with 24 hours of fuel backed by contract for 24-hour fuel delivery
- Enterprise Uninterruptable Power Supply (UPS)
- Redundant network providers with automatic switching in times of emergency

MicroPact has the ability to operate indefinitely during a power failure and maintains a one-week supply of fuel on site. MicroPact's data center air conditioning units are also powered by a backup power system and MicroPact employs a Power Engineer to help validate the reliability of power management, HVAC, and backup systems.

MAXIMUS Federal Disaster Recovery and Business Continuity Plan

The purpose of the MAXIMUS Federal Disaster Recovery and Business Continuity Plan (DR/BC Plan) is to provide procedures for continuation of necessary services in the event of a system outage or facility-related emergency. We will have in place a DR/BC Plan for the IMR Project.

Planned Outages

MAXIMUS Federal will notify DWC of any planned outages at least three working days in advance of the planned outage. These planned outages are scheduled with releases of upgrades and improvements to the program and as stated in this RFP, these planned outages are not calculated as part of the minimum system availability requirement. Each month, MAXIMUS Federal will submit the required report on case workflow system availability according to the calculation methodology described in the RFP. We understand that this is a percentage of the actual availability divided by the required minimum availability and that this is measured by the minute.

If the system availability falls below 99 percent for two consecutive months or falls below 95 percent in a single month, we agree to present DIR with a remediation plan detailing steps we will take to improve case workflow tracking system availability.

System Readiness Testing and Penalties

The MAXIMUS Federal case workflow tracking system, *entellitrak*, is already in place and performing the required functions for IMR Review. We understand that there are additional improvements to the current system required to meet all specifications in this Request for Proposals. These system improvements are already in various stages of development and are planned to be tested and in place prior to the January 1, 2015 deadline. We understand that there will be financial charges associated with a delay in user testing beyond this date as well as ongoing fees associated with the system availability percentage. We understand that these fees are not intended as a penalty and are in addition to any other rights or remedies the State has for unsatisfactory performance under the contract.

MAXIMUS Federal acknowledges the statements provided in the RFP Section 14 and re-printed below.

- (a) DWC will review the functionality of the system and report to Contractor in writing by January 31, 2015, if the requirements are not met. If Contractor does not implement system changes to correct the reported issues by July 1, 2015, Contractor shall make a payment in the amount of 20 percent of all fees charged to employers and claims administrators for independent medical reviews from July 1, 2015, to the date the system changes are implemented.

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(b) If the system is not ready for user acceptance testing by January 1, 2015, the dates specified in paragraph (a) shall be extended by the number of days from January 1, 2015, until Contractor notifies DWC that the system is ready for user acceptance testing, and Contractor shall make a payment of 40% of all fees charged employers and claims administrators arising from applications received by Contractor prior to the date Contractor notifies DWC that the system is ready for user acceptance testing.

(c) If the system availability percentage falls below 99% in two consecutive months, Contractor shall make a payment in the amount of 20 percent of all fees charged to employers and claims administrators in the most recent affected month and in any subsequent month that system availability continues to be below 99%.

(d) If the system availability percentage falls below 95% in any month, Contractor shall make a payment in the amount of 20 percent of all fees charged to employers and claims administrators in that month.

DWC shall notify a Contractor in writing of any payment due under this section. Contractor shall make the required payment within thirty days of receipt of the notice. These payments are not intended as a penalty, and they are in addition to any other rights or remedies the State has for unsatisfactory performance under the contract.

4.3 Technical Support and Administration

RFP Section A.c (1-4), Page 6

We have learned through our almost 40 year history of operating complex government programs, that placing an emphasis on open communication and close collaboration with our clients yields superior program results. We apply this same strategy of collaboration when establishing technical support and administration processes. Our focus is on efficiently providing our clients the support they require, as conveniently as possible. As the incumbent contractor on the IMR program we have in place an existing support infrastructure that includes a technical support line, notification protocols, training materials, system documentation, and system change processes.

Over the past 18 months we have continuously refined our technical support infrastructure through continued dialogue with the IMR management team. Our goal is to continue to improve our support of the IMR program. We consider our technical support infrastructure an important aspect of our service delivery approach and will work closely with DIR/DWC to implement incremental changes that help increase the value we provide to the project. The following sections include details on both the existing infrastructure in place and the support approach we will have established by the start of the new contract.

4.3.1 Case Tracking System Technical Support

RFP Section A.c.1, Page 6

The IMR program is currently supported by our toll-free support line. The support line is operated from our Folsom, California office and is available during normal business hours (Monday-Friday, 8 am – 5 pm PST, excluding California State Holidays). Callers are routed to the appropriate MAXIMUS Federal representative that is the designated individual for their subject matter. We also have a lead support manager responsible for receiving advanced topic calls that require significant effort for resolution. In the event of an after-hours call, we also offer callers the ability to leave a message, with the option to flag the message as urgent. Urgent messages will be followed up by an authorized MAXIMUS Federal representative during after-hours.

MAXIMUS Federal will notify the IMR team of any Severity 1 (outage) issues on a 24 hour per day, 7 day per week basis. We have an established Severity 1 protocol in place that will be followed by the designated MAXIMUS Federal point of contact. The protocol tells the emergency point of contact to immediately notify the appropriate DWC points of contact of the outage. When communicating with DWC we will also provide an estimate on the duration of the system outage. We recommend DWC

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consider testing the Severity 1 outage protocols on an annual basis to ensure the proper communication channels are followed. Our case workflow tracking system is hosted in a secure data center and is replicated at a secondary facility, minimizing the potential risk for system outages. While this is an immense asset of our system, it leads to infrequent use of the emergency protocols. Annual training would help reinforce that proper protocols are followed by MAXIMUS Federal and DWC staff in the event of an actual outage.

User account setup for our case workflow tracking system is administered through our toll-free support line available to all DWC personnel. We have found that central account administration helps ensure that new accounts are configured with access rights compliant with project policy. Centralized account creation also helps create a more secure environment and is one of the aspects incorporated into our security approach. The support line will create all accounts within one business day of the user administration service and/or change request.

4.3.2 Case Tracking User Training and Materials

RFP Section A.c.2 Page 6

Since the IMR program's inception we have conducted numerous "train-the-trainer" seminars both in person and by webinar. As indicated in section 4.2, Case Workflow Tracking System, we have a number of system enhancements planned before the new contract start date. Our training team will prepare training materials on all enhancements and deliver the training prior to the release date for all system enhancements. We will deliver the training either in person or by webinar depending on DWC's preference and the level of training required. Since we have already trained the primary DWC trainers the majority of our training will be focused on system enhancements and/or changes and not full system training. In addition to the periodic system enhancement training, we will also deliver annual refresher training to the DWC trainers and provide them with updated materials. This approach will allow us to keep the DWC trainers updated on key system enhancements as well as keep the overall training materials up to date.

Our training team will provide copies of all training materials in both hard-copy and electronic media. For system enhancement training we will deliver training and updated training materials a minimum of two weeks in advance of the planned system enhancement implementation. After we deliver the training materials we will have a team on stand-by available to answer any questions the DWC staff may have. We recognize that the majority of the questions will come during the two week period between training delivery and system enhancement implementation and will accommodate DWC by having our team ready to answer questions during that time period. After the delivery of all training materials we will meet with the DWC Trainers to update our training lessons learned and implement them into future training sessions.

Our training methodology includes the instructional design process beyond the industry standard ADDIE model from—Analysis, Design, Development, Implementation, and Evaluation—to Planning, Analysis, Design, Development, Implementation, Evaluation, and Lessons Learned. We recognize that the analysis phase is one of the most critical components of the ADDIE model and has a significant role in our training approach. To ensure we provide quality training products that elicit measurable workforce performance improvement, we work closely with our clients to understand their specific needs and desired learning outcomes.

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4.3.3 Case Workflow Tracking System Updates and Changes

RFP Section A.c.3, Page 6

We will deliver detailed system documentation at least four weeks prior to the implementation of any change to the case workflow tracking system. The system documentation will include a list of major features, any process changes, training requirements, and improvements that will be attained by the system release. If the system release will cause a change to any of the workflow processes we will prepare a Change Alert Document and deliver it to DWC along with the system documentation. The CAD template is included in *Appendix C*, and includes:

- Purpose of the CAD – define the purpose of the alert and what changes will be made to the associated process(es)
- Current Process – define the current process and what is being changed
- Change in Process – define the new process or new requirements and include screenshots

Two weeks prior to the implementation of a case workflow tracking system change we will deliver to DWC a system impact assessment that details the technical support requirements of the system release. The system impact assessment will include, but not be limited to, the following:

- URLs
- IP Addresses
- Supported Browsers

The system documentation that is provided to DWC will include both detailed system documentation and a non-technical summary of the upgrade. The non-technical summary will provide details of the upgrade in non-technical terms and include a summary of the impact of the upgrade on process workflows. We have incorporated the cost of reasonable future modifications into our per unit pricing rate. Reasonable future modifications will not be billed separately. For additional information please refer to our *Cost Proposal*.

4.3.4 Additional Functionality Requested

RFP Section A.c.4, Page 6

We recommend that an official change control process be established to review and approve all system enhancements. The change control process would be managed by a designated change control board. Our proposed change control board is included in *Exhibit 4.3.4-1: Change Control Board*. The change control board would consist of personnel from the DWC management team, DWC technology team, MAXIMUS Federal management team, and the MAXIMUS Federal technology leadership. The change control board would meet regularly to review proposed system enhancements. The board would evaluate the impact of proposed system enhancements and evaluate their overall impact on the IMR program.

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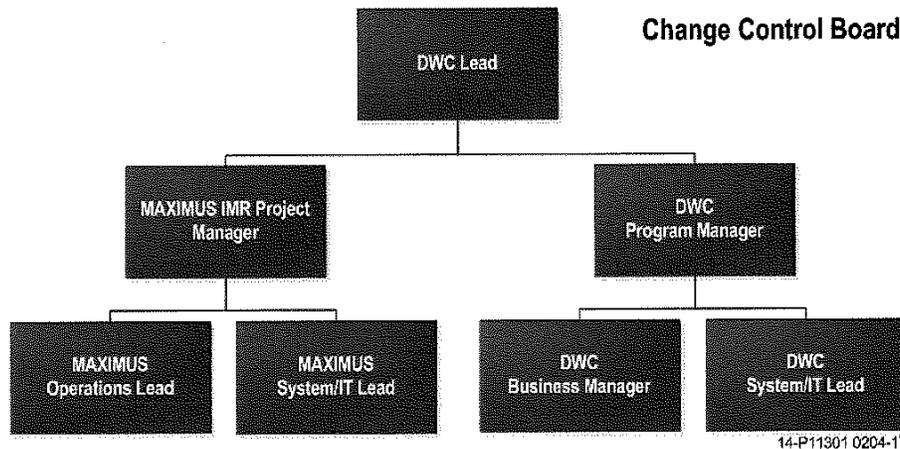


Exhibit 4.3.4-1: Change Control Board. MAXIMUS Federal proposes the implementation of a formal Change Control Board to review and approve system change requests.

MAXIMUS Federal would prepare a system enhancement analysis document that evaluates the estimated implementation level of effort and the effect the implementation would have on IMR workflow processes. DWC would have the lead role on the change control board and have the final decision on whether or not a proposed enhancement will be included in a future system release. Upon approval on the system enhancement from DWC the change control board would initiate system enhancement process with MAXIMUS Federal. MAXIMUS Federal would then prepare a system enhancement project plan that includes the estimated implementation date and deliver the documentation to DWC.

4.4 Deliverables

4.4.1 Preliminary Review of Cases

RFP Section A.1 (a-b), Page 7

In this section we discuss our preliminary review process and our direct toll-free telephone access.

4.4.1.1 Preliminary Review of All Applications for IMR

RFP Section A.1.a, Page 7

We will apply those lessons learned and best practices developed in collaboration with DWC in processing more than 40,000 preliminary reviews since January 2013, including the creation of a dedicated Preliminary Review Team. This team is specifically tasked with completing the eligibility review, including validating the data included in the IMR application against information in the Utilization Review (UR) Denial letter. The Preliminary Review Team will also identify any other potential eligibility issues, such as reviews not being filed within 30 days of the UR Denial Letter being issued or for a conditional non-certification (lack of medical records). They also identify the treatment(s) in dispute and enter this information into *entrellitrak*. If this process identifies potential eligibility issues with the IMR it is routed to DWC for an eligibility determination. If DWC determines the case is ineligible, the IMR is terminated. If DWC determines the case is eligible, MAXIMUS Federal is notified and the case moves to Case Assignment process.

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In order to ensure that we were able to meet this deadline we instituted our own pre-preliminary review where we created a notice that was sent to the injured worker to help ensure that the Request for Authorization Form (RFA-1) included the IMR application or DWC Form IMR-1. This simple innovation helped increase the receipt of completed IMR requests by 25 percent and, more importantly, helped to facilitate a timely preliminary review process. While we understand that the rules have changed and if the RFA-1 does not include a copy of the IMR application it is automatically denied, this innovation displays our commitment to the success of the DWC IMR program.

Each RFA-1 must include the following information:

- Identify the treatment and provider
- Specify the recommended treatment
- Include documentation showing the medical necessity of the treatment

We understand that disputes not involving medical necessity are not eligible for IMR. We have designated a subset of our Appeal Officers as a Preliminary Review Team. This team will perform the preliminary reviews pursuant to DWC's eligibility guidelines. By designating a specific team we will believe we will be able to complete these preliminary reviews in a more efficient manner. Our process is fully scalable and can be ramped up to meet project volumes as necessary.

Once the preliminary review is complete, the Appeals Officer updates *entellitrak*. If the case appears to be ineligible, the Appeals Officer indicates that a DWC eligibility review is necessary in *entellitrak* and the task is added to the DWC work queue. At this point DWC will perform its own eligibility review to determine if the case should remain ineligible. DWC is responsible for sending out the ineligibility notice unless the reason the IMR was deemed ineligible was due to no signature on the IMR Application or the UR Denial Letter was not included in the submission. In these instances, the IMRO will send out a non-eligibility notice on DWC letterhead.

If deemed eligible, the injured worker will be sent the Notice of Assignment and Request for Information (NOARFI) and the IMR process begins. Please see *Section 4.4.2: Assignment for Cases for IMR* for additional information regarding the IMR Process.

We understand that an IMR may be terminated at any time if the employer decides to approve treatment. As with all other IMR actions, *entellitrak* will be updated to reflect the new case status.

4.4.1.2 Direct Toll-Free Telephone Access

RFP Section A.1.b. Page 7

MAXIMUS Federal provides toll free 24-hour-a-day, 7-day a week (24/7) telephone service and has the capability to receive and act upon information 24/7 (including holidays) if notified in writing by facsimile or electronic mail. Our toll free telephone number is (855) 865-8873. The Folsom, California office is staffed with both administrative and professional personnel from 8:00 am to 5:00 pm PST, Monday through Friday. At all times that the office is not staffed, the MAXIMUS Federal phone system automated attendant prompts callers, at their option, to leave a message or request direct and immediate connection to a "live" representative. This live after hours phone coverage is provided by a professional medical answering service. When the answering service receives a call, the name of the caller and nature of the caller's request are obtained. The service then contacts one of five professionals who are on-call on a rotating basis. Our IMR Project Manager and an Appeal Officer familiar with the Project are on the on-

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call list and will be available for emergency contact 24-hours a day, 7 days a week. In addition, the MAXIMUS Federal Medical Director or his designee is available 24/7 for consultation with the IMR Project Manager to address emergency appeals.

We encourage DWC, when assigning expedited requests for external review outside normal business hours or on a holiday, to call before sending a case. Telephone calls received during these times are handled as described above, and the answering service will contact the IMR Project Manager. Our Director of Professional Relations, Medical Director, and IMR Project Manager have discretionary authority to contact MAXIMUS Federal MPRs after standard business hours. In addition, arrangements can be made with our physician reviewers for them be available evenings and weekends when it is known that an expedited review is expected. MAXIMUS Federal also makes arrangements for certain physician reviewers to be available on holidays and over holiday weekends.

In order to prevent any problems in the event of power outages or suspension of phone service at our Folsom, California office where the DWC IMR Project is housed, clients are provided with telephone numbers and other contact information for our offices in Rancho Cordova, California; Columbia, Maryland; Moosic, Pennsylvania; Pittsford, New York; and Victor, New York.

4.4.2 Assignment-of-Cases for Independent Medical Review

RFP Section A.2 (a-e), Page 7

In this section we discuss our process for IMR case assignment. Please see *Section 3: Overview* for a detailed discussion of our proposed IMR workflow, including IMR case assignment.

4.4.2.1 Case Deemed Assigned for IMR

RFP Section A.2.a, Page 7

IMR Applications are eligible for assignment after our Preliminary Review Team has deemed the case eligible for review. As noted above, if we deem a case ineligible it is forwarded to DWC for their eligibility review. DWC may reverse our determination and deem the case eligible for an IMR.

Our current DWC IMR Project Management Team worked closely with DWC to develop an online IMR Application, which is expected to be fully deployable by July 1, 2014. Our *entellitrak* case management system has already been modified to receive and upload applications.

4.4.2.2 Notwithstanding Preliminary Review Requirements Specified

RFP Section A.2.b (1-2), Page 7

In addition to the methods discussed above, a case can be deemed eligible by the Preliminary Review Team if it is designated for expedited review based upon either of the following situations:

- Written certification by the treating physician, in a form or manner determined by DWC, that the disputed medical treatment has not been provided and an imminent and serious threat to the health of the injured employee may exist, including but not limited to serious pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of the health of the employee
- The Claims Administrator conducted an expedited review, as defined in 8 C.C.R. Section 9792.6.1(j), to make its utilization review decision

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We understand that an expedited review will not be completed nor an IMR determination issued if, prior to completion, DWC notifies us that the case is not eligible for IMR.

The Preliminary Review Team will elevate a standard IMR request to an expedited review if warranted by the employee's medical condition based on a review of the application and records. We understand that requests elevated to expedited review in this manner will not incur additional cost compared to a standard review.

4.4.2.3 Consolidate Two or More Eligible IMR Applications

RFP Section A.2.c, Page 7

Our Preliminary Review Team will consolidate two or more eligible IMR applications by a single employee for resolution in a single determination if the applications involve the same requesting physician and the same date of the injury.

4.4.2.4 Notify Interested Parties Under 8.C.R.R. Section 9792.10.4

RFP Section A.2.d, Page 7

Within one day of assignment, our administrative staff, via *entellitrak*, will generate written notices to the interested parties indicating the case has been assigned for IMR. Our notification must contain the following elements:

- The MAXIMUS Federal IMR Project name and address
- Clear identification of the disputed medical treatment, including the date of the request for authorization, the name of the requesting physician, and the date of the claims administrator's utilization review decision
- The date the application for IMR, DWC Form IMR, was received
- A statement whether the IMR will be conducted on a regular or expedited basis
- For standard or regular reviews, a statement that within 15 calendar days of the date designated on the notification, if the notification was provided by mail, or within 12 calendar days of the date designated on the notification if the notification was provided electronically, the independent review organization must receive the documents indicated in section 9792.10.5
 - For the notification provided to the claims administrator, the statement shall provide that, pursuant to Labor Code section 4610.5(i), in addition to any other fines, penalties, and other remedies available to the Administrative Director, the failure to comply with section 9792.10.5 could result in the assessment of administrative penalties up to \$5,000.00
- For expedited review, a statement that within 24 hours following receipt of the notification the independent review organization must receive the documents indicated in section 9792.10.5
 - For the notification provided to the claims administrator, the statement shall provide that, pursuant to Labor Code section 4610.5(i), in addition to any other fines, penalties, and other remedies available to the Administrative Director, the failure to comply with section 9792.10.5 could result in the assessment of administrative penalties up to \$5,000.00

In those instances where a regular or standard IMR is converted into an expedited review, if subsequent to the receipt of the Application for Independent Medical Review the independent review organization receives from the employees' treating physician a certification that the employee faces an imminent and

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serious threat to his or her health (see 9792.10.1(a)(3)), we will immediately notify the parties by the most efficient means available of this conversion.

Exhibit 4.4.2.4-1: Assignment Notice illustrates the current content of the assignment notice.

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**ATTACHMENT A:
DOCUMENTS THAT MUST BE SUBMITTED BY THE CLAIMS ADMINISTRATOR**

(1) A copy of all of the employee's medical records, within six months prior to the date of the request for authorization, in the possession of the employer or under the control of the employer relevant to each of the following:

How to submit

- (1) Facsimile to
- (2) U.S. Postal S
- (3) Delivery Ser

For U.S. Postal S
MAXIMUS Fed
Independent Me
P.O. Box 138009
Sacramento, CA

**BOTH PARTIES
WITH EACH
IMR PROCESS**

What Happens
Federal Services
required docum
independent me
send you a letter

Additional inform
<http://www.dir.ca.gov>

encl.

MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270



Notice of Assignment and Request for Information

Sequence Number
PARTICIPANT NAME
PARTICIPANT ORGANIZATION
ADDRESS 1
ADDRESS 2
CITY, STATE ZIP

DATE (Month Day, YYYY)

IMR Case Number:	CM13-0000000	Date of Injury:	MM/DD/YYYY
Claims Number:	000000000000000000	UR Denial Date:	MM/DD/YYYY
Priority:	Expedited / Standard	Application Received:	MM/DD/YYYY
Employee Name:	Participant First Name Middle Initial Last Name Suffix		
Provider Name:	Participant First Name Middle Initial Last Name Suffix		
Treatment(s) in Dispute Listed on IMR Application:	"TRANSCRIBED TEXT FROM APPLICATION"		

Dear Parties:

The California Department of Industrial Relations Division of Workers' Compensation has assigned MAXIMUS Federal Services to conduct an independent medical review for the above case.

Injured Workers or their Appointed Representatives:

- You may provide any documents in support of your request for medical items or services.
- If you choose to provide documents, they must be received by MAXIMUS Federal Services within 15 days of the date of this notice.
- If you provide to us documents that you have not previously provided to the Claims Administrator, you must provide copies to the Claims Administrator now.
- You should also expect to receive within 15 days of the date of this notice either copies or a list of the documents submitted to us by the Claims Administrator.

Claims Administrators:

- You must provide MAXIMUS Federal Services with copies of all documents listed on Attachment A (enclosed) within 15 days of the date of this notice.
- If you provide to us copies of documents that you have not previously provided to the Injured Worker, you must provide copies to the Injured Worker now.
- If copies of the documents have previously been provided to the Injured Worker, you are now required to send to the Injured Worker only a list of the documents being provided to us.
- To help us with our medical record review process, please also provide us with a list of the documents you are submitting to MAXIMUS Federal Services.

V4.0

v2.0

14-P11301.0204-11

Exhibit 4.4.2.4-1: Assignment Notice. This document illustrates the current content of our assignment notice.

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4.4.2.5 Compliance with Labor Section 139.5 and Any Other Conflicts of Interest Requirements

RFP Section A.2.e, Page 7

MAXIMUS Federal offers DWC the only contractor that is absolutely free of any actual or perceived conflicts of interest. For the past 12 years providing IMRs to DWC, CDI DMHC, and CalPERS, MAXIMUS Federal has scrupulously avoided affiliations with any California licensed workers' compensation insurer or workers' compensation claims administrator, health plan or medical group, or any California health care facility. Furthermore, we screen all staff, Directors, and Officers for potential conflicts of interest. The only relationships we have in California that might create a potential conflict of interest is our relationship with our California MPRs. These conflicts are avoided through a rigorous screening of every IMR case file before, during, and after case assignment. It is through the above policies and procedures that MAXIMUS Federal can guarantee DWC absolutely conflict free services. As such, we are confident we meet the conflict of interest requirements described in Labor Section 139.5. Please see *Appendix D: Conflict of Interest Policy and Procedures* for a detailed description of our conflict of interest measures. Please see *Appendix E: MPR Application*, which requires reviewers to list their material professional, familial, or financial affiliations if any.

Prohibiting Conflicts of Interest

As set forth in Section 1 of this proposal, based upon our business philosophy and the absolute need to maintain our independence and integrity, we have decided not to provide any services to or contract with any or health or disability insurer or health plan where it would create a conflict with a government program. MAXIMUS Federal has no commercial clients. Therefore, if a potential or actual conflict exists with a government program, we do not provide any services (for example, clinical review, technology assessment, consulting) or have any relationship with any health plan or health or disability insurer nor at any time in the future will we enter into any contractual agreements with any health plan or health or disability insurer for the provision of any similar services. As such, we have no existing relationships of any kind with any California-licensed health or disability insurer or health plan. Moreover, we have no relationship with any national health or disability insurer that is doing business in California.

Because MAXIMUS Federal's primary health care business is IMR, complete avoidance of conflict of interest is not only important to our clients, but is also one of our strategic core competencies. We maintain and continually improve upon a comprehensive and documented Conflict and Compliance Plan, which is monitored by our Director of Compliance under the direction of the Compliance Committee of our independent Board of Directors. In addition, our compliance with the conflict plan is independently verified not less than annually by means of an independent ISO registration, as part of URAC accreditation reviews, and by a separate agreed upon procedures audit. In summary, our policy and procedures preclude any ownership, financial interest, or significant familial relationship with any government agency client, with any provider, with any drug or device manufacturer, and with any party to an individual case. To ensure lack of conflict in an individual case, we submit both staff and consultants to a case specific conflict verification and attestation process.

Specifically, conflicts of interest checks occur at several points in the clinical review process. When a new case is assigned to MAXIMUS Federal, a conflict determination is made with respect to the insured and health insurer. Upon receipt and review of the case file and prior to assignment to the MPR, the file is

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screened for any potential conflicts with providers involved in the case and/or manufacturers of any device or medication at issue in the appeal.

During the case assignment process, the Nurse Supervisors determine if a selected Appeal Officer has any conflicts of interest with the given case. During the process of selection and assignment of an MPR for a case, the Appeal Officer in consultation with the Director of Professional Relations determines whether a specific MPR has no known conflicts of interest regarding the pending review. Finally, the MPR is required to execute a case-specific conflict attestation during case processing.

MAXIMUS Federal ensures that no person associated with MAXIMUS Federal has any material affiliation with any of the parties associated with an IMR. Additionally, prior to the assignment of a case to an expert reviewer, it is screened for material, professional, familial, or financial relationship with any of the following persons:

- The employer, insurer or claims administrator, or utilization review organization
- Any officer, director, employee of the employer, or insurer or claims administrator
- A physician, the physician's medical group, the physician's independent practice association, or other provider involved in the medical treatment in dispute
- The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer, would be provided
- The developer or manufacturer of the principal drug, device, procedure, or other therapy proposed by the employee 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

MAXIMUS Federal also researches all professional and financial affiliations our MPRs have with any health care institutions, health care providers, and managed care organizations. This allows us to determine prior to the assignment of a case whether an actual or apparent conflict of interest exists between the selected reviewer and the parties to the clinical review. Further, each MPR is contacted and the case file is discussed as an additional means to avoid any conflicts of interest.

All MAXIMUS Federal MPRs are contractually obligated to review each case reviewed for potential or actual conflicts of interest and to notify MAXIMUS Federal immediately if an actual or potential conflict exists so that the case may be promptly reassigned. Per MAXIMUS Federal internal standards, actual or potential conflicts include but are not limited to financial interest with the health plan, provider relationship with the health plan or a delegated group, relationship with the covered person/patient, and relationship with a provider of a (disputed) drug or device. As an added safeguard, MAXIMUS Federal Appeal Officers review case files to identify potential conflicts of interest prior to assigning the case. The MPR is also contacted and the case file is discussed in order to further rule out actual or potential conflicts.

In addition to screening for conflicts, MAXIMUS Federal screens MPRs and their reviews to ensure that physician Reviewers are neutral and display no general bias. The importance of neutrality and objectivity is also stressed in MPR orientation and training. MAXIMUS Federal Appeal Officers screen all MPR referrals for any signs of inappropriate or inflammatory language or any other indications of bias. If there appears to be any issue of objectivity or neutrality, the MPR is suspended from the MAXIMUS Federal

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panel and subject to additional review by the Medical Director and the Director of Professional Relations' Credentialing Committee.

Our MPR Referral and Report form includes a certification regarding conflict of interest that the MPR is required to complete as a part of his or her recommendation. A copy of the MPR Referral Report Form with referenced attestation is contained in *Appendix F: MPR Referral Form*.

4.4.3 Information to Conduct Independent Medical Review

RFP Section A.3 (a-e), Pages 7-8

In this section we discuss the procedures our Case Assessment Team will use to request and review the information needed to conduct IMR.

4.4.3.1 Requesting All Information Needed to Conduct the Review

RFP Section A.3.a, Page 7

After IMR assignment and written notification to the Interested Parties, our Case Assessment Team is responsible for requesting all the information necessary to perform the IMR in the manner set forth in 8 C.C.R. section 9792.10.4(b). The Appeal Officer will use *entellitrak* to generate a Notice of Assignment and Request for Information (NOARFI) that is sent to the Claims Administrator (CA) requesting medical records. See *Exhibit 4.4.2.4-1: Assignment Notice* for a copy of the NOARFI we create electronically.

We will also send a copy of the NOARFI to the injured worker and/or applicant attorney. As noted above, the Claims Administrator has 15 days (if by mail) or 12 days (if electronic) of receipt of the NOARFI to submit the following documentation:

- A copy of all reports by the employee's treating physician relevant to the employee's current medical condition produced within one year prior to the date of the request for authorization, including those that are specifically identified in the request for authorization or in the utilization review determination
- A copy of the adverse determination by the Claims Administrator notifying the employee and the employee's treating physician that the disputed medical treatment was denied, delayed, or modified
- A copy of all information, including correspondence, provided to the employee by the Claims Administrator concerning the utilization review decision regarding the disputed treatment
- A copy of any materials the employee or the employee's provider submitted to the Claims Administrator in support of the request for the disputed medical treatment
- A copy of any other relevant documents or information used by the Claims Administrator in determining whether the disputed treatment should have been provided, and any statements by the Claims Administrator explaining the reasons for the decision to deny, modify, or delay the recommended treatment on the basis of medical necessity
- The Claims Administrator's response to any additional issues raised in the employee's application for independent medical review

In order to help expedite the process, our Appeal Officer will request that the Claims Administrator include a list of the documents submitted for review. This list will help us ensure that all of the required documentation has been submitted.

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Additionally, the Claims Administrator is required to provide any new relevant medical records that were discovered after sending the documents to the IMRO. If this is the case, the Claims Administrator must also provide a copy of these documents to the injured worker, their representative, or their treating physician, unless otherwise declined.

The injured worker is also instructed, within 15 days for a standard review and 24 hours for an expedited review, that they have the ability to submit the following documents in support of their IMR:

- The treating physician's recommendation indicating that the disputed medical treatment is medically necessary for the employee's medical condition
- Medical information or justification that a disputed medical treatment, on an urgent care or emergency basis, was medically necessary for the employee's medical condition
- Reasonable information supporting the position that the disputed medical treatment is or was medically necessary, including all information provided by the employee's treating physician, or any additional material that the employee believes is relevant

If any of these documents are new, the injured worker or their designee must also provide them to the Claims Administrator.

4.4.3.2 Review All Information Received

RFP Section A.3.b, Page 7

Our Case Assessment Team is responsible for reviewing all information received from DWC and the Interested Parties for legibility, completeness, and relevance to the case before forwarding it to the Panel Scheduling Team to assign an appropriate reviewer(s). Within two business days of receipt, an Appeal Officer will contact the sender by telephone, facsimile, or secure messaging regarding any illegible or incomplete information in order to ensure a timely and effective review and determination.

4.4.3.3 Claims Administrator and Additional Notice

RFP Section A.3.c, Page 8

If the Claims Administrator fails to provide the required documentation within the required timeframes, Our Case Assessment Team will provide them with an additional notice indicating that these documents must be received within two business days. The content of this notice shall be specified by DWC. At the same time, we will notify DWC of the Claims Administrator's failure to provide the required case documentation within the mandated timeframe. If the Claims Administrator fails to provide required documents to us within two business days after this additional notice, we will conduct IMR based solely on information provided by the employee or the treating physician.

In the absence of information provided by the parties, our Case Assessment Team will dismiss the IMR application and notify DWC of the Claims Administrator's failure to provide documents. As noted above, we may contact the treating physician, as applicable, for additional information regarding the employee's condition and the need for the requested treatment. We can also consider documents submitted by the employee or treating physician in addition to those submitted by the Claims Administrator.

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4.4.3.4 Delivery of Cases Accepted for Expedited Review

RFP Section A.3.d, Page 8

For expedited cases we will transmit notifications in the most expeditious manner possible. The expedited NOAFRI will include instructions that the parties in question have 24 hours to provide us with required or additional information. If the Claims Administrator fails to provide required documents to us within 24 hours, we can conduct IMR based solely on information provided by the employee or the treating physician. However, in the absence of information by provided the parties, the Case Assessment Team will dismiss the IMR application and notify DWC of the Claims Administrator's failure to provide documents. Similar to standard reviews, we have the ability to contact the treating physician for additional information regarding the employee's condition and need for the requested treatment. We can also consider documents submitted by the employee or treating physician in addition to those submitted by the Claims Administrator. In the absence of information provided the parties, the Contractor will dismiss the IMR application and notify DWC of the Claims Administrator's failure to provide documents. For expedited review requests that do not included required documentation within the timeframe required for expedited review, we will convert the request to a standard review to allow more time for submission of documents.

4.4.3.5 Additional Information from Any Interested Party or Treating Physician

RFP Section A.3.e, Page 8

All accepted IMRs undergo a thorough examination by the assigned Appeal Officer for legibility and completeness. If during the course of this internal assessment we determine that additional information is required to reach a decision we will reach out directly to the appropriate Interested Party or treating physician. Copies of any such requests and any responses to such requests will be provided to all other Interested Parties. *entellitrak* will be updated accordingly to include a notation of any such request. The information provided in response to this request will also be noted in the final decision letter.

4.4.4 Timeframes for Completing Reviews

RFP Section A.4 (a-c), Page 8

In this section we address the timeframes we will meet for standard and expedited reviews.

4.4.4.1 IMR Completed and Determination Issued to Interested Party within Thirty (30) Days

RFP Section A.4.a, Page 8

For standard reviews we will complete the IMR and submit the determination in writing to the Interested Parties within 30 days after receipt of all documents needed to complete the review.

4.4.4.2 IMR Completed and Determination Issued to Interested Party within Three (3) Days

RFP Section A.4.b, Page 8

Expedited reviews will be completed within three calendar days after receipt of all documents needed to complete the review.

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4.4.4.3 Deadline Extended for Up to Three Additional Days

RFP Section A.4.c, Page 8

If we require more time to complete the review, these deadlines may be extended to for up to three additional days in extraordinary circumstances or for good cause.

4.4.5 Case Information and Changes in Case Status

RFP Section A.5 (a-f), Pages 8-9

In this section we introduce *entellittrak*, our case workflow tracking system, and discuss how it tracks case information and changes in case status. Please refer to *Section 4.2: Case Workflow Tracking System* for a detailed discussion of *entellittrak*'s functionality.

4.4.5.1 Maintain a Case Workflow Tracking System

RFP Section A.5.a, Page 8

As discussed in more detail in *Section 4.2: Case Workflow Tracking System* and mentioned throughout this bid, we will use *entellittrak* as our case workflow tracking system to track the receipt, acceptance, assignment, and current status of applications and cases accepted for IMR. We implemented this system in January of 2013 to help us meet the increasing IMR volumes. We will continue to work closely with DWC to offer enhancements to this system based on lessons learned over the course of the contract. For example, in a coming release of *entellittrak*, an online IMR application capability will be available to injured workers (in addition to the paper application form). This online capability enhances the speed with which an appeal application can be made. The injured worker is able to access a web portal to request the appeal, submit structured data about the injury and the utilization review action resulting in the desire to appeal, and securely submit documents in support of the appeal. The injured worker will also be able to see the status of his or her own case using a secure log in and password that provides confidentiality of medical records and personal information. This access does not include the identity of IMR reviewers or any information required to be kept confidential from the worker by law or this agreement.

DWC will continue to have direct access to the *entellittrak* system to review the status of any case using read-only, role-based access that does not allow changes to the case. DWC staff members receive a system-generated alert when assigned to complete eligibility review of an IMR case. DWC can also view documents submitted in support of the appeal, and view the status of cases through use of the standard and advanced search functions.

In addition to *entellittrak*, MAXIMUS Federal plans to augment its systems capability by deploying the Expert Gateway to the clinical panel providing the IMRs. The Expert Gateway enables both medical records and discrete questions for a specific appeal to be directed electronically to an assigned MPR. More information about the Expert Gateway, including security and confidentiality, can be found in *Section 4.2.7. System Security*.

4.4.5.2 Data and Monitoring

RFP Section A.5.b, Pages 8-9

We understand that all data acquired in the course of performance of the contract is the property of DWC and will not be used by MAXIMUS Federal without permission of DWC for any purpose other than the performance of this contract. "Data acquired in the course of performance of the contract" does not

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include the substantive content of medical treatment guidelines used in the course of reviews or individually identifiable information about reviewing physicians. We will use an anonymous identification number for each reviewer's identification that will be associated with the reviewer's specialty, board certification, state licensure, and years of practice. That number will be disclosed to DWC in each case but not included in the determination itself.

MAXIMUS Federal shall continue to provide all the data acquired while performing to the requirements of the contract to DWC. *Exhibit 4.4.5.2-1: Data Requirements* demonstrates the MAXIMUS Federal Approach to addressing these data requirements.

Data Requirements	MAXIMUS Federal Approach
<ul style="list-style-type: none"> ■ Provide the determination for the parties. 	<ul style="list-style-type: none"> ■ Our MPR Report form contains the reviewer's decision and will be uploaded into <i>entellittrak</i> after it has successfully undergone an internal audit by the assigned Appeal Officer and Nurse Reviewer for completeness, accuracy, and clarity ■ Each determination notice will be pre-populated to increase accuracy and minimize the need for error correction ■ We will use <i>entellittrak</i> to generate a determination notice to be sent to the Interested Parties ■ Bulk transfer of data also occurs through the use of our secure file transfer protocol (sFTP) tool, MOVE-IT. Information regarding data transfer methods is found in <i>Section 4.2.4. Bulk Data Transmission</i>.
<ul style="list-style-type: none"> ■ Provide a de-identified version of the determination for public disclosure. 	<ul style="list-style-type: none"> ■ <i>entellittrak</i> has the functionality to create a redacted case report suitable for posting on the DWC website ■ <i>entellittrak</i> will automatically ensure that no individually identifiable information, as defined in Labor Code Section 138.7, is included in our redacted case report by pulling only from fields that do not include personally identifying information ■ This report includes the IMR outcome determination and the redacted case reports as described in <i>Section 4.2.2: Redacted Final Determination Forms</i>.
<ul style="list-style-type: none"> ■ Enable complete workflow monitoring and individual case tracking from the date of receipt of an IMR application through the date of mailing of the final determination and through additional review. Tracking shall include, but not be limited to: <ul style="list-style-type: none"> ■ The date of receipt of each document or set of documents by the Contractor from DWC or any party in a case; ■ the date of mailing or transmission by the Contractor of any document or documents to DWC or any party in a case; 	<ul style="list-style-type: none"> ■ <i>entellittrak</i> is proven scalable workflow monitoring and individual case tracking system that tracks the IMR, by date, from receipt to dissemination of the final determination letter, as well as any additional review required due to WCAB appeal and remand ■ Each case related action, including any initiated mailings or transmissions, is recorded in <i>entellittrak</i> ■ <i>entellittrak</i> also monitors all decisions and changes to case status including the date and the staff member, or automated process that makes the change ■ We use an alert system to facilitate timely completion of process steps requiring case action by staff members. Staff members must enter a reason for the delay if the task is past due in order to be completed. ■ The system includes a reason when a process is ended prematurely, such as an incomplete application or required records not submitted ■ The information tracked by <i>entellittrak</i> is used by our QA Department to identify trends and areas for improvement. We incorporate this information into our continuous improvement recommendations and actions, such as refresher training and system releases. ■ To date, <i>entellittrak</i> has been used to process more than 45,000 IMRs ■ Information on cases in process will also be tracked by our MAXDat reporting solution. MAXDat is discussed in <i>Section 4.2.8. Case Tracking Reports</i>

Exhibit 4.4.5.2-1: Data Requirements.

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Data Requirements	MAXIMUS Federal Approach
<ul style="list-style-type: none"> ■ The date of each status change or decision made (include preliminary review of application, eligibility determination, referral to DWC for ■ eligibility determination, assignment to IMRO, assignment to reviewer, etc. ■ The reason for each point where a case does not progress to the next step in a predetermined time (for example, incomplete application, no records received, workload backlog, etc.). 	
<ul style="list-style-type: none"> ■ Enable monitoring the quality assurance in the IMR process, including providing DWC with a means to sort the reviews conducted by each reviewer, such as a reviewer ID number. 	<ul style="list-style-type: none"> ■ We capture a unique reviewer ID number and include this number with associated cases to DWC as part of our weekly and other periodic reports ■ Incorporate required medical professional reviewer ID number information in the <i>entellittrak</i> system—enabling sorting of review results by the unique reviewer ID.
<ul style="list-style-type: none"> ■ Enable research into patterns of utilization reviews and IMR applications and IMR outcomes, including but not limited to diagnoses, proposed treatments, prescribing physicians, utilization review physicians and organizations, IMR applications, and medical treatment guidelines relied upon by physicians. 	<ul style="list-style-type: none"> ■ <i>entellittrak</i> captures uniform data on diagnosis, treatments, names of treating physicians, descriptions of issues in dispute, classification of the citations employed by the utilization review firms, and classification of citations used by MAXIMUS Federal medical professional reviewers ■ The system uses standardized codes to represent clinical attributes (ICD-9-CM for diagnosis, CPT or MTUS for treatments), enabling comparison across jurisdictions ■ MAXDat provides the ability to analyze patterns of decisions that are reversed upon appeal versus approved on appeal. ■ Our clinical staff is trained to look for patterns that show utilization firms are incorrectly identifying clinical conditions or treatment modalities (based on appeal outcomes) ■ Contract with expert consultant, Frank Neuhauser, on Worker's Compensation research to assist in design and execution of analysis

Exhibit 4.4.5.2-1: Data Requirements (continued).

4.4.5.3 Enter All Information Collected on the IMR Application

RFP Section A.5.c, page 9

MAXIMUS Federal Data Entry Specialists and Appeals Officers enter all information collected on the IMR application and submitted documentation into the *entellittrak* system. Information from completed reviews is also incorporated into *entellittrak* automatically. DWC staff members have access to *entellittrak* and may access specific case data in real time. In addition, the MAXDat reporting platform described in *Section 4.2.8. Case Tracking Reports* provides access to a wide variety of current and cumulative reports on case tracking data from the *entellittrak* system.

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4.4.5.4 Enter in the Case Work-flow Management System Any Changes in Case Status

RFP Section A.5.d, page 9

Our Appeal Officers are tasked with promptly entering any changes in case status in the case workflow management system. In addition, our Appeal Officers use *entellitrak* to promptly generate a notice informing the Interested Parties in writing, or in any other manner that provides actual and expeditious notice, when any of the following changes occur:

- Change in nature or type of medical treatment under dispute
- Type of review (standard or expedited)
- Status of case as entitled or not entitled to expedited review
- IMR terminated because Requesting Party has withdrawn the application, Claims Administrator has authorized the disputed medical treatment, or a settlement between the parties or other change in circumstances has eliminated the need for IMR

Section 4.4.8: Distribution of Completed Reviews and *Section 4.4.3: Information to Conduct IMR* includes more information on notices including sample notices.

4.4.5.5 IMR Terminated

RFP Section A.5.e, page 9

If the IMR is terminated because the Requesting Party has withdrawn the application, the Claims Administrator has authorized the disputed medical treatment, or a settlement between the parties or other change in circumstances has eliminated the need for IMR, we will cease our review and will not provide any analyses or substantive determinations to the parties. We will charge a partial fee for an IMR that was initiated but not completed.

4.4.5.6 Database Allow Generation of Reports

RFP Section A.5.f, page 9; Appendix A, Pages 55-57

As described in *Section 4.2.8: Case Tracking Reports*, we continue to generate and house all case tracking data in *entellitrak*, including the data elements listed in Appendix A. These data are used by our MAXDat reporting platform to provide DWC with web-based access to our reporting and data visualization tools that are easy to use for ad hoc reports, including the generation of charts and graphs to show trends. Additional analysis can be generated as tabular, statistical, graphical, and online analytical processing (OLAP) style reporting. OLAP style reporting consists of three operations - aggregating data for trends (drill-up), being able to examine the details (drill-down); and extracting specific sets of data and then viewing the data from various viewpoints. MAXDat will be designed to include available system information on the status of IMRs as they move through case processing. As such, each step in an IMR review will be tracked and serve as data for reporting purposes.

4.4.6 Number and Type of Reviewers

RFP Section A.6 (a-c), Page 10

As emphasized throughout this proposal, MAXIMUS Federal can offer DWC access to more than 950 California-licensed physicians and other health care professionals available to complete IMRs. Please see *Appendix G: California-licensed MPRs* for a listing of our California-licensed reviewers. Many of our

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California-licensed reviewers are board certified in multiple specialties and can provide IMRs in these clinical areas. As such, we can offer the DWC more than 460 California certifications, which effectively increases our panel scope by 25 percent. We have also entered into a number of subcontracting agreements with URAC accredited IROs and have added another 600 California licensed clinicians to our MPR Panel, bring the total number of MPR resources to 950 MPRs. With these commitments and resources we are confident that we have the capacity to process up to 40,000 IMRs a month. Finally, we can also offer DWC access to more than 400 additional physicians and other health care professionals licensed in other states. Please see *Appendix H: Non-California Licensed MPRs* for a listing of these individuals.

Per program requirements, we will give preference to California licensed practitioners. Over the last year as the incumbent for the DWC IMR Program, we have used California-licensed reviewers to perform a majority of DWC IMRs. Our goal for the new contract is to increase this to 90 percent by January 1, 2015. All of our MPRs are independent contractors. We avoid employee MPRs as we believe employment could lead to impinging upon a reviewer's objectivity and independence. In addition, all of our MPRs to be used for this bid are currently in active practice at 24 hours (60 percent) per week, which exceeds DWC's 30 percent active requirement for at least 2 of the preceding 4 years. We believe reviewers who are still involved in clinical practice provide a more well-rounded review and often have easier access to the most up-to-date medical and scientific evidence

Our MPRs also represent every ABMS and AOS specialty and most subspecialties, which ensures ability to match reviewers to a case based on same of similar specialties/subspecialties. *Exhibit 4.4.6-1: California Clinical Specialties and Subspecialties Offered* below details the MPR resources that will work on this project.

Type of Board Certifications	Number of Certifications	Type of Board Certifications	Number of Certifications
Addiction Psychiatry	3	Nuclear Medicine	2
Allergy and Immunology	3	Obstetrics and Gynecology	3
Anatomic Pathology	2	Occupational Medicine	22
Anesthesiology	13	Oncology	4
Cardiac Electrophysiology	3	Ophthalmology	5
Cardiovascular Disease	6	Orthopedic Surgery	47
Child & Adolescent Psychiatry	5	Osteopathic Board Neurology & Psych	2
Colon and Rectal Surgery	3	Otolaryngology	8
Critical Care Medicine	6	Pain Management	19
Dermatology	4	Pediatric Critical Care	1
Dermatopathology	1	Pediatric Hematology/Oncology	1
Diagnostic Radiology	3	Pediatric Infectious Disease	1
Emergency Medicine	7	Pediatrics	10
Endocrinology & Metabolism	1	Physical Medicine & Rehabilitation	41
Family Practice	11	Plastic Surgery	4
Gastroenterology	1	Podiatric Surgery	3
General Vascular Surgery	1	Podiatrist	3

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Type of Board Certifications	Number of Certifications	Type of Board Certifications	Number of Certifications
Genetics	1	Preventive Medicine	10
Geriatric Medicine	3	Psychiatry	19
Geriatric Psychiatry	3	Pulmonary Disease	10
Hand Surgery	3	Radiation Oncology	2
Internal Medicine	44	Radiology	4
Interventional Cardiology	2	Sports Medicine	4
Maternal and Fetal Medicine	1	Surgery	14
Medical Oncology	3	Surgical Critical Care	1
NA-Chiropractor	30	Thoracic Surgery	5
NA-Dentist	3	Urology	3
NA-Chiropractic	8	Hospice & Palliative Medicine	1
NA-Dentistry	1	Sleep Medicine	3
NA-Oriental Medicine	9	Neurotology Pediatric	1
NA-Psychologist	14	Neurodevelopmental Behavioral Pediatrics	1
Neonatal Perinatal Medicine	1	Neuromuscular Medicine	3
Neurological Surgery	13	Pediatric Urology	1
Neurology	11	NA-Optometry	3
Neurology-Spec Qualifications Child	2		
General Vascular Surgery	1	Podiatrist	1
Genetics	1	Preventive Medicine	10
Geriatric Medicine	3	Psychiatry	19
Geriatric Psychiatry	3	Pulmonary Disease	10
Hand Surgery	3	Radiation Oncology	2
Internal Medicine	44	Radiology	4
Interventional Cardiology	2	Sports Medicine	4
Maternal and Fetal Medicine	1	Surgery	14
Medical Oncology	1	Surgical Critical Care	1
NA-Chiropractor	30	Thoracic Surgery	5
NA-Dentist	3	Urology	3
NA-Chiropractic	8	Hospice & Palliative Medicine	1
NA-Dentistry	1	Sleep Medicine	1
NA-Oriental Medicine	9	Neurotology Pediatric	1
NA-Psychologist	14	Neurodevelopmental Behavioral Pediatrics	1
Neonatal Perinatal Medicine	1	Neuromuscular Medicine	2
Neurological Surgery	13	Pediatric Urology	1
Neurology	11	NA-Optometry	1
Neurology-Spec Qualifications Child	2	Total Count Certifications:	487

Exhibit 4.4.6-1: California Clinical Specialties and Subspecialties (continued) offers a snapshot of our California-licensed MPR resources.

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Exhibit 4.4.6-2: Non-California Specialties and Subspecialties details our additional MPR resources that are available on an as-needed basis.

Board Certifications	Count	Board Certifications	Count
Allergy and Immunology	4	Ophthalmology	11
Anatomic Pathology	1	Oral Facial & Maxillary Surgery	3
Anesthesiology	17	Orthopedic Surgery	52
Blood Banking/Immunopathy	2	Osteopathic Brd Neurology & Psych	3
Cardiac Electrophysiology	1	Otolaryngology	6
Cardiovascular Disease	10	Pain Management	16
Child & Adolescent Psychiatry	4	Pediatric Cardiology	2
Clinical Pathology	1	Pediatric Critical Care	2
Colon and Rectal Surgery	2	Pediatric Dentistry	1
Critical Care Medicine	3	Pediatric Emergency Medicine	3
Critical Care Surgery	1	Pediatric Endocrinology	2
Dermatology	5	Pediatric Hematology/Oncology	2
Diagnostic Radiology	5	Pediatric Infectious Disease	1
Emergency Medicine	18	Pediatric Surgery	1
Endocrinology & Metabolism	6	Pediatrics	24
Family Practice	25	Periodontology	1
Forensic Psychiatry	1	Physical Medicine & Rehab	44
Gastroenterology	5	Plastic Surgery	10
General Vascular Surgery	5	Podiatric Surgery	4
Geriatric Medicine	6	Podiatrist	3
Geriatric Psychiatry	2	Preventive Medicine	7
Gynecologic Oncology	2	Psychiatry	31
Hand Surgery	6	Public Health & Gen Prev Med	1
Hematology	7	Pulmonary Disease	4
Infectious Disease	3	Radiation Oncology	6
Internal Medicine	111	Radiology	5
Interventional Cardiology	2	Reproductive Endocrinology	2
Maternal and Fetal Medicine	1	Rheumatology	4
Medical Oncology	4	Sports Medicine	5
Medical Toxicology	2	Surgery	35
NA-Chiropractor	16	Thoracic Surgery	2
NA-Dentist	10	Urology	9
NA-Nurse Practitioner	2	Neuroradiology	1
NA-Chiropractic	5	Vascular & Inter Radiology	3
NA-Dentistry	1	NA-Registered Nurse	1
NA-Pediatric Dentistry	1	NA-LPN	1
NA-Physical Therapy	1	Hospice & Palliative Medicine	4
NA-Podiatrist	5	Undersea & Hyperbaric Medicine	1
NA-Psychologist	7	Sleep Medicine	2

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Board Certifications	Count	Board Certifications	Count
NA-Psychology	2	Transplant Hepatology	1
NA-Social Work	1	Neuropathology	1
NA-Speech Therapy	2	Neuromuscular Medicine	1
Neonatal Perinatal Medicine	2	Pediatric Rehab	1
Nephrology	5	Psychosomatic Medicine	1
Neurological Surgery	5	NA-Optometry	1
Obstetrics and Gynecology	14	NA-Nurse Anesthetist	1
Occupational Medicine	10		
Oncology	3	Total Count Certifications:	693

Exhibit 4.4.6-2: Other Clinical Specialties and Subspecialties (continued) offers a snapshot of our MPR resources licensed in other states.

Recruiting California Licensed MPRs

Our standalone Recruiting Department has an ongoing initiative to recruit, credential, and train reviewer candidates licensed in California to help ensure an adequate number of reviewers for DWC for increasing volumes and/or new requirements.

Exhibit 4.4.6-3: Completed Reviews illustrates the types of specialties required to complete MPRs for March 2014. We share this information with our Recruiting Department to identify priorities for their recruitment efforts. We recently launched an intensive California-licensed reviewer recruitment effort targeting reviewers that are board-certified in Occupational Medicine, Physical Medicine and Rehabilitation, Orthopedic Surgery, and Psychiatry, in addition to other specialties/subspecialties. As such, we have identified an additional 80 qualified MPR candidates who are in the process of joining our panel. We will continue our California-licensed MPR recruitment efforts to continue to ensure we have secured multiple California-licensed physicians and allied health care professionals in all specialties and subspecialties.

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Completed Reviews by Expertise - March 2014

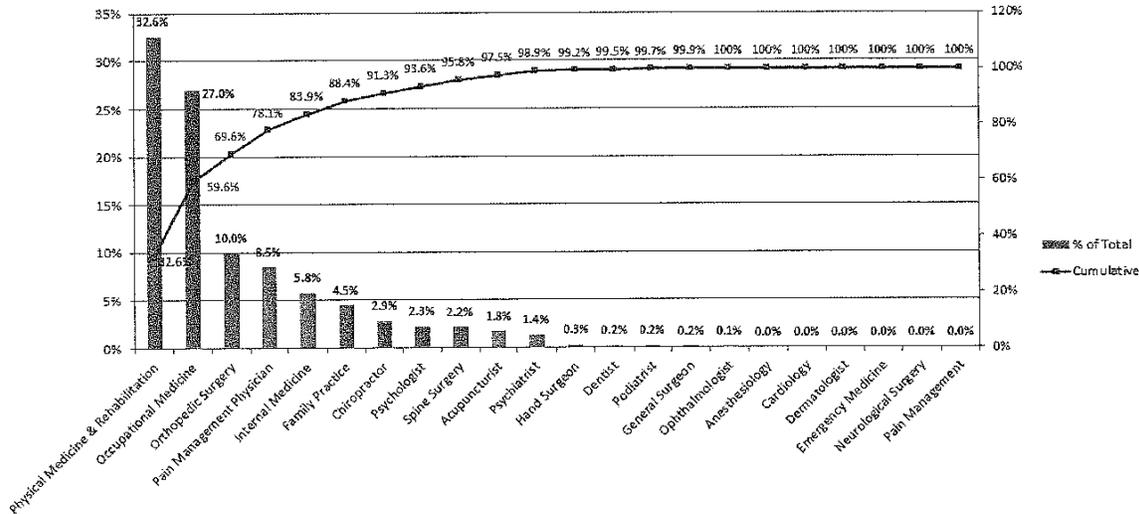


Exhibit 4.4.6-3: Completed Reviews: Completed Reviews illustrates the types of specialties required to complete MPRs for March 2014.

In addition to the ongoing recruitment efforts of the Director of Professional Relations, MAXIMUS Federal has existing agreements with the University of Rochester School of Medicine and Dentistry Medical Faculty Group, Morehouse School of Medicine, and the University of California at Davis School of Medicine to expedite recruitment of needed specialists. If these sources cannot provide qualified and acceptable candidates to credential, we contact specialty societies, advertise at State Boards, and place advertisements in the listservs for the most reputable specialty journal for that type of clinician. Upon occasion we review the medical literature and contact a recognized expert in a sub-sub-specialty area for a particular review. Over the past 10 years such calls have been 100 percent successful with many reviewers remaining on our panel.

As noted above, we have subcontracted with other URAC accredited IROs to enhance the scope and breadth of our California licensed reviewer panel. As result of this strategy we have added another 600 physicians and allied health care practitioners to our panel resources.

We do not add panel members solely for the purpose of marketing claims about panel size. Excellence in reviewer performance is a function of repetition. Accordingly, we purposefully limit the number of redundant panelists in each sub-specialty to ensure that each panelist conducts a reasonable number of reviews per year.

4.4.6.1 Select Reviewers Based on Clinical Experience

RFP Section A.6.a, Page 10

The Appeal Officer, in conjunction with the Medical Director and Director of Professional Relations determines the appropriate medical and professional specialty necessary to render a timely, objective, and effective report. In order to make this determination the Appeal Officer will determine the medical issue at dispute. If the Appeal Officer has any questions, he or she will consult with the Project Manager and the Medical Director and/or Director of Professional Relations as necessary.

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4.4.6.2 Determine the Medical and Professional Specialties

RFP Section A.6.b, Page 10

Once the appropriate specialty/subspecialty has been determined, the Appeal Officer will contact our Professional Relations Department to select an appropriate reviewer from our reviewer database. If the Appeal Officer has any questions regarding the selection of the MPR(s), the Appeal Officer will discuss assignment with the Medical Director or the Director of Professional Relations for resolution.

Upon completion of the MPR Referral Form, the case file is prepared for submission to the MPR. The assigned MPR is telephoned and informed that a copy of the case file will be delivered. At this time, the MPR is reminded of the facts and circumstances of the case and the date the review is due, and is directed to immediately contact MAXIMUS Federal if additional information is required, if it is determined that a conflict of interest exists, or if the review cannot be completed within the required timeframe.

At the end of each business day prior to sending cases to MPRs, Appeal Officers forward case assignments to the Director of Professional Relations and/or the Medical Director for review. If either the Director of Professional Relations or the Medical Director has any questions regarding case assignment, these questions are resolved prior to forwarding the cases to MPRs.

4.4.6.3 Select One Reviewer to Conduct the Review

RFP Section A.6.c, Page 10

Unless otherwise instructed by DWC, we will select one reviewer to conduct the review. As noted above, the reviewer will be selected based on the type of medical treatment in dispute or the complexity of the dispute.

4.4.7 Content of Reviews

RFP Section A.7 (a-c), Page 10

In this section we provide an overview of medical record review and assessment procedures for the DWC IMR Project.

4.4.7.1 Review All Pertinent Medical Records and Other Appropriate Information

RFP Section A.7.a, Page 10

As noted above, for each assignment our Case Assessment Team organizes the case file and our Panel Scheduling Team creates an MPR Referral Form to help facilitate the review. Our Panel Scheduling Team then submits these documents to the MPR via Expert Gateway. The assigned MPR is contacted and informed that a copy of the case file is available on Expert Gateway. At this time, the MPR is reminded of the facts and circumstances of the case, the date the review is due, and is directed to immediately contact MAXIMUS Federal if additional information is required, if it is determined that a conflict of interest exists, or if the review cannot be completed within timeframe.

When all case file information has been received, the MPR reviews the case file and completes the MPR Referral Report. The MPR Referral Report will require the MPR to 1 provide an assessment of the quality and completeness of the case file information, provide a summary of the medical facts at issue, provide citations to medical and scientific literature considered in completing the review, and answer the specific questions posed by DWC.

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The MPR Referral Report also requires the MPR to certify and attest that the MPR is qualified to review the case, that the MPR has no conflicts of interest, and that there has not been a change in the MPR's credentialing status since the MPR's submission of information to MAXIMUS Federal for credentialing. Upon completion of the review, the MPR will forward the completed review to MAXIMUS Federal.

4.4.7.2 Reviewers Confer as Deemed Appropriate and Necessary

RFP Section A.7.b, Page 10

If more than one reviewer is selected to review a case, reviewers may confer as they deem appropriate and necessary, and the recommendation of the majority shall prevail. If the reviewers are evenly split as to whether the disputed medical treatment should be provided, the decision shall be in favor of providing the treatment.

4.4.7.3 Provide an Individual Assessment

RFP Section A.7.c, Page 10

As part of their initial training, prior to case assignment, and via the MPR Referral Form, we provide training and instructions on the individual assessment of cases, including how to provide professional analysis and determination on whether the disputed medical treatment is medically necessary.

The MPR is instructed to write all reviews in plain English to the extent practicable. We will confer with DWC regarding all modifications to the template for medical determinations. The reviews will state the reasons supporting the answers to DWC's questions specifically referencing the injured worker's medical condition; the relevant medical records and other records reviewed, including a detailed list of the documents reviewed; and detailed relevant findings associated with the standard set forth in Labor Code Section 4610.5(c)(2).

Labor Code Section 4610.5(c)(2) provides a definition of "medically necessary" and "medical necessity" - a 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 following standards:

- The guidelines adopted by the administrative director pursuant to Section 5307.27
- Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service
- Nationally recognized professional standards
- Expert opinion
- Generally accepted standards of medical practice
- Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious

This information is included on our MPR Referral form as a best practice. As our rationale supporting the analysis, reviewers are also instructed that these standards will be applied in the order listed above, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition.

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4.4.8 Distribution of Completed Reviews

RFP Section A.8 (a-b), Page 10

In this section, we discuss our procedures for distributing completed IMRs, including the final determination.

4.4.8.1 Complete IMR, Enter Determination and Upload Supporting Documents into the Case Work-flow Management System

RFP Section A.8.a, Page 10; A.4 (a-c), Page 8

Upon return of the completed MPR Referral Form, the Case Closing Team will review the determination for quality and completeness and ensure that all questions posed by DWC have been answered. The Appeal Officer shall immediately contact the MPR for clarification of any issues. The Appeal Officer will contact the Nurse Supervisor, Project Manager, and/or Medical Director as necessary for resolution of issues. Once the Appeal Officer has completed the audit process the determination will be entered, all supporting documents will be uploaded into *entellitrak*, and a written determination will be generated. The final determination will be sent to the injured worker and/or their authorized representative, the Claims Adjudicator and/or their authorized representative, and the injured employee's provider if not a requesting party or interested party.

4.4.8.2 Final Determination

RFP Section A.8.b, Page 10

All final determinations will be generated in *entellitrak* and will include the following information:

- A statement that it constitutes the final determination of DWC's Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4610.6(h)
- The supporting analysis of each reviewer who participated in the IMR
- A summary biography of the medical qualifications of each reviewer, including the jurisdiction where the reviewer is licensed and the specialty or subspecialty of the reviewer

All standard reviews will be completed within 30 days after receipt of all documents needed to complete the review. Expedited reviews will be completed within three calendar days after receipt of all documents needed to complete the review. Please see *Exhibit 4.4.8.2-1: Final Determination Letter* for a copy of what we send to the Interested Parties.

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Appeals and Remands are handled within the appropriate timeframes and in accordance with pertinent rules and regulations.

4.4.9.1 Notice that an IMR Determination Has Been Appealed

RFP Section A.9.a, Page 10

The Expedited IMR Team will make the case record for the IMR available for electronic transmittal by DWC to the WCAB for those cases where we receive notice that an IMR determination has been appealed to the WCAB pursuant to Labor Code section 4610.6(h). We understand that the case record must include the following:

- The request for IMR
- All documents submitted to or considered by MAXIMUS Federal for the IMR
- All correspondence between MAXIMUS Federal and the Interested Parties
- The final determination and all accompanying documents

4.4.9.2 Notice that an IMR Determination Has Been Reversed and Remanded

RFP Section A.9.b, Page 11

For those IMR determinations that have been reversed and remanded to DWC for another IMR we will assign the case for IMR to a different reviewer. The new reviewer cannot have any involvement in the initial IMR and must not have any connections to the reviewer(s) who participated in the initial IMR. The new reviewer will be provided with the case record from the first IMR but not the final determination, supporting analysis, or description of the medical qualifications of any reviewer who participated in the first IMR.

Unless the otherwise specified by the WCAB or the reviewing court, the record provided to the new reviewer is deemed complete, subject to our authority to request additional information as specified in *Section 4.4.3: Information to Conduct IMR*. We will complete the new review and issue a new final determination in accordance with the requirements within 30 days of receipt of notification from the DWC that the case has been remanded or within three days of receipt of such notification if the remand order requires an expedited review.

We understand that we cannot charge an additional fee for an IMR involving a case where our previous IMR determination was reversed and remanded, unless the reversal was based on grounds other than MAXIMUS Federal error or negligence.

4.4.10 Confidentiality of Records and Information

RFP Section A.10 (a-e), Page 11

In this section, we provide an overview of our procedures to ensure the confidentiality of records and related IMR information associated with the DWC IMR Project. DWC can be assured that MAXIMUS Federal understands and is experienced with confidential record protection of DWC IMR case files.

To ensure confidential protection of case files and attendant data to assist in maintaining protection of all information and data, MAXIMUS Federal employs a Director of Quality Assurance. This individual is charged with analysis of, and corporate compliance with, applicable confidentiality and privacy protection laws, statutes, and regulations, including Labor Code 9792.10.5 (d). On this basis, we have established

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formal and exhaustive confidentiality protection procedures. Please see *Appendix I: Confidentiality Policy and Procedures* for an overview of our confidentiality program. Below we provide an overview of our rigorous confidentiality measures.

MAXIMUS Federal Staff and Vendor Confidentiality Agreements

MAXIMUS Federal requires that all staff, reviewers, subcontractors, and vendors sign confidentiality agreements acknowledging that information relating to clinical review is confidential and agreeing to prevent unauthorized disclosure of any kind. Staff and associates are not permitted to remove or take confidential information upon termination. All MPR contracts include terms which require that all information provided by MAXIMUS Federal is kept strictly confidential and shall not be disclosed or re-disclosed to any person or party except those authorized by law.

Personnel Security

The MAXIMUS Federal corporate facility holds a top secret designation. On the basis of our qualifications, we have in-depth experience interfacing with federal and state government procedures for personnel risk classification, background investigations, and security clearances.

MAXIMUS Federal requires all staff to promptly conform to federal government user ID requests and associated security profile requirements. Employee system access is conditioned upon initial HIPAA and network security training delivered by our corporate Center for Employee Development (CED) and the IMR Project training team. Completion of any security training required by the client and the successful completion of all required training is tracked through our learning management system. Similarly, our subcontractors are required to complete system security training prior to assignment. *Exhibit 4.4.10-1: Information Security Training Course* shows the security training course that users are required to complete prior to accessing our project systems. We will ensure that all members of our team take the required security training.

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Information Security & Privacy Training

Some Words You Should Be Familiar With

- **Privacy** relates to an individual's desire to control access to their personal information.
- **Confidentiality** relates to the obligation of the holder of personal information to protect an individual's privacy. This obligation is determined by common practice, federal and state laws, and regulations which vary from state to state.
- **Security** is the extent to which information can be stored and provided with access limited to those who are authorized and have a legitimate "need to know".
- **"Need-to-Know"** states that only those officers and employees of an Agency who have a need for access to information in the performance of their duties should have access to it. (Privacy Act of 1974)
- **Individual:** Under the Privacy Act, an individual is a citizen of the United States or an alien admitted for permanent residency. The Privacy Act does not apply to the deceased, non-resident aliens, or businesses.

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Exhibit 4.4.10-1: Information Security Training Course. *This screen illustrates a portion of our security and training program.*

Physical Security

The DWC contract will be run from our secure Folsom, California facility. Physical access to the office during working hours is via a secure and locked reception area, which is designed to also accommodate mail and case file delivery. Vendors and unauthorized personnel are not permitted past this area. The remainder of the facility is segregated into zones, such as the mailroom/operations area, computer equipment room, records room, and work team areas. Consistent with the ISA, a zone provides appropriate access only to those with a need for access. Each zone is controlled and protected by a smart card authorized user access system. Movement of all personnel is tracked through this smart card system. During non-business hours, access to the entire building is by authorized access code only.

MAXIMUS Federal recognizes that the review file contains protected health information that can be used to steal one's ID, and because public news accounts of lost or stolen PHI are becoming more frequent, we endeavor to provide DWC with the most stringent case security. IMR case file and PHI protections are fully compliant with the HIPAA, HITECH, and related federal and state privacy and confidentiality rules and regulations. Files and supplementary material are logged, tracked, and retained in a secure records room area. In addition, all workstations include locking files that are used to secure material when staff not present. Drafts of obsolete records are deposited in secure bins prior to destruction by certified vendors. In addition, MAXIMUS Federal maintains ISO-controlled procedures covering the records management process, and such procedures are subject to periodic verification by trained ISO auditors.

We have an on-site secure medical records room which is used to secure submitted case file documentation before and after it is scanned and uploaded to *entellitrak*. Upon completion of each IMR

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case, the hard copy documentation is securely destroyed by certified vendors while an electronic version of the documentation is retained in the *entellitrak*. We understand DWC will require the successful contractor to maintain case files, including all records, correspondence, reference materials, and documents pertaining to the review for at least five years or for three years after final payment under the contract, whichever is later, as well as ensuring all files are available for audit requirements set for in the proposed contract. It is MAXIMUS Federal standard policy to maintain records for a minimum of seven years from the date of the last action which could be taken on the file, and our files are regularly audited by internal and external auditors so we are very comfortable meeting such requirements.

4.4.10.1 Information Protected Against Unauthorized Disclosure

RFP Section A.10.a, Page 11

MAXIMUS Federal understands that for the DWC IMR project, the Contractor will ensure that any physical or electronic transfer and storage of medical records and confidential information is protected against unauthorized disclosure as required by federal and state law. Furthermore, we understand information about the diagnosis, treatment, health, and personal identifying information of any injured employee will be made available to reviewers and other personnel only to the extent necessary to ensure performance under the contract. Per DWC's requirements, MAXIMUS Federal shall maintain electronic case files, including all records, correspondence, reference materials, and documents pertaining to the review for at least five years or for three years after final payment under the contract, whichever is later, as well as ensuring all files are available for audit requirements set for in the proposed contract.

4.4.10.2 Records and Information Provided

RFP Section A.10.b, Page 11

In addition to the above, MAXIMUS Federal understands that no records and information provided to, obtained by, or prepared by MAXIMUS Federal in connection with any IMR performed are DWC records and cannot be used for any purpose not specified under this contract. We will refer all data requests and case information requests to DWC and not independently give out data without the prior written consent of DWC. We will promptly and without delay forward all records and information for any IMR in progress or for any completed IMR to DWC or to such other person or entity as DWC may designate.

4.4.10.3 Unauthorized Persons

RFP Section A.10.c, Page 11

We are confident that our confidentiality of records and information measures will help to ensure that unauthorized persons shall not have access to any materials furnished by DWC to MAXIMUS Federal.

4.4.10.4 Information Designated Confidential by DIR or DWC

RFP Section A.10.d, Page 11

All financial, statistical, personal, technical, and other data and information relating to DWC's operations that are designated confidential by DWC and made available to MAXIMUS Federal in order to carry out this Agreement, or which become available to MAXIMUS Federal in carrying out this Agreement, will be protected by MAXIMUS Federal from unauthorized use and disclosure. The methods and procedures employed by MAXIMUS Federal for the security of DWC's data and information may not be changed unless DWC has given its prior approval in writing. No information obtained by MAXIMUS Federal, its staff, its contractors or subcontractors under this Agreement, or from their performance hereunder, shall

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be used for marketing, solicitation, or other commercial purposes. Any disclosure or use of information developed, received, or maintained under this Agreement that is not directly related to the review, quality assurance, or accreditation activities of MAXIMUS Federal's or DWC's IMR process, requires written consent of DWC.

4.4.10.5 Publicly Available Information

RFP Section A.10.e, Page 11

We understand that we will not be required under the provisions of this section to keep confidential any data or information that is or becomes publicly available, is already rightfully in MAXIMUS Federal's possession, is rightfully obtained from third parties, or is independently developed by MAXIMUS Federal outside the scope of this Agreement

4.4.11 Quality Assurance Oversight

A.11 (a-k), Pages 11-12

Below we provide an overview of our MAXIMUS Federal Services' Quality Assurance (QA) Program and address the specific QA requirements outlined in RFP Section A.11.

4.4.11.1 Overview

Our Quality Assurance Program is designed to ensure that our services meet client and stakeholder expectations. We have an established written quality policy with quality objectives that emphasizes the continual improvement of work processes by establishing objectives for quality results at all job levels. The quality assurance process occurs after the work has been completed and is conducted in the interest of identifying trends and initiatives for quality improvement. This is in addition to operations quality control in which medical reviews and cases are reviewed by Nurse Reviewers to ensure completeness and adherence to standards (see *Exhibit 4.4.11.1-1: MAXIMUS Federal Services Quality Objectives*).

Quality Objectives

MAXIMUS Federal establishes goals or expectations for quality throughout its processes that support:

- **Timeliness** of all provided services and related actions
- **Accuracy** in all work performed
- **Conflict-free and impartial** performance of all required tasks
- **Expertise** of staff to complete assigned activities

Exhibit 4.4.11.1-1: MAXIMUS Federal Services Quality Objectives. *This exhibit outlines our quality objectives.*

MAXIMUS Federal further applies industry best practices in quality assurance, such as the internationally recognized ISO 9001:2008 standard for quality management and URAC accreditation. The eight fundamental principles of ISO 9000 guide our commitment to quality: Customer Focus; Leadership; Involvement of People; Process Approach; System Approach to Management; Continual Improvement; Factual Approach to Decision Making; Mutually Beneficial Supplier Relationships.

MAXIMUS currently maintains ISO 9001:2008 certifications for the following projects:

- NY Medicaid Choice
- Medicare QICs (6 total Projects)
- SSA Ticket-to-Work Program

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- California Health Care Options
- California Healthy Families
- Georgia Families
- MAXNetWork

ISO 9001:2008 specifies the requirements for a quality management system (QMS) that an organization must fulfill to demonstrate its ability to consistently provide services that enhance customer satisfaction and meet applicable statutory and regulatory requirements. The ISO 9000 family of standards provide internationally recognized guidelines for establishing a Quality Management System (QMS). The ISO 9001 standard is the most common in practice and the only set in the series that can be used for external certification.

MAXIMUS Federal Services holds accreditation as an Independent Review Organization by URAC. URAC, an independent, nonprofit organization, is well-known as a leader in promoting health care quality through its accreditation, education, and measurement programs. URAC offers a wide range of quality benchmarking programs and services that keep pace with the rapid changes in the health care system and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry. Our URAC accredited programs are audited between reaccreditation periods by representatives of URAC.

We know that the State's ultimate concern is not how our QA Program is implemented, but rather the measureable results it provides. Our QA Program provides an effective solution for exceeding RFP requirements, which result in tangible benefits to our government clients and the constituents they serve. Additionally, we have demonstrated (without cost to our clients) that if our processes fail to maintain an acceptable level of deliverable quality, our corrective action process quickly remediates such issues and eliminates their root cause.

Quality Assurance Program

MAXIMUS Federal Services Quality Assurance (QA) Program is closely integrated with our approach to project management, both of which are designed to ensure our services meet client and stakeholder expectations.

Our QA Program includes accommodations for critical quality management tasks that drive continual improvement, including:

- **Internal Audits:** Objectively assess conformance to all applicable regulations, requirements, policies, and processes
- **Corrective and Preventive Action Program:** Track issues critical to project success
- **Monitoring, Measurement, and Analysis:** Collect and report on key performance indicators; perform retrospective reviews of completed product
- **Document Control:** Establish protocols and work instructions for staff and consistency
- **Compliance Program:** Identification and integration of all regulatory requirements

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The guiding principle of our QA Program is our insistence that all functions are defined and documented as "repeatable" processes. This systematic approach allows MAXIMUS Federal to easily identify and eliminate variation in project deliverables. We have an extensive library of controlled process documentation related to medical appeals adjudication. Our documentation is a resource for staff members at all levels of appeal processing, and ensures that staff is uniformly educated and trained on medical appeal processing. Many workflow documents have also been written to apply to any type of work we take on, allowing for a rapid consistent deployment of our QA Program to any new work. For example, ISO 9001:2008 requires six procedures that cover corrective actions, preventive actions, internal audits, control of nonconformities, control of documents, and control of records. These processes and documents are easily repeatable and can be deployed during an implementation.

Our QA Department continually monitors performance to requirements and desired program outcomes. Wherever possible, quantitative data will be captured and analyzed along with qualitative data attained through auditing or from client and stakeholder feedback. These data will be captured, utilized for the development of performance benchmarks, and analyzed for compliance with benchmarks as well as trending. Quality assurance reports will be provided on a routine basis to project management throughout the engagement.

In addition to monitoring the high-level evaluation success criteria, MAXIMUS Federal has tools to monitor discrete elements of IMR quality. The frequency to which quality reviews are performed can vary based on volume and performance over time. We use statistically sound and proven sampling techniques that increase as the volume of completed IMRs increases. MAXIMUS Federal has qualified expert statisticians on staff that can provide representative or stratified samples for quality review.

In addition to quality assurance monitoring by the QA Department, we build in quality control checks in each process. Staff at any step in the review cycle can flag potential errors for review and correction prior to completion. We use a four-level quality control process for IMR Decisions which allows for Appeals Officers, Nurse Reviewers, and Medical Directors to review cases and final decision letters as needed. All final decision letters receive a quality control check for completeness, readability, and accuracy before mailing. These data, in addition to quality assurance data, can be used to modify and improve processes or to provide focal mentoring and training for staff. All quality data are ultimately used to assess staff performance and provide incentive for achieving the project goals and outcomes.

Quality Assurance Committee

MAXIMUS has established a Quality Assurance (QA) Committee to oversee its Quality Assurance Program. The Quality Assurance Committee includes the Director of Quality Assurance; Medical Directors; Vice President, Operations; Project Managers; Director, Regulatory Compliance; and Director, Information Systems. The Quality Assurance Committee is charged by MAXIMUS Federal senior management with implementing a process to oversee, monitor, and improve quality of services provided in all MAXIMUS Federal business lines. Oversight of credentialing of Medical Reviewers is the responsibility of the MAXIMUS Federal Services Credential Committee under the Director of Professional Relations.

The Quality Assurance Manager, reporting to the Director of Quality Assurance, is responsible for the general oversight of the quality management system, internal audits, quality reviews of data and work product, corrective/preventive actions, and implementation of ISO 9001 and/or URAC, as applicable. The

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Medical Director is responsible for the general oversight of the clinical aspects of review, and is specifically responsible for implementing Medical Director or peer reviews of Medical Reviewers work products.

4.4.11.2 Compliance with Labor Code 139.5(d) (3)

In this section we address how our QA mechanism specifically meets the specifications set in forth in Labor Code 139.5(d)(3) and listed below:

- Ensures that any medical professionals retained are appropriately credentialed and privileged
- Ensures that the reviews provided by the medical professionals or bill reviewers are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis
- Ensures that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions and the medical necessity of treatments or therapies in question
- Ensures the confidentiality of medical records and review materials, consistent with the requirements of this section and applicable state and federal law
- Ensures the independence of the medical professionals or bill reviewers retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts of interest, pursuant to paragraph (5)

4.4.11.3 Credentialing and Privileging Program

The Director of Professional Relations is responsible for our credentialing process. The MAXIMUS Federal credentialing program is extremely rigorous and we are confident it exceeds the standards mandated DIR/DWC and the relevant legislation. Our standards surpass the combined requirements of the National NCQA and URAC. Please see *Appendix J: Credentialing Policies and Procedures* for a copy of our credentialing measures. Please note that all the MPRs we will access through our URAC IRO partners are credentialed in accordance URAC and MAXIMUS Federal's stringent requirements.

Our MPR panel consists of more than 350 health care professionals licensed to practice in California and more than 400 additional physicians in all recognized specialties and subspecialties, as well as other health care professions (for example physical therapists and nurse practitioners). To even be considered for our panel, an MPR must meet the following minimum qualifications:

- Must be board certified in a recognized American Board of Medical Specialties (ABMS) or the Advisory Board of Osteopathic Specialties (ABOS) specialty. A practitioner who is only board eligible with no board certifications will not be accepted to our panel
- Must be in active practice (defined as at least 24 hours of clinical practice a week)
- Must have at least five years of experience as a practicing clinician
- Must not have any unexplained or indefensible lapses in employment of three months or greater
- Must have an active and valid license with no history of any disciplinary actions
- Must have an active and valid DEA license
- Must have no history of sanctions or disciplinary actions
- Must provide their most recent five-year malpractice history

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- Must provide verification of hospital affiliation, privileges, and academic appointment
- Must provide multiple recommendations
- Must be credentialed by our Credential Committee

A detailed discussion of our recruitment and credentialing process is set forth below. In addition to rigorous credentialing standards, we ensure the quality of our product through continuing education and training of our MPRs.

Our credentialing and training program meets or exceeds URAC requirements. In addition, our Credentialing Coordinators are in the process of becoming Certified Credentialing Specialists through National Association of Medical Staff Services. Furthermore, we have obtained application materials and plan to proceed with applying for NCQA accreditation as a Credential Verification Organization in FY14.

MAXIMUS Federal initiates the credentialing process via an MPR Application form, which requires candidates to provide the following information:

- Curriculum Vitae
- American Medical Association Profile
- Medical License Verification
- DEA Verification
- Board Certification Verification
- Work History Analysis
- Malpractice Claim History and Disciplinary Action Review
- Malpractice Insurance Coverage Verification
- Hospital Affiliation, Privileges, and Academic Appointment Verification
- Recommendations

Once the application and supporting documents have been returned to MAXIMUS Federal, the documents are subject to an initial screening process. During this process, the Director of Professional Relations reviews the application for completeness. If the application is not complete, a letter explaining the deficiency is sent. MPR applications that have not been corrected and/or completed within 90 days are rejected.

If the application is complete and all required documentation has been received, a referral is made to the American Medical Association's Physician Profile Service. This profiling service offered by the American Medical Association meets the primary source verification requirements set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), NCQA, and URAC.

Once completed, the profile is reviewed by both the Director of Professional Relations and the Medical Director, a file is established, and a letter of confirmation is sent to the physician applicant notifying him/her that the application is in process.

American Medical Association (AMA) Profile Verification

If the applicant is a medical doctor or a doctor of osteopathic medicine, the Director of Professional Relations or appointed designee completes a request for a profile from the AMA. The AMA Profile Service uses primary source verification for the purpose of



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credentialing of these physicians. MAXIMUS Federal uses this profile to verify the education and training and board certifications of the applicant. If the data provided by the applicant differ from that received from the AMA, MAXIMUS Federal contacts the AMA to remedy the discrepancy.

Medical/Clinical License Verification

As part of the credentialing process, MAXIMUS Federal requires a valid license or medical registration certificate issued by the state in which the clinical practitioner, dentist, or physician is currently practicing. Verification is accomplished through primary source verification with the State Licensing Board that issued the license or medical certificate. This is usually accomplished online. Most states provide verification via a state-sponsored website on the Internet. However, not all states offer online verification. When online verification is unavailable, MAXIMUS Federal requires that licensure must be verified in writing and a hard copy of that license/certification is required.

DEA Certification Verification

NCQA and URAC credential standards indicate that a DEA certificate need not be verified with the issuing agency. A DEA certificate is verified by possession of a valid hard copy of the actual DEA certificate on file. The AMA Profile Service does provide information verifying the DEA certificate and indicates whether the certificate is current. MAXIMUS Federal uses this service to verify DEA certificates when necessary.

Board Certification

MAXIMUS Federal requires that all Physician Reviewers be board-certified by at least 1 of the 24 boards recognized by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialties. We mandate that each physician provide a current copy of his or her board certification. As stated earlier, board certification is verified through the AMA Physician Profile. The MAXIMUS Federal clinical peer reviews database tracks the expiration date of the certificates, and renewed hard copy certificates are requested on an ongoing basis.

Work History

The MAXIMUS Federal MPR Application requires an employment history for the last five years. Employment history is reviewed to ensure that each applicant possesses sufficient medical practice experience. Employment history is also reviewed for any gaps in employment. If a three-month or longer gap is discovered, the applicant is requested to account for this period of time when he/she was not practicing.

Malpractice Claim History

As part of the credentialing process, all applicants must provide the name and address of their malpractice insurer(s) for the last five years. MAXIMUS Federal sends a letter to each malpractice insurer requesting verification. Once the information is received, it is compared to the information listed on the MPR Application to verify accuracy.

Sanctions and Disciplinary Actions History

MAXIMUS Federal utilizes a variety of resources to discover and verify any sanctions or disciplinary action levied on the applicants. Resources used include the National Practitioner Data Bank, the AMA Physician Profile Service, and any relevant state Office of Professional Conduct. Any information

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discovered indicating that sanctions or disciplinary actions have been imposed is brought to the immediate attention of our Engagement Director and Medical Director.

Once enlisted, MPRs are contractually required to inform us of any action taken by a licensing, certification, or credentialing body to revoke or suspend the physician's license, certification, or credentials (in whole or in part), or of any action which is likely to lead to such revocation or suspension. The MPRs also agree to notify MAXIMUS Federal of any change in hospital affiliation(s) and insurance coverage, any move, prolonged absence, disability, or other event that would impair the MPR's ability to comply with their MAXIMUS Federal or Department obligations.

Re-Credentialing Process

MAXIMUS Federal recognizes that the practice of medicine is dynamic and that the licensure status of a physician may change at any time. Therefore, we include in our credentialing process the requirement that each physician be re-credentialed at a minimum of every three years. Every three years, current reviewers are expected to complete an application and verification process. The Committee will review and discuss the application and determine the appointment status of the current reviewer. The appointment statuses for current reviewers include Permanent, Temporary/Provisional, Application Pended (need clarifying information), and Remove.

Routine Checking for Sanctions

To further ensure that only appropriate reviewers are utilized, on a quarterly basis MAXIMUS Federal staff check all relevant Internet-based sources to verify that the MPR's license is current and in good standing.

As an added quality assurance safeguard, reviewers are contractually required to inform us of any action taken by a licensing, certifying, or credentialing body to revoke or suspend the MPR's license, certification or credentials (in whole or in part), or upon any action which is likely to lead to such revocation or suspension. The MPRs also agree to notify us of any change in hospital affiliation(s) and insurance coverage.

All MPR contracts are renewed on an annual basis (one month prior to the anniversary date). We reserve the right to terminate the contract at any time. Reasons for immediate termination include limitation, suspension, or revocation of the reviewer's professional license; conviction of a felony or misdemeanor; or any evidence that he/she has acted in a manner constituting professional misconduct or gross negligence. We investigate malpractice suits/awards, a loss or change in hospital admitting privileges, and a loss of malpractice insurance coverage and may terminate a reviewer's contract upon 30 days written notice.

4.4.11.4 Timely, Clear and Credible Reviews

Below we outline our Four-level Quality Assurance/Quality Control Process for IMR decisions to ensure timely, clear, and credible reviews:

- Level 1: Orientation and ongoing training for MPRs to ensure they understand program requirements. This onboarding process involves a direct interface with the Medical Director and experienced reviewers serving as MPRs

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- Level 2: Prospective, initial assessment of all new reviewers with detailed feedback from the Medical Director until they are deemed ready to review on their own
- Level 3: Final decision letter including quality assessment of MPR summary, rationale, and outcome that involves a daily random sample covering 24 technical and substantive elements
- Level 4: Each final decision letter undergoes an audit performed by the Appeal Officer to ensure legibility, completeness, and accuracy prior to distribution

4.4.11.5 Selection and Matching of MPRs or Bill Reviewers

Our Case Assessment Team identifies the specialty and/or subspecialty required to perform the IMR. Our Panel Scheduling Team will then determine the appropriate MPR to conduct the IMR. This involves a careful review of the credentialing database to identify qualified California-licensed MPR candidates to perform the review. The Appeal Officer will contact each appropriate California MPR to determine availability to review the case. If at any time the Panel Scheduling Team is unclear as to what specialty should review the case, the Appeal Officer will contact the Medical Director or Director of Professional Relations for their input.

Upon contacting an appropriate MPR, the Panel Scheduler will determine if the MPR is available to review the assigned case. This process involves the provision of specific case file information to the MPR. Upon initial contact, Panel Scheduling Team will explain to the MPR that a case has been received from an injured worker and ask the MPR if they can complete the review of the case within the specified timeframe. If the MPR indicates that they are available to complete the case within the specified timeframe, staff will then explain the facts and circumstances surrounding the case to determine if the MPR is qualified to complete the review and absent of any material familial, financial, or professional affiliation with the parties to the case. As part of our ongoing quality control process, staff will ask the MPR the following questions to verify their qualifications provided in our credentialing database as it relates to the specific review:

- Are you credentialed in the diagnosis and treatment of the medical condition defined in the case?
- Are you credentialed in the specific procedure or treatment in dispute in the case?
- Have you treated one or more patients with the injured worker's condition in this case in the past 12 months?
- If you have not treated a patient with such condition or provided the disputed procedure in the last 12 months, do you represent yourself as fully knowledgeable concerning the medical condition of the injured worker and treatment options for the injured worker?
- Do you certify that aside from this case that you have not been involved in the diagnosis or treatment of the injured worker in this case?
- Do you certify that you do not have any relationship with any party to this case which would constitute a material familial, financial, or professional affiliation as defined in your contract with MAXIMUS Federal?

Once an appropriate MPR has been identified and fully vetted, the MPR assignment is entered into *entellittrak*.

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4.4.11.6 Confidentiality of Medical Records and Review Materials

Please see *Section 4.4.10: Confidentiality of Records and Information* for a detailed discussion of our procedures that ensure the confidentiality of medical records and review materials in accordance with 139.5(d)(3).

4.4.11.7 Conflict of Interest Policies and Procedures

Please see *Section 4.4.2.5: Compliance with Labor Section 139.5 and Any Other Conflicts of Interest Requirements* and *Section 6.2.14: Freedom from Conflicts of Interest Plan* for our procedures to help ensure the independence of MPRs or bill reviewers retained to perform the IMRs/IBRs reviews through conflict-of-interest policies and prohibitions and ongoing screening for conflicts of interest.

4.4.11.8 Qualified Medical Evaluator Restrictions

Pursuant to Labor Code Section 139.2, our Panel Scheduling Team will not assign a case for IMR to any physician holding an appointment as a qualified medical evaluator (QME). Please note that we do not recruit or credential physicians that are QMEs.

4.4.11.9 Complaints

Our Director of Quality Assurance and/or Project Manager will confer with DWC as necessary to review any complaints received about a particular review or to discuss issues relating to the overall IMR program. We will meet the following timelines related to this task:

- Within 5 days after receiving a request from DIR/DWC concerning a case reviewed during the preceding 30 days
- Within 15 days after receiving a request concerning other matters, including any systemic issues or problems relating to performance under this Agreement or pursuant to DIR/DWC's general oversight of the IMR program

4.4.11.10 Summary Report

Our QA team will prepare a summary report of the reviews on a weekly basis to submit to DWC. Our report will be available MAXDat and will include data elements in a format specified by DWC listed in Appendix B of the RFP, and additional data elements to be specified by DWC.

4.4.11.11 Monthly Summary Report

Within 15 days of each month-end, our QA team will prepare a summary report of the reviews completed during the previous month to submit to DIR/DWC. This report will include the following data listed in Appendix C of the RFP and additional data elements to be specified by DWC.

4.4.11.12 Year-end Summary Report

Within 45 days of each year-end, our QA team will prepare a summary report of the work completed during the previous year to submit to DWC. The report will include the information contained in the monthly reports as per Appendix C in addition to the information contained in Appendix D in a format specified by DWC and additional data elements to be specified by DWC.

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4.4.11.13 Ongoing Collaboration with DWC

We will continue to confer with DWC as necessary to ensure consistent and effective implementation of the IMR system, including but not limited to instructions provided to reviewers on optimal methods to conduct reviews and issue decisions, and identification of designated points of contact.

4.4.11.14 Quality Control Measures

As outlined above we will use a Four-level QC process for all IMRs issued and will provide corrective instruction to and take corrective action against individual reviewers as needed. Our Four-level process is outlined below:

- Level 1: Orientation and ongoing training for MPRs to ensure they understand program requirements. This onboarding process involves a direct interface with the Medical Director and experienced reviewers serving as MPRs
- Level 2: Prospective, initial assessment of all new reviewers with detailed feedback from the Medical Director until they are deemed ready to review on their own
- Level 3: Final decision letter quality assessment of MPR summary, rationale, and outcome that involves a daily random sample covering 24 technical and substantive elements
- Level 4: Each final decision letter undergoes an audit performed by our Appeal Officer to ensure legibility, completeness, and accuracy prior to distribution

4.4.11.15 Decision Tools

In a collaborative effort to utilize best practices, we will continue to confer with and assist DWC in identifying important decisions that will be used as a learning tool for MPRs, DWC staff, providers, and claims administrators.

4.4.11.16 On-site Quality Assurance Review

With at least one week's advance notice, we understand that DWC may conduct an on-site quality assurance review of our office procedures and record systems.

4.4.11.17 Random Case Audits

We understand that DWC may conduct random audits of cases to ensure that MPRs meet required professional qualifications, relevant documents and records are requested, written analyses and determinations are complete and supported by the available documents and other records, medically appropriate decisions are made, and applicable deadlines are met. We further understand that DWC may use MAXIMUS Federal to revise policies and procedures as needed to correct to any pattern of deficiencies in these areas, and may direct MAXIMUS Federal to discontinue the use of any reviewer whose decisions are determined to have been medically inappropriate.

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4.4.12 Customer Service

RFP Section A.12, Page 12

To ensure program continuity, we will use the same toll-free telephone number, the same fax number, and the same email address we currently use to ensure all interested parties have immediate access to our staff.

This information is provided below:

Toll Free Number: (855) 865-8873

Fax: (916) 605-4270

E-mail: imrhelp@maximus.com

We understand that we will be responsible for documenting all complaints and reporting such complaints to DWC. All complaints are documented in *entellitrak* and then forwarded to DWC within one business day of receipt. We include a summary of all complaints received as part of our ongoing monthly report to DWC.

If addressing other inquiries we receive from interested parties, we will limit our response to the current status of the party's case, and information on how to contact DWC to address any other questions or concerns. We will not and have not provided any advice, legal or otherwise, to interested parties. Any inquiries from an interested party that are not directly related to the current status of a case will be directed to DWC.

4.4.13 Timeliness

RFP Section A.13, Pages 12-13

We understand that we will be required to maintain a 95 percent timeliness rate in the completion of IMRs. The timeliness rate of 95 percent will be calculated monthly based upon the percentage of open cases that have not been completed within the required timeframes and for which an extension has not been granted by DWC.

If our Appeal Officer determines that we need an extension of time to complete an IMR separate and apart from any other extensions afforded, we will make the extension request in writing to DWC. Each request will contain good cause for DWC to grant the extension. We understand that the extension will not be considered granted unless it is provided in writing, including via email, by DWC to MAXIMUS Federal. DWC in its sole discretion will determine whether or not there is good cause for the extension.

If upon review of monthly timeliness data our performance falls below 95 percent, payment to the state Workers' Compensation Administrative Revolving Fund (WCARF) will apply, as follows:

- A monthly timeliness below 90 percent shall result in a payment of 10 percent of all fees charged in the subject month
- A monthly timeliness below 95 percent in each month in a three-month period shall result in a payment of 10 percent of all fees charged in the third month of the three-month period
- A monthly timeliness below 80 percent shall result in a payment of 20 percent of all fees charged in the subject month
- A monthly timeliness below 70 percent shall result in a payment of 30 percent of all fees charged in the subject month

Use or disclosure of data contained on this sheet is subject to the restrictions on the title page of this proposal

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Notwithstanding the foregoing, no payment to WCARF shall apply in any subject month wherein MAXIMUS Federal receives an increased volume of IMR applications of 35 percent or greater than the previous month's volume. DWC will notify MAXIMUS Federal in writing of any WCARF payment owed because of our untimely performance. We will make the required payment within 30 days of receipt of notice of the payment owed. These payments are not intended to be a penalty and are in addition to any other legal rights or remedies the State has for unsatisfactory performance of this Agreement.

4.4.14 Case Workflow Tracking System Availability Requirements

RFP Section A.14 (a-d), Page 13

Please *Section 4.2.9: System Availability* for a detailed discussion our case workflow tracking system availability.

4.4.15 Fraud and Quality of Care Reporting

RFP Section A.15, Page 13

Identifying potential issues of fraud and/or quality of care is an inherent part of the MAXIMUS Federal IMR process. For all of our IMR clients we ensure that our Appeal Officers and Medical Professional Reviewers (MPRs) take fraud and quality of care into consideration when reviewing IMRs. If there is any evidence of fraud or the provision of substandard care, our Appeal Officers or MPRs will report this information to the IMR Project Manager and Medical Director. This information is then submitted to the client for discussion. For the DWC project we will include a section in the monthly report detailing any potential fraud or quality of care issues identified by our Appeal Officers or MPRs. We have a long history of assisting government agencies in identifying issues of fraud and quality of care.

As part of our consulting services contract with the Department of Managed Health Care's Provider Complaint Unit, MAXIMUS Federal reviewed a sampling of several hundred appeals involving payment disputes between a large scale hospital group and a major California HMO. These cases involved disputes over payment for hospital fees related to inpatient admissions to non-contracted facilities following emergency department treatment. MAXIMUS Federal was tasked with determining whether there was a pattern of unnecessary hospital admissions by the provider or unfair payment practices on the part of the health plan. A detailed clinical review of each of the cases involved in the sample was performed to determine if the patients were stable enough for transfer or discharge at any point during the inpatient stay. Based upon our review of the cases involved in the random sample, we were able to identify a pattern of unnecessary hospital admissions, which aided the client in settling the dispute between the two parties.

Similarly in 2013 we performed a case study of 200 files from a durable medical equipment provider for the United States Department of Health and Human Services, Office of the Inspector General. Based upon this review we determined the provider was fraudulently billing Medicare for power operated vehicles. As a result of this review the federal government fined the DME provider more than \$30 million dollars. We have similar experience providing quality of care reviews for government agencies. We have contracted with the Massachusetts and Montana Medical Boards for more than a decade and are responsible for reviewing complaints of substandard care and determining whether the complaints are valid. We have also contracted with the Department of Veterans Affairs since 2006 to provide peer review services and determine whether substandard care was provided. Through our contract with the VA we have also

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completed large scale quality of care studies. For example, after a rash of suicides at one VA Medical Center we completed a case review study containing 200 files to determine if the Psychiatric Services Department was providing appropriate standard of care.

4.4.16 Certificate of Insurance

RFP Section A.16, Page 14; C.4.a.2, Page 19

Upon contract award, MAXIMUS Federal will furnish a certificate of insurance stating that we have liability insurance presently in effect of not less than \$2,000,000 per occurrence for bodily injury and property damage liability combined.

4.4.17 Prohibited Conflicts of Interest

RFP Section A.17, Pages 14-15

As emphasized throughout this bid, MAXIMUS Federal can offer DWC an industry best conflicts of interest avoidance strategy. Based upon our business philosophy and the absolute need to maintain our independence and integrity, we do not and will not provide any services to, or contract with any health or disability insurer or health plan where it would create a conflict with a federal or state government IMR program. We believe we are the only URAC accredited IRO that can make this claim. Therefore, we are certain we meet DWC's conflict of interest requirements delineated in RFP Section A.17 and outlined below.

MAXIMUS Federal is not an affiliate or a subsidiary of, nor in any way owned or controlled by, a workers' compensation insurer, claims administrator, or a trade association of workers' compensation insurers or claims administrators. No MAXIMUS Federal board member, director, officer, or employee is a board member, director, or employee of a workers' compensation insurer or claims administrator. Additionally, no MAXIMUS Federal board member, director, or officer of a workers' compensation insurer or claims administrator or a trade association of workers' compensation insurers or claims administrators serves as a MAXIMUS Federal board member, director, officer, or employee of Contractor.

As discussed earlier, MAXIMUS Federal and our designated reviewers do not have any material professional, material familial, or material financial affiliation with any of the following:

- For MAXIMUS Federal: The employer, workers' compensation insurer or claims administrator, or a medical provider network of the insurer or claims administrator
- For our MPRs: They are screened throughout the IMR process to ensure they do not have any material professional, material familial, or material financial affiliation, the employer, workers' compensation insurer or claims administrator, or a medical provider network of the employer, insurer, or claims administrator
- For both MAXIMUS Federal and our designated MPRs:
 - Any officer, director, or management employee of the employer or workers' compensation insurer or claims administrator
 - The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment
 - The institution at which the treatment would be provided

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- The development or manufacture of the treatment proposed for the employee whose condition is under review
- The injured employee or the injured employee's immediate family

Ongoing Conflict of Interest Monitoring

Please see *Appendix D: Conflict of Interest Policies and Procedures* for a copy of our written policies and procedures that are used to ensure that our ownership, management, employees, professional staff, and reviewers do not have any actual or apparent conflicts of interest related to the provision of DWC IMR services. Please see *Section 4.4.2.5: Compliance with Labor Section 139.5 and Any Other Conflicts of Interest Requirements* for additional information regarding the series of steps utilized in our case management process to ensure our reviewers are conflict free when performing an IMR.

Timely and Effective Case Referral

Please see *Appendix B: Case Referral Policies and Procedures* features our Panel Scheduling Outgoing Cases document, which is designed used to ensure qualified MPRs are assigned to IMRs.

FPPC Form 700

We agree to ensure that, on an annual basis, all required officers, directors, and management employees of and designated reviewers providing IMR services on behalf of DWC will complete the FPPC Form 700, Statement of Economic Interests.

4.4.18 Payment

RFP Section A., Page 15

We understand that we must submit invoices directly to, and receive payments directly from, the Claims Administrators that are a party to the review. Invoicing will be for payment in arrears. Direct payment is not intended to constitute a material affiliation between the IMRO and Claims Administrators.

Invoicing and payment are based on fees set forth in the regulations. We understand that DWC and MAXIMUS Federal may agree to renegotiate the fees for 2015 based on the volume of cases in 2014 and that MAXIMUS Federal may charge reasonable interest to compensate for late payments.

4.4.19 Monitoring of Contract Performance

RFP Section A., Page 15, A., Page 3

We understand that the individual designated as the Departmental Project Manager will have the overall responsibility to monitor and evaluate our performance in providing IMR services for DWC. In this role the Departmental Project Manager will review all reports for technical quality and compliance with the contract terms. At the discretion of DWC, specifications for revisions necessary to remove discrepancies will be set forth by the Departmental Project Manager in writing and are binding on MAXIMUS Federal as long as the specifications do not exceed the scope of the work required in the contract.

We agree to provide monthly written progress reports to the DWC Executive Medical Director or her designee(s) beginning February 15, 2015, for the previous month, until completion of the contract.

We agree to revise and deliver to the Department Project Manager any product deemed unacceptable by the Project Manager within 15 working days.

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4.4.20 DWCs Role and Responsibilities

RFP Section A., Page 15

We understand that DWC will be responsible for the following project-related activities:

- Overseeing the entire IMR process, including implementation and execution of all applicable statutes, regulations, and procedures
- Reviewing any case in which the Contractor notifies DWC that it appears the case may be ineligible for IMR or the information submitted with the application is insufficient to begin the IMR process, and making an independent determination as to whether the case is eligible for IMR
- Ensuring that Contractor is in compliance with applicable deadlines
- Ensuring that Contractor conducts reviews and issues final determinations in a professional, appropriate, and timely manner
- Responding to complaints and requests for information about specific cases and the IMR process overall

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5. Management and Staffing

MAXIMUS Federal has an unparalleled ability to handle large and fluctuating volumes of Independent Medical Review (IMR) requests with proven infrastructure and continuing low-risk improvements in efficiency. DWC can place trust in MAXIMUS to continue to provide the ample staff and expert management necessary to maintain this growing program.

RFP Section C.4.a.2, Page 19

MAXIMUS Federal can provide DWC with a detailed understanding the IMR program and a solid history of project management experience with government healthcare projects. By leveraging the knowledge and experience we have gained through independent claims review projects of similar scope and in our role as the incumbent for the IMR Project, MAXIMUS Federal will continue to provide a project management approach that is sensitive to the unique needs of DWC before the new contract even begins.

Our adherence to the Project Management Institute's (PMI) Project Management Body of Knowledge (PMBOK®), the International Organization for Standardization's (ISO) 9001:2008 standards for total quality management and quality systems, and other industry-accepted methods, provides us with the tools necessary for a consistent, effective project management strategy. Use of these standards and methods, paired with our commitment to the principles and continuous process improvement, gives the MAXIMUS Team the flexibility to rapidly respond to changing requirements and volumes.

We maintain a comprehensive Quality Management program for this Project as described in *Section 4.4.11: Quality Assurance*. Our quality approach is based on ISO principles and focused on the orderly and timely completion of high quality review processes.

In addition, MAXIMUS Federal has achieved full accreditation from URAC as an Independent Review Organization (IRO). URAC accreditation is the only nationally recognized independent review organization accreditation program. We have been accredited by URAC since accreditation became available in 2000 and have five times received full re-accreditation with no areas for improvement noted. Please see *Appendix A: URAC Certificate* for the most recent copy of our URAC certificate. We will continue to adhere to URAC IRO standards to the project as part of our overall work plan.

Orderly and Timely Completion of Work

All Project tasks and deliverables follow a strict management work plan. This includes systems implementations and upgrades, reports, deliverables, training, recruitment, and quality management activities. We manage ongoing tasks, such as preliminary reviews and claims reviews, on an ongoing basis by way of close monitoring of our case tracking system, alerts for work slippage, and immediate implementation of corrective and preventive action whenever necessary.

Our scalable workflow and staffing models allow MAXIMUS to confirm that we always have multiple staff and expert reviewers available to address expected and unexpected variances in the workload. See

did you KNOW

- We have more than 350 California-licensed MPRs ready to complete IMRs, 600 currently in credentialing and/or training, and 400 additional MPRs licensed in other states
- MAXIMUS brings more than 100 staff members with a least a year of experience and a committed management that knows DWC and the IMR Project

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Section 6.2.4: Ability to Handle High-Volume Case Workload for more information on our organizational capacity to handle high volumes of reviews.

Exhibit 5-1: Project Work Plan Excerpt provides an example of the type of work plan we manage to when launching a new project or launching an initiative to update the project to new contract requirements such as we will with the IMR Project.

Task Name	Duration
Define New Contract Reporting Requirements	43 days
▪ Define New Reporting Requirements	15 days
▪ Develop Reporting Requirements Document	5 days
▪ Review Reporting Requirements Document	3 days
▪ Update Reporting Requirements Document	5 days
▪ Review Reporting Requirements Document	3 days
▪ Finalize Reporting Requirements Document	5 days
▪ Submit Reporting Requirements Document to the DWC	0 days
▪ DWC Review of Reporting Requirements Document	3 days
▪ Update of Reporting Requirements Document	1 day
▪ DWC Review of Reporting Requirements Document	3 days
▪ Sign-Off on Reporting Requirements Document	0 days

Exhibit 5-1: Project Work Plan Excerpt. MAXIMUS manages to a structured project work plan that confirms we stay on track to complete project requirements.

Project Management Meetings with DWC

MAXIMUS understands the importance of communication with DWC leadership. We intend to continue regularly scheduled meetings to review the required monthly status reports and address the progress towards continuous improvement of project operations and well as the progress of regularly scheduled work plan tasks. In addition to formally scheduled meetings, the Project Director, Lou Shields, and Project Manager, Robert Nydam, are available by e-mail, facsimile and telephone. The Client Executive, Mr. Thomas Naughton, is also available to discuss any ideas or issues that require input from MAXIMUS executive management.

Work Management

As mentioned in *Section 4.2.8: Case Tracking Reports*, Nurse Supervisors and the Project Manager monitor the project through near real-time case tracking data contained in the MAXDat dashboards. Supervisors always know the status of the caseload at all times and use alerts, both in *entellitrak* and MAXDat to quickly become aware of any potential bottlenecks and correct them before they create an issue.

Discussed below under *Training*, no new Medical Professional Reviewer (MPR) or Appeals Officer conducts independent work until they have successfully completed a trial period of reviews or case management work under close supervision of the appropriate Nurse Supervisor, Associate Medical Director or Medical Director. After the initial period of intense observation, a sample of all work is subject to quality control review by the Nurse Quality Reviewers who audit each case file before the final determination letters are sent. The Medical Director and Associate Medical Director handle any problems,

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concerns, or issues with a review. In addition, we also provide the quality assurance review process discussed in *Section 4.4.11: Quality Assurance* to analyze data for trends and continuous improvement initiatives.

Performance Reviews

The performance of all employees, and particularly of Appeal Officers, is continually assessed through quality assurance reviews as found in *Section 4.4.11: Quality Assurance*. The Project Manager oversees the process of supervisor-conducted personnel reviews which review the quality assurance results as well as supervisor and mentor observations and feedback. The supervisor identifies the need for any additional refresher training, guidance, or corrective actions.

Training

Project Staff Training

The MAXIMUS overall training approach is applied to MAXIMUS project employees and management with specific supplemental elements provided to consultant reviewers, as necessary. MAXIMUS staff members receive the comprehensive training necessary to support both their independent functions within the project, such as scanning documents into the system, as well as the overall policies and purposes of the IMR program. We understand that a solid foundation for any project begins with new hire training, but that a successful project does not stop there. The IMR quality and training departments continuously identify and develop refresher training, new skills training, and process improvement training based on trends in quality data. We include sample training materials for both Appeals Officers and Medical Professional Reviewers in *Appendix K: Training Materials*.

The Quality Assurance (QA) Manager, with guidance from the Project Manager, is responsible for identifying all training needs and putting the appropriate training in place. To identify training requirements, the QA Manager and training team review all policies and procedures, pertinent legislation and regulations, and the results of quality assurance and performance data. The QA Manager also incorporates suggestions from project management and supervisory staff as well as all operations positions.

All employees are required to complete required training provided by the corporate Center for Employee Development (CED) such as standards of ethics and HIPAA requirements. CED provides training support for training teams and supervisors by developing core business curriculum and fostering collaboration among project training teams. They also MAXIMUS University, our enterprise web-based Learning Management System used to administer and manage corporate training activities, as well as to deliver web-based training.

Independent of corporate training efforts, MAXIMUS Federal employees should take personal responsibility for "life-long learning" in areas related to enhanced current or future job performance. Not less than monthly, staff should routinely review at least one source (for example, print periodical, web site, and so on) of key and current developments in their field of work. Staff should maintain at least one area of focused self-directed learning.

On-the-Job Training

Training doesn't stop in the classroom. All new Appeal Officers are assigned a trainer or mentor from their operations team who will review all operations process work during a training period and provide

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one-on-one guidance. The length of the on-the-job training is dependent on the quality review scores from the Appeals Officer's completed work and the complexity of the specific team responsibilities.

Medical Professional Reviewer (MPR) Initial Orientation

Formal orientation of all MAXIMUS Federal MPRs involves the Project Manager, Associate Medical Directors, the Medical Director, and the Director of Professional Relations as well as MAXIMUS Federal corporate staff. The MPR orientation program is exhaustive and is meant to provide them with a broad-based understanding of clinical peer reviews as well as a detailed understanding of each client's specific requirements. MPRs are instructed and oriented in the following areas:

- Overview of MAXIMUS Federal
- Overview of the California IMR Process
 - Case administration
 - Case assignment
 - Case delivery and return
 - Billing and payment
- Proper methods of preparing IMR determinations using evidence-based medicine
- Clinical peer review standards for analysis and review writing
- Confidentiality and HIPAA requirements
- Conflict of interest monitoring and reporting
- Quality assurance
- Legislative overview including the requirements of Labor Code section 4610.5(c)(2)

After credentialing and orientation, MPRs begin their initial training. Initial MPR training consists of MPRs completing their first IMR with the assistance of a Nurse Reviewer and Associate Medical Director. Prior to assigning an IMR to the MPR-in-training, the Nurse Reviewer and the Associate Medical Director contact the MPR to discuss IMR program expectations. This briefing includes important details of the IMR and a refresher of the confidentiality, HIPAA, reporting and conflict of interest requirements.

While the MPR is completing the IMR, the Nurse Reviewer and Associate Medical Director are available to answer any questions or provide clarification of any issues. After return of the review by the MPR, the report is reviewed by the Nurse Reviewer and the Medical Director. This review consists of the following:

- Report presentation style
- Report completeness
- Quality of analysis
- Report outcome

Upon completion of this review the Associate Medical Director contacts the MPR to provide feedback on the report and indicate areas where the report was deficient or required improvement. The above process continues until the MPR completes two IMRs without deficiency.

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On-going MPR Training

Similar to staff training, MPR training occurs on a continual basis. Ongoing MPR training is coordinated and operated by the Associate Medical Directors, Nurse Reviewers, and the Director of Professional Relations. Ongoing MPR training includes the following:

- Monthly random sample quality review of MPR reports
- Immediate contact and counseling for any reports found to be deficient
- Immediate updates on any new policies, procedures, work processes, or statutory requirements
- Regular updates on new and emerging technologies
- Regular updates on new published studies
- Annual quality reports on MPR quality performance

All training protocols and documentation of training for reviewers will be provided to DWC annually, including any changes.

5.1 Staff Organization Plan

RFP Section C.2.a, Page 17

MAXIMUS Federal offers an elite management team that includes experts in all facets of the IMR claims review program. Our staffing plan includes a discussion of qualified and experienced management personnel, an organizational chart to demonstrate our proposed staffing structure, job descriptions, and proposed full-time equivalency (FTE) rates for proposed management staff. Our organizational structure is designed to provide both stability and flexibility in the face of changing volumes.

Project Management Roles

Our primary management staff members are all full-time MAXIMUS employees committed to this project. Additionally, we contribute the oversight and guidance of our Client Executive and Director of Information Systems. These executives provide ongoing attention to the project from a corporate perspective, ensuring that the dedicated project management staff members provide the best service for DWC leadership.

Specifically our management team consists of the following senior executives:

Client Executive – Thomas C. Naughton, JD., LLM

Tom Naughton is a Senior Vice President of MAXIMUS Federal Services and serves as the Client Executive for the California IMR and IBR Projects. In this capacity, he has overall responsibility for project performance and client satisfaction. Mr. Naughton's responsibilities include the overall management and performance of multi-million dollar health care appeals and consulting projects for more than 45 state and federal clients including regulatory and contract compliance, client relations and quality oversight. He is considered subject matter expert in health care dispute resolution and independent medical review. He served as subject matter expert to the in development and implementation of independent medical review and provider payment dispute resolution program for the California Workers' Compensation system.

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Project Director – Lou Shields

Lou Shields is an experienced business executive who brings information technology expertise to the continuous improvement goals of the IMR Project systems and operational processes. Mr. Shields has worked with DWC on the IMR Project since 2013, overseeing effective project initiatives to meet the evolving needs of DWC. Prior to this, he successfully led technical projects at major companies such as AT&T, Zenith, and Ernst & Young. He has managed the implementation and turnaround of multi-million dollar system development projects including development of necessary infrastructure to support ongoing expansion. Mr. Shields will continue to oversee the continuous improvement of the *entellitrak* system and operational processes supporting the IMR Project.

Project Manager – Robert Nydam

Robert Nydam has served the IMR Project since 2013 and has provided significant contributions to the continuous improvement of the project while leading business process management (BPM) initiatives. Mr. Nydam's understanding of both core BPM principles and operational efficiency efforts have also been key to the success of several recent project improvement efforts. Mr. Nydam was responsible for developing and implementing automated decision letter writing programs for our large-scale Medicare IMR programs. Before attending law school, he worked as a paralegal at a California law firm whose areas of practice included workers' compensation. His experience there included practical exposure to the extensive workers' compensation reform package introduced in California in 2004 under Senate Bill 899. This legal background helps ensure IMR Project policies are consistent with laws, regulations and the contract.

Medical Director – Paul Manchester, MD, MPH (California License #52883, Medical Board of California)

Paul Manchester is a California licensed physician with nearly 30 years medical experience and 10 years of utilization review experience—all in California. His experience practicing family and occupational medicine contributes to his clinical body of knowledge. From 2004 to 2011, Dr. Manchester provided consultative services to the State Compensation Insurance Fund, including utilization review and claims management. After working at the State Compensation Insurance Fund, Dr. Manchester continued to provide full-time utilization review services to several utilization review organizations. Dr. Manchester has served as the Medical Director for the California IMR Project since 2013 and will continue in this position, providing a wealth of knowledge that can only come from decades of experience.

Associate Medical Director – Bernice Stein, MD

Dr. Stein has more than 20 years experience in physical medicine, rehabilitation, workers compensation and disability review. She currently serves as a Senior Physician Reviewer for the MAXIMUS Federal Medicare Part A Medical Review Team. In this capacity she is responsible for the timely and quality completion of over a thousand medical reviews a year and for having an expert understanding of all applicable Medicare and Social Security Administration (SSA) disability statutes, regulations, and coverage policies as well as all relevant medical and scientific literature.

Associate Medical Director - A. David Matian, D.O.

Dr. A. David Matian is a American Osteopathic Board of Family Physicians Board Certified Diplomat, a former Qualified Medical Examiner (QME) with the California State Department of Industrial Relations, and has nearly 15 years of medical practice experience. He is currently the Founder and Medical Director

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of Prime Care Physicians and and Associate Clinical Professor at Western University of Health Sciences (WesternU), College of Osteopathic Medicine of the Pacific (C.O.M.P.). Mr. Matian is an expert and frequent guest speaker on utilization review and workers compensation. He brings this expertise to the IMR Project as Associate Medical Director assisting with complex review questions and issues.

Director of Professional Relations – Kimberly Donselaar, CPCS, LPN

Ms. Donselaar has more than 25 years of professional experience in the recruitment, credentialing and day-to-day management of the MAXIMUS Federal Services physician specialist and clinical practitioner consultant panel. She is a member of the National Association for Medical Staff Services (NAMSS) and serves as the Western Regional Representative to the Board of Directors for the New York State Association for Medical Staff Services. Ms. Donselaar is a Certified Provider Credentialing Specialist (CPCS).

Director of Quality Assurance – Kevin Gregory, ASQ CQIA, PMP

Kevin Gregory has obtained quality-related certifications including RABQSA Internal Auditor for ISO 9001: 2000 and ASQ Certified Quality Improvement Associate (CQIA). He has completed multiple internal audits of quality management systems and provided staff training on ISO 9001: 2000. Mr. Gregory is a Senior Member of the American Society for Quality (ASQ), an international organization of quality professionals, and an active member of the Project Management Institute (PMI).

Director of Reporting – James Phillips

Mr. Phillips brings more than 25 years of experience in the design and management of automated systems and reporting systems. He is currently responsible for statistical reports provided to the Centers for Medicare and Medicaid Services (CMS) and has been instrumental in the design of many data and reporting systems associated with medical appeals programs. He designed and implemented systems for tracking Medicare appeal cases, reconsideration determinations, as well as for triaging and processing of Administrative Law Judge and Departmental Appeal Board requests, complaints for possible reopening of cases or other subsequent actions, and Freedom of Information Act (FOIA) requests. Mr. Phillips as also designed a system for automation of routine correspondence requirements and developed an appeals inquiry system to enable MAXIMUS Medical Management Division staff to identify the status of the appeal when fielding telephone inquiries from Medicare enrollees and Medicare Managed Care Organizations (MCO).

Expert Reporting and Data Analysis Consultant – Frank Neuhauser

Mr. Neuhauser comes to MAXIMUS as an expert consultant on public policy as it concerns the impact of worker's compensation legislation and quality of medical-legal reports written by physicians with different levels of professional qualifications. Mr. Neuhauser is the Executive Director of the Center for the Study of Social Insurance at the University of California, Berkeley. He has previously assisted DWC with the UC DATA project, where he assessed the data resources and needs for both administration and research. Mr. Neuhauser brings more than 20 years of public policy research experience to assist the IMR Project and advise DWC.

Director of Information Systems – Richard Brunner

Richard Brunner is a MAXIMUS Vice President responsible for MAXIMUS Federal application solutions and is the liaison with internal development teams and external software service providers to

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define and deliver quality software solutions for our program operations in support of their client missions. He has been with MAXIMUS for over a decade and in that time has led numerous efforts in the selection and development of innovative software to support all aspects of medical appeals processing operations across federal projects.

In Exhibit 5.1-1: Dedicated Management Team Responsibilities we demonstrate our commitment to providing ample management oversight as well as identify final responsibility for IMR tasks.

Management Position	Job Description (Including Work Plan Tasks)	Full-Time Equivalency	Proposed Resource
Client Executive	<ul style="list-style-type: none"> Provides executive oversight for the project including confirming the resources and infrastructure are in place to successfully meet all contract requirements Available as an escalated contact point for the Department Program Manager for any issues or concerns pertaining to contract requirements or performance 	0.25 FTE*	Thomas C. Naughton, JD, LLM
Project Director	<ul style="list-style-type: none"> Serves as the primary point of contact for the Department Program Manager Oversees all project management staff to ensure timely and appropriate compliance with the contract requirements Monitors all project activities including verifying accurate and timely reviews are progressing as required Confirms the Certificate of Insurance is requested and provided from the corporate office 	1 FTE*	Lou Shields
Project Manager	<ul style="list-style-type: none"> Supervises project operations including the work of the project administrative staff and nurse supervisors Provides direction and oversight to project processes and improvement initiatives Coordinates with the other management staff to help ensure timely and appropriate completion of the requirements of the project 	1 FTE	Rod Nydam
Medical Director	<ul style="list-style-type: none"> Provides top level reviews and analysis of more complex review issues Serves as a quality resource for verifying the accuracy of selected reviews and improving outputs as needed Provides expert review guidance for the reviewer team Serves as a resource for all reviewer questions and concerns regarding the review process Manages the process of reviews including monitoring and facilitating timely review completion by all reviewers 	1 FTE*	Paul Manchester, MD, MPH <i>California License #52883, Medical Board of California</i>
Associate Medical Director I	<ul style="list-style-type: none"> Provides expert review guidance for the reviewer team Provides second level reviews and analysis of more complex review issues Serves as a quality control resource for verifying the accuracy of selected reviews and improving outputs as needed Serves as a back-up Medical Director 	1 FTE	Bernice Stein, MD

Exhibit 5.1-1: Dedicated Management Team Responsibilities. MAXIMUS provides a committed management team with clear responsibilities for ensuring the accurate and timely completion of all task activities.

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Management Position	Job Description (Including Work Plan Tasks)	Full-Time Equivalency	Proposed Resource
Associate Medical Director II	<ul style="list-style-type: none"> ■ Provides expert review guidance for the reviewer team ■ Provides second level reviews and analysis of more complex review issues ■ Serves as a quality control resource for verifying the accuracy of selected reviews and improving outputs as needed ■ Serves as a back-up Medical Director 	1 FTE	A. David Matian, DO
Director of Professional Relations	<ul style="list-style-type: none"> ■ Manages the credentialing coordinator group responsible for recruiting and verifying the credentials of reviewers ■ Responsible for ensuring the Number and Type of Reviewers necessary to handle changing IMR volumes ■ Supports on-call expert reviewers to answer questions and resolve problems ■ Manages the reviewer training program ■ Performs conflict of interest checks ■ Enforces reviewer confidentiality requirements ■ Maintains the confidentiality of medical records and other data 	1 FTE	Kimberly Donselaar, CPCS, LPN
Director of Quality Assurance	<ul style="list-style-type: none"> ■ Oversees, monitors, and improves the quality of services provided by the IMR Project ■ Represents the project in MAXIMUS Federal and MAXIMUS Corporate Office of Quality and Risk Management quality programs ■ Identifies specific issues that require a corrective action and provide independent verification of performance improvement reports ■ Advises Program Manager and Director of Professional Relations on quality-related issues and monitoring ■ Responsible for fraud and quality of care reporting 	1 FTE*	Kevin Gregory, ASQ CQIA, PMP
Director of Reporting	<ul style="list-style-type: none"> ■ Serves as the primary report developer ■ Works with the DWC to improve and customize reports using available case tracking data ■ Supervises reporting analysts ■ Ensures all reports are completed in a timely and appropriate manner ■ Focuses on meeting the reporting needs of the contract and providing responsive answers to DWC reporting inquiries 	1 FTE*	Jim Phillips
Director of Information Systems	<ul style="list-style-type: none"> ■ Oversees all project systems including <i>entellitrak</i> maintenance and improvements ■ Ensures case workflow tracking system availability requirements are met ■ Serves as a resource and broker between MAXIMUS corporate system resources and expertise and the project staff 	0.25 FTE*	Richard Brunner

* Selected senior management staff may also contribute limited time to the California Independent Medical Billing Project if awarded to MAXIMUS Federal. This is currently a successful and efficient allocation of resources that benefits DWC by providing expanded access to management expertise.

Exhibit 5.1-1: Dedicated Management Team Responsibilities (continued). MAXIMUS provides a committed management team with clear responsibilities for ensuring the accurate and timely completion of all task activities.

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5.1.1 Roles and Responsibilities

In the section above, we provided our detailed description of our management personnel and their assigned roles. *Exhibit 5.1.1-1: IMR Organization Chart* illustrates our project organization—further details are provided in the biographies of our management staff.

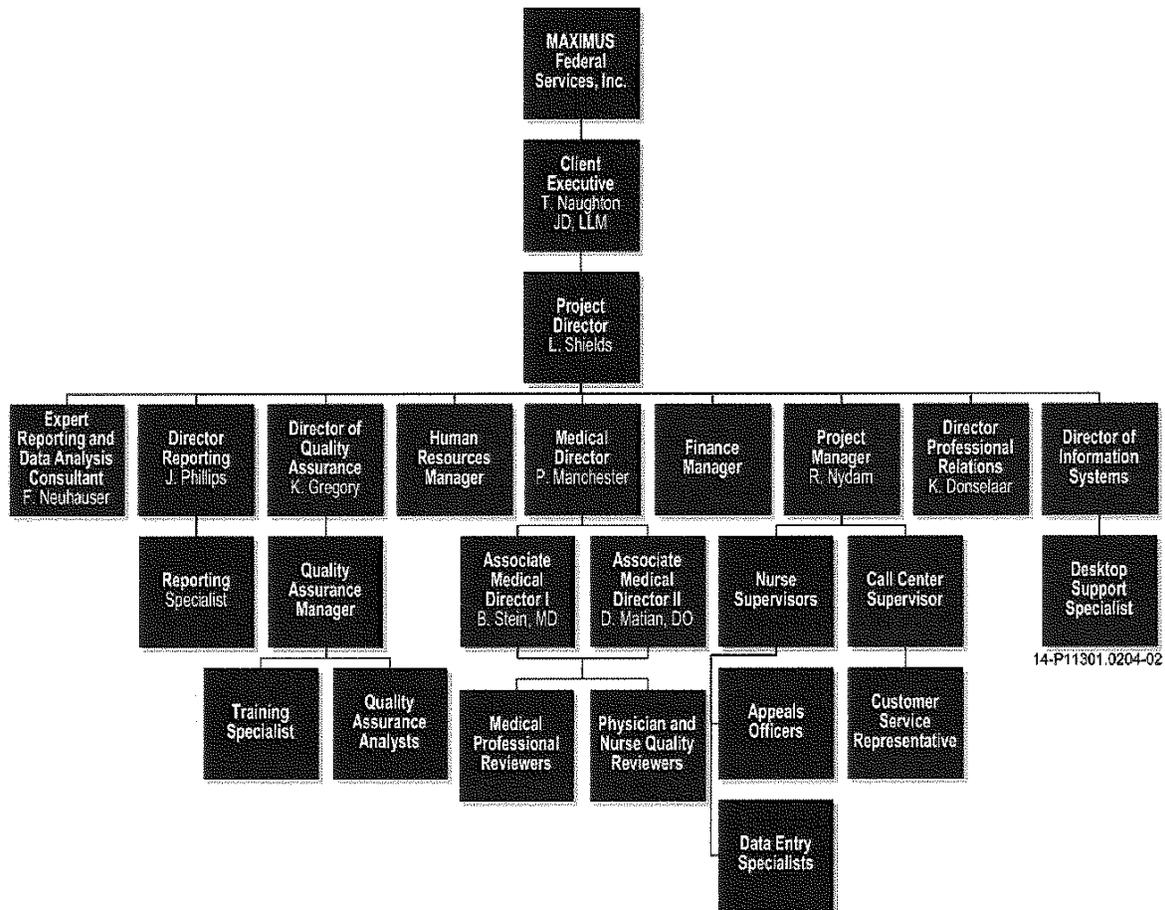


Exhibit 5.1.1-1: IMR Organization Chart.

Qualified Reviewers

MAXIMUS Federal brings a combined consultant and subcontractor panel of 950 California licensed Medical Professional Reviewers (MPRs), in active practice, representing every American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) specialty. More than 350 of these are MAXIMUS consultants and 600 are via subcontractors and currently in the process of credentialing and training. In addition, we have another 400 MPRs licensed outside of California, but ready to assist if needed.

We continuously recruit new reviewers and work with many reviewers certified in multiple specialties. All of our reviewers are independent contractors or subcontractors, rather than employees. This status provides the best scenario to avoid conflicts of interest and maintain objectivity for all medical reviews.

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All members of our review panel are actively practicing medicine and represent every American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) specialty and most subspecialties. As required, our review panel consists of reviewers with a minimum of 30 percent of their time spent in clinical practice in at least two of the preceding four years. In fact, MAXIMUS exceeds this requirement as we require a 60 percent active practice requirement for our reviewers.

We believe this clinical practice requirements is essential to providing the perspective necessary for informed and unbiased reviews. This clinical perspective is coupled with qualified educational and professional credentials as described in *Section 4.4.6.1: Select Reviewers Based on Clinical Experience*. We also understand and currently comply with the direction to focus recruiting efforts on California-licensed practitioners.

Exhibit 5.1.1-2: California Specialty Board Certifications Offered shows the caliber of coverage our panel will provide for all review specialties. Our MPRs also represent every ABMS and AOS specialty and most subspecialties, which ensures ability to match reviewers to a case based on same of similar specialties/subspecialties.

Type of Board Certifications	Number of Certifications Offered	Type of Board Certifications	Number of Certifications Offered
Addiction Psychiatry	3	Nuclear Medicine	2
Allergy and Immunology	3	Obstetrics and Gynecology	3
Anatomic Pathology	2	Occupational Medicine	22
Anesthesiology	13	Oncology	4
Cardiac Electrophysiology	3	Ophthalmology	5
Cardiovascular Disease	6	Orthopedic Surgery	47
Child & Adolescent Psychiatry	5	Osteopathic Board Neurology & Psych	2
Colon and Rectal Surgery	4	Otolaryngology	8
Critical Care Medicine	6	Pain Management	19
Dermatology	4	Pediatric Critical Care	1
Dermatopathology	1	Pediatric Hematology/Oncology	1
Diagnostic Radiology	3	Pediatric Infectious Disease	1
Emergency Medicine	7	Pediatrics	10
Endocrinology & Metabolism	1	Physical Medicine & Rehabilitation	41
Family Practice	11	Plastic Surgery	4
Gastroenterology	1	Podiatric Surgery	3
General Vascular Surgery	1	Podiatrist	3
Genetics	1	Preventive Medicine	10
Geriatric Medicine	3	Psychiatry	19
Geriatric Psychiatry	3	Pulmonary Disease	10
Hand Surgery	3	Radiation Oncology	2
Internal Medicine	44	Radiology	4
Interventional Cardiology	2	Sports Medicine	4
Maternal and Fetal Medicine	1	Surgery	14
Medical Oncology	3	Surgical Critical Care	1

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Type of Board Certifications	Number of Certifications Offered	Type of Board Certifications	Number of Certifications Offered
NA-Chiropractor	30	Thoracic Surgery	5
NA-Dentist	3	Urology	3
NA-Chiropractic	8	Hospice & Palliative Medicine	1
NA-Dentistry	1	Sleep Medicine	3
NA-Oriental Medicine	9	Neurotology Pediatric	1
NA-Psychologist	14	Neurodevelopmental Behavioral Pediatrics	1
Neonatal Perinatal Medicine	1	Neuromuscular Medicine	3
Neurological Surgery	13	Pediatric Urology	1
Neurology	11	NA-Optometry	3
Neurology-Spec Qualifications Child	2	Total Count Certifications:	487

Exhibit 5.1.1-2: Specialty Board Certifications Offered. MAXIMUS offers coverage for all necessary board certifications to provide timely assignment and completion of reviews.

Exhibit 5.1.1-3: Non-California Specialties and Subspecialties details our additional MPR resources that are available on an as-needed basis.

Board Certifications	Count	Board Certifications	Count
Allergy and Immunology	4	Ophthalmology	11
Anatomic Pathology	1	Oral Facial & Maxillary Surgery	3
Anesthesiology	17	Orthopedic Surgery	52
Blood Banking/Immunopathology	2	Osteopathic Brd Neurology & Psych	3
Cardiac Electrophysiology	1	Otolaryngology	6
Cardiovascular Disease	10	Pain Management	16
Child & Adolescent Psychiatry	4	Pediatric Cardiology	2
Clinical Pathology	1	Pediatric Critical Care	2
Colon and Rectal Surgery	2	Pediatric Dentistry	1
Critical Care Medicine	3	Pediatric Emergency Medicine	3
Critical Care Surgery	1	Pediatric Endocrinology	2
Dermatology	5	Pediatric Hematology/Oncology	2
Diagnostic Radiology	5	Pediatric Infectious Disease	1
Emergency Medicine	18	Pediatric Surgery	1
Endocrinology & Metabolism	6	Pediatrics	24
Family Practice	25	Periodontology	1
Forensic Psychiatry	1	Physical Medicine & Rehab	44
Gastroenterology	5	Plastic Surgery	10
General Vascular Surgery	5	Podiatric Surgery	4
Geriatric Medicine	6	Podiatrist	3
Geriatric Psychiatry	2	Preventive Medicine	7
Gynecologic Oncology	2	Psychiatry	31
Hand Surgery	6	Public Health & Gen Prev Med	1

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Board Certifications	Count	Board Certifications	Count
Hematology	7	Pulmonary Disease	4
Infectious Disease	3	Radiation Oncology	6
Internal Medicine	111	Radiology	5
Interventional Cardiology	2	Reproductive Endocrinology	2
Maternal and Fetal Medicine	1	Rheumatology	4
Medical Oncology	4	Sports Medicine	5
Medical Toxicology	2	Surgery	35
NA-Chiropractor	16	Thoracic Surgery	2
NA-Dentist	10	Urology	9
NA-Nurse Practitioner	2	Neuroradiology	1
NA-Chiropractic	5	Vascular & Inter Radiology	3
NA-Dentistry	1	NA-Registered Nurse	1
NA-Pediatric Dentistry	1	NA-LPN	1
NA-Physical Therapy	1	Hospice & Palliative Medicine	4
NA-Podiatrist	5	Undersea & Hyperbaric Medicine	1
NA-Psychologist	7	Sleep Medicine	2
NA-Psychology	2	Transplant Hepatology	1
NA-Social Work	1	Neuropathology	1
NA-Speech Therapy	2	Neuromuscular Medicine	1
Neonatal Perinatal Medicine	2	Pediatric Rehab	1
Nephrology	5	Psychosomatic Medicine	1
Neurological Surgery	5	NA-Optometry	1
Obstetrics and Gynecology	14	NA-Nurse Anesthetist	1
Occupational Medicine	10		
Oncology	3	Total Count Certifications:	693

Exhibit 5.1.1-3: Other Clinical Specialties and Subspecialties (continued) offers a snapshot of our MPR resources licensed in other states.

Other Project Roles

The MAXIMUS IMR Project includes the following administrative and operations positions and associated key process responsibilities discussed throughout the work plan. These positions play an essential role on the project. *Exhibit 5.1.1-3: Administrative and Operations Roles and Responsibilities* outlines our proposed project employees and their key task responsibilities and well as the number of FTEs proposed for each role. All staff members, including both management and operations staff, are responsible for confidentiality of records and information, timeliness, and adhering to conflict of interest requirements.

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Administrative/ Operations Position	Key Task Responsibilities (aligned with Work Plan Tasks)	FTEs
Data Entry Clerk	<ul style="list-style-type: none"> ■ Scans incoming review requests and documentation ■ Reviews the IMR request for completeness (requests must include denial letter and appropriate documentation) ■ Enters data from the review request and associated documentation into <i>entellittrak</i> 	3 FTEs
Appeals Officers	<ul style="list-style-type: none"> ■ Responsible for Preliminary Review of Cases ■ Validates data from application against information in utilization review denial letter ■ Identifies potential eligibility issues ■ Routes cases with potential eligibility issues to DWC for review ■ Responsible for Assignment of Cases for IMR ■ Assesses completeness of medical records received from parties ■ Develops detailed list of medical records received ■ Organizes file for medical reviewer ■ Determines medical specialty required to conduct medical review ■ Provides clear statements of treatments in dispute ■ Identifies and assigns IMR to medical reviewer of the appropriate specialty ■ Responsible for securing additional Information to Conduct IMR, as needed ■ Enters Case Information and Changes in Case Status to <i>entellittrak</i> ■ Transfers complete case file to medical reviewer ■ Responsible for ensuring the Content of Reviews meets requirements ■ Responsible for the Distribution of Completed Reviews ■ Assesses final determination for completeness ■ Assures that authorities cited are consistent with disputed treatments ■ Responsible for the Appeal and Review of Remanded Cases; this is specifically the expedited review team 	100 FTEs
Physician Quality Reviewer	<ul style="list-style-type: none"> ■ Serves as additional, Physician review of the case to make certain that all steps were completed appropriately and determinations are accurate ■ Provides final quality control check on all case information and letter contents prior to sending final determination letter ■ Responsible for ensuring the Content of Reviews meets requirements ■ Responsible for the Distribution of Completed Reviews ■ Initiates mailing of final determination letter when the final reviewer ■ Closes IMR case in <i>entellittrak</i> when the final reviewer 	5 FTEs
Nurse Quality Reviewer	<ul style="list-style-type: none"> ■ Serves as additional, second review of the case to make certain that all steps were completed appropriately ■ Provides final quality control check on all case information and letter contents prior to sending final determination letter ■ Responsible for ensuring the Content of Reviews meets requirements ■ Responsible for the Distribution of Completed Reviews ■ Initiates mailing of final determination letter ■ Closes IMR case in <i>entellittrak</i> when the final reviewer 	5 FTEs

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Administrative/ Operations Position	Key Task Responsibilities (aligned with Work Plan Tasks)	FTEs
Nurse Supervisor	<ul style="list-style-type: none"> ■ Responsible for Timeframes for Completing Reviews ■ Oversees the work of all administrative positions including day-to-day supervision of Appeals Officers ■ Assignment of cases to Appeals Officer and associated conflict of interest checks screening ■ Maintains the confidentiality of medical records and other data 	5 FTEs
Training Specialist*	<ul style="list-style-type: none"> ■ Designs and administers training for both project operations staff and reviewers, including creating system and process instructions 	3 FTEs
Call Center Supervisor*	<ul style="list-style-type: none"> ■ Manages the operation of the call center associated with the toll-free service line as well as facsimile (fax) and email ■ Supervises the Customer Service Representatives 	1 FTE
Customer Service Representative*	<ul style="list-style-type: none"> ■ Provides customer service to interested parties through the toll-free service line as well as facsimile (fax) and email ■ Answers questions regarding the current status of the case and refers parties to DWC as appropriate 	4 FTEs
Desktop Support Specialist*	<ul style="list-style-type: none"> ■ Maintains project hardware and updates desktop software as necessary ■ Provides on-site technical support for project staff ■ Updates system access profiles for project staff, reviewers, and DWC staff members accessing the system 	1 FTE
Quality Assurance Manager*	<ul style="list-style-type: none"> ■ Coordinates with the Quality Assurance Director to implement project quality initiatives ■ Recommends process improvements and coordinates with the training specialists to initiate refresher training when applicable ■ Manages the work of the quality assurance analysts and training specialists 	1 FTE
Quality Assurance Analyst*	<ul style="list-style-type: none"> ■ Performs quality assurance reviews on a sample of completed medical reviews, including those ineligible or withdrawn, to track project compliance with policies and procedures as well as identify trends and opportunities for improvement ■ Performs analysis on the results of performance and review statistics to identify areas in need of process changes, system improvements, or refresher training ■ Creates, modifies, and updates project policies and procedures 	10 FTEs
Reporting Specialists*	<ul style="list-style-type: none"> ■ Maintains reporting documentation and updates reporting templates when necessary ■ Initiates and distributes reports, as required, and verifies they are available in the MAXDat system 	1 FTE
Human Resources Manager*	<ul style="list-style-type: none"> ■ Manages recruitment, onboarding, termination, and other human resource functions of project employees 	1 FTE
Finance Manager*	<ul style="list-style-type: none"> ■ Prepares financial statements and invoices for Project Director approval and submission to DWC ■ Prepares financial reports for the corporate Finance Department ■ Tracks project revenue and expenditures and maintains the project budget 	1 FTE

* Selected operations support staff may also contribute limited time to the California Independent Medical Billing Project, based on current volumes, if awarded to MAXIMUS Federal. This cross-functional allocation of resources will continue to provide superior service to DWC and will be augmented with additional staff if necessary.

Exhibit 5.1.1-3: Administrative and Operations Roles and Responsibilities. MAXIMUS offers coverage for all necessary board certifications to provide timely assignment and completion of reviews.

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6. Related Experience and References

MAXIMUS Federal is the leading provider of independent medical review services. We currently serve more than 50 federal and state agencies and have processed more than 2.5 million reviews since 1989, including more than 800,000 in 2013 alone. Our team also offers extensive California specific experience having completed more than 55,000 independent medical reviews to date. We operate three separate contracts that each processed in excess of 100,000 independent medical reviews during 2013, with the largest exceeding 300,000.

RFP Section C.4.a.2, Page 19; B.2, Page 16

In this section we describe our related experience conducting IMR services and our capability to operate the DWC IMR project. We provide references and qualifications to support the capabilities that we describe throughout our response.

6.1 Understanding of California's Workers' Compensation System

RFP Section C.5.d.2, Page 22

Prior to the introduction of IMR through SB863, the process for resolving disputes over medical treatment in the California workers' compensation system was time-consuming, costly and challenging. The process involved many steps and often required judicial intervention. The process all too frequently culminated with workers' compensation judges being forced to evaluate and choose between competing expert opinions presented by an independent medical evaluator and the injured worker's treating physician.

MAXIMUS Federal understands how IMR eliminates much of the inefficiency associated with disputing medical treatments in the workers' compensation setting. Under the old system, the process for initiating a dispute proved complex and cumbersome. With the passing of SB 863 injured workers now gain access to the process simply by submitting an IMR application request. The "dispute-within-a-dispute" nature of determining who conducted the evaluation in the old system has been eliminated under IMR – now, that decision rests solely with the IMRO, and can be made almost instantly. With IMR, judges are no longer asked to assess the relative value of opposing medical opinions. An IMR stands on its own, and is considered binding and final on the parties except in very rare and limited circumstances. Most compellingly, a process that once took a year or more to resolve can now come to fruition in less than 45 days.

MAXIMUS Federal also understands the complete workers' compensation process, and by extension, how and where IMR fits into that overall process. We appreciate that, by the time injured workers request IMR, they are likely frustrated by the denial of medical care by their employer, a claims administrator or a utilization review organization. Our call center staff are trained to be sensitive to the concerns of injured workers who may be in pain, people who do not understand why they were denied care or how to go about requesting review of that denial. MAXIMUS Federal also understands the significant consequences of errors at the IMR stage and we have implemented multiple levels of quality assurance into our service delivery approach.

did you KNOW

MAXIMUS Federal ...

- Manages more than 50 federal and state projects providing similar IMR services
- Processed more than 2.5 million IMRs since 1989 and is currently processing more than 80,000 reviews per month
- Operate 3 separate contracts that each process in excess of 100,000 annual IMRs
- Possesses more than 12 years of direct California IMR experience with more than 55,000 IMRs completed to date

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Lastly, MAXIMUS Federal recognizes the groups and individuals involved in the California workers' compensation arena and, in particular, IMR. We know that the Division of Workers' Compensation is the rulemaking body responsible for promulgating regulations consistent with laws such as SB863. We understand how work we do as an IMRO is really being done as the chosen delegate on behalf of the Administrative Director of the DWC. MAXIMUS Federal understands the complexity of the UR process in California, and especially how difficult it can be for an injured worker to determine who administers that process. For example, understanding that a claims administrator can mean an employer, an insurance carrier, an attorney on behalf of either, or someone/something else entirely – what seems like a simple matter can in fact be quite daunting for anyone not well versed in California's workers' compensation system.

While MAXIMUS Federal can proudly boast expertise in the medical review process in general, we understand that quality work for California workers' compensation IMR requires an in-depth understanding of and appreciation for the specific context within which such independent reviews are conducted. That is precisely why MAXIMUS Federal actively recruits and hires personnel with diverse backgrounds spanning all aspects of California workers' compensation. On our staff, we have former UR physicians, QMEs, hearing officers, claims administrators, workers' compensation caregivers – we make every effort to ensure that our staff can contribute expertise from every facet of California workers' compensation.

6.2 Knowledge of Independent Medical Review Requirements

RFP Section C.5.d.2, Page 22

MAXIMUS Federal is uniquely positioned to deliver all of the efficiencies intended with the design and implementation of IMR under SB863. Our team has extensive experience with SB863, California labor codes, statutes, regulation and DWC processes. We understand the California Workers Compensation dispute process and will continue leveraging our experience to enhance the IMR services we provide to DWC. With over three decades of experience adjudicating disputes over medical treatment in a variety of settings, no other organization in the country can match our experience and expertise in the independent medical review arena. We employ a team of professionals with extensive experience working in evidence-based medical review organizations. Many of those staff can boast a sophisticated understanding of the rules and regulations specifically applicable to medical treatment in the California workers' compensation setting.

Over the years, MAXIMUS Federal has also refined the process for conducting an independent medical review to eliminate inefficiency and promote quality. While the rules from one IMR project to another might differ, the process by which this work is conducted remains relatively consistent. That being the case, the same process, and quality protocols we have vetted and utilized successfully for years elsewhere can be quickly redeployed to great effect for California workers' compensation IMR. Additionally, MAXIMUS Federal's unrivaled understanding of the independent medical review process has paved the way for the development of sophisticated technological solutions that support and augment the review process to the highest possible degree.

Perhaps most importantly, MAXIMUS Federal understands the criticality of preserving the independent character of its medical reviews. Unlike most competitors, MAXIMUS Federal has never taken on work

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that would require advocating on behalf of either party to a dispute – we have always performed medical reviews that were independent in the truest sense of the word. MAXIMUS Federal provides rigorous instruction to all staff regarding the importance of maintaining an impartial approach to the adjudication of medical disputes; we are proud to employ a zero-tolerance policy when it comes to advocating for one side or the other in a medical dispute. MAXIMUS Federal’s reputation has been built on a staunch and uncompromising commitment to the principle of fair, unbiased, and truly independent review. Above all else, it is this commitment to the integrity of independent review that makes MAXIMUS Federal the best choice for California workers’ compensation IMR.

6.2.1 License to do Business in the State of California

RFP Section C.5.d.2, Page 22

Please see *Appendix M: California Business License* for a copy of our license to do business in the State of California.

6.2.2 Case Flow Tracking System Experience

RFP Section C.5.d.2, Page 22

As stated in *Section 4.2: Case Tracking System*, the current, proven case-tracking system, *entellittrak*, has already been configured specifically for the cases being submitted for review in accordance with the IMR contract. This system has been rigorously tested through real volume fluctuations, reducing any risk associated with future changes.

As of the time of this proposal, use of *entellittrak* is unique to this work within MAXIMUS, but MAXIMUS implements, customizes, and even designs case flow tracking systems for a wide-variety of health and human services projects through the country and the world. *entellittrak* was specifically selected as the best option for tracking and facilitating IMR cases based on extensive knowledge, best practices, and lessons learned as well as providing DIR/DWC the best value. The *entellittrak* system itself is used by dozens of federal government agencies as well as commercial clients and is well-proven to meet the requirements of appeals case management tracking.

6.2.3 Experience and Familiarity with Evidence-based Medical Treatment and Guidelines

RFP Section C.5.d.2, Page 22

MAXIMUS Federal has extensive experience and familiarity with evidence-based medical treatment and guidelines. For example, in our California IMR Projects, our reviewers are trained and instructed to determine whether the disputed health care service is medically necessary based on the specific medical needs of the enrollee and consideration of evidence-based medical treatment and guidelines, such as the California Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM) Occupational Medicine Practice Guidelines, and the Official Disability Guidelines (ODG). All of our reviewers maintain a clinical practice in accordance with the DIR/DWC requirements. Because of our reviewers’ academic affiliations and clinical practice experience, Maximus reviews will reference the most current standards of care and evidence-based medical treatments.

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Since our MPR panel represents all 24 ABMS specialties and subspecialties, we can offer the DIR/DWC unmatched medical professional reviewer coverage and expertise. Having completed more than 55,000 IMRs (including eligibility determinations, final determinations, and terminations) for our California IMR Program, our reviewers are well-versed in the application of current evidence-based medical treatment and guidelines to the facts and circumstances involved in each IMR.

As the incumbent for the DIR/DWC IMR program, we rely on the following guidelines (latest versions) and medical evidence to guide and support our decisions in accordance with the IMR statutes:

- **First Layer: Medical Treatment Utilization Schedule (MTUS)**
- **Second Layer: Peer-reviewed scientific and medical evidence, which includes evidence-based guidelines like the Official Disability Guidelines, primary medical literature, and other sources which are primarily based on high quality medical evidence**
- **Third through sixth Layers: includes “nationally recognized professional standards”, “expert opinion”, and other evidence of lower scientific quality**

Below we briefly describe these guidelines that we will continue to utilize for DIR/DWC IMRs.

First Layer

The first layer is the MTUS, which incorporates the ACOEM Practice Guidelines, 2nd Edition (2004), Chapters 1, 2, 3, and 5; and the following specific clinical topic chapters:

- Neck and Upper Back Complaints (Chapter 8)
- Shoulder Complaints (Chapter 9)
- Elbow Disorders (Chapter 10), updated 2007
- Forearm, Wrist, and Hand Complaints (Chapter 11)
- Low Back Complaints (Chapter 12)
- Knee Complaints (Chapter 13)
- Ankle and Foot Complaints (Chapter 14)
- Stress Related Conditions (Chapter 15)
- Eye (Chapter 16)
- Special Topics (refers to clinical topic areas where the Administrative Director has determined that the clinical topic sections of the MTUS require further supplementation (section 9792.24)
- Acupuncture medical treatment guidelines contained in section 9792.24.1 supersede the applicable ACOEM Chapters when acupuncture treatment is the issue at dispute.
- Chronic Pain medical treatment guidelines in section 9792.24.2 are used as follow-ons to the ACOEM chapters, when recovery has not taken place with respect to pain at the end of any respective clinical topic medical treatment guideline contained within the ACOEM chapters.
- If surgery has been performed for a specific complaint or condition, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. The applicable major headings for postsurgical treatment in the MTUS include:
 - Ankle & Foot

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- Burns
- Cardiopulmonary
- Carpal Tunnel Syndrome
- Elbow & Upper Arm
- Forearm, Wrist, & Hand
- Head
- Hernia
- Hip, Pelvis and Thigh (femur)
- Knee
- Low Back
- Neck & Upper Back
- Shoulder
- Appendix C – Postsurgical Treatment Guidelines Evidence-Based Review (May 2009)
- Appendix E – Postsurgical Treatment Guidelines Work Loss Data Institute-Official Disability Guidelines References (May 2009)
- Chronic Pain medical treatment guidelines (section 9792.24.2) apply in the absence of any cure for the patient who continues to have pain, who is beyond the anticipated time of healing, and who is not currently treated according to the Post-Surgical Treatment Guidelines.

Second Layer

The second layer applies to those conditions or injuries not addressed by the MTUS, and shall be in accordance with other scientifically and evidence-based medical treatment guidelines and medical evidence.

Third through sixth Layer

As described in the Statutes, other evidence of lesser scientific quality, such as “nationally recognized professional standards” and “expert opinion”, may be used when higher quality evidence is not available.

ECRI Institute

We will also leverage our relationship with the ECRI Institute for complex IMRs to ensure that we have access to the most current standards of evidence-based care. ECRI is a nonprofit organization that is expert in determining the best and most current evidence-based medical procedures, devices, drugs, and processes. ECRI has the unique ability to marry practical experience and uncompromising independence with the thoroughness and objectivity of evidence-based research. ECRI is designated as an Evidence-Based Practice Center by the United States Agency for Healthcare Research and Quality and listed as a federal Patient Safety Organization by the United States Department of Health and Human Services.

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6.2.4 Ability to Handle High-Volume Case Workload

RFP Section C.5.d.2, Page 22

Since 1989, MAXIMUS Federal has conducted more than 2.5 million independent medical reviews for more than 50 state and federal government agencies, including DIR/DWC, CDI, DMHC, Cal PERS, the Veterans Health Administration (VHA), The Centers for Medicare & Medicaid Services (CMS), the Office of the Inspector General (OIG), and the Office of Personnel Management (OPM). We have achieved URAC IRO accreditation six consecutive times as an independent review organization. Across all our projects, our medical review decisions addressing the full spectrum of claims including: medical advisory, torts, facility, medical necessity, experimental/investigational, cosmetic, and provider qualification disputes. In the year 2014, we expect to process an additional one million reviews and are currently processing more than 80,000 reviews per month across all projects.

We have been able to continually meet these high volumes by utilizing a scalable case workflow management tool, our extensive panel of actively practicing, board certified, credentialing physicians and allied health care practitioners, and our staff of more than 100 Appeal Officers. Specifically, for this effort to meet increasing high volumes we will take the following steps:

- Continue to automate the IMR process on our end via *entrellittrak*, which will facilitate the IMR process by pre-populating the various program notices, which expedite the IMR process and eliminate human error
- Continue to work closely with DIR/DWC to fully implement the IMR Online Application on July 1, 2014. Our case management system, staff and reviewers will be fully ready for this important innovation
- Ongoing staff augmentation to ensure we have qualified Appeal Officers to help manage the increasing case volume, ensure timelines are met, and help reduce the backlog. We currently have 100 Appeal Officers working on this Project
- Identified and partnered with URAC accredited IROs who will provide us with 600 additional California licensed MPR resources, bringing our panel to 950 MPRs. Our Appeal Officer resources with our expanded panel will give us the capacity to process 40,000 IMRs a month
- Targeted Recruiting Initiative for California licensed MPRs with 80 reviewer candidates currently in application and credentialing pipeline
- Expansion of Panel of Scheduling/Professional Relations Department to ensure qualified reviewers, are vetted for conflict of interest and assigned with the same or similar specialty at issue in the review
- Implementation of Expert Gateway, which will facilitate our reviewer assignment process and allow our reviewers to securely download case file materials via *entellittrak*
- Use of Remote Appeal Officer staff with the expansion of *entellittrak* for additional resources to ensure cases are completed within in DIR/DWC IMR timelines and help to eliminate the backlog

In addition to our unparalleled independent medical review services and proven resources, we have been deemed completely conflict free by CMS every year in an Annual Conflict of Interest Compliance Audit. This will effectively eliminate delays related to organizational conflict of interest, where another vendor would be precluded from providing an IMR because of an existing relationship with a California disability insurer or some other precluded entity.

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Lastly, we have established ourselves as a long standing trusted partner to California agencies. For example in our 2013 Customer Survey, CDI and DMHC rated MAXIMUS Federal as "excellent" or "exceptional" in every category, including the quality of IMR products and services delivered. This collaborative relationship ensures that strategies can be quickly developed and solutions implemented immediately helping to ensure we can meet expected and unexpected volumes.

Based on the forgoing we are confident we can provide the DIR/DWC with a cost-effective, low-risk IMR services solution designed to decide disputes between physicians and Claims Administrators related to necessary medical treatment for injured workers in accordance Senate Bill 863.

6.2.5 Successfully Handling 100,000 Reviews Per Year

RFP Section C.5.d.2, Page 22

We have the required independent review management program experience and expertise to ensure timely, understandable, high quality peer reviews in anticipated or unanticipated spikes in review volumes. As demonstrated in *Exhibit 6.2.5-1: Appeal Volumes*, we have helped develop and refine a medical review process that allows the processing of hundreds of thousands of timely claims for CMS Qualified Independent Contractor (QIC) over the past three years.

All Appeals					
Year	Part A	Part B	Part C	Part D	Total
2010	52,761	83,325	63,931	19,364	219,381
2011	72,313	58,940	68,813	13,897	213,963
2012	176,409	84,687	109,188	14,481	384,765
2013	525,622	102,621	118,681	24,155	771,079
Totals	827,105	329,573	360,613	71,897	1,589,188

Exhibit 6.2.5-1: Appeal Volumes.

We have direct experience with California IMRs having completed more than 55,000 for DIR/DWC, CDI, DHMC, and CalPERS over the last several years. We will use the same management staff that managed our DIR/DWC IMR Project to oversee this Project. Our California IMR experience and expertise, our 100 trained Appeal Officers, our specialized team approach, and our 950 California-licensed MPRs provides us with the capacity to easily meet this 100,000 review per year threshold.

6.2.6 Experience Managing Electronic Submission of Reviews

RFP Section C.5.d.2, Page 23

We have significant experience receiving electronic medical records from all stakeholders for our IMR services for government agencies, individuals, and providers. For example, our proprietary case tracking system features a secure contains a self-service portal, available to program stakeholders, enabling a secure method to initiate cases and review case status via the internet, while ensuring the confidentiality and integrity of sensitive information. Across all of IMR projects we currently receive in excess of 15,000 electronic medical records a month.

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6.2.7 Breadth of Experience Conducting IMR

RFP Section C.5.d.2, Page 23

MAXIMUS Federal is a national leader in independent medical review services for regulatory agencies. We have provided more than 2.5 million medical reviews for more than 50 state and federal clients. We are fully accredited by the Utilization Review Accreditation Commission (URAC) since 2000.

MAXIMUS Federal currently operates independent medical review projects for 37 state regulatory agencies and through the Affordable Care Act's (ACA)'s federal external review program we process reviews for an additional 10 states and 5 territories. The closest URAC accredited IRO has 16 such projects in operation, or less than half of those currently managed by MAXIMUS. Please see *Exhibit 6.2.7-1: State Independent Medical Review Clients* for a list of our state projects. Please note that all of these projects are ongoing and involve the provision of independent clinical review and oversight services similar to those required under the DIR/DWC project.

State Independent Clinical Review Clients		
Alaska Department of Administration	Kentucky Department of Insurance	Oklahoma Department of Insurance
Arizona Department of Insurance	Maine Department of Insurance	Rhode Island Department of Insurance
Arkansas Department of Insurance	Maryland Department of Health and Mental Hygiene	South Carolina Department of Insurance
California Department of Insurance	Maryland Insurance Administration	South Dakota Department of Insurance
California Department of Managed Health Care	Massachusetts Office of Patient Protection	Tennessee Department of Commerce and Insurance
California Public Employment Retirement System	Michigan Division of Insurance	Texas Department of Insurance
Colorado Division of Insurance	Minnesota Department of Health	Utah Department of Insurance
Connecticut Insurance Department	Minnesota Department of Commerce	Vermont Division of Health Care Administration
Florida Agency for Health Care Administration	Minnesota Department of Human Services	Virginia Bureau of Insurance
Georgia Department of Community Health	New Jersey Department of Banking and Insurance	Virginia Department of Managed Health Care
Idaho Department of Insurance	Nevada Department of Insurance	Washington Department of Health
Illinois Department of Insurance	New Hampshire Department of Insurance	Wisconsin Department of Insurance
Indiana Department of Insurance	North Carolina Department of Insurance	Wyoming Department of Insurance
Iowa Division of Insurance	Pennsylvania Department of Insurance	
	Ohio Department of Insurance	

Exhibit 6.2.7-1: Independent Medical Review Projects. MAXIMUS Federal currently provides medical peer review services for these 37 state agencies.

We also provide independent medical review services for the following Federal Agencies

- Centers for Medicare and Medicaid Qualified Independent Contractor (CMS QIC) Projects for Parts A, B, C, D
- Health and Human Services (HHS), Office of Inspector General, Medicare Part A & B review
- Office of Personnel Management (OPM) Federal External Review (FER) Project
- Office of Personnel Management (OPM) Multi-state Plan Program
- Office of Personnel Management (OPM) Pre-existing Condition Insurance Program

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- Veterans Administration VISN Network 23 Clinical Peer Review Project
- Veterans Administration VISN 10 Peer Review Project

6.2.8 Ability to Provide Data Regarding Case Status and Outcomes

RFP Section C.5.d.2, Page 23

We understand how important it is to use accurate, easy to use, and flexible reporting tools to facilitate oversight of project operations by providing critical performance data for monitoring, program forecasting, and quality customer service, in particular case status and outcomes. We extend this understanding into our production of reports to ensure that the DWC has the information needed for the oversight of the IMR Project. Our MAXDat reporting and data analysis technology, capabilities, and procedures reflect a commitment to operate our projects in a transparent manner to show that our staff are partnering with you to serve the stakeholders in California.

Our proven solution includes the following:

- **Web-based Reporting and Analytics:** We provide key performance indicators, dashboards, reports, and analytics as well as mandatory state reports and best practice data visualizations
- **Business Process Centric Data Management:** We consolidate data from our *entellitrak* application, ACTS and the Expert Gateway, to provide both historical analysis and current business intelligence
- **Ability to Attach to Reporting through Mobile Devices:** A mobile interface is available from iPads™ and Android™ devices, making up-to-date performance data available while on the move
- **Change Management:** We have the ability to respond to, and manage, requests for new reports, analyses, and statistics in a timely manner
- **Reporting and Analytics Specialists:** MAXIMUS provides reporting and analytics specialists who understand the process and build the reporting specifications based on operational needs

In addition, we provide an expert consultant to assist with developing reports that meet the needs of DWC. Mr. Neuhauser is the Executive Director of the Center for the Study of Social Insurance at the University of California, Berkeley. Mr. Neuhauser has extensive experience with Workers' Compensation in California and has previously assisted the DWC on a series of initiatives to use data on injured workers to providing meaningful contributions to policies governing delivery of care to the injured worker population. In his capacity as a consultant, Mr. Neuhauser will bring his extensive experience with the Workers' Compensation program to bear on the design of data structures that support DWC. Complete information on reporting and MAXDat is found in *Section 4.2.8: Case Tracking Reports*.

6.2.9 Capability to Provide Reviews in Accordance with RFP

RFP Section C.5.d.2, Page 23

For all the reasons set forth throughout this proposal, MAXIMUS Federal is capable of providing reviews in accordance with this RFP.

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6.2.10 California Office Space

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Our corporate office is located in Reston, VA at:

MAXIMUS Federal Services, Inc.
1891 Metro Center Drive
Reston, VA 20190

This office houses our corporate leadership along with our Directors of Compliance, Finance, and Human Resources.

Since 2009, we have had a full-service office outside of Sacramento in Folsom, California. This full-service office houses our California IMR staff. This office and its staff have been responsible for completing all of DWC's IMRs since 2013. If awarded this contract, we will continue to operate DWC's IMR program out of this office. The address for this fully secure and operational facility is:

MAXIMUS Federal Services, Inc.
625 Coolidge Drive, Suite 150
Folsom, CA 95630

Included among the professional level IMR staff located in the Folsom, California office are the Project Director, a seasoned technology leader who provides executive oversight for the project, the Project Manager, a licensed health care attorney who supervises project operations and ensures compliance with project requirements, and the IMR Medical Director, a California licensed physician board certified in Occupational Medicine who provides expert review guidance and quality assurance for the MAXIMUS Federal reviewer panel. The Folsom facility also houses a cadre of administrative and operations staff who are essential to the DWC IMR project.



6.2.11 Sufficient Number of Reviewers

RFP Section C.5.d.2, Page 23

As detailed throughout this proposal, MAXIMUS Federal can provide access to 350 California-licensed physicians and other health care professionals to complete IMRS which includes more than 460 California certifications. We have entered into a number of subcontracting agreements with URAC accredited IROs in order to accommodate an increase in the workload and have added 600 California licensed clinicians to our MPR Panel, bringing the total number of MPR resources to 950. Given these commitments and resources we are confident we now have the capacity to process up to 40,000 IMRs a month. We will continue our California-licensed MPR recruitment efforts to ensure we have secured a sufficient number of California-licensed physicians and allied health care professionals in all specialties and subspecialties. See *Section 4.1.6: Recruiting California Licensed MPRS* for more information on our ability to enhance the breadth of our California licensed reviewer panel to accommodate increased volumes.

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6.2.12 Sufficient Number of Staff

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MAXIMUS Federal has an experienced team of professional and operations staff who are well versed in all facets of the IMR program. *Section 5.2* of this proposal provides a detailed description of the roles and responsibilities of our designated staff including those assigned to the following tasks: recruiting and verifying credentials of reviewers; conflicts of interest checks; managing the process of reviews; drafting; reviewing and revising written determinations; and maintaining the confidentiality of medical records and other data. MAXIMUS Federal utilizes scalable workflow and staffing models to confirm that we always have multiple staff fully trained in client and project requirements available to address expected and expected variances in the workload. See *Section 6.2.4: Ability to Handle High-Volume Case Workload* for more information on our organizational capacity to handle high volumes of reviews.

6.2.13 References of Services of Same or Similar Size and Scope

RFP Section C.5.d.2, Page 23

MAXIMUS Federal is a national leader in providing independent review services for regulatory agencies. We have provided more than two million clinical reviews for more than 40 state and federal clients. MAXIMUS Federal is pleased to provide the following sampling from our portfolio as references. All of these projects involve the provision of independent clinical review and oversight services similar to those required under the Department of Industrial Relations (DIR) Division of Workers' Compensation (DWC) Independent Medical Review program.

Reference #1

RFP Section C.5.d.2, Page 23

California Department of Industrial Relations/Division of Workers' Compensation – Independent Medical Review (IMR) Agreement # 41230038	
Name of Customer	California Department of Industrial Relations, Division of Workers' Compensation
Contact Person and Telephone Number	Rupali Das, Executive Medical Director (510) 286-3700
Date of Service	January 1, 2013 to December 31, 2014

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**California Department of Industrial Relations/Division of Workers'
Compensation – Independent Medical Review (IMR)
Agreement # 41230038**

Project Abstract	<p>MAXIMUS Federal provides independent medical review (IMR) services to the Department of Industrial Relations (DIR) and the Division of Workers' Compensation (DWC) to help resolve disputes about the medical treatment of injured employees. MAXIMUS Federal conducts IMR for worker's compensation cases where claims have been denied or medical care has been discontinued because services are deemed not medically necessary during the Utilization Review process.</p> <p>Once IMR applications are received, MAXIMUS Federal obtains any missing information, completes a preliminary review to ensure the case is eligible for IMR, and then assigns the case to a panel of credentialed physician reviewers make the IBR determination.</p> <p>When the Project went live on July 1, 2013, the volume of IMR applications far exceeded the anticipated 4,000 per month. In order to meet the rapidly increasing workload, MAXIMUS Federal quickly scaled up project operations, recruiting and training additional project front end data entry staff and adding additional physicians to serve on our medical review panel. MAXIMUS Federal receives between 12,000 and 15,000 IMR applications per month and has sent out over 24,500 IMR Final Determination Letters through April 16, 2014.</p>
Relevancy to Scope of Services	<p>As the existing contract for RFP#DIR-DWC-RFP#14-00, this contract is highly relevant with a vastly similar scope of services. The case intake, case review and case closing processes currently being utilized on the IMR contract will be modified to meet the requirements as defined by the current RFP. Our experience on the current contract will be a continued asset under the new contract as the IMR program continues to develop.</p>

Proposed Staff Role and Responsibilities

Staff listed below are proposed management staff for this proposal.

- Thomas Naughton, **Client Executive** was responsible for overall management, contract compliance, and project quality assurance to ensure consistent application of all laws, regulations, policies, and procedures pertinent to the Project.
- Rob Nydam, as **Project Manager** responsible for directing business process management (BPM) and manages staff devoted to California workers' compensation medical review
- Lou Shields, as **Vice President of Operations** responsible for IT solutioning, IT Infrastructure, PMO, QA, Training, Facilities, Business Process Management (BPM), and Operational Efficiency
- Paul Manchester, **Medical Director** for California Independent Medical Review (IMR)

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Reference #2

RFP Section C.5.d.2, Page 23

**Centers for Medicare and Medicaid – Part C Qualified Independent Contractor (QIC)
Contract Number and Task Order HHSM-500-2004-000071, HHSM-500-T0004**

Name of Customer	Centers for Medicare and Medicaid Services (CMS)
Contact Person and Telephone Number	Mark Smolenski, Contracting Officer (410) 786-0175
-Date of Service	July 1, 2011 – June 30, 2015
Project Abstract	Under Qualified Independent Contractor (QIC) Part C contracts, MAXIMUS Federal provides standard and expedited reconsiderations of denials and appeals related to Medicare Advantage and PACE plans. Our Appeal Officers, typically licensed or dual degreed attorneys, provide coverage review; and medical necessity determinations are made by our panel of over 700 credentialed physicians. MAXIMUS Federal is also responsible for oversight of plan compliance to Administrative Law Judge (ALJ) effectuation procedures, routine and ad-hoc reporting, Health Plan communications (Reconsideration Manual and Newsletters), Medicare Appeals Council (MAC) and Freedom of Information Act (FOIA) processing and record management and storage (currently manage over 450,000 records). The project operates under International Organization for Standardization (ISO) 9001:2008 standard for continuous quality assurance and registration. It has exceeded contract standards for timeliness for the standard and the expedited reconsiderations. In April 2006, CMS selected MAXIMUS Federal as the Part C QIC, thereby enabling MAXIMUS Federal to continue to serve the Medicare managed care appeals program through independent review of coverage denials.
Relevancy to Scope of Services	Part C processed over 115,000 cases during 2013 and utilizes many of the same independent medical review processes that are used on the DIR/DWC IMR project. The scope of this contract includes similar medical review services to the CA IMR contract and

Proposed Staff Role and Responsibilities

Staff listed below are proposed management staff for this proposal.

- Thomas Naughton, **Sr. Subject Matter Expert** was responsible for providing subject matter expertise regarding to the QIC operations team. He provided expertise regarding the overall independent medical review process and best practices that could be deployed to the QIC program to enhance service results.
- Rob Nydam, **Subject Matter Expert/Operations Efficiency Lead** for the project and was responsible for providing SME in support of the adjudication process. He also lead a team responsible for evaluating business processes and implementing changes to streamline operations.
- Lou Shields, as **Vice President of Operations** responsible for IT solutioning, IT Infrastructure, PMO, QA, Training, Facilities, Business Process Management (BPM), and Operational Efficiency.

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Reference #3

RFP Section C.5.d.2, Page 23

California Department of Insurance – Independent Medical Review (IMR) Contract Number 9016CA	
Name of Firm	California Department of Insurance
Contact Person and Telephone Number	Janelle Roy, Contracting Officer (213) 346-6575
Date of Service	July 1, 2009 thru June 30, 2012
Project Abstract	<p>MAXIMUS Federal completed more than 1,500 independent medical reviews for the California Department of Insurance (CDI). The Project included both standard and expedited reviews addressing the full spectrum of health care issues including medical necessity, experimental therapies, and emergent and urgent care issues. The CDI IMR Project was housed in Sacramento. Reviews were conducted by California licensed attorneys working in conjunction with our panel of more than 1,000 actively practicing fully credentialed physicians and other clinical practitioners. Review of experimental cases required utilizing a panel of three medical reviewers.</p> <p>Throughout the term of the Project, working collaboratively with CDI, MAXIMUS Federal expertly addressed a number of controversial issues including, surgical treatment of morbid obesity, long-term antibiotics for the treatment of Lyme disease, and new and emerging therapies for the diagnosis, and treatment of autism.</p>
Relevancy to Scope of Services	The scope of services we provide under our CDI IMR contract includes many of the same features as the DIR/DWC IMR program. Under both programs we are responsible for providing independent, conflict free medical review services. We utilize the same panel of medical expert reviewers and have the same credentialing and active participation requirements.

Proposed Staff Role and Responsibilities

Staff listed below are proposed management staff for this proposal.

- Thomas Naughton, **Client Executive** was responsible for overall management, contract compliance, and project quality assurance to ensure consistent application of all laws, regulations, policies, and procedures pertinent to the Project.

Reference #4

RFP Section C.5.d.2, Page 23

California Department of Managed Health Care – Independent Medical Review (IMR) Contract Number 00MC-SA058 & 06MC-SA029	
Name of Firm	California Department of Managed Health Care
Contact Person and Telephone Number	Dan Southard, Project Officer (916) 255-2498
Date of Service	January 1, 2001 to Present
Project Abstract	In November 2000, MAXIMUS Federal was selected as the primary contractor by the State of California Department of Managed Health Care (DMHC) to perform independent medical reviews. Under this contract, MAXIMUS provides

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California Department of Managed Health Care – Independent Medical Review (IMR) Contract Number 00MC-SA058 & 06MC-SA029	
	<p>independent medical reviews of denials affecting California managed care enrollees in participating California Managed Care Organizations. MAXIMUS medical necessity and experimental/investigational findings are made by its panel of California-licensed, independent clinical consultants. Consultants are not employees of MAXIMUS, they contract with MAXIMUS independently.</p> <p>The DMHC IMR Project is located in Sacramento, California and staffed with California licensed attorneys who work with a panel of credentialed medical professional reviewers. Day to day case management of DMHC external reviews is supervised by MAXIMUS Appeal Officers. While many medical reviewers are attorneys, some are physicians, nurses, or other licensed health professionals.</p>
Relevancy to Scope of Services	<p>The scope of services we provide under our DMHC IMR contract includes many of the same features as the DIR/DWC IMR program. Under both programs we are responsible for providing independent, conflict free medical review services. We utilize the same panel of medical expert reviewers and have the same credentialing and active participation requirements.</p>

Proposed Staff Role and Responsibilities

Staff listed below are proposed management staff for this proposal.

Thomas Naughton, **Client Executive** was responsible for overall management, contract compliance, and project quality assurance to ensure consistent application of all laws, regulations, policies, and procedures pertinent to the Project.

Reference #5

RFP Section C.5.d.2, Page 23

Centers for Medicare and Medicaid – Part A East Qualified Independent Contractor (QIC) Contract Number and Task Order HHSM-500-2004-000071, HHSM-500-T0008	
Name of Customer	Centers for Medicare and Medicaid Services (CMS)
Contact Person and Telephone Number	Mark Smolenski, Contracting Officer (410) 786-0175
Date of Service	Sept 14, 2005 -- Present
Project Abstract	<p>The Part A East QIC contract encompasses all Medicare standard and expedited appeals for the Medicare Fee for Services Part A workload, which is comprised of 27 States, the U.S. Virgin Islands, and Puerto Rico. Under this contract, MAXIMUS Federal provides independent review for disputed Medicare Part A claims and provider service terminations for discharges from skilled nursing facilities, home health services, and hospice services. Under this contract, MAXIMUS Federal provides independent review for disputed Medicare Part A claims and Provider Service Terminations. MAXIMUS Federal conducts independent reviews involving denials based upon medical necessity, coverage and coding. MAXIMUS Federal also conducts independent expedited reviews of Provider Service Terminations for discharges from residential facilities, hospice, and home health services. During 2013 we processed over 300,000 appeals under this contract.</p> <p>Medical reviewers, including licensed physicians, allied health professionals, nurses and attorneys work in conjunction with a clinical panel of more than more</p>

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**Centers for Medicare and Medicaid – Part A East Qualified Independent Contractor (QIC)
Contract Number and Task Order HHS-500-2004-000071, HHS-500-T0008**

	<p>than 1,000 actively practicing fully credentialed physicians and other clinical practitioners to review claims and render reconsideration decisions. As the Part A West QIC, MAXIMUS Federal has also successfully negotiated and maintained Joint Operating Agreements (JOA) with other contractors, including Medicare Affiliated Contractors, Quality Improvement Organizations, and Program Safeguard Contractors. MAXIMUS Federal established secure Medicare Data Communication Network (MDCN) connectivity and implemented the Medicare Appeals System (MAS) solution, while also providing subject matter expert services.</p> <p>From February 2012 through February 2013 the appeals volume had an unprecedented increase of 253%. Our approach to meeting the volume surge involved technology enhancements and process changes. To evaluate our existing approach, we conducted end-to-end business process mapping. Using SAVVION, a recognized business process modeling tool, we identified ways to enhance our operations to effectively and efficient address the volume surge. We worked collaboratively with CMS to ensure that all new process improvements were implemented with the lowest levels of risk to ensure that they were successful. Our new approach was constructed to provide ongoing scalability and flexibility in our operations, allowing for the ebb and flow of appeal volumes, both anticipated and unanticipated.</p>
<p>Relevancy to Scope of Services</p>	<p>Part A East processes approximately 300,000 cases a year and utilizes many of the same independent medical review processes that are used on the DIR/DWC IMR project. Additionally, this program experienced an unprecedented 253% increase in appeals volume over a 1 year time period. We will apply the same lessons learned and best practices attained while meeting that volume surge to address potential volume fluctuations on the DIR/DWC IMR program.</p>

Proposed Staff Role and Responsibilities

Staff listed below are proposed management staff for this proposal.

- Bernice Stein, **Medical Director** for CMS QIC Part A East project.
- Thomas Naughton, **Sr. Subject Matter Expert** was responsible for providing subject matter expertise regarding to the QIC operations team. He provided expertise regarding the overall independent medical review process and best practices that could be deployed to the QIC program to enhance service results.
- Rob Nydam, **Subject Matter Expert/Operations Efficiency Lead** for the project and was responsible for providing SME in support of the adjudication process. He also lead a team responsible for evaluating business processes and implementing changes to streamline operations.
- Lou Shields, as **Vice President of Operations** responsible for IT solutioning, IT Infrastructure, PMO, QA, Training, Facilities, Business Process Management (BPM), and Operational Efficiency.

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Reference #6

RFP Section C.5.d.2, Page 23

**Centers for Medicare and Medicaid Services - Part B South Qualified Independent Contractor (QIC)
Contract Number and Task Order HHS-500-2004-000010J, HHS-500-T0004**

Name of Firm	Centers for Medicare and Medicaid Services (CMS)
Contact Person and Telephone Number	Mark Smolenski, Contracting Officer (410) 786-0175
Date of Service	September 2005 – Present
Project Abstract	<p>As the Part B South Qualified Independent Contractor, MAXIMUS Federal provides independent medical review of denials and service terminations affecting Medicare beneficiaries and providers with respect to Medicare Part B. The Part B South Project encompasses all Medicare independent medical reviews for the Medicare Fee For Services Part B South region, covering 15 states, the Virgin Islands, and Puerto Rico. The Project also handles medical reviews for Railroad Retirement Board nationwide. During 2013 we processed more than 100,000 appeals under this contract.</p> <p>Independent reviews cover an array of medical services including requests for doctor's services, outpatient medical and surgical services, diagnostic tests, ambulatory surgery, outpatient mental health care, and outpatient physical and occupational therapy. Specific tasks performed in the Part B South project include creating electronic case files; applying Medicare law and regulations to the cases; identifying potential fraud and abuse; ensuring proper payment of claims; and communicating review outcomes. To date, MAXIMUS Federal has achieved an industry best of 46.85 days to complete Part B South independent medical reviews.</p> <p>Note: Work performed by Q2 Administrators (Q²A), a subsidiary of MAXIMUS Federal.</p>
Relevancy to Scope of Services	Part B South takes in approximately 80,000 cases a year with an average case file page count of 60. For our core workload, this equates to 4,800,000 pages annually received, controlled, imaged, filed, reviewed, and shipped to long term storage. For each of these cases we generate and send at minimum 4 correspondences to appellants and business partners, in both electronic and paper formats.

Proposed Staff Role and Responsibilities

Staff listed below are proposed management staff for this proposal.

- Thomas Naughton, **Sr. Subject Matter Expert** was responsible for providing subject matter expertise regarding to the QIC operations team. He provided expertise regarding the overall independent medical review process and best practices that could be deployed to the QIC program to enhance service results.
- Rob Nydam, **Subject Matter Expert/Operations Efficiency Lead** for the project and was responsible for providing SME in support of the adjudication process. He also lead a team responsible for evaluating business processes and implementing changes to streamline operations.
- Lou Shields, as **Vice President of Operations** responsible for IT solutioning, IT Infrastructure, PMO, QA, Training, Facilities, Business Process Management (BPM), and Operational Efficiency.

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6.2.14 Freedom from Conflicts of Interest Plan

RFP Section C.5.d.2, Page 23; B.1, Page 16

As emphasized throughout this proposal, we are completely free from any organizational conflicts of interest. We can make this assertion because we do not provide independent medical review for any commercial clients, including California licensed health or disability insurer, health plan or medical group or any California health care facility. We solely provide IMR services to state and federal government entities, which is the crux/foundation of our conflicts of interest plan. From a reviewer and staff conflict of interest process we able to avoid actual and apparent conflicts via a rigorous screening of every IMR case file throughout the IMR process. The first conflict of interest assessment occurs during case receipt, another occurs once a reviewer has been selected, and the final assessment is done by the reviewer once all the case files have been received. Please see *Appendix D: Conflict of Interest Policy and Procedures* for a detailed description of our conflict of interest measures. Please see *Appendix E: MPR Application*, which requires reviewers to list their material professional, familial, or financial affiliations if any.

Lastly, no MAXIMUS Federal officer, director, or management employee of the independent review organization has that would constitute a five percent interest of total annual revenue or total annual income of the independent review organization or of any officer, director, or management employee of the independent review organization as defined in the California Labor Code. Please see *Section 4.4.2.5: Compliance with Labor Section 139.5 and Any Other Conflicts of Interest Requirements* for additional information regarding the series of steps utilized in our case management process to ensure our reviewers are conflict free when performing an IMR. Based on the foregoing, we are confident we meet the conflict of interest requirements described in Labor Section 139.5. California Labor Code 139.5(d)(1), (d)(5)(A-F), (d)(6)(A-C). It is through the above strategy that MAXIMUS Federal can guarantee DIR/DWC absolutely conflict free services.

State of California

Bid DIR DWC RFP14-001

Department of Industrial Relations

DIR DWC RFP#14-001

ATTACHMENT 1

REQUIRED ATTACHMENTS CHECK LIST

A complete proposal or proposal package will consist of the items identified below. Complete this checklist to confirm the items in your proposal. Place a check mark or "X" next to each item that you are submitting to the State. For your proposal to be responsive, all required attachments must be returned. This checklist should be returned with your proposal package also.

<u>Attachment</u>	<u>Attachment Name/Description</u>
<u>X</u>	Attachment 1 Required Attachments Check List
<u>X</u>	Attachment 2 Proposal/Proposer Certification Sheet
<u>X</u>	Attachment 3 Cost Sheet
<u>X</u>	Attachment 4 Proposer References
<u>X</u>	Attachment 5 Disabled Veteran Business Enterprise Participation Forms and Instructions
<u> </u>	Attachment 6 Payee Data Record (STD 204) (if currently not on file) <i>(Required upon award of contract)</i>
<u> </u>	Attachment 7 Contractor Certification Clauses (CCC) 610. The CCC can be found on the Internet at www.ols.dgs.ca.gov/Standard+Language . <i>(Required upon award of contract)</i>
<u>X</u>	Attachment 8 Darfur Contracting Act Certification
<u> </u>	Attachment 9 Assignment of Work and Restricted License regarding Deliverable (Attachment 9: not included in RFP)
<u>N/A</u>	Attachment 10 Target Area Contract Preference Act (TACPA) *
<u>N/A</u>	Attachment 11 Local Agency Military Base Recovery Area (LAMBRA) Act*
<u>N/A</u>	Attachment 12 Enterprise Zone Act (EZA) *

*If applicable

Note for Attachment 10, 11, and 12: Although MAXIMUS Federal and its parent company MAXIMUS, Inc. employees more than 900 staff with numerous offices throughout the state, we do not qualify for the Target Area Contract Preference Act (TACPA), the Local Agency Military Base Recovery Area (LAMBRA) Act, or the Enterprise Zone Act (EZA).

State of California

Bid DIR DWC RFP14-001

Department of Industrial Relations

DIR DWC RFP#14-001

ATTACHMENT 2

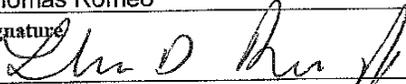
PROPOSAL/PROPOSER CERTIFICATION SHEET

This Proposal/Proposer Certification Sheet must be signed and returned along with all the "required attachments" as an entire package in duplicate with original signatures. The proposal must be transmitted in a sealed envelope in accordance with RFP instructions.

Do not return Section C, Proposal Requirements and Information (pages 7 through 17) nor the "Sample Agreement" at the end of this RFP.

- A. Place all required attachments behind this certification sheet.
- B. I have read and understand the DVBE Participation requirements and have included documentation demonstrating that I have met the participation goals or have made a good faith effort.
- C. The signature affixed hereon and dated certifies compliance with all the requirements of this proposal document. The signature below authorizes the verification of this certification.

**An Unsigned Proposal/Proposer Certification Sheet
May Be Cause for Rejection**

1. Company Name MAXIMUS Federal Services		2. Telephone Number (703-336-8135	2a. Fax Number (703-251-8240
3. Address 1891 Metro Center Drive, Reston, Virginia 20190			
Indicate your organization type:			
4. <input type="checkbox"/> Sole Proprietorship		5. <input type="checkbox"/> Partnership	6. <input checked="" type="checkbox"/> Corporation
Indicate the applicable employee and/or corporation number:			
7. Federal Employee ID No. (FEIN) 20-2998066		8. California Corporation No. C3014438	
9. Indicate applicable license and/or certification information: URAC Certification California Business License No. C3014438			
10. Proposer's Name (Print) Thomas Romeo		11. Title President	
12. Signature 		13. Date May 12, 2014	
14. Are you certified with the Department of General Services, Office of Small Business Certification and Resources (OSBCR) as:			
a. California Small Business Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, enter certification number: _____		b. Disabled Veteran Business Enterprise Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, enter your service code below: _____	
<p>NOTE: A copy of your Certification is required to be included if either of the above items is checked "Yes". Date application was submitted to OSBCR, if an application is pending: _____</p>			

State of California

Bid DIR DWC RFP14-001

Department of Industrial Relations

DIR DWC RFP#14-001

ATTACHMENT 3

COST PROPOSAL WORK SHEET

See the Cost Proposal for Attachment 3.

State of California

Bid DIR DWC RFP14-001

Department of Industrial Relations

DIR DWC RFP#14-001

ATTACHMENT 4

PROPOSER REFERENCES

Submission of this attachment is mandatory. Failure to complete and return this attachment with your proposal will cause your proposal to be rejected and deemed nonresponsive.

List below six references for services performed within the last five years, which are similar to the scope of work to be performed in this contract (similar in scope is considered to be actuarial and auditing services including regulatory consulting services provided to self-insured workers' compensation state regulators. Compliance work provided directly to self-insured employers or groups may be substituted in the absence of work performed directly for regulators. California references may be considered more similar than non-California based references). If six references cannot be provided, please explain why on an attached sheet of paper.

REFERENCE 1

Name of Firm	Centers for Medicare and Medicaid Services Part B South Qualified Independent Contractor (QIC)			
Street Address	Division of Appeals Operations	City	Baltimore	State Maryland Zip Code 21244
	7500 Security Blvd, Mailstop: B2-14-21			
Contact Person	Mark Smolenski, Contracting Officer		Telephone Number	(410) 786-0175
Dates of Service	September 2005 – Present		Value or Cost of Service	\$55,969,574

Brief Description of Service Provided
The Part B South QIC (Part B South) project provides independent review of denials and service terminations affecting Medicare beneficiaries and providers with respect to Medicare Part B. This project encompasses all Medicare appeals for the Medicare Fee for Services Part B South region, covering 15 states, the Virgin Islands, and Puerto Rico. In addition, the Part B South Project also performs independent review of Railroad Retirement Board claims nationwide.

REFERENCE 2

Name of Firm	Centers for Medicare and Medicaid Services Part A West Qualified Independent Contractor (QIC)			
Street Address	Division of Appeals Operations	City	Baltimore	State Maryland Zip Code 21244
	7500 Security Blvd, Mailstop: B2-14-21			
Contact Person	Mark Smolenski, Contracting Officer		Telephone Number	(410) 786-0175
Dates of Service	September 2005 to Present		Value or Cost of Service	\$64,199,948

Brief Description of Service Provided
As the CMS Part A West Qualified Independent Contractor, MAXIMUS Federal provides independent review for disputed Medicare Fee for Services Part A claims and provider service terminations. The project scope includes standard and expedited review for the West region which is comprised of 24 States, Guam, Northern Mariana Islands and American Samoa. Also under this contract, MAXIMUS Federal provides independent expedited reviews for discharges from skilled nursing facilities, home health services and hospice services.

REFERENCE 3

Name of Firm	California Department of Insurance Independent Medical Review (IMR)			
Street Address	300 South Spring Street	City	Los Angeles	State California Zip Code 90013
Contact Person	Janelle Roy, Contracting Officer		Telephone Number	(213) 346-6575
Dates of Service	July 1, 2009 to June 30, 2012		Value or Cost of Service	\$1,600,000

Brief Description of Service Provided
MAXIMUS Federal completed more than 1,500 independent medical reviews for the California Department of Insurance. The project included both standard and expedited reviews addressing the full spectrum of health care issues including medical necessity, experimental therapies, and emergent and urgent care issues. Reviews were conducted by California licensed attorneys working in conjunction with a panel of more than 1,000 actively practicing fully credentialed physicians and other clinical practitioners. Experimental case reviews required utilizing a panel of three medical professional reviewers.

State of California

Bid DIR DWC RFP14-001

Department of Industrial Relations

DIR DWC RFP#14-001

REFERENCE 4

Name of Firm	California Department of Managed Health Care Independent Medical Review (IMR)		
Street Address	980 Ninth Street, Suite 500	City Sacramento	State California Zip Code 95814
Contact Person	Dan Southard, Project Officer	Telephone Number	(916) 255-2498
Dates of Service	January 1, 2001 to Present	Value or Cost of Service	\$15,203,000

Brief Description of Service Provided

Since 2001 MAXIMUS Federal has performed independent medical reviews for all managed care enrollees participating in California Managed Care Organizations (MCOs). MAXIMUS renders binding external and impartial independent determinations regarding disputed prior authorization denials for services that are not considered medically necessary by the MCO or in cases where the MCO has determined that the services in question are considered experimental or investigational for treatment of an enrollee's medical condition. MAXIMUS medical necessity and experimental/investigational findings are made by its panel of contracted, independent clinical consultants.

REFERENCE 5

Name of Firm	California Department of Industrial Relations/Division of Workers' Compensation Independent Bill Review		
Street Address	1515 Clay Street, 18th Floor	City Oakland	State California Zip Code 94612
Contact Person	Rupali Daa, Executive Medical Director	Telephone Number	(510) 286-3700
Dates of Service	January 1, 2013 to Present	Value or Cost of Service	\$22,358,668

Brief Description of Service Provided

Since January 1, 2013, MAXIMUS Federal serves as the independent bill review organization conducting IBR for medical treatment and medical-legal billing disputes in cases where medical providers disagree with the amount paid by a claims administrator. MAXIMUS Federal conducts the bill review process working with our panel of credentialed medical reviewers to make IBR determinations. Since project initiation, MAXIMUS Federal has processed 1,600 IBR applications and sent 385 IBR Final Determination Letters.

REFERENCE 6

Name of Firm	California Department of Industrial Relations/Division of Workers' Compensation Independent Medical Review		
Street Address	Office of the Director 1515 Clay St. 18th Fl.	City Oakland	State California Zip Code 94612
Contact Person	Rupali Das, Executive Medical Director	Telephone Number	(510) 286-3700
Dates of Service	January 1, 2013 to Present	Value or Cost of Service	\$26,421,251

Brief Description of Service Provided

As of July 1, 2013, MAXIMUS Federal provides independent medical review (IMR) services to the Department of Industrial Relations (DIR) and the Division of Workers' Compensation (DWC) to help resolve disputes about the medical treatment of injured employees. MAXIMUS Federal conducts IMR for worker's compensation cases where claims have been denied or medical care has been discontinued because services are deemed not medically necessary. MAXIMUS Federal receives between 12,000 and 15,000 IMR applications per month and has sent out over 24,500 IMR Final Determination Letters.

Solicitation Number **DIR/DWC #14-001**

State of California—Department of General Services, Procurement Division
GSPD-05-105 (EST 8/05)

BIDDER DECLARATION

1. Prime bidder information (Review attached Bidder Declaration Instructions prior to completion of this form):

- a. Identify current California certification(s) (MB, SB, SB/NVSA, DVBE): _____ or None (If "None," go to Item #2)
- b. Will subcontractors be used for this contract? Yes No _____ (If yes, indicate the distinct element of work your firm will perform in this contract e.g., list the proposed products produced by your firm, state if your firm owns the transportation vehicles that will deliver the products to the State, identify which solicited services your firm will perform, etc.). Use additional sheets, as necessary.

- c. If you are a California certified DVBE: (1) Are you a broker or agent? Yes No
(2) If the contract includes equipment rental, does your company own at least 51% of the equipment provided in this contract (quantity and value)? Yes No N/A _____

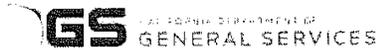
2. If no subcontractors will be used, skip to certification below. Otherwise, list all subcontractors for this contract. (Attach additional pages if necessary):

Subcontractor Name, Contact Person, Phone Number & Fax Number	Subcontractor Address & Email Address	CA Certification (MB, SB, DVBE or None)	Work performed or goods provided for this contract	Corresponding % of bid price	Good Standing?	51% Rental?
SWIFT Print, Inc. P: (559) 268-4555 F: (559) 268-7505	P.O. Box 6554 Fresno, California 93705	DVBE and SB	Office supplies Printing services Paper Envelopes	3%		

CERTIFICATION: By signing the bid response, I certify under penalty of perjury that the information provided is true and correct.

Page _____ of _____

PROCUREMENT DIVISION - Small Business & DVBE Services | State of California | State Consumer Services Agency
707 3rd Street, 1st Floor, Room 400 | West Sacramento, CA 95605 | t 916.375.4940 f 916.375.4950



Governor Edmund G. Brown Jr.

Oct 5, 2012

DATE 04-23-2014

DVBE API

TO MAXIMUS

Supplier #475
SWIFT PRINT INC
P O BOX 6554
FRESNO CA 93703

THIS DVBE CERTIFICATE MAY ONLY BE USED FOR
BID # DIR/DWC RFP #14-001

A NEW DVBE CERTIFICATE WILL BE PROVIDED FOR EACH BID NUMBER

Dear Business Person:

Congratulations on your Disabled Veteran Business Enterprise (DVBE) certification with the State of California. Your business is now entitled to compete in the State's goal to spend three percent of its annual contracting dollars with DVBE businesses. For more information or to verify certification status, visit www.eprocure.dgs.ca.gov

Certification Period

From Oct 3, 2012 to Oct 31, 2014

Business Types

Service

Non-Manufacturer

Conflict of Interest for Current and Former State Employees

Prior to contract award, agencies will assure the vendor is in compliance with Public Contract Code, Section 10410 et seq. addressing conflict of interest for State employees or former employees.

Annual Submission Requirement

Submit copies of the ENTIRE federal tax return to the Office of Small Business and DVBE Services (OSDS). In addition to the business tax returns, each partner of a partnership business must also submit individual federal tax returns. Businesses that rent equipment to the State must submit individual federal tax returns for each disabled veteran owner within 90 days of the individual's tax return filing due date. If you have been granted a tax filing extension with the Internal Revenue Service, submit a copy of the extension form and annual financial statements then, submit a copy of the tax return once filed.

PROCUREMENT DIVISION - Small Business & DVBE Services | State of California | State Consumer Services Agency
707 3rd Street, 1st Floor, Room 400 | West Sacramento, CA 95605 | t 916.375.4940 f 916.375.4950



Governor Edmund G. Brown, Jr.

DATE 04-23-2014
TO MAXIMUS SB APP
Supplier #475
SWIFT PRINT INC
P O BOX 6554
FRESNO CA 93703
THIS SB CERTIFICATE MAY ONLY BE USED FOR
BID # DIR/DWC RFP #14-001
A NEW SB CERTIFICATE WILL BE PROVIDED FOR EACH BID NUMBER

Dear Business Person:

Congratulations on your Small Business (SB) certification with the State of California. Your business is now entitled to compete in the State's goal to spend 25 percent of its annual contracting dollars with small businesses. Each certified SB receives a five percent bid preference on applicable solicitations. This certification also guarantees higher interest penalties for late payment of undisputed invoices. You may purchase a rubber stamp by completing the Prompt Payment Rubber Stamp Order form at www.documents.dgs.ca.gov/pd/smallbus/ppstampreq.pdf. For more information or to verify certification status, visit www.eprocure.dgs.ca.gov.

Certification Period

From Oct 3, 2012 to Oct 31, 2014

Business Types

Service
Non-Manufacturer

Conflict of Interest for Current and Former State Employees

Prior to contract award, agencies will assure the vendor is in compliance with Public Contract Code, Section 10410 et seq. addressing conflict of interest for State employees or former employees.

Annual Submission Requirement

Submit copies of the ENTIRE federal tax return to the Office of Small Business and DVBE Services (OSDS). If you have been granted a tax filing extension with the Internal Revenue Service, submit a copy of the extension form and annual financial statements; then, submit a copy of the tax return once filed. If you have employees, include the California Employment Development Department's "Quarterly Contribution Return and Report of Wages (Continuation)" (Form DE9C). If you have out-of-state employees, submit the employee documentation comparable to Form DE9C. These annual submissions also apply to all affiliated businesses.

Maintaining Your Online Certified Firm Profile

Visit www.eprocure.dgs.ca.gov/default.htm to update your certification profile. You may report changes to the following: mailing and principal office address; contact information; keywords and service areas; United Nations Standard Products and Services Codes, North American Industry Classification System (applicable only to Manufacturers). This certification may be impacted if you update information beyond the aforementioned. To report changes by mail, complete a "Certification Information Change" form located at www.documents.dgs.ca.gov/pd/smallbus/certchange.pdf.

- 2 -

Certification Renewal

Please complete an online application at www.eprocure.dgs.ca.gov 90 days prior to the expiration date whether or not you receive a renewal notice. If you hold dual certifications, SB and DVBE certifications, you must renew both certifications at the same time. Please contact us at 800.559.5529, 916.375.4940 or by email at OSDSHelp@dgs.ca.gov if you have any questions.

Sincerely,

Office of Small Business and DVBE Services

Maintaining Your Online Certified Firm Profile

Visit www.eprocure.dgs.ca.gov/default.htm to update your certification profile. You may report changes to the following: mailing and principal office address; contact information; keywords and service areas; United Nations Standard Products and Services Codes, North American Industry Classification System (applicable only to Manufacturers). This certification may be impacted if you update information beyond the aforementioned. To report changes by mail, complete a "Certification Information Change" form located at www.documents.dgs.ca.gov/pd/smallbus/certchange.pdf

Certification Renewal

Please complete an online application at www.eprocure.dgs.ca.gov 90 days prior to the expiration date whether or not you receive a renewal notice. If you hold dual certifications, SB and DVBE certifications, you must renew both certifications at the same time. Please contact us at 800.559.5529, 916.375.4940 or by email at OSDSHelp@dgs.ca.gov if you have any questions.

Sincerely,

Office of Small Business and DVBE Services

State of California

Bid DIR DWC RFP14-001

Department of Industrial Relations

DIR DWC RFP#14-001

ATTACHMENT 8

DARFUR CONTRACTING ACT CERTIFICATION

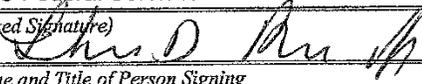
Public Contract Code Sections 10475 -10481 applies to any company that currently or within the previous three years has had business activities or other operations outside of the United States. For such a company to bid on or submit a proposal for a State of California contract, the company must certify that it is either a) not a scrutinized company; or b) a scrutinized company that has been granted permission by the Department of General Services to submit a proposal.

If your company has not, within the previous three years, had any business activities or other operations outside of the United States, you do **not** need to complete this form.

OPTION #1 - CERTIFICATION

If your company, within the previous three years, has had business activities or other operations outside of the United States, in order to be eligible to submit a bid or proposal, please insert your company name and Federal ID Number and complete the certification below.

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that a) the prospective proposer/bidder named below is **not** a scrutinized company per Public Contract Code 10476; and b) I am duly authorized to legally bind the prospective proposer/bidder named below. This certification is made under the laws of the State of California.

<i>Company/Vendor Name (Printed)</i> MAXIMUS Federal Services		<i>Federal ID Number</i> 20-2998066
<i>By (Authorized Signature)</i> 		
<i>Printed Name and Title of Person Signing</i> Thomas Romeo, President		
<i>Date Executed</i> May 12, 2014	<i>Executed in the County and State of</i> Virginia	

OPTION #2 – WRITTEN PERMISSION FROM DGS

Pursuant to Public Contract Code section 10477(b), the Director of the Department of General Services may permit a scrutinized company, on a case-by-case basis, to bid on or submit a proposal for a contract with a state agency for goods or services, if it is in the best interests of the state. If you are a scrutinized company that has obtained written permission from the DGS to submit a bid or proposal, complete the information below.

We are a scrutinized company as defined in Public Contract Code section 10476, but we have received written permission from the Department of General Services to submit a bid or proposal pursuant to Public Contract Code section 10477(b). A copy of the written permission from DGS is included with our bid or proposal.

Company/Vendor Name (Printed) *Federal ID Number*

Initials of Submitter

Printed Name and Title of Person Initialing

APPENDIX A: URAC CERTIFICATE

Certificate Number: XE132 R - 3030



Certificate of Full Accreditation

is awarded to
MAXIMUS Federal Services, Inc.
3130 Kilgore Road, Suite 400
Rancho Cordova, CA 95670

for compliance with
Independent Review Organization: External Review
Accreditation Program

pursuant to the
Independent Review Organization: External Review, Version 5.0

*Effective from the Sunday 1st of December of 2013 through the Thursday 1st of
December of 2016*

William R. Vandervennet, Jr.

William Vandervennet
Chief Operating Officer

Susan M. DeMarino

Susan DeMarino
Vice President of Accreditation Services



ACCREDITED
INDEPENDENT REVIEW
ORGANIZATION:
EXTERNAL

*URAC accreditation is assigned to the organization and
address named in this certificate and is not transferable to
subcontractors or other affiliated entities not accredited by
URAC.*

*URAC accreditation is subject to the representations
contained in the organization's application for accreditation.
URAC must be advised of any changes made after the grantin
of accreditation. Failure to report changes can affect
accreditation status.*

*This certificate is the property of URAC and shall be returned
upon request.*

APPENDIX B: CASE REFERRAL POLICY AND PROCEDURES



Panel Scheduling Outgoing Cases

Work Instructions v2.4
April 14, 2014



Version	Date	Author	Significant Updates
2.1	3/13/2014	Eric Lian	Ported to new template from 2.0 work instructions. Updated process changes
2.2	3/20/2013	Eric Lian	Updated instructions for new process associated with MPR Draft. Added video.
2.3	3/21/2014	Eric Lian	Added information about selecting from the Specialties for Password Protected folder.
2.4	4/14/2014	Eric Lian	Added instructions for bulk case transfers assigned by entellitrak.



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Cases Already Sent.....	9
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Modify Due Date.....	11
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Video.....	12
Upload Documents to MOVEIT.....	13

Overview

There are two ways in which cases are assigned to Expert Reviewers:

- manually determined by the Panel Scheduler
- determined by entellitrak

Manual Determination

Panel Schedulers determine which Expert Reviewers will receive which MPR packets for Independent Medical Review (IMR).

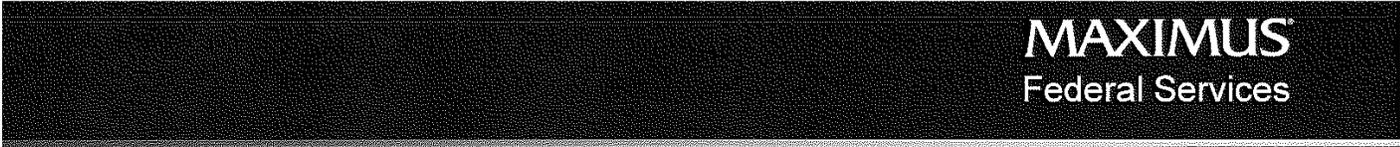
They then retrieve completed MPR packets from the shared drive perform the following tasks:

- Enter the Panel Scheduler information into entellitrak
- Modify the MPR Draft
- Send single cases to the Expert Reviewer through MOVEiT

Determined by entellitrak

For cases sent in bulk to medical groups, entellitrak determines which cases are sent to which medical group. A manifest (Excel spreadsheet) is generated that lists the medical group and the cases assigned to them on the day the manifest is generated. The Panel Scheduler performs the following tasks:

- Review the manifest to see which cases are assigned to which medical groups
- Verify the information entered by entellitrak on the Expert Review screen
- Retrieve the MPR Packets from the Specialty folder OR creates the MPR Packets if they do not already exist in the Specialty folder
- Send the cases to the medical group through MOVEiT



Folder Structure

Panel Schedulers work within a set of organized folders on the shared drive:
S:\IMR\Case Review Sweep Folder

The Case Review Sweep Folder

The **Case Review Sweep** folder contains folders named for the medical consulting groups we contract with and the number of cases they will accept per day.

For example, **Nexus.150**. 150 means Nexus will accept 150 cases per day.

The **Specialties** folder and the **Specialties for Password Protected** contain all of the MPR packets that are ready to be sent to Expert Reviewers.

Name ^	Date modified	Type
C Shin.30	3/12/2014 10:58 AM	File folder
HSAG	3/14/2014 8:26 AM	File folder
Individual Reviewers	3/13/2014 11:04 AM	File folder
MET.25	3/12/2014 11:23 AM	File folder
NEW ONLY ALLA!!!	3/13/2014 2:24 PM	File folder
NEXUS. 150	3/11/2014 8:04 AM	File folder
PBMM.10	3/11/2014 12:29 PM	File folder
S Ayyar.40	3/13/2014 8:32 AM	File folder
Specialties	3/14/2014 8:39 AM	File folder
Specialties for Password Protected	3/14/2014 8:02 AM	File folder
TriRivers.50	3/13/2014 1:49 PM	File folder

The Specialties Folder

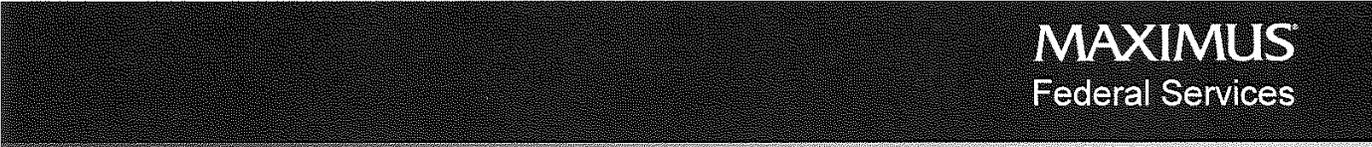
Each case consists of 2 documents:

- .pdf document that contains the Application, UR, and medical records
- Word document that is the MPR form

Panel Schedulers select a group of cases that share the same specialty and move them to personal upload folders before sending to the Expert Reviewer through Movelt.

Name ^	Date modified	Type
C Shin.30	3/12/2014 10:58 AM	File folder
HSAG	3/14/2014 8:26 AM	File folder
Individual Reviewers	3/13/2014 11:04 AM	File folder
MET.25	3/12/2014 11:23 AM	File folder
NEW ONLY ALLA!!!	3/13/2014 2:24 PM	File folder
NEXUS. 150		
PBMM.10		
S Ayyar.40		
Specialties		
Specialties for Password Protected		
TriRivers.50		

Name ^	Date modified	Type	Size
CM13-0055285 PSYCHIATRIST.pdf	3/10/2014 2:52 PM	Adobe Acrobat Doc...	8,691 KB
CM13-0055286.docx	3/10/2014 2:51 PM	Microsoft Word Doc...	52 KB
CM13-0055494 PSYCHIATRY.pdf	3/12/2014 1:02 PM	Adobe Acrobat Doc...	6,244 KB
CM13-0055494.docx	3/12/2014 1:03 PM	Microsoft Word Doc...	65 KB
CM13-0055791 OCCUPATIONAL MEDICINE.pdf	3/11/2014 9:46 AM	Adobe Acrobat Doc...	6,347 KB
CM13-0055791.docx	3/11/2014 9:43 AM	Microsoft Word Doc...	65 KB
CM13-0055832 OCC MED.pdf	3/11/2014 8:56 AM	Adobe Acrobat Doc...	23,221 KB
CM13-0055832.docx	3/11/2014 8:54 AM	Microsoft Word Doc...	53 KB
CM13-0055936 OCC MED.pdf	3/10/2014 5:37 PM	Adobe Acrobat Doc...	167,246 KB
CM13-0055936.docx	3/10/2014 5:38 PM	Microsoft Word Doc...	53 KB
CM13-0055939 OCC MED.pdf	3/10/2014 3:58 PM	Adobe Acrobat Doc...	24,573 KB
CM13-0055939.docx	3/10/2014 3:55 PM	Microsoft Word Doc...	53 KB



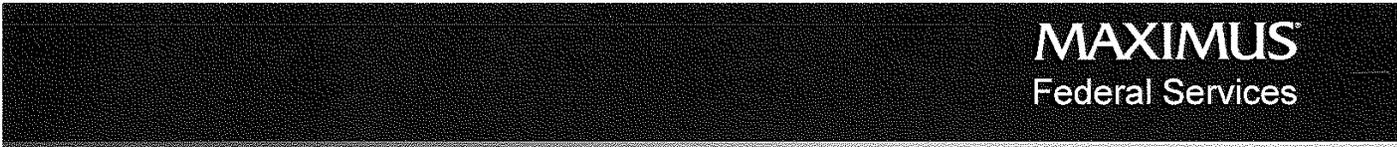
Specialties for Password Protected

Each case consists of 3 documents:

- Part 1.pdf
- Part 2.pdf
- (Part 3.pdf in some cases)
- Word document that is the MPR form

Panel Schedulers select a group of cases that share the same specialty and move them to upload folders before sending to the Expert Reviewer through MOVEIT.

MSAG	3/21/2014 11:48 AM	File folder	
Incorrect formatting for MPR forms - drafts	3/20/2014 4:07 PM	File folder	
Individual Reviewers	3/20/2014 2:17 PM	File folder	
MET-25	3/21/2014 9:41 AM	File folder	
NEW ONLY ALLA11	3/19/2014 1:15 PM	File folder	
NEXUS-150			
PSMM-10			
S Ayyar-90			
Specialties			
Specialties for Password Protected			
Travers-50			
CM13-0055664 OCC MED PART 1.pdf	3/10/2014 4:18 PM	Adobe Acrobat Doc...	189 KB
CM13-0055664 OCC MED PART 2.pdf	3/10/2014 4:21 PM	Adobe Acrobat Doc...	30,679 KB
CM13-0055664.docx	3/10/2014 4:22 PM	Microsoft Word Doc...	53 KB
CM13-0055737 INTERNAL MED PART 1.pdf	3/11/2014 11:51 AM	Adobe Acrobat Doc...	16,849 KB
CM13-0055737 INTERNAL MED PART 2.pdf	3/11/2014 11:52 AM	Adobe Acrobat Doc...	16,849 KB
CM13-0055737 INTERNAL MED PART 3.pdf	3/11/2014 11:49 AM	Adobe Acrobat Doc...	165,424 KB
CM13-0055737.docx	3/11/2014 11:38 AM	Microsoft Word Doc...	53 KB
CM13-0058394 OCC MED PART 1.pdf	3/19/2014 2:16 PM	Adobe Acrobat Doc...	11,434 KB
CM13-0058394 OCC MED PART 2.pdf	3/19/2014 2:17 PM	Adobe Acrobat Doc...	20,355 KB
CM13-0058394.docx	3/19/2014 2:13 PM	Microsoft Word Doc...	65 KB



Moving Cases to the Upload Folder

Note: Panel Schedulers sending files to medical groups should refer to the manifest to see which cases have been assigned to the medical groups you service.

1. Navigate to the **Specialties** folder and select the MPR packets you want to send to your Expert Reviewer.
2. Move the MPR packets to your upload folder by dragging or cutting from the Specialties folder and pasting to the upload folder.

! Note: You are removing MPR packets from Specialties folder so other panel schedulers do not send the same MPR packets to other Expert Reviewers.

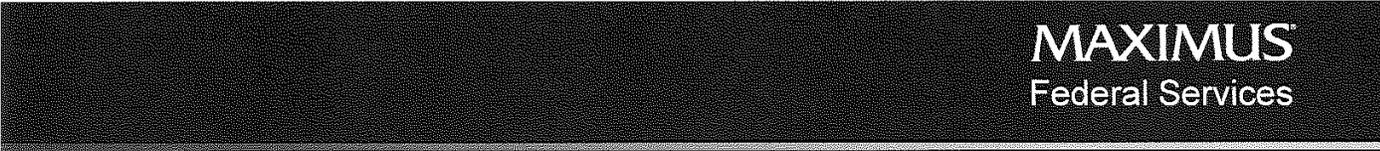
Do not copy MPR packets in the Specialties folder and paste to your upload folder.

Specialties folder

CM13-0059374.docx	3/13/2014 1:14 PM	Microsoft Word Doc...	96 KB
CM13-0059380 PMR.pdf	3/13/2014 1:19 PM	Adobe Acrobat Doc...	30,973 KB
CM13-0059380.docx	3/13/2014 1:11 PM	Microsoft Word Doc...	75 KB
CM13-0059382 PMR.pdf	3/13/2014 3:46 PM	Adobe Acrobat Doc...	3,010 KB
CM13-0059382.docx	3/13/2014 3:46 PM	Microsoft Word Doc...	53 KB
CM13-0059384 INTERNAL MED.pdf	3/13/2014 2:40 PM	Adobe Acrobat Doc...	19,008 KB
CM13-0059384.docx	3/13/2014 2:37 PM	Microsoft Word Doc...	64 KB
CM13-0059394 PMR.pdf	3/13/2014 1:56 PM	Adobe Acrobat Doc...	4,048 KB
CM13-0059394.docx	3/13/2014 1:53 PM	Microsoft Word Doc...	53 KB
CM13-0059395 PMR.pdf	3/13/2014 1:48 PM	Adobe Acrobat Doc...	5,449 KB
CM13-0059395.docx	3/13/2014 1:44 PM	Microsoft Word Doc...	76 KB
CM13-0059397 PMR.pdf	3/13/2014 1:29 PM	Adobe Acrobat Doc...	71,974 KB
CM13-0059397.docx	3/13/2014 1:21 PM	Microsoft Word Doc...	53 KB
CM13-0059400 PMR.pdf	3/13/2014 1:43 PM	Adobe Acrobat Doc...	13,478 KB
CM13-0059400.docx	3/13/2014 1:39 PM	Microsoft Word Doc...	64 KB
CM13-0059401 PAIN MNGMT.pdf	3/13/2014 3:13 PM	Adobe Acrobat Doc...	8,359 KB
CM13-0059401.docx	3/13/2014 3:12 PM	Microsoft Word Doc...	66 KB
CM13-0059404 FAMILY PRACTICE INTERNA...	3/13/2014 3:55 PM	Adobe Acrobat Doc...	11,765 KB
CM13-0059404.docx	3/13/2014 3:52 PM	Microsoft Word Doc...	64 KB

Upload folder

Name	Date modified	Type
CM13-0055591 PMR.pdf	3/11/2014 11:31 AM	Adobe Acrobat Doc...
CM13-0055591.docx	3/11/2014 11:29 AM	Microsoft Word Doc...
CM13-0055639 PMR.pdf	3/13/2014 9:26 AM	Adobe Acrobat Doc...
CM13-0055639.docx	3/13/2014 9:24 AM	Microsoft Word Doc...
CM13-0056062 PMR.pdf	3/11/2014 9:57 AM	Adobe Acrobat Doc...
CM13-0056062.docx	3/11/2014 9:56 AM	Microsoft Word Doc...
CM13-0056176 Occ Med PMR Pain Manage.pdf	3/11/2014 11:23 AM	Adobe Acrobat Doc...
CM13-0056176.docx	3/11/2014 11:22 AM	Microsoft Word Doc...
CM13-0056200 OCC MED, PMR, PAIN.pdf	3/11/2014 12:48 PM	Adobe Acrobat Doc...
CM13-0056200.docx	3/11/2014 12:44 PM	Microsoft Word Doc...



Enter Information into entellitrak

Before sending the documents through MOVEiT, we need to enter information into entellitrak and modify the MPR form. Do the following for each case:

Note: If you send cases in bulk to medical groups, most of the information will already be populated by entellitrak. Verify that the fields have been populated and enter any fields that have not been.

3. In entellitrak, search for and open the case.
4. Navigate to the **Expert Review** screen.
5. Select the Expert Reviewer:

- If you are not sending to a medical group, select the Expert Reviewer's name from the **Expert Name drop-down**.

Expert Name drop-down

6. Enter the date you are sending the case in the **Date Sent** field.

Note: For bulk, this date is automatically set to today's date plus 1 day.

7. Enter your initials in the **Auth Comment** field.

8. Click **Save**.

! Note: If you send bulk cases to medical groups and the **Auth Comment** field has already been populated, it means this case has already been sent. See the next section, **Cases Already Sent**, on how to work this issue.



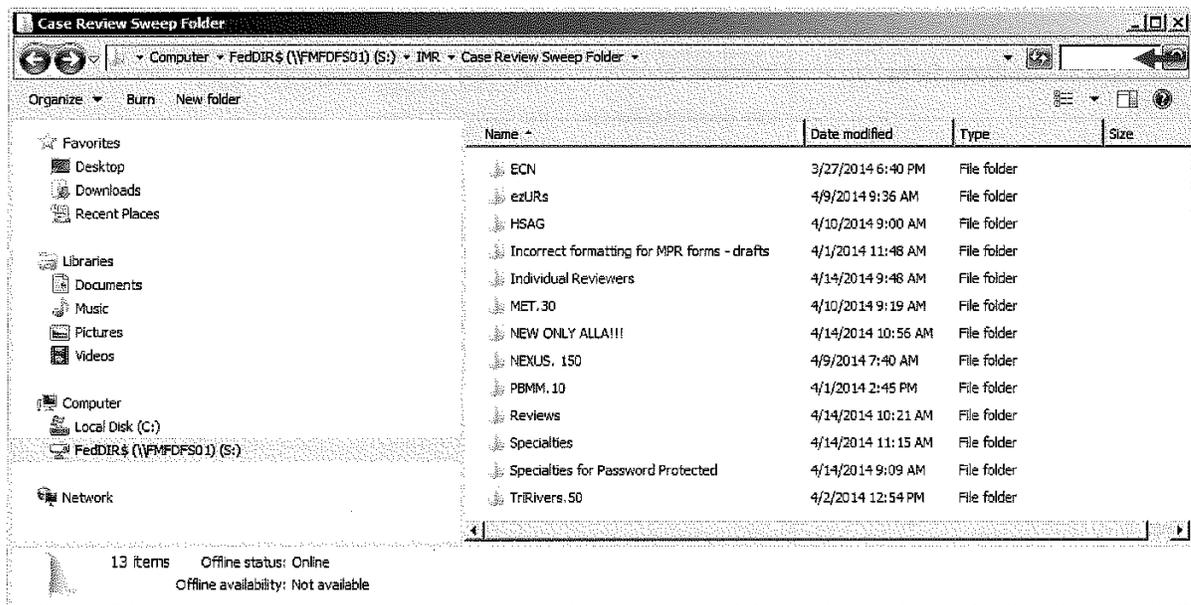
Cases Already Sent

Special, one-time scripts are sometimes used in the system to move cases from queue to queue. In early April, one of these scripts moved a small number of cases that had already been sent to Expert Reviewers back into the Panel Scheduling queue.

If you come across one of these cases, the information originally entered by the Panel Scheduler in the **Expert License** and **Date Sent** fields may have been removed by entellitrak and replaced with erroneous information.

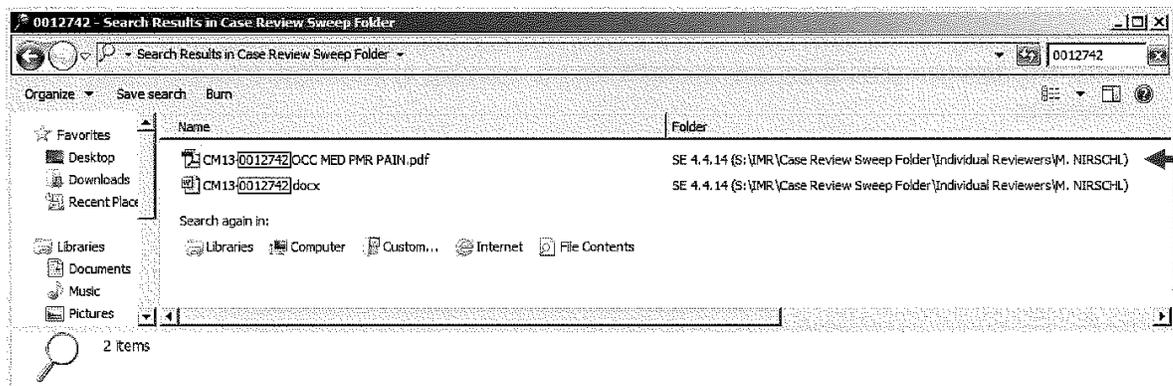
- This information needs to be overwritten with the information sent originally with the case
- The case needs to be routed to the Pending Expert Review queue

1. To find the Expert Reviewer and the date the case was originally sent, navigate to **S:\IMR\Case Review Sweep Folder**.
2. Enter the last 7 digits of the case number in the search field in the upper right corner.



If the Panel Scheduler who sent out this case originally keeps their upload folders in the Case Review Sweep Folder, the documents that were sent will be displayed in the search window.

Note: If the Panel Scheduler does not keep their upload folder in the Case Review Sweep Folder, you will need to ask them to look up the case information for you.



3. Find the Expert Reviewer the case was originally sent to.

- If the name matches the name in **Expert Name** and there is a name in the **Expert License** drop-down, make the **Expert License** drop-down blank.
- If there is no name in **Expert Name** and the name in **Expert License** is different from the Expert Reviewer in the original case, select the original name from the **Expert License** drop-down.

4. Find the date the case was sent to the Expert Reviewer and enter it in the **Date Sent** field in the Expert Review screen.

5. Route the case to **Assign to Expert Reviewers**.

Modify the MPR Form

You will make two modifications to the MPR Draft:

- enter the due date
- delete any pages in which an Issue at dispute is not entered

Modify Due Date

1. Open the MPR Draft.
2. On the first page of the MPR Draft, click the Date Due field and change to 7 days from today's date. The date you enter is the date the MPR form is due back to MAXIMUS from the Expert Reviewer.

Note: If you are working on a Saturday, make the due date Friday (plus 6 days).
If you are working on a Sunday, make the due date Monday (plus 8 days).

MEDICAL PROFESSIONAL REVIEWER'S DECISION REPORT FORM CALIFORNIA WORKERS' COMPENSATION INDEPENDENT MEDICAL REVIEW	
DATE AND TIME DUE BACK TO MAXIMUS:	March 11, 2014 08
Medical Professional Reviewer	City
MAXIMUS Case Number:	Name Last Name, MPR Degree>
Medical Reviewer Licensing State	

Calendar details for March 2014:
Su Mo Tu We Th Fr Sa
23 24 25 26 27 28 1
2 3 4 5 6 7 8
9 10 11 12 13 14 15
16 17 18 19 20 21 22
23 24 25 26 27 28 29
30 31 1 2 3 4 5
Today

Delete Pages that do not Contain Issues at Dispute

1. Scroll through the MPR Draft. Every MPR will have at least one issue in dispute listed on page 2. This will be written as **Decision for [Issue at Dispute]**. The last page of the MPR Draft is the Attestation page.

The MPR Draft has placeholders for up to 15 issues at dispute.

2. Delete any pages in which the **Decision for** field is blank.
3. Make the Attestation page the last page. The Attestation page should fit entirely on one page.
4. Save the MPR Draft.

MEDICAL PROFESSIONAL REVIEWER TO COMPLETE

1. Decision for Norco 10/325mg #120:

a) Evidence-Basis for the Decision:

Evidence-Based Criteria Cited By Expert Reviewer:

MTUS Guidelines

- American College of Occupational and Environmental Medicine (ACCOEM), 2nd Edition, (2004) <Insert Chapter>, page(s) <Insert Page Number or Numbers>
- Chronic Pain Medical Treatment Guidelines <Insert Section>, page(s) <Insert Page Number or Numbers>
- Acupuncture Medical Treatment Guidelines
- Post-Surgical Treatment Guidelines <Insert Title of Surgery>, page(s) <Insert Page Number or Numbers>

Other Guidelines

- Official Disability Guidelines (ODG) <Insert Section (for example Knee)>, <Insert Topic (for example Total Knee Arthroplasty)>
- Other Medical Treatment Guideline or Medical Evidence: <Insert Other Basis/Criteria>

b) After a professional and thorough review of the documents, my analysis is that the above listed issue:

- Is/was **NOT** medically necessary
- I am reversing the prior UR decision. My decision is that the issue listed above **IS** medically necessary. The reasons for reversing the prior UR decision are listed in the rationale below.

c) My rationale for why the requested treatment/service is or is not medically necessary:

Insert Rationale

Video

Modify the MPR Form

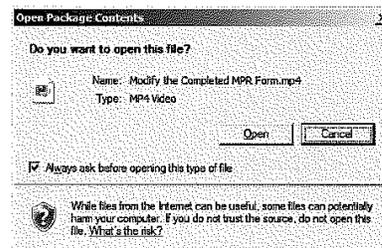
(55 seconds – No Audio)

Double click the video icon to launch.



Modify the MPR form.mp4

When the **Open Package Contents** dialog displays, click **Open**.





Upload Documents to MOVEiT

Upload and send the MPR packets to the Expert Reviewer.

Refer to the MOVEiT User Manual for instructions on how to use MOVEiT.

APPENDIX C: CAD DOCUMENT

Independent Medical Review
State of California, DIR, DWC



MAXIMUS CALIFORNIA IMR/IBR CHANGE ALERT DOCUMENT (CAD)	
Change Alert Document #:	(Filled out by Document Control)
Change Alert Document Title:	(Filled out by Business Owner)
Change Alert Document Owner:	(Filled out by Business Owner)
Department(s)/Process Effected:	(Filled out by Business Owner)
Documents Effected:	(Filled out by Business Owner)
Distribution Date:	(Filled out by Document Control)
Effective Date:	(Filled out by Business Owner)

Purpose of CAD:

(Document the purpose of the alert and what changes will be made to the process)

Current Process:

(Define what is currently being done or what process is being changed)

Change in Process:

(Define the new process or new requirements, include screen shots if applicable)

APPENDIX D: CONFLICT OF INTEREST POLICY AND PROCEDURES

POLICY 4.0: CALIFORNIA INDEPENDENT MEDICAL REVIEW AND INDEPENDENT BILL REVIEW PROJECTS PROFESSIONAL STAFF AND PROFESSIONAL REVIEWER CONFLICT

AUTHOR: Director Regulatory Compliance

PURPOSE: This document contains the standards for the prevention and monitoring of MAXIMUS Federal Services, Inc. Professional Staff and Professional Reviewer conflicts of interest.

SCOPE AND AUDIENCE: The conflict of interest standards contained herein apply to all MAXIMUS Federal Services, Inc. (MAXIMUS Federal) California lines of business, unless the California Department of Industrial Relations (DIR) mandates different conflict of interest standards or an applicable state or federal law requires different conflict of interest standards. If DIR mandates a change, a variance must be approved, in writing, by the MAXIMUS Federal Division President. The audience for this policy is all MAXIMUS Federal staff and associates.

SUMMARY: In accordance with the information contained herein, MAXIMUS Federal shall be committed to the prevention and monitoring of any potential or actual conflicts of interest.

REFERENCE CRITERIA: California Labor Code Sections 139.5, 4603.6, 4610.5, 4610.6, and 8 CCR 9792.10.1 et seq. other Federal and State law related to conflicts of interest, and private contract requirements.

4.1 Policy Statement

MAXIMUS Federal is committed to the prevention and monitoring of all Professional Staff and Professional Reviewer conflicts of interest by the laws of the State of California, the United States, and any state or commonwealth in which MAXIMUS Federal provides services and understands that Professional Staff and Professional Reviewer conflicts of interest must be prevented and monitored to ensure MAXIMUS Federal independence, objectivity, and neutrality. MAXIMUS Federal shall pursue and ensure the prevention and monitoring of conflicts of interest by the laws of the State of California, the United States, and any state or commonwealth in which MAXIMUS Federal provides services.

The following terms are applicable to MAXIMUS Federal policy regarding the prevention and monitoring of Professional Staff and Professional Reviewer conflicts of interest for the MAXIMUS Federal California Independent Medical Review (IMR) and Independent Bill Review (IBR) Projects.

Professional Reviewer: For the purposes of this policy the term Professional Reviewer means any physician, whether a Medical Doctor or Doctor of Osteopathy, dentist, chiropractor, other provider of health care, or a health care claims professional who contracts with MAXIMUS Federal either individually or collectively through their medical group for the provision of IMR or IBR Services for clients who formally contract with MAXIMUS Federal.

Independent Medical Review Services: For the purposes of this policy the term Independent Medical Review (IMR) Services means the review of Employer modifications, delays, and denials of medical treatment services for injured employees and a determination as to whether the Employer's modification, delay, or denial should be upheld, overturned, or partially overturned.

Independent Bill Review Services: For the purposes of this policy the term Independent Bill Review (IBR) Services means the review of Employer denials of all or a portion of payments requested by

California Department of Industrial Relations



providers for services rendered and a determination as to whether the Employer's denial should be upheld, overturned, or partially overturned.

Employer: For the purposes of this policy the term Employer means the employer, an attorney or agent for the employer, a workers' compensation insurer, a workers' compensation claims administrator, or the state Uninsured Employers Benefits Trust Fund. In IMR cases, the term Employer also includes a utilization review organization.

Material Familial Affiliation: For the purposes of this policy the term Material Familial Affiliation means any relationship as a spouse, child, parent, sibling, spouse's parent, spouse's child, child's parent, child's spouse, or sibling's spouse.

Material Financial Affiliation: For the purposes of this policy the term Material Financial Affiliation means any financial interest of more than five percent of total annual revenue or total annual income of MAXIMUS Federal or its officers, directors or management employees or contracted Professional Reviewers engaged to conduct an IMR or IBR. The term Material Financial Affiliation for the purposes of this policy does not and shall not include payment by the employer to MAXIMUS Federal to conduct an IMR or IBR, nor does the term Material Financial Affiliation include a Professional Reviewer's participation as a contracting medical provider where the expert is affiliated with an academic medical center of a National Cancer Institute-designated clinical cancer research center.

Material Professional Affiliation: For the purposes of this policy the term Material Professional Affiliation means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any Professional Reviewer or any officer or director of MAXIMUS Federal. The term material professional affiliation does not include affiliations that are limited to staff privileges at a health facility.

Professional Staff: For the purposes of this policy the term Professional Staff means any employee of MAXIMUS Federal who is engaged in the provision of IMR or IBR services or has access to information about individual cases.

4.2 Professional Staff and Conflict of Interest Prevention: Responsibilities

MAXIMUS Federal Management has the final authority and responsibility for the prevention of Professional Staff and Professional Reviewer potential or actual conflicts of interest. MAXIMUS Federal Professional Staff and Professional Reviewers are responsible for being aware and knowledgeable of this policy and for implementing the requirements of this policy on a daily basis.

4.2.1 Professional Reviewers

MAXIMUS Federal Professional Reviewers shall at all times be able to attest to the following:

- As part of their contractual agreement with MAXIMUS Federal, all MAXIMUS Federal Professional Reviewers shall agree and warrant that, unless permitted by law, they shall not review or in any way involve themselves in a case file whereby it is determined that the MAXIMUS Federal Professional

Reviewer has a potential or actual material professional, financial or familial affiliation with any of the parties to a case, including, but not limited to, the referring entity, the employer, the patient, the attending provider or any other health care provider involved in a case, the facility at which the recommended treatment would be provided (if applicable), or the developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the patient (if applicable).

- As part of their contractual agreement with MAXIMUS Federal, all MAXIMUS Federal Professional Reviewers shall agree and warrant that they shall review each and every case file to determine whether a potential or actual material professional, financial, or familial affiliation exists between the MAXIMUS Federal Professional Reviewer and any of the parties to a case.

All MAXIMUS Federal Professional Reviewers shall provide a signed attestation with each external case file reviewed indicating that the MAXIMUS Federal Professional Reviewer has reviewed the case file to determine whether a potential or actual material professional conflict exists.

For IMR cases, the form and effect of the attestation shall read:

- *I certify that I do not have any past or present, direct or indirect, professional, familial, financial, research or other affiliation or relationship with any of the following in this case: (1) the employer, insurer or claims administrator, utilization review organization, or a medical provider network of the insurer or claims administrator; (2) any officer, director, or employee of the employer, or insurer or claims administrator; (3) a physician, the physician's medical group, the physician's independent practice association, or other provider involved in the medical treatment in dispute; (4) the facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer, would be provided; (5) the development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee whose treatment is under review, or the alternative therapy, if any, recommended by the employer; or (6) the injured employee, the injured employee's immediate family, or the injured employee's attorney. In addition, I certify that I have not and will not accept any compensation that is dependent in any way on the specific outcome of this Independent Medical Review case file and that I had no involvement in this Independent Medical Review case file prior to its referral to me by MAXIMUS Federal.*

For IBR cases, the form and effect of the attestation shall read:

- *I certify that I do not have any past or present, direct or indirect, professional, familial, financial, research or other affiliation or relationship with any of the following in this case: (1) the employer, insurer or claims administrator, utilization review organization, or a medical provider network of the insurer or claims administrator; (2) any officer, director, or employee of the employer, or insurer or claims administrator; (3) a physician, the physician's medical group, the physician's independent practice association, or other provider involved in the payment in dispute; or (4) the injured employee, the injured employee's immediate family, or the injured employee's attorney. In addition, I certify that I*

have not and will not accept any compensation that is dependent in any way on the specific outcome of this Independent Bill Review case file and that I had no involvement in this Independent Bill Review case file prior to its referral to me by MAXIMUS Federal.

In the event that a MAXIMUS Federal Professional Reviewer determines that a potential or actual material professional, financial or affiliation exists, the MAXIMUS Federal Professional Reviewer shall immediately cease any involvement in the case file and will inform MAXIMUS Federal so that the case file may be reassigned.

In the event it is determined that a MAXIMUS Federal Professional Reviewer was unknowingly involved in any way in a case file in which the MAXIMUS Federal Professional Reviewer had a potential or actual material professional, financial or familial affiliation with any party to the case file and the particular MAXIMUS Federal Professional Reviewer reasonably could not have known of the potential or actual material professional, financial or familial affiliation, corrective action up to and including re-training the MAXIMUS Federal Professional Reviewer with regard to conflict of interest prevention and monitoring shall be taken as soon as practicable.

In the event it is determined that a MAXIMUS Federal Professional Reviewer was knowingly involved in any way in a case file in which it was determined that the MAXIMUS Federal Professional Reviewer had an unresolved potential or an actual material professional, financial or familial affiliation with any parties to the case file, the particular MAXIMUS Federal Professional Reviewer shall have his or her agreement with MAXIMUS Federal terminated immediately with cause.

4.2.2 Professional Staff

MAXIMUS Federal Professional Staff shall at all times be able to attest to the following:

- Members of MAXIMUS Federal Professional Staff shall agree and warrant that they shall not review or in any way involve themselves in a case file in which they have a potential or actual material professional, financial or familial affiliation with the parties to a case file.
- In the event it is determined that a member of the MAXIMUS Federal Professional Staff was unknowingly involved in a case file with which that member had a potential or actual material professional, financial or familial affiliation with any party to the case file and the particular member reasonably could not have known of the potential or actual material professional, financial or familial affiliation, corrective action up to and including re-training the member with regard to conflict of interest prevention and monitoring shall be taken as soon as practicable.
- In the event it is determined that a member of MAXIMUS Federal Professional Staff was knowingly involved in any way in a case file in which that that MAXIMUS Federal Medical Professional Reviewer had an unresolved potential or an actual material professional, financial or familial affiliation with any party to the case file, and MAXIMUS Federal determines that the particular member reasonably should have known of the potential or actual material professional, financial or familial affiliation, corrective action up to and including referral to the MAXIMUS Federal Human Resources Department for appropriate disciplinary action shall be taken.

4.3 Professional Staff and Professional Reviewer Conflict of Interest Monitoring: Responsibility

MAXIMUS Federal Management has the final authority and responsibility for the monitoring of potential or actual organizational conflicts of interest. MAXIMUS Federal Professional Staff and Professional Reviewers are responsible for being aware and knowledgeable of this policy and for implementing the requirements of this policy on a daily basis.

4.3.1 Professional Reviewers

On an annual basis, the MAXIMUS Federal Director of Professional Relations shall submit a letter to all MAXIMUS Federal Professional Reviewers requiring that MAXIMUS Federal be provided with an updated list of all material professional, familial or financial affiliations has with any employer, workers' compensation insurer, claims administrator, physicians medical group or independent practice association, professional corporation or professional association, and any developer or manufacturer of a drug, device procedure or other therapy.

4.3.2 Professional Staff

MAXIMUS Federal Professional Staff shall at all times be able to attest to the following:

- All case files assigned to MAXIMUS Federal shall be reviewed by a member of the MAXIMUS Federal professional staff in order to determine if any material professional, financial, or familial affiliations exist between the parties to the case file and MAXIMUS Federal. If the member of MAXIMUS Federal Professional Staff reviewing a case file determines that he or she has a potential of actual material professional, financial or familial affiliation with parties to the case file, the case file will be reassigned to another member of MAXIMUS Federal Professional Staff who has no actual or potential material, professional, financial or familial affiliation with parties to the case file.
- All case files submitted to MAXIMUS Federal which require assignment to a MAXIMUS Federal Professional Reviewer, shall be reviewed by a Professional Staff member prior to the assignment of the case file to a MAXIMUS Federal Professional Reviewer, to ensure that no potential or actual material professional, financial or familial affiliations exists.
- If it is determined that an actual or potential material professional, financial or familial affiliation exists between the selected MAXIMUS Federal Professional Reviewer and the parties to the case file, the case file shall be assigned to another MAXIMUS Federal Professional Reviewer who, based upon the Professional Staff member's review of the case file, has no potential or actual material professional, financial or familial affiliation with the parties to the case file.
- The Professional Staff Member will ensure that the MAXIMUS Federal Professional Reviewer has provided a signed attestation. If the signed attestation is not provided with the MAXIMUS Federal Professional Reviewer's report, the professional Staff member shall immediately contact the MAXIMUS Federal Director of Professional Relations who in turn will contact the MAXIMUS Federal Professional Reviewer to determine the reasons for the non-signature of the attestation.

PROCEDURE 4.1: CALIFORNIA INDEPENDENT MEDICAL REVIEW AND INDEPENDENT BILL REVIEW PROJECTS MONITORING OF ORGANIZATIONAL, PROFESSIONAL STAFF, AND PROFESSIONAL REVIEWER CONFLICT OF INTEREST

AUTHOR: Director, Quality Assurance

PURPOSE: This document contains the procedure for monitoring of MAXIMUS Federal Organizational, Professional Staff and Professional Reviewer conflicts of interest on the basis of Policies 3.0 and 4.0.

SCOPE AND AUDIENCE: The conflict of interest standards contained herein apply to the MAXIMUS Federal California Independent Medical Review (IMR) and Independent Bill Review (IBR) Projects, unless the California Department of Industrial Relations (DIR) mandates different conflict of interest standards or an applicable California State or Federal law requires different conflict of interest standards. If DIR mandates a change, a variance must be approved, in writing, by the Division President, MAXIMUS Federal. The audience for this policy is all MAXIMUS Federal staff and associates.

SUMMARY: In accordance with the information contained herein, MAXIMUS Federal will be committed to the monitoring of any potential or actual conflicts of interest.

REFERENCE CRITERIA: California Labor Code Sections 139.5, 4603.6, 4610.5, and 4610.6, other Federal and State law related to conflicts of interest, and private contract requirements.

4.4 Procedure Statement

The following terms are applicable to MAXIMUS Federal procedure regarding the prevention and monitoring of Professional Staff and Professional Reviewer conflicts of interest.

Professional Reviewer: For the purposes of this policy the term Professional Reviewer means any physician, whether a Medical Doctor or Doctor of Osteopathy, dentist, chiropractor, other provider of health care, or a health care claims professional who contracts with MAXIMUS Federal either individually or collectively through their medical group for the provision of IMR or IBR Services for clients who formally contract with MAXIMUS Federal.

Independent Medical Review Services: For the purposes of this policy the term Independent Medical Review (IMR) Services means the review of Employer modifications, delays, and denials of medical treatment services for injured employees and a determination as to whether the Employer's modification, delay, or denial should be upheld, overturned, or partially overturned.

Independent Bill Review Services: For the purposes of this policy the term Independent Bill Review (IBR) Services means the review of Employer denials of all or a portion of payments requested by providers for services rendered and a determination as to whether the Employer's denial should be upheld, overturned, or partially overturned.

Employer: For the purposes of this policy the term Employer means the employer, an attorney or agent for the employer, a workers' compensation insurer, a workers' compensation claims administrator, or the state Uninsured Employers Benefits Trust Fund. In IMR cases, the term Employer also includes a utilization review organization.

California Department of Industrial Relations



Material Familial Affiliation: For the purposes of this policy the term Material Familial Affiliation means any relationship as a spouse, child, parent, sibling, spouse's parent, spouse's child, child's parent, child's spouse, or sibling's spouse.

Material Financial Affiliation: For the purposes of this policy the term Material Financial Affiliation means any financial interest of more than five percent of total annual revenue or total annual income of MAXIMUS Federal or its officers, directors or management employees or contracted Professional Reviewers engaged to conduct an IMR or IBR. The term Material Financial Affiliation for the purposes of this policy does not and shall not include payment by the employer to MAXIMUS Federal to conduct an IMR or IBR, nor does the term Material Financial Affiliation include a Professional Reviewer's participation as a contracting medical provider where the expert is affiliated with an academic medical center of a National Cancer Institute-designated clinical cancer research center.

Material Professional Affiliation: For the purposes of this policy the term Material Professional Affiliation means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any Professional Reviewer or any officer or director of MAXIMUS Federal. The term material professional affiliation does not include affiliations that are limited to staff privileges at a health facility.

Professional Staff: For the purposes of this policy the term Professional Staff means any employee of MAXIMUS Federal who is engaged in the provision of IMR or IBR services or has access to information about individual cases.

4.4.1 Conflict of Interest Monitoring Responsibilities

The Director, Quality Assurance is the manager responsible for oversight of conflict of interest monitoring. The Director is personally responsible, working with the Division President, for review of organizational conflict by review of pending MAXIMUS Federal contracts. The Director is responsible for advising the Legal Counsel, MAXIMUS, Inc., on the conflict requirements of MAXIMUS Federal, to ensure that MAXIMUS, Inc. does not enter into relationships that would constitute a conflict of interest. The Director advises human resources staff on the requirements related to obtaining conflict information and attestations from MAXIMUS Federal employment candidates. The Director delegates to the Director, Professional Relations, the authority to obtain and maintain conflict information from MAXIMUS Federal Professional Reviewers as part of the Credentialing process. The Director delegates to Project Managers, and through the Project Managers to Appeal Officers, the responsibility to obtain case specific attestations from Professional Reviewers.

4.4.2 Contract Review

The Director, Quality Assurance, in conjunction with the Division President, will review any agreement with the State of California or with a California corporate entity to ensure compliance with MAXIMUS Federal organizational conflict policies.

California Department of Industrial Relations



4.4.3 Management Attestations

The Director, Quality Assurance will require human resources to obtain from candidates for management positions, information and attestations to determine and avoid management employee conflict of interest.

The Director, Quality Assurance will require human resources to obtain updated conflict attestations from management annually.

4.4.4 Professional Reviewer Conflict of Interest Monitoring

The Director, Quality Assurance will require the Director, Professional Relations to obtain and review conflict information as part of the Professional Reviewer application process. The Director will include suitable material on conflict of interest in Professional Reviewer orientation material.

On an annual basis, the MAXIMUS Federal Director, Professional Relations shall submit a letter to all MAXIMUS Federal Professional Reviewers requesting that MAXIMUS Federal be provided with an updated list of all material professional, familial or financial affiliations.

Project Managers will require Appeal Officers to review each individual Professional Reviewer report to ensure that a signed conflict attestation is included.

4.4.5 Professional Staff Conflict of Interest Monitoring

The Director, Quality Assurance will require human resources to obtain affiliation and conflict information from each job applicant, and to refresh this information on an annual basis. The Director will require the appropriate manager to include training on conflict of interest as part of all new staff orientation.

4.4.6 Compliance and Quality Assurance

4.4.6.1 Performance Measures

The Director, Quality Assurance will report the following performance measures monthly to the Division President:

- Number of new client contracts reviewed for conflict;
 - Number approved
 - Number not approved or modified
- Number of contracts pending review
- Number of management new hires
 - Number with conflict review and attestation
 - Number pending conflict review and attestation
- Number of Periodic Management Conflict Updates Completed

California Department of Industrial Relations



- Number of Periodic Management Conflict Updates Pending
- (from Credentialing) number of Consultant's credentialed (to any status)
 - Number with approved affiliation/conflict determination
 - Number without approved affiliation/conflict determination
- Number of Professional Reviewer Conflict Updates Processed
- Number of Professional Reviewer Conflict Updates Pending
- Number and percent of Professional Reviewer cases with conflict attestations

The Director, Quality Assurance will also provide a brief, confidential, description of any specific violation of MAXIMUS Federal conflict policy.

4.4.6.2 Quality Assurance Verification

Every six months the Quality Assurance Committee will audit and verify performance measures and performance of conflict of interest monitoring. Verification will be based upon: (1) review of a sample of employment files, (2) review of a sample of Professional Reviewer files, (3) review of a sample of MAXIMUS Federal (new) contracts and (4) review of a sample of completed Professional Reviewer reviews for attestation.

APPENDIX E: MPR APPLICATION

CONTINUING MEDICAL EDUCATION:			
List all courses completed during the previous year:			
PROFESSIONAL LIABILITY INSURANCE:			
Insurance Company Name:			
Address:			
Maximum \$ Per Occurrence:		Maximum \$ Per Aggregate:	
Policy Number:		Agent's Name:	
Provide the names and addresses of your professional liability carriers for the past 5 years, if different from your current carrier:			
Have you ever been denied professional liability insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> (if Yes, explain):			
Has your professional liability insurance ever been terminated? Yes <input type="checkbox"/> No <input type="checkbox"/> (if Yes, explain):			
PROFESSIONAL LICENSING: (Attach a copy of all certificates/professional licenses)			
List the State(s) in which you hold or have held a medical license:			
(State)	(License No.)	(Date Issued)	(Expiration Date)
(State)	(License No.)	(Date Issued)	(Expiration Date)
(State)	(License No.)	(Date Issued)	(Expiration Date)

If extra space is needed, please attach additional sheet(s).

SPECIALTY BOARD CERTIFICATIONS: (Attach a copy of your certification(s))

1.	(Specialty Board)	(Date of Certification)	(Date of Expiration)
2.	(Specialty Board)	(Date of Certification)	(Date of Expiration)
3.	(Specialty Board)	(Date of Certification)	(Date of Expiration)

ACADEMIC APPOINTMENTS (Start with most recent):

1.	(Institution)	(Position)	(Dates)
2.	(Institution)	(Position)	(Dates)
3.	(Institution)	(Position)	(Dates)

CURRENT HOSPITAL AFFILIATIONS AND ADMITTING PRIVILEGES:

Please attach a copy of the declaration of privileges for each hospital or facility.

(Facility)	(Location)	(Status)	(Dates)
(Facility)	(Location)	(Status)	(Dates)
(Facility)	(Location)	(Status)	(Dates)

If extra space is needed, please attach additional sheet(s).

CURRENT EMPLOYMENT (Include self, corporate, practice and other):	
Company or Professional Corporation:	Federal Tax ID #:
Classify your company or corporation: Hospital <input type="checkbox"/> Private Practice <input type="checkbox"/> Group Practice <input type="checkbox"/> University <input type="checkbox"/> Other <input type="checkbox"/> (Explain other):	
Address:	Phone #:
	Fax #:
Contact Person:	
Days that you can be reached at this address: S M T W R F S None	
Your title within your company or corporation:	
Classify your primary medical work: Practitioner <input type="checkbox"/> Researcher/Teacher <input type="checkbox"/> Other <input type="checkbox"/> (Explain other)	
CURRENT MEDICAL PRACTICE:	
% of time devoted to medical practice:	
Subspecialty or focus of practice: (optional)	
Medical Areas that you feel comfortable reviewing:	
1.	
2.	
3.	



MEDICAL EMPLOYMENT HISTORY (List most current first):	
1. EMPLOYER: ADDRESS: DATES:	POSITION: DUTIES:
2. EMPLOYER: ADDRESS: DATES:	POSITION: DUTIES:
3. EMPLOYER: ADDRESS: DATES:	POSITION: DUTIES:
4. EMPLOYER: ADDRESS: DATES:	POSITION: DUTIES:
5. EMPLOYER: ADDRESS: DATES:	POSITION: DUTIES:
Please attach an explanation of gaps in employment greater than 6 months.	
CONFLICTS OF INTEREST (List direct or familial relationships):	
List each current or planned affiliation with any health insurer utilization review firm, provider network or drug/device supply company. (CHDR defines affiliation as an owner, shareholder, partner, officer, director, employee, consultant, contracted provider or a familial relationship to any of the above. Ownership of more than 5% or any commission, royalty or similar arrangement should be listed.)	
1. (Entity Name)	(Affiliation)
2. (Entity Name)	(Affiliation)
3. (Entity Name)	(Affiliation)

If extra space is needed, please attach additional sheet(s).

QUESTIONS:		
If the answer to any of the following is "Yes", then please supply a detailed explanation on a separate sheet.		
YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	A. Has your license to practice medicine or prescribe controlled substances in any jurisdiction ever been revoked, suspended, denied or voluntarily suspended, or is any such action or other disciplinary or misconduct action pending or withdrawn?
<input type="checkbox"/>	<input type="checkbox"/>	B. Have clinical privileges or staff membership at any hospital ever been denied, revoked, suspended, reduced, not renewed, voluntarily surrendered or withdrawn or is any such action pending or withdrawn.
<input type="checkbox"/>	<input type="checkbox"/>	C. Has membership in any medical organization ever been suspended, revoked, limited or denied, or is any such action pending or withdrawn?
<input type="checkbox"/>	<input type="checkbox"/>	D. Are there any pending administrative agency or court cases, or administrative agency or court decisions, judgment or settlements in which you are alleged to have violated, or was found guilty of violating any criminal law? (Exclude minor traffic violations)
<input type="checkbox"/>	<input type="checkbox"/>	E. Have any professional liability lawsuits ever been initiated against you?
<input type="checkbox"/>	<input type="checkbox"/>	F. Has any judgment or settlement been made against you in any professional liability case or is any case pending?
<input type="checkbox"/>	<input type="checkbox"/>	G. Are there any prior or pending government agency or third party payer proceedings or litigation challenging or sanctioning your patient admission, treatment, discharge, charging, collection or utilization practices, including but not limited to Medicare/Medicaid fraud and abuse proceedings and convictions?
If the answer to question D, E, F, or G is "Yes", then, as part of the full detailed explanation required, please give the name of the court in which the lawsuit was brought, the caption and docket number of the case, the name and address of the attorney defending you, or the substance of the allegations in the lawsuit or proceeding.		

REPRESENTATIONS

I certify that the information on this application form is, to my knowledge, accurate, complete and true.

I understand that any misstatements in or omissions from this application constitute cause for non-eligibility or termination as a consultant.

I hereby release from liability any person or entity who provides information to MAXIMUS Federal Services concerning my application.

I hereby authorize MAXIMUS Federal Services and its representatives to consult with and solicit information from whatever third parties may have information bearing on the application and consent to the release and inspection of any such information.

This authorization shall be valid during the time my application is pending with MAXIMUS Federal Services, and shall be valid during each year thereafter while I maintain a consulting relationship with MAXIMUS Federal Services.

A photocopy of the authorization will be as valid as the original.

I certify that my mental and physical health status does not present any impediment to the treatment of patients and acting as a consultant to MAXIMUS Federal Services

Should there be any changes in my licensure, hospital affiliation(s), insurance coverage, and/or address, I will immediately notify MAXIMUS Federal Services of the change.

Consultant Signature

Date

Print Name

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

If extra space is needed, please attach additional sheet(s)

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APPENDIX F: MPR REFERRAL FORM

**MAXIMUS Federal
MPR REFERRAL AND REPORT**

Case Name:

Case Number:

This case is due back on: Date ___/___/___ Time _____ AM PM

Please return case via: ___ **FAX (do not include identifiers)**
 ___ **Overnight mail (envelop enclosed)**
 ___ **Call for Courier Pick-Up**

Your MAXIMUS Federal Appeal Officer (point of contact) for this case is:

Phone: _____ **Fax:** _____ **Email:** _____

After Hours Contact Instructions:

1. ENROLLEE RELEVANT HISTORY AND MEDICAL CONDITION:

___ I accept as written

___ I modify as follows:

**2. STATEMENT OF SERVICE OR TREATMENT DENIED BY HEALTH PLAN AND
HEALTH PLAN RATIONALE:**

___ I accept as written

___ I modify as follows:

3. QUESTIONS TO BE ADDRESSED BY REVIEWER:

Contact MAXIMUS Federal prior to your review if you do not understand the “questions” for your review.

4. INFORMATION INCLUDED WITHIN THIS CASE FILE:

5. ASSESSMENT OF COMPLETENESS/QUALITY OF CASE FILE INFORMATION

___ I find the medical records and material submitted by the health plan, patient or provider to be complete and sufficient for my determination

___ I find the medical records and material submitted by the health plan, patient or provider to be incomplete or inadequate for my professional review. The records or clarification(s) I require are:

Contact MAXIMUS Federal immediately if you determine that records are not adequate for review.

6. SUMMARY REVIEW DETERMINATION

___ I determine that the disputed service or treatment is medically necessary:

___ I determine that the disputed service or treatment is not medically necessary.

7. REVIEWER RATIONAL FOR DETERMINATION

Address the standards, criteria or clinical rationale presented by the health plan. Address whether or not the disputed service is safe, appropriate and cost effective. Consider and cite relevant evidence.

8. MEDICAL EVIDENCE CITATION

Publication	Author	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. EXPERT REVIEWER CERTIFICATION

I certify to the following as indicate (check all that apply) :

A. Expert Reviewer Expertise

I am credentialed or, as applicable, have privileges from a licensed health care facility or provider in the diagnosis and treatment of the medical condition defined in this case.

I am credentialed, or as applicable, have privileges from a licensed health care facility or provider in the specific procedure or treatment in dispute in this case.

I have been practicing in such area of specialty for at least five years.

I have treated one or more patients with the condition in the past 12 months

If I have not treated a patient with such condition, or provided the disputed procedure, I represent myself as fully knowledgeable about the condition and treatment options.

B. Conflict of Interest

I certify that aside from this review, I have not been involved in the diagnosis or treatment of the patient in this case.

I certify that I do not have any relationship with any party to this case which would constitute a material conflict of any of the following forms (as further defined in my contract with MAXIMUS Federal):

- *material familial affiliation*
- *material professional affiliations*
- *material financial affiliation*

C. Change in Credential Status

I certify that my standing and status in the practice of medicine has not changed since submission of information to MAXIMUS Federal for credentialing and specifically that I have not been subject to any disciplinary action by any health care institution, licensing authority, professional society or government health care payment program.

Signature

Date

Name (Print)

Board Certification

APPENDIX G: CA-LICENSED MPRs

Independent Medical Review
State of California, DIR, DWC



Appendix G: CA Licensed Clinicians who are Eligible to Review for CA IMR

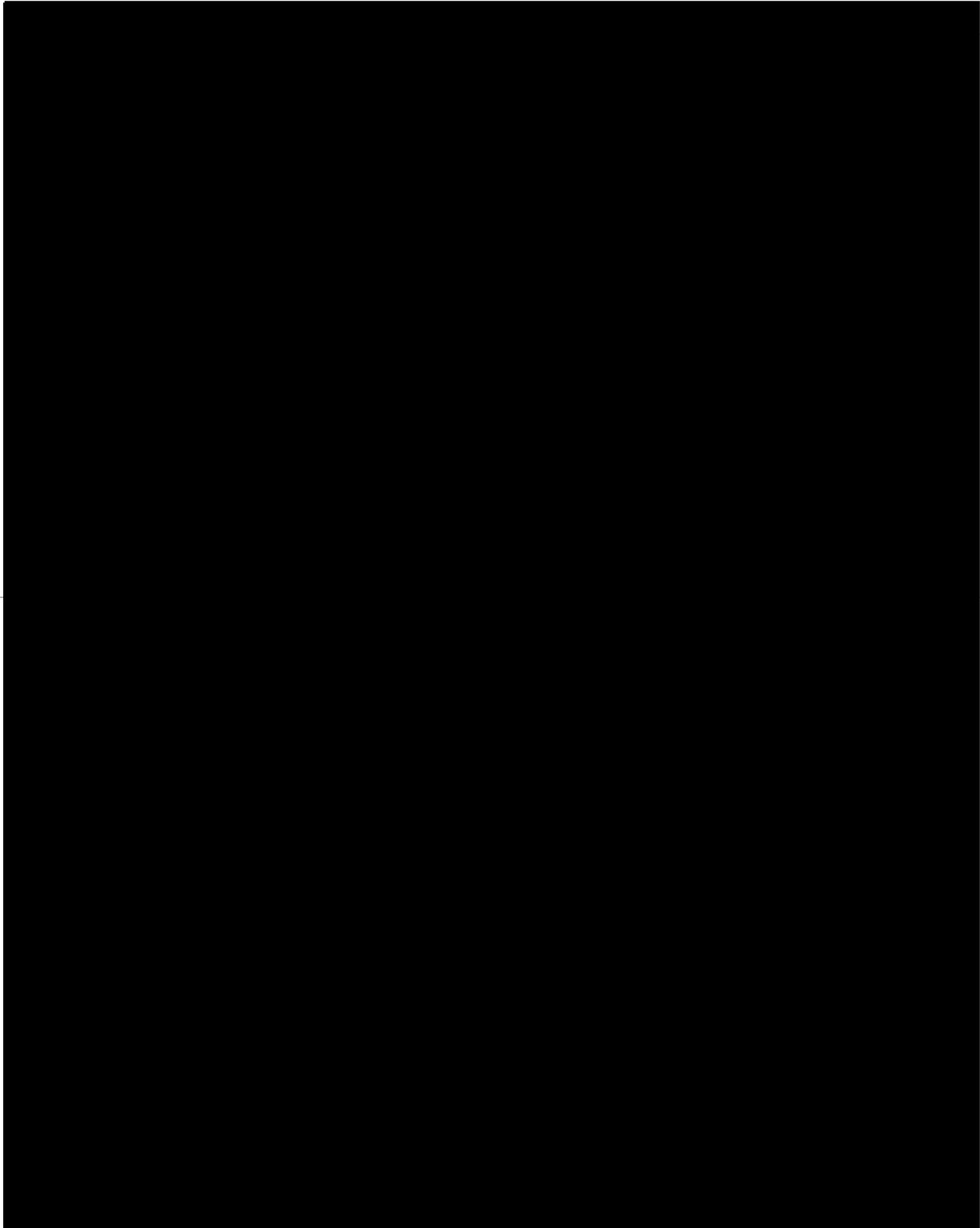
This list only includes the MAXIMUS Federal California-licensed Medical Professional Reviewers (MPRs) in active practice and eligible to provide IMR services on behalf of DWC. Please note that this does not include the 600 eligible California-licensed MPRs will access through our subcontracting arrangements with URAC accredited IROs. These 600 reviewers have passed the MAXIMUS Federal credentialing process and are currently undergoing IMR training. When their training is complete they will be officially added to our panel. They are scheduled to officially join our panel in July 2014. We will provide DWC with an updated MPR List when these candidates have completed our credentialing and training processes.

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State of California, DIR, DWC



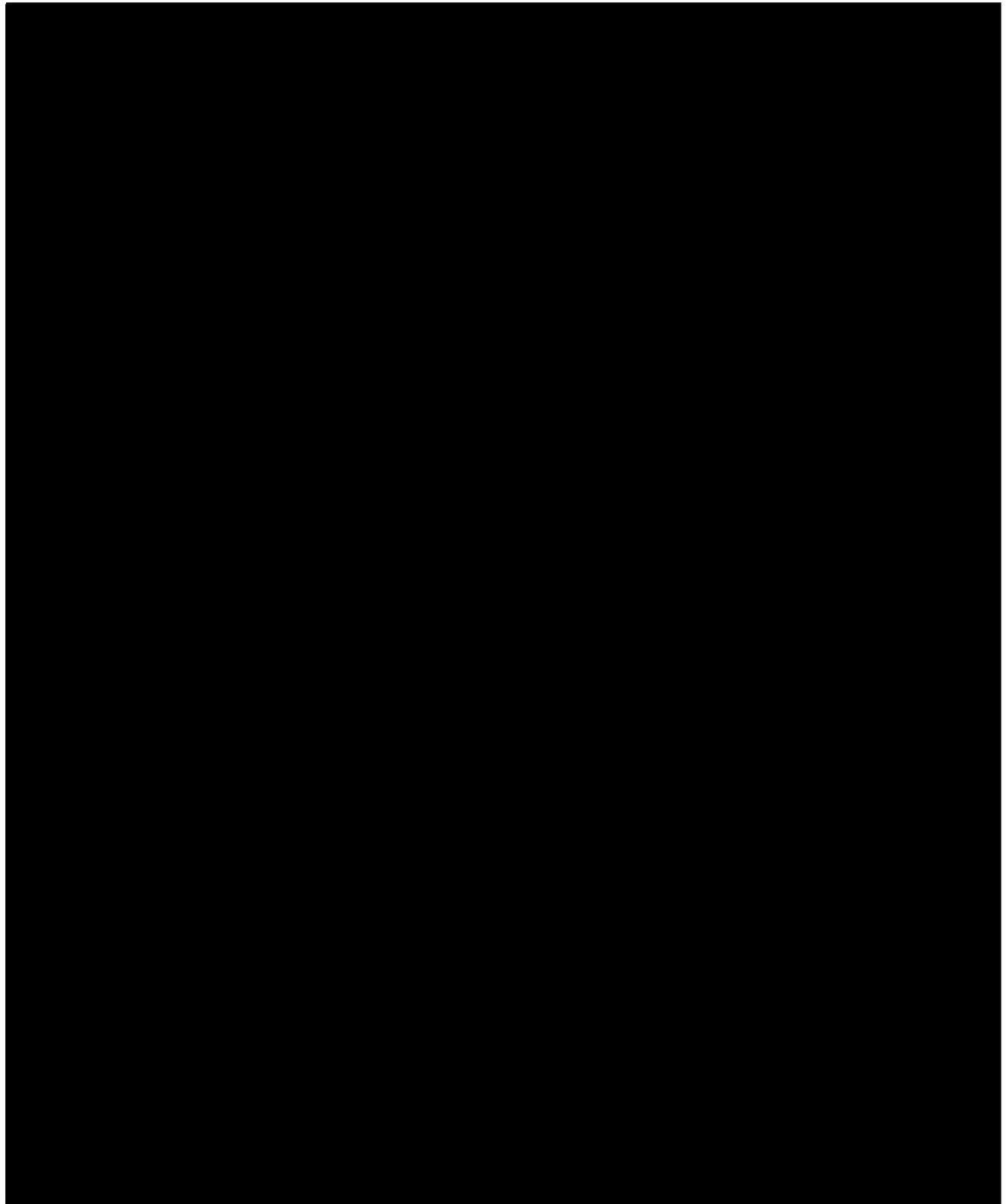
Appendices G and H have been redacted. The information contained in these appendices is exempt from production under the Public Records Act pursuant to, inter alia, 6254(k), Evidence Code section 1060 and Labor Code section 4610.6(f).

Independent Medical Review
State of California, DIR, DWC



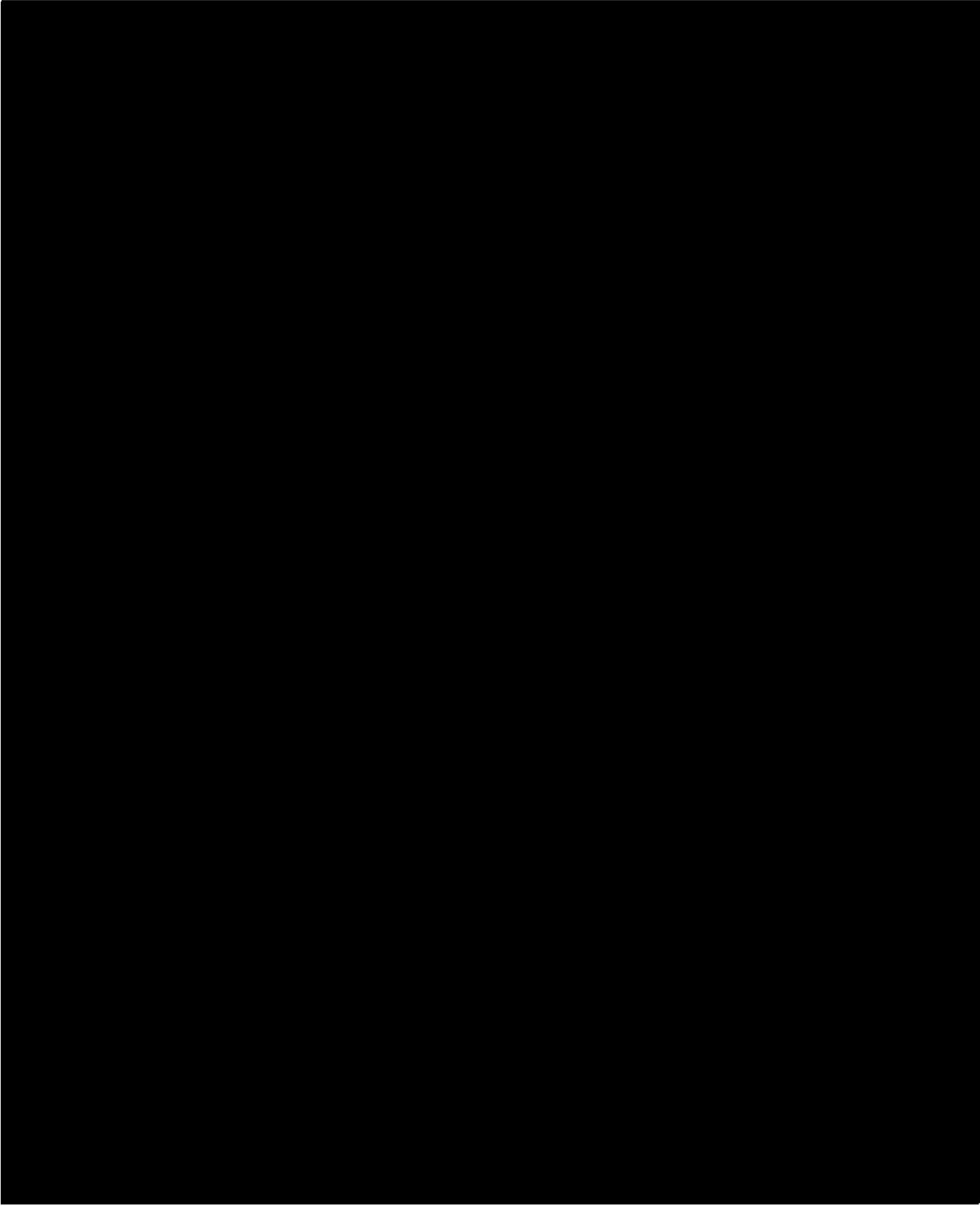
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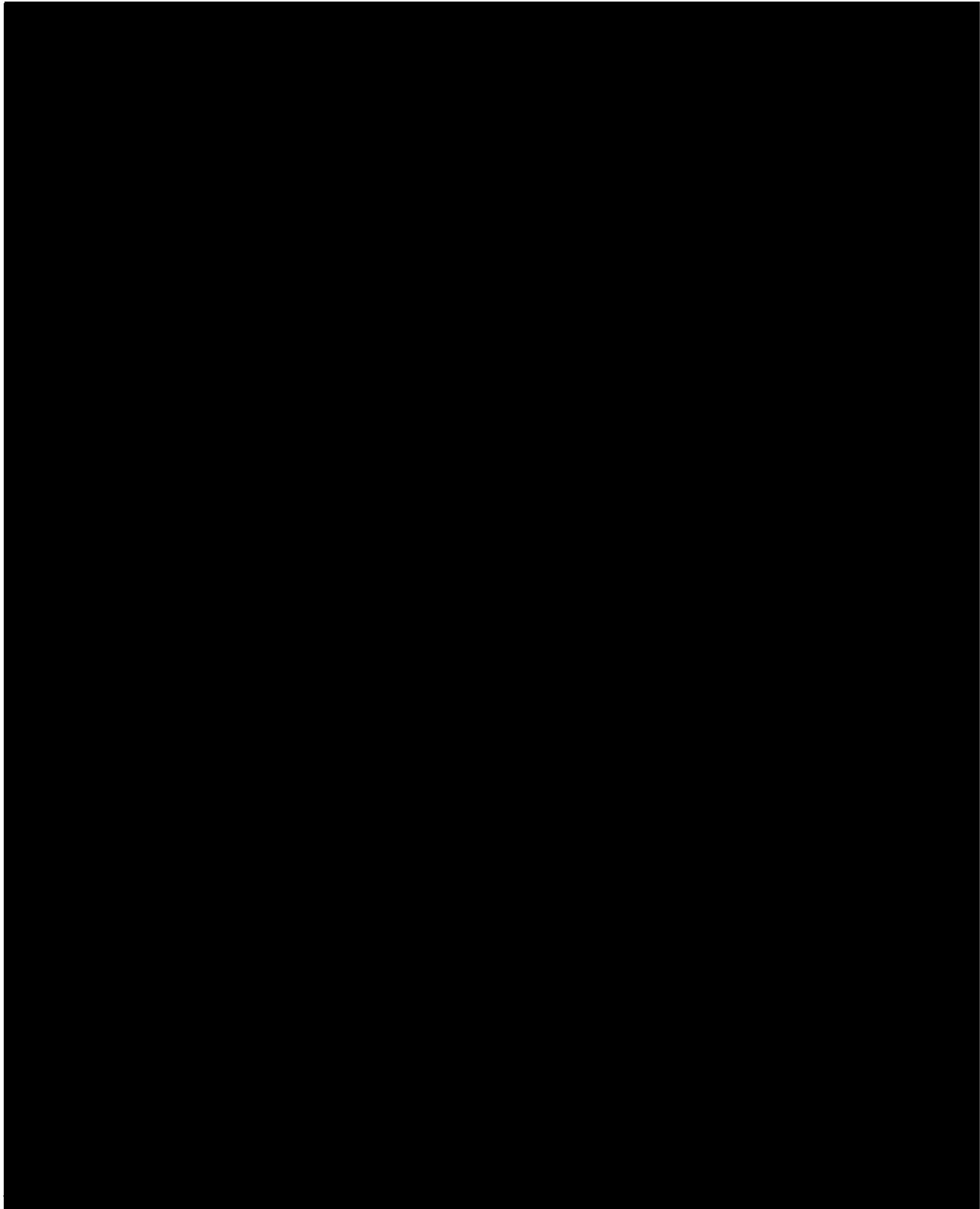
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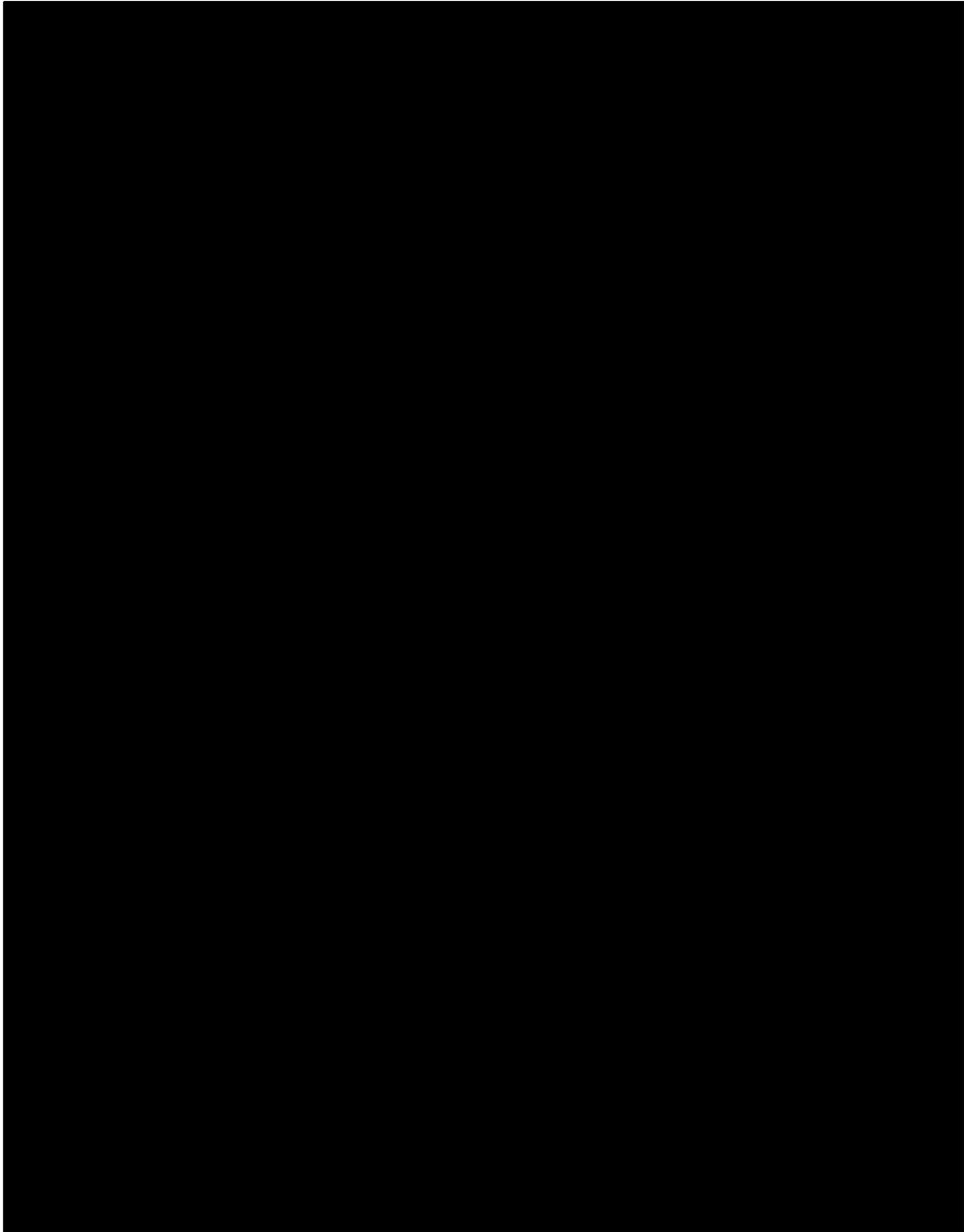
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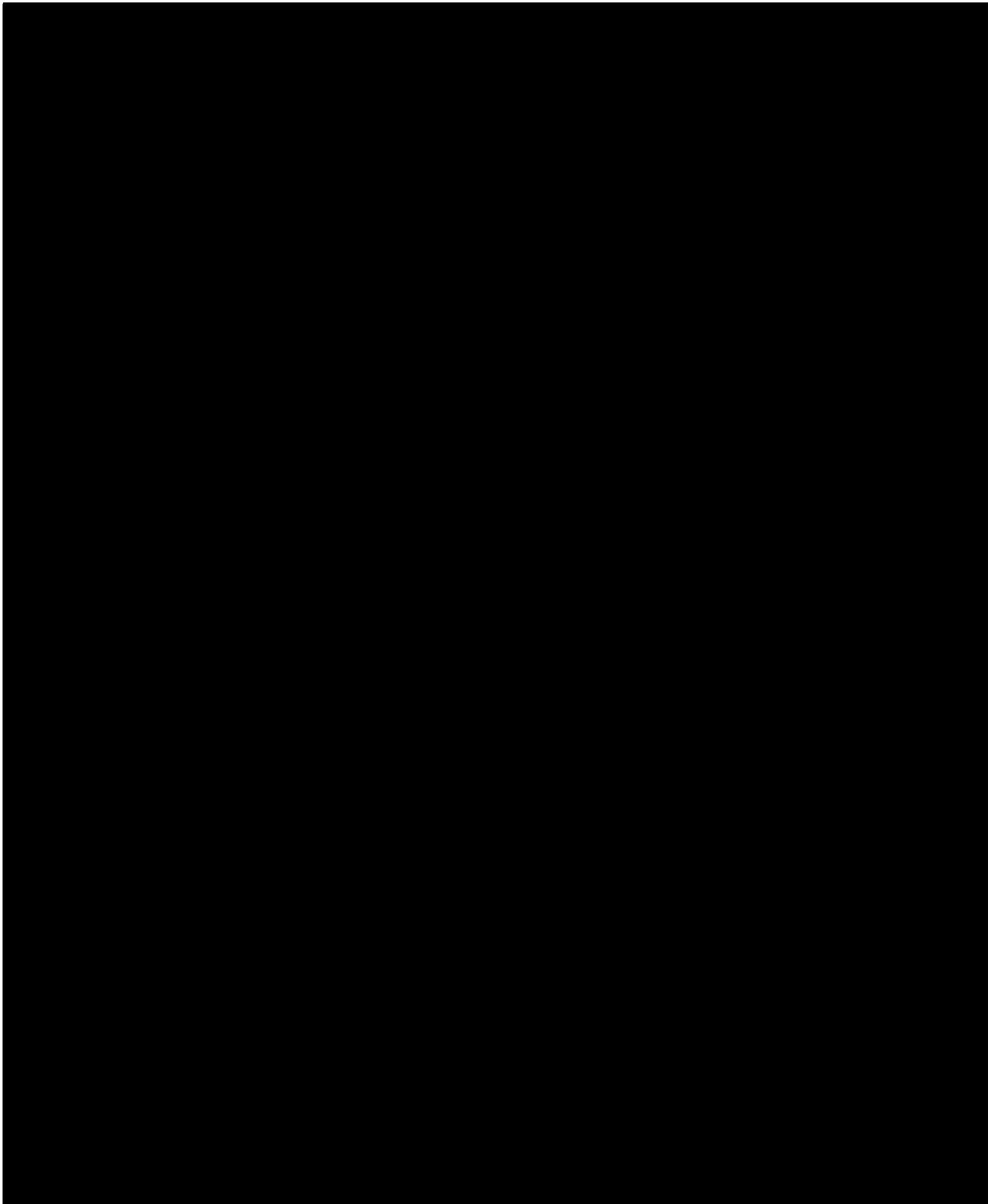
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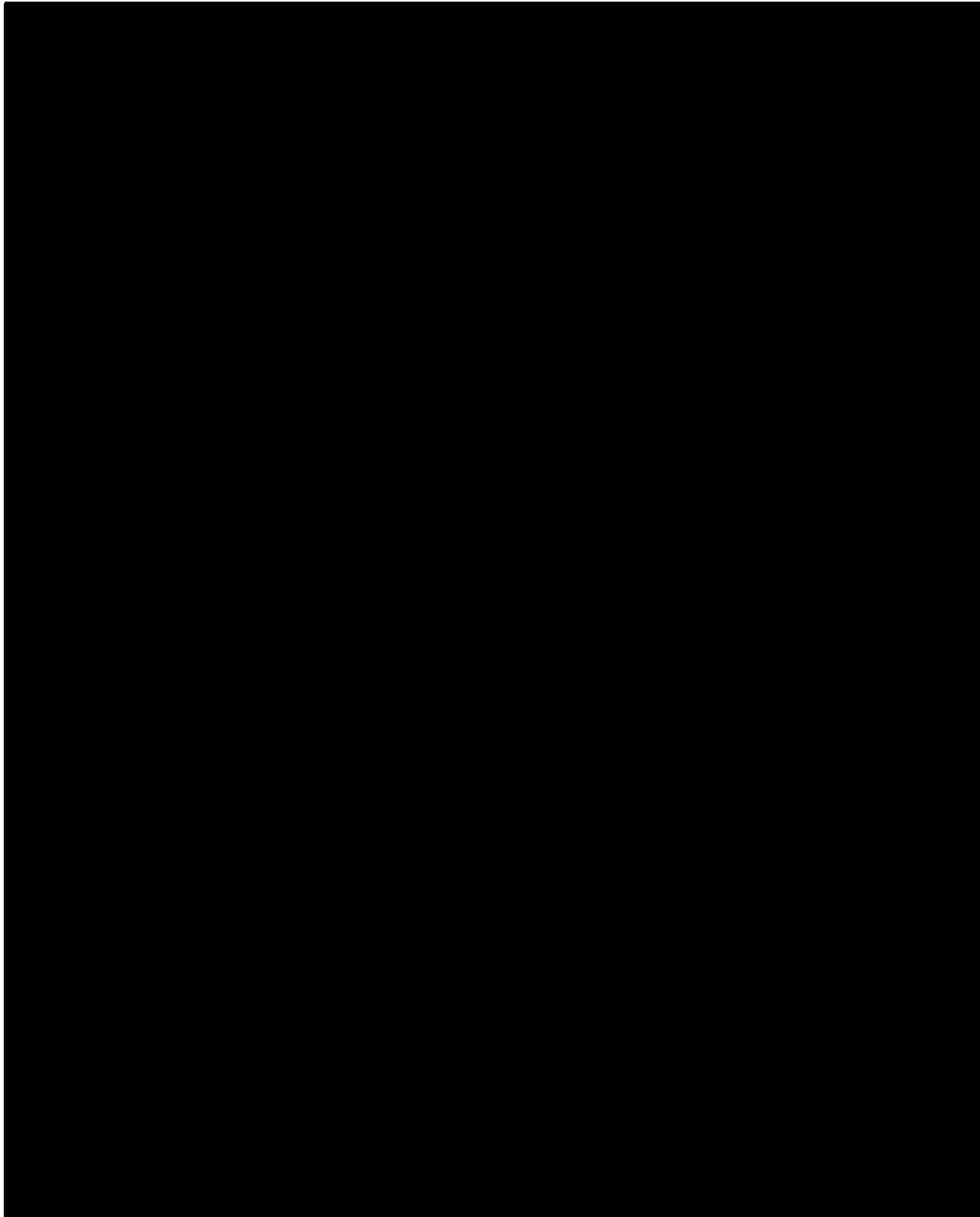
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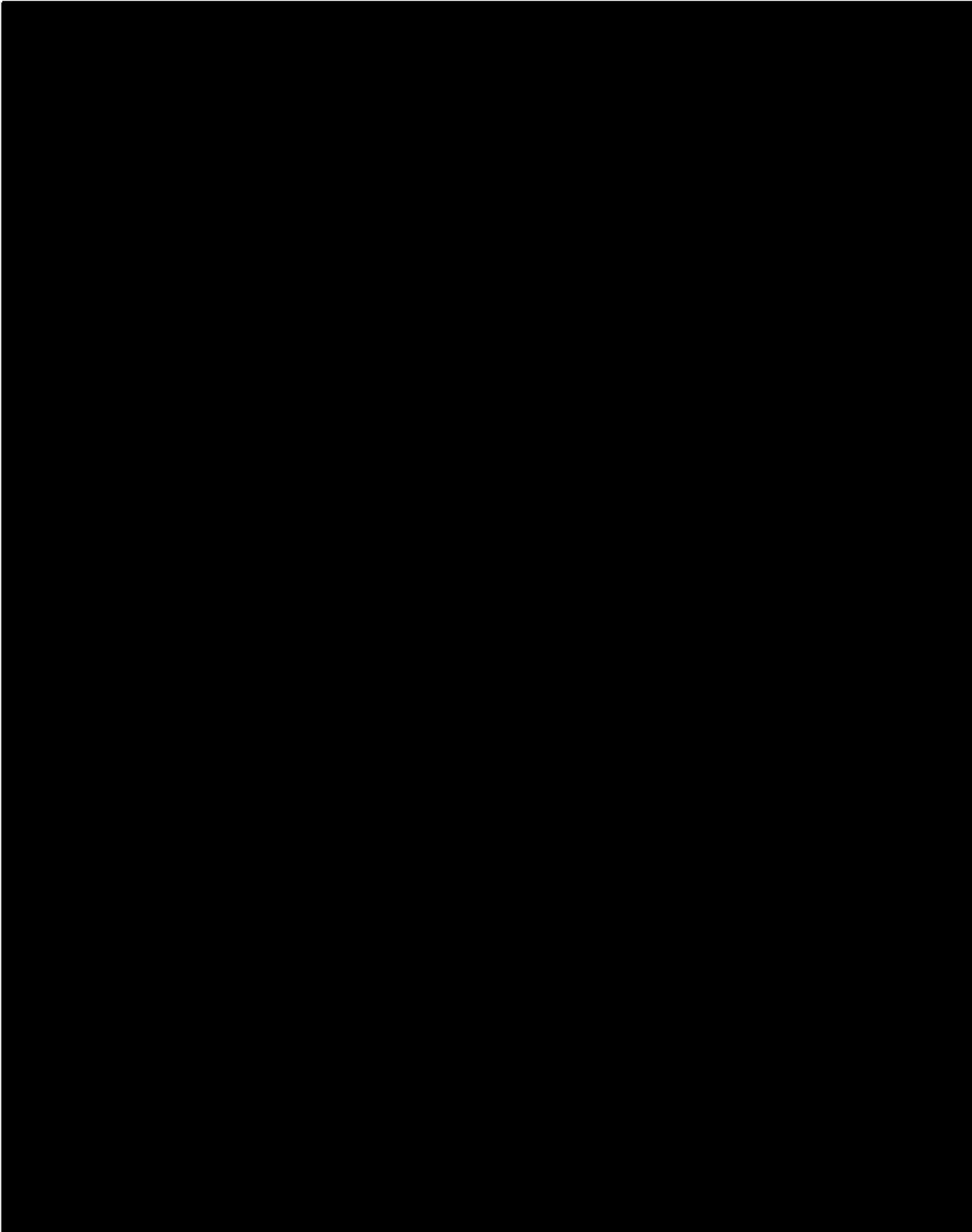
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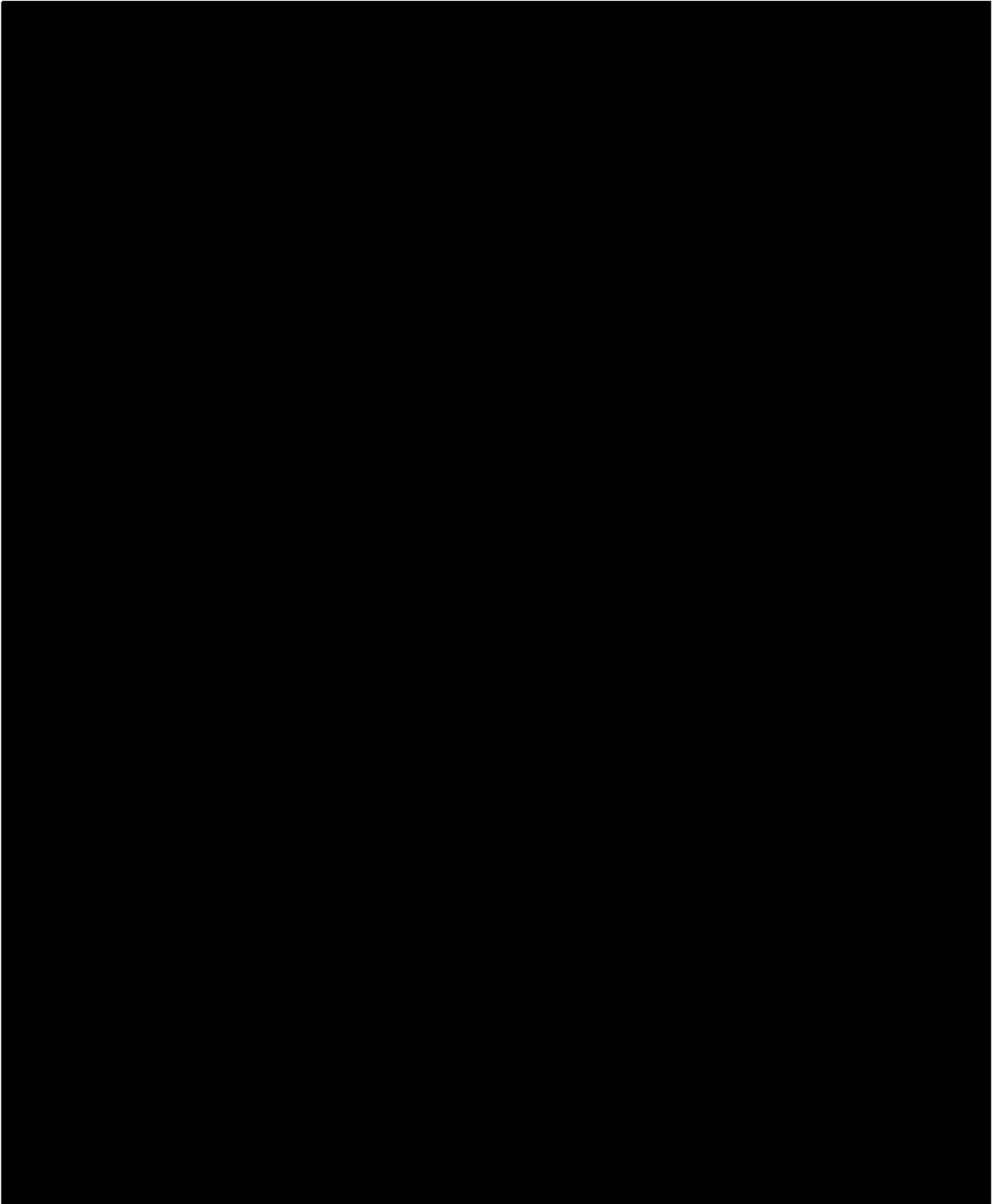
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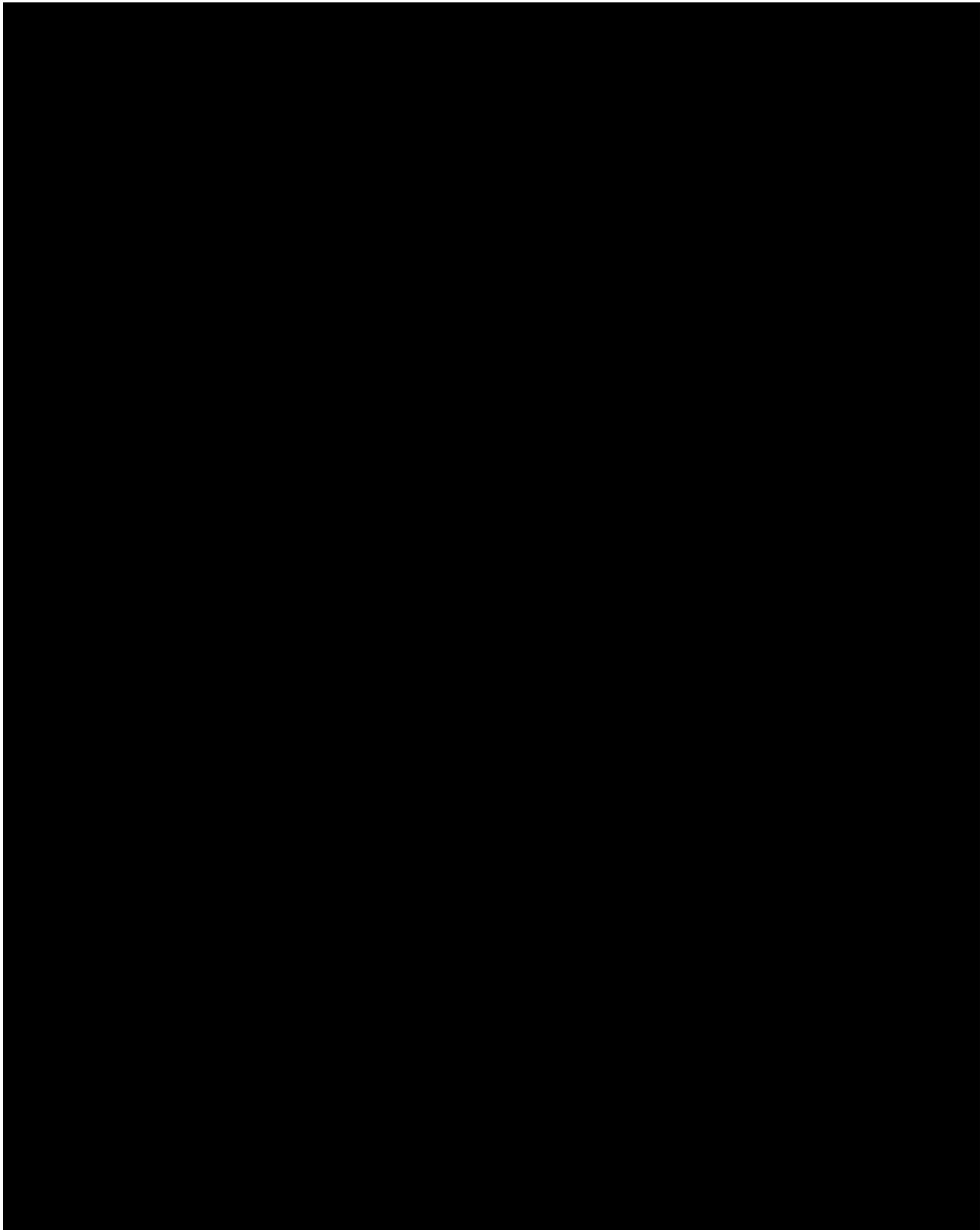
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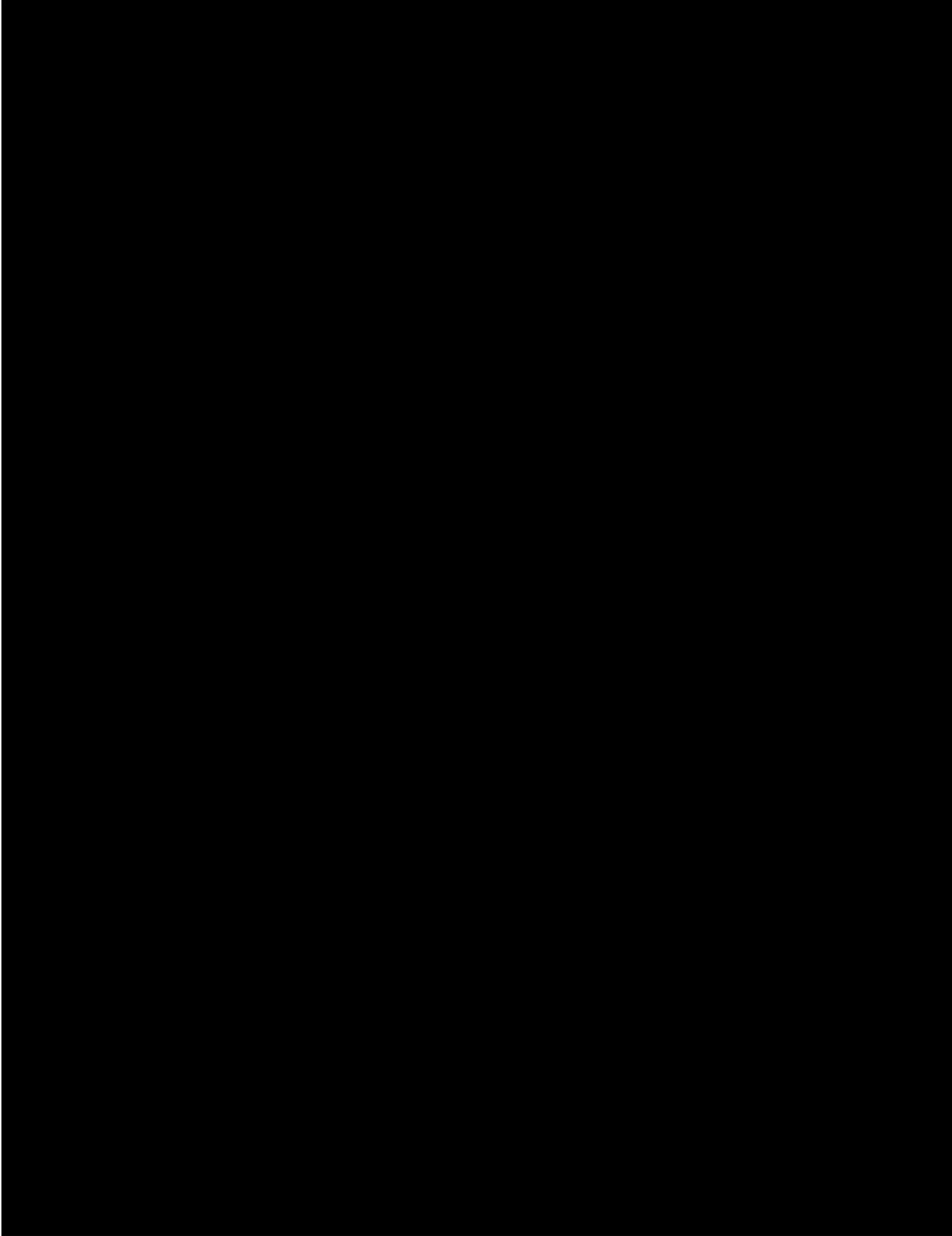
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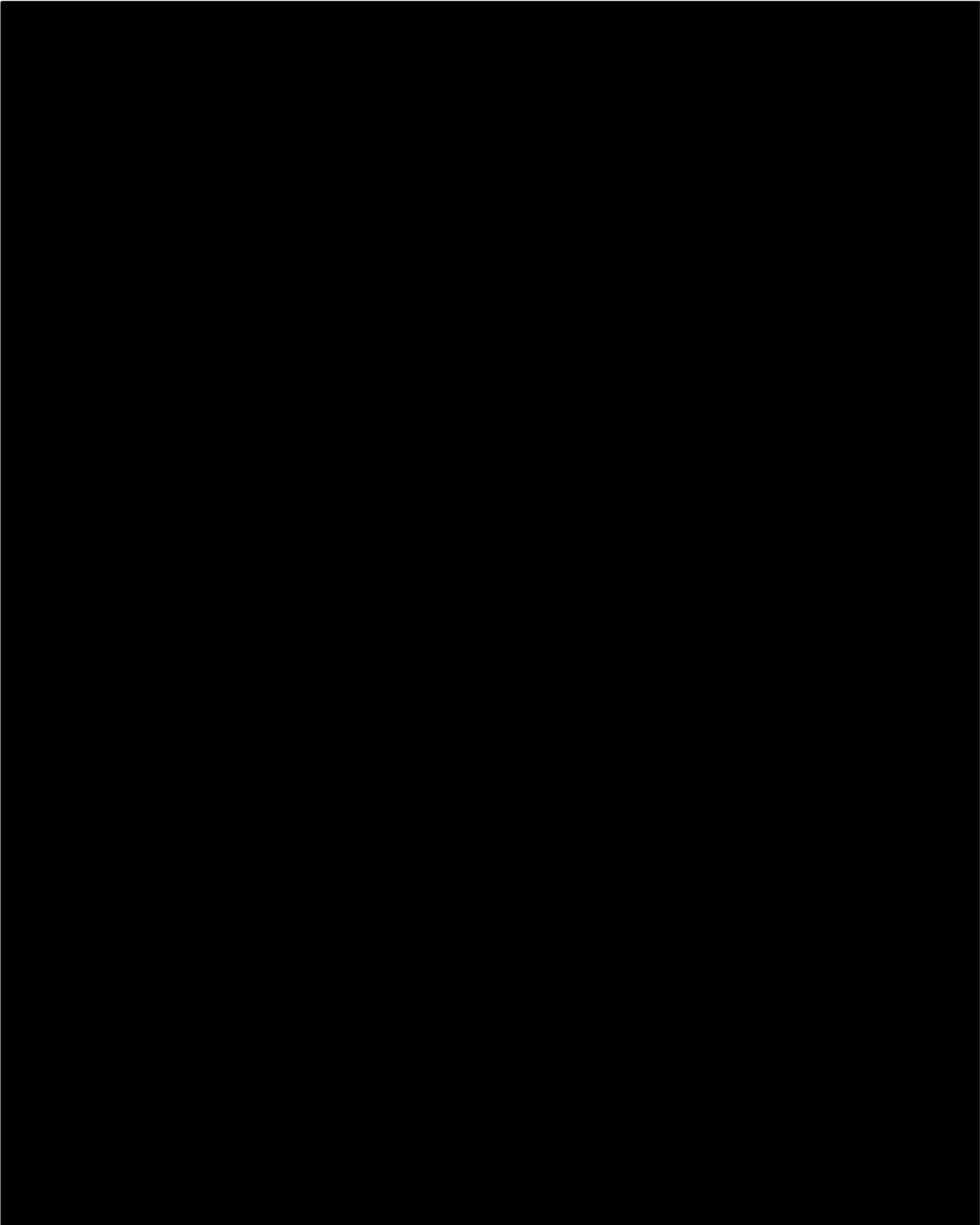
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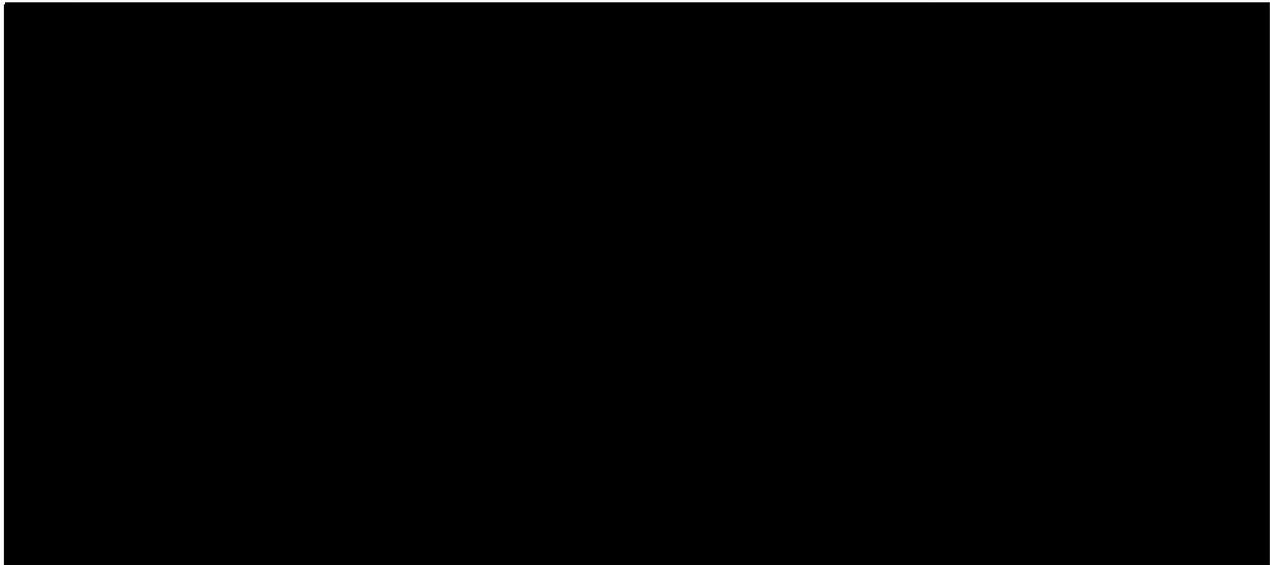
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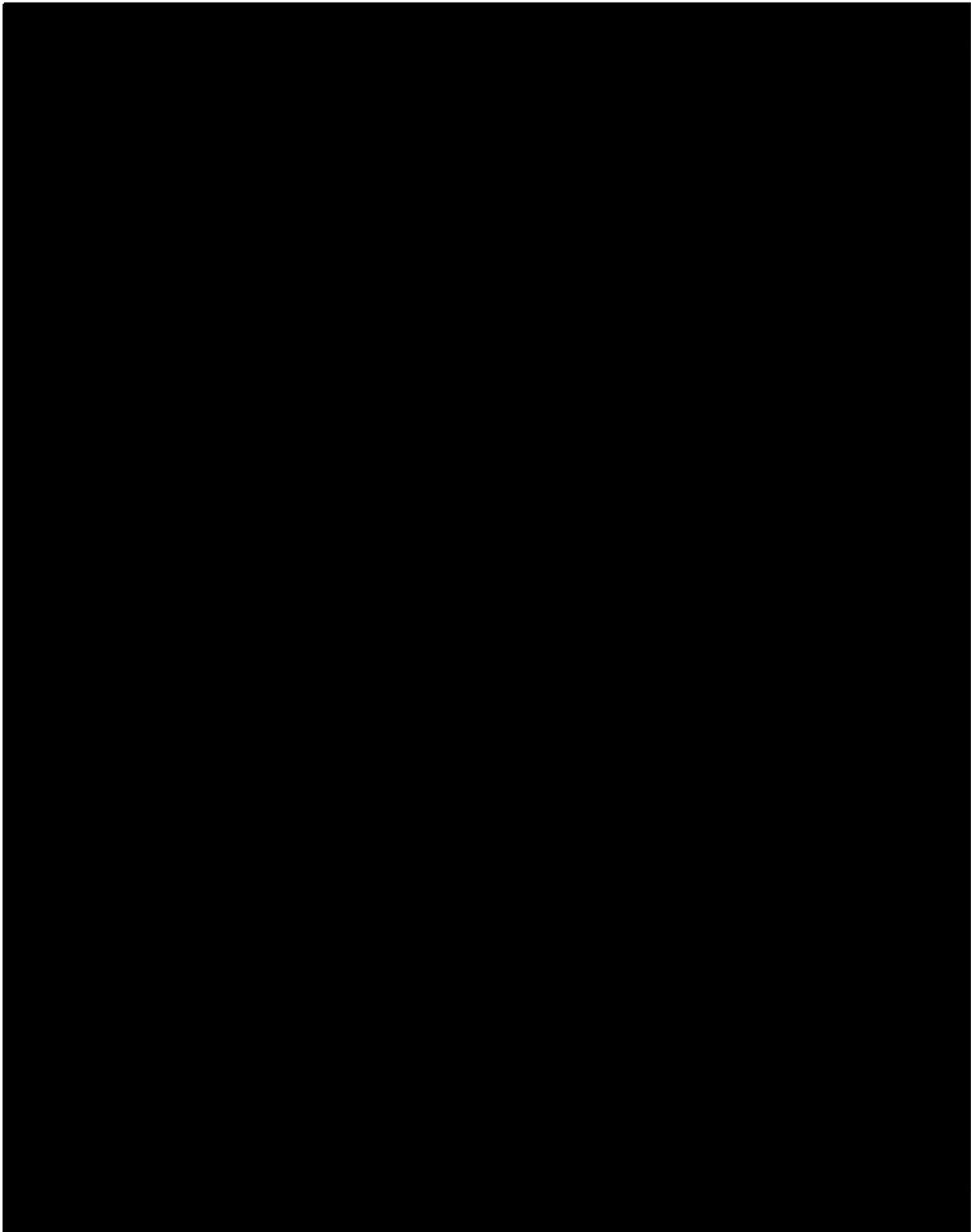
APPENDIX H: NON-CA-LICENSED MPRs

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State of California, DIR, DWC



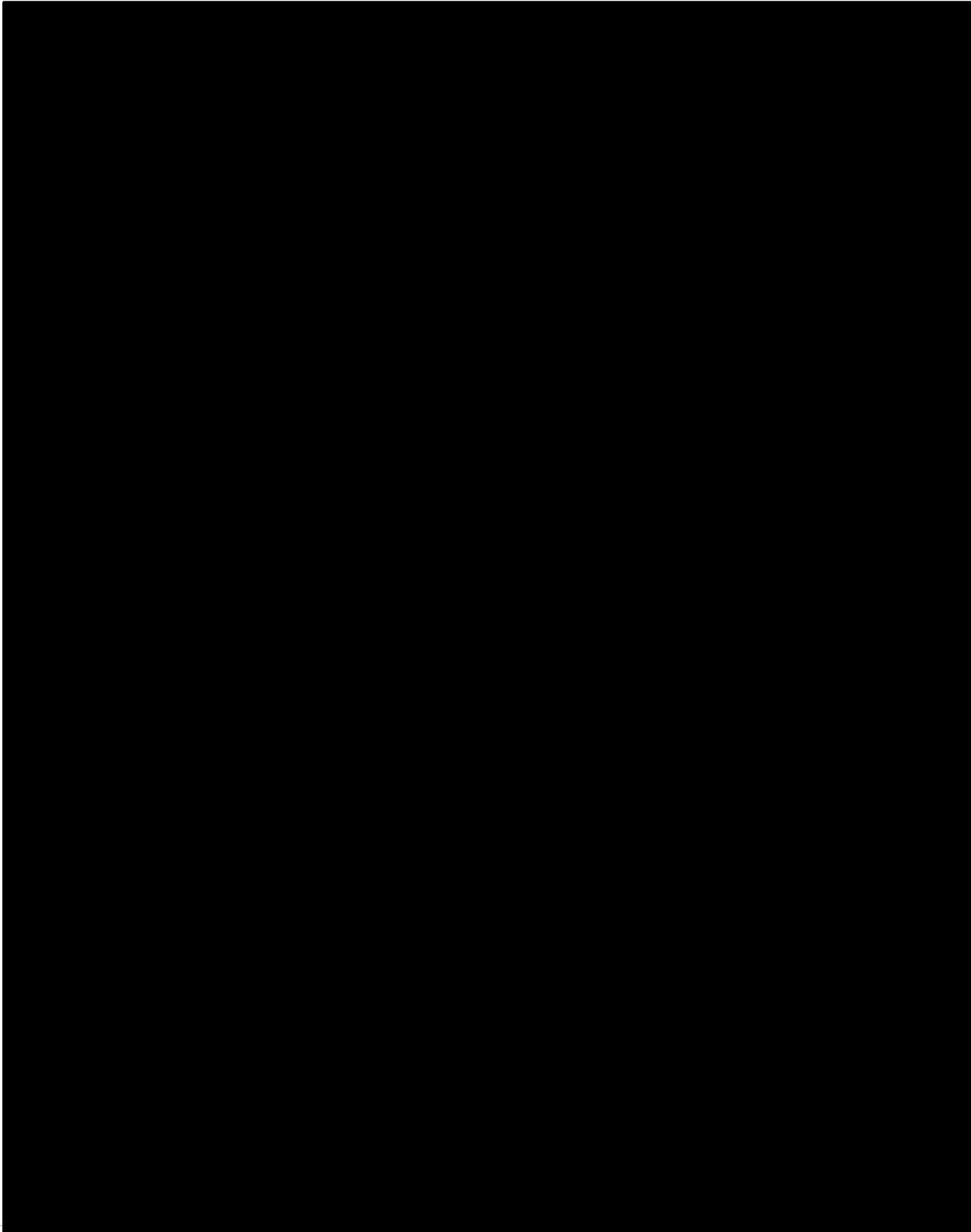
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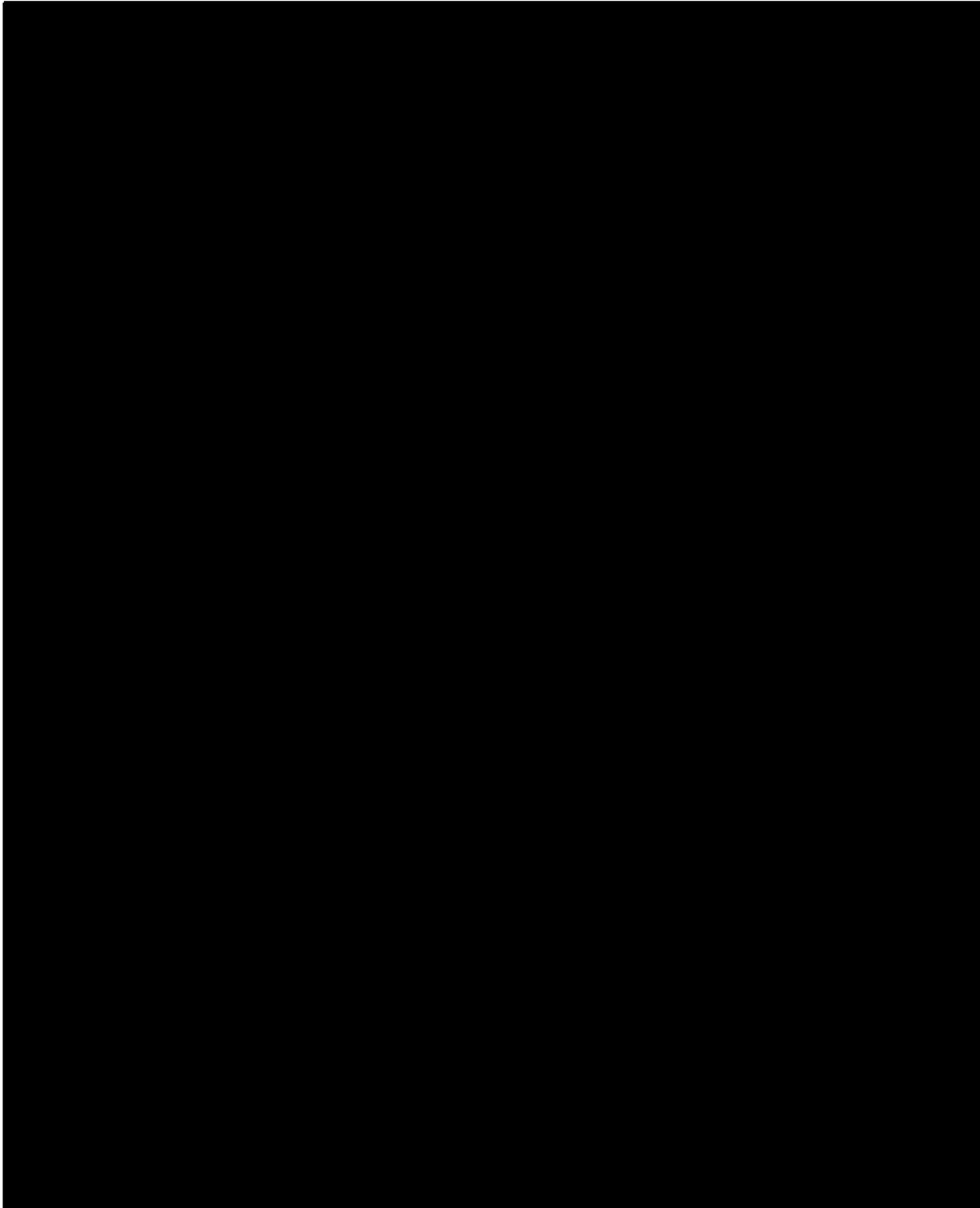
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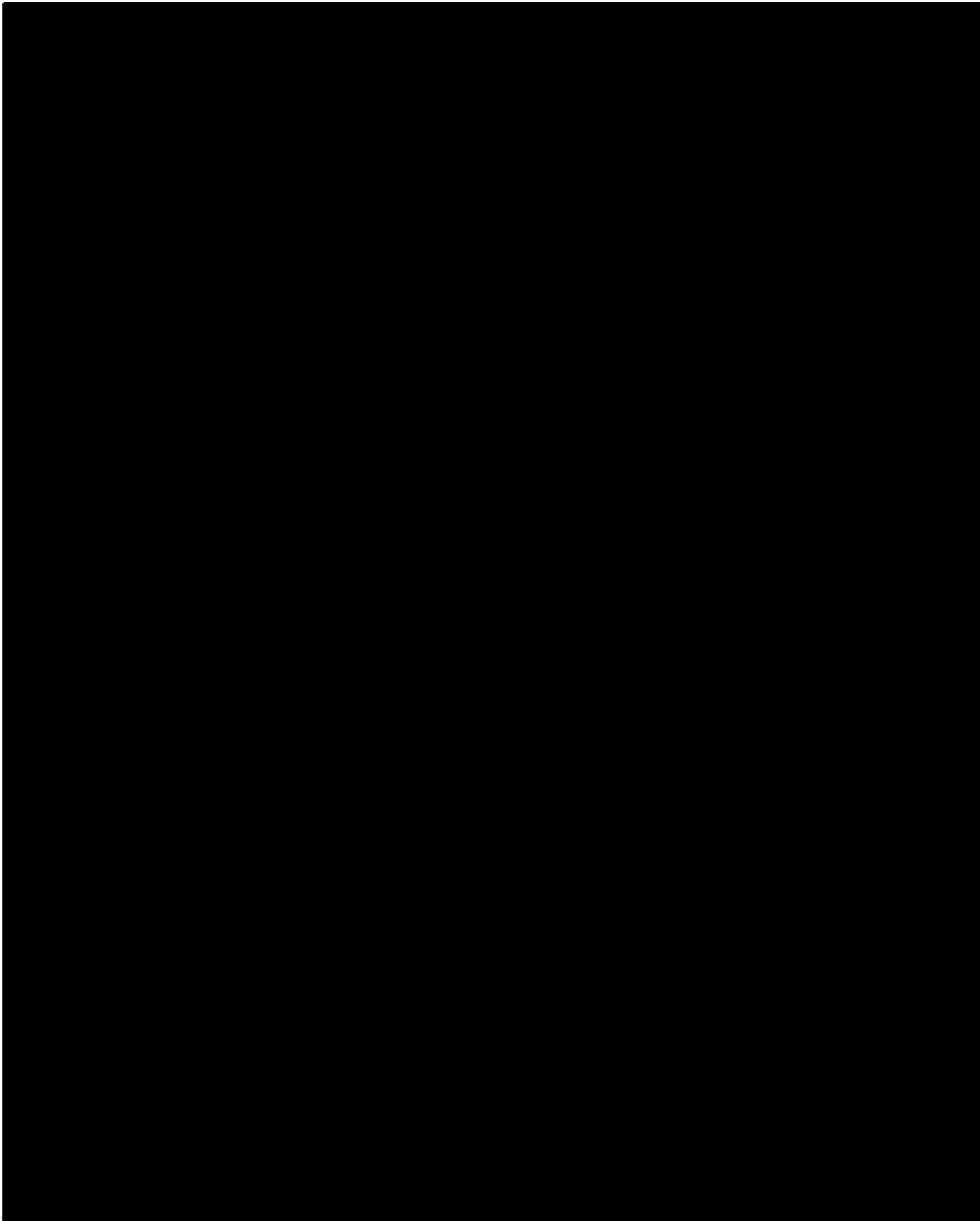
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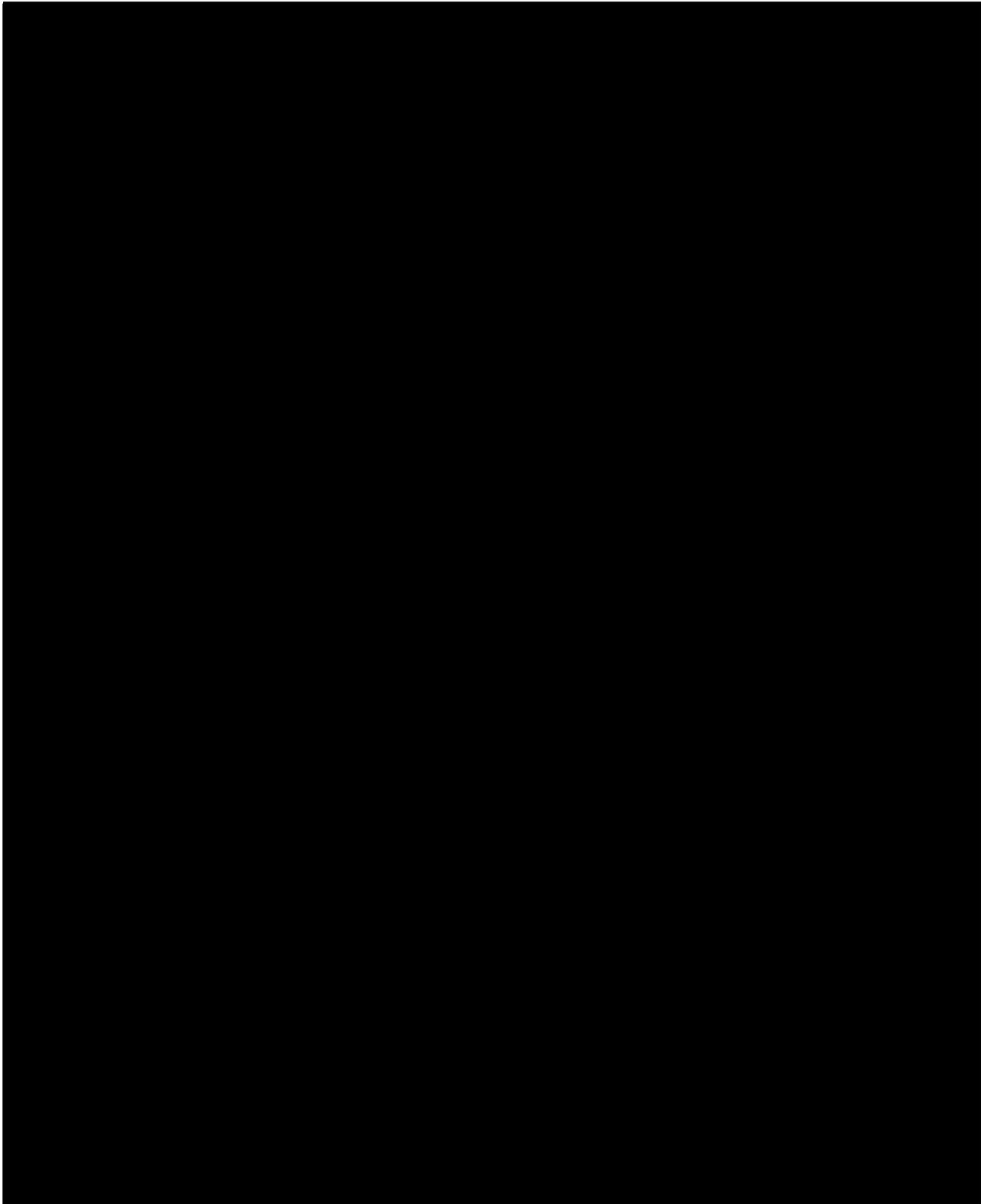
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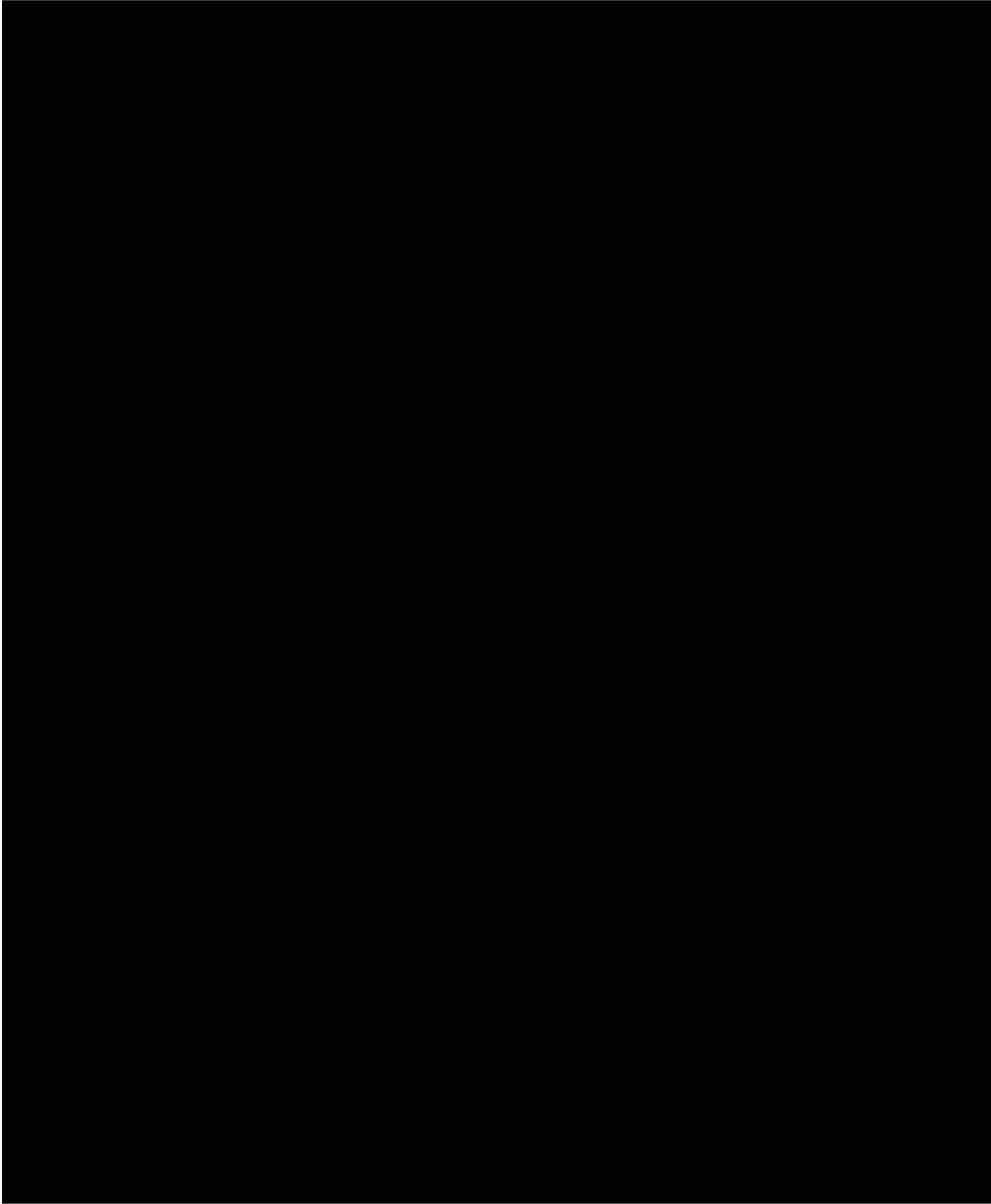
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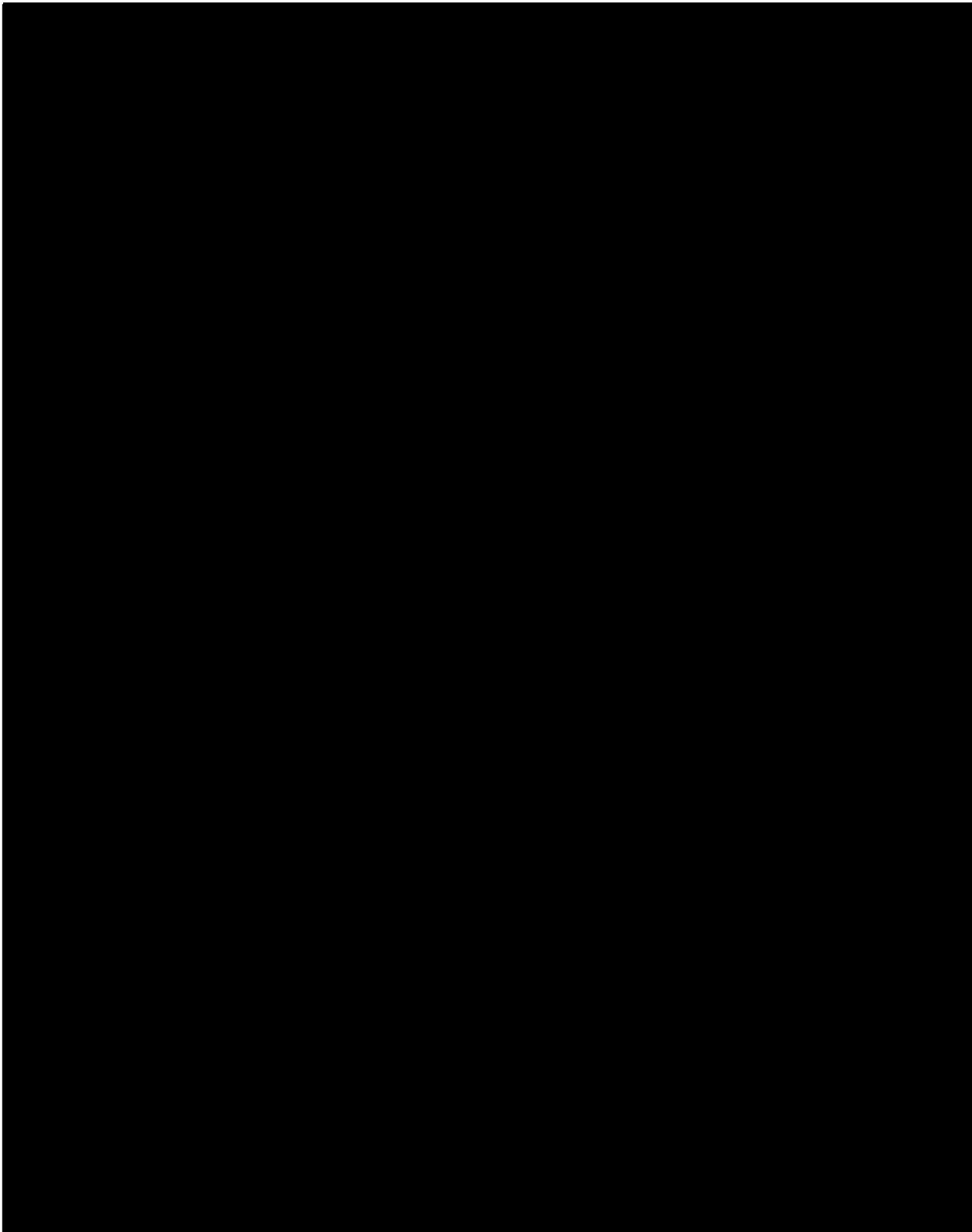
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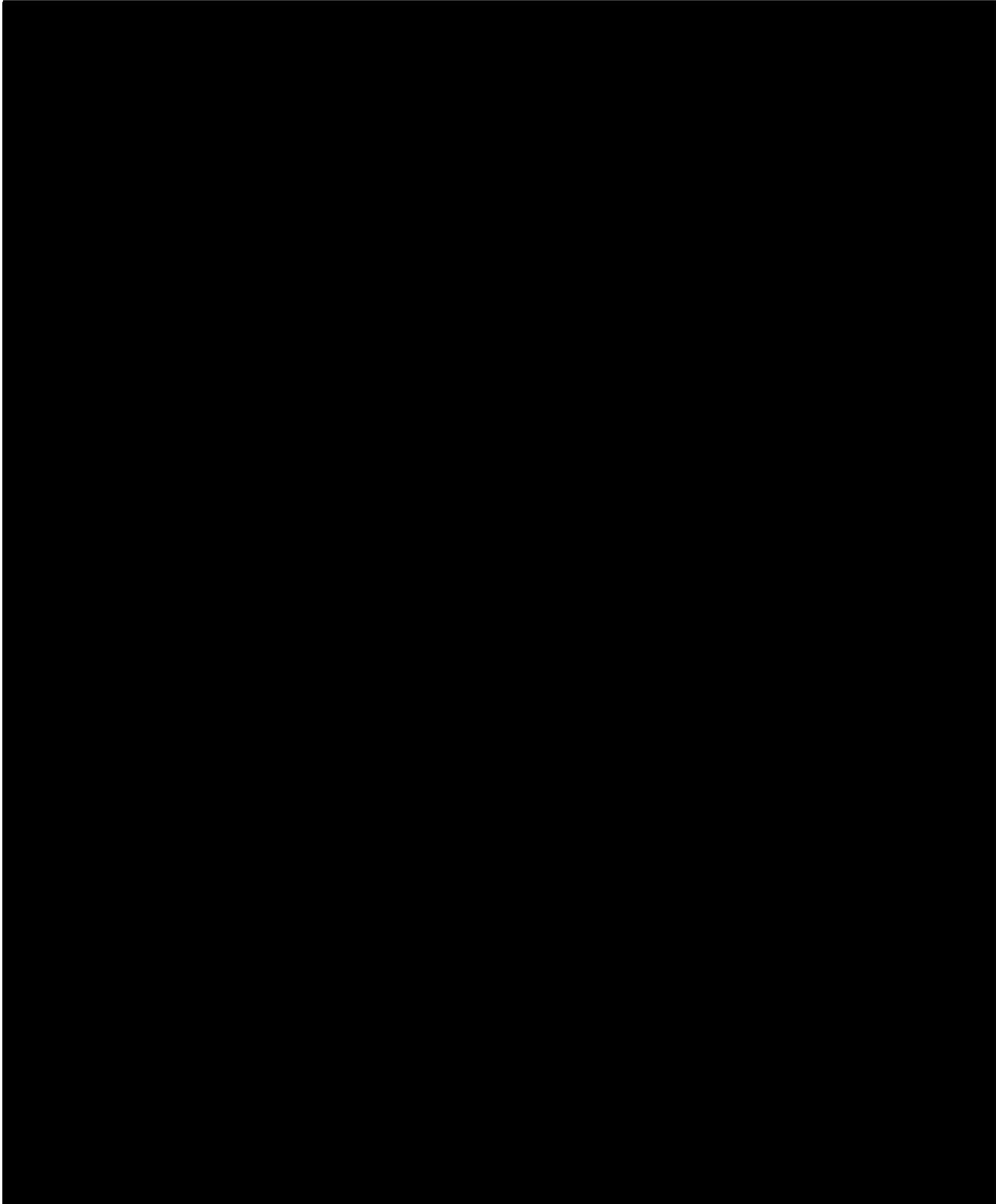
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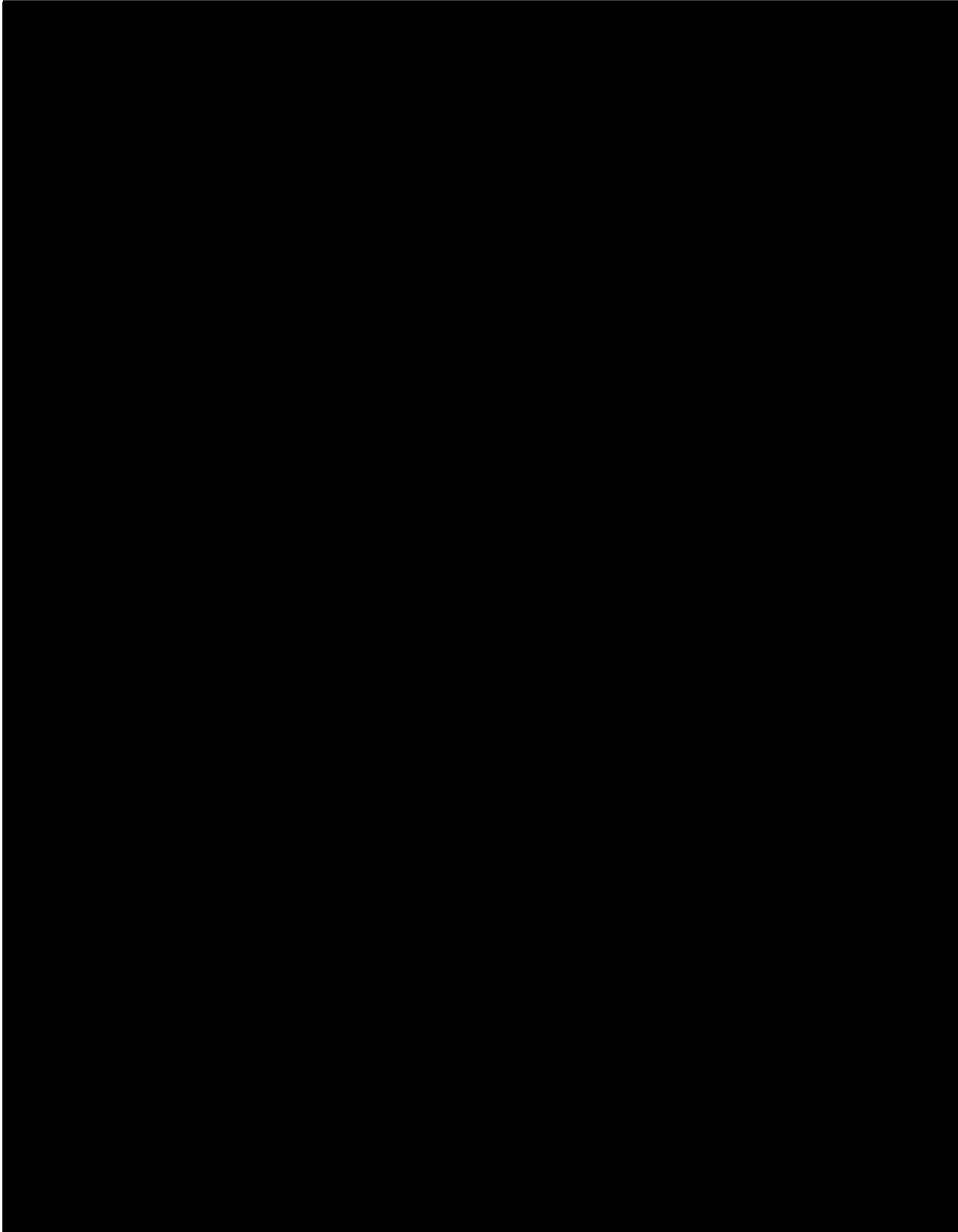
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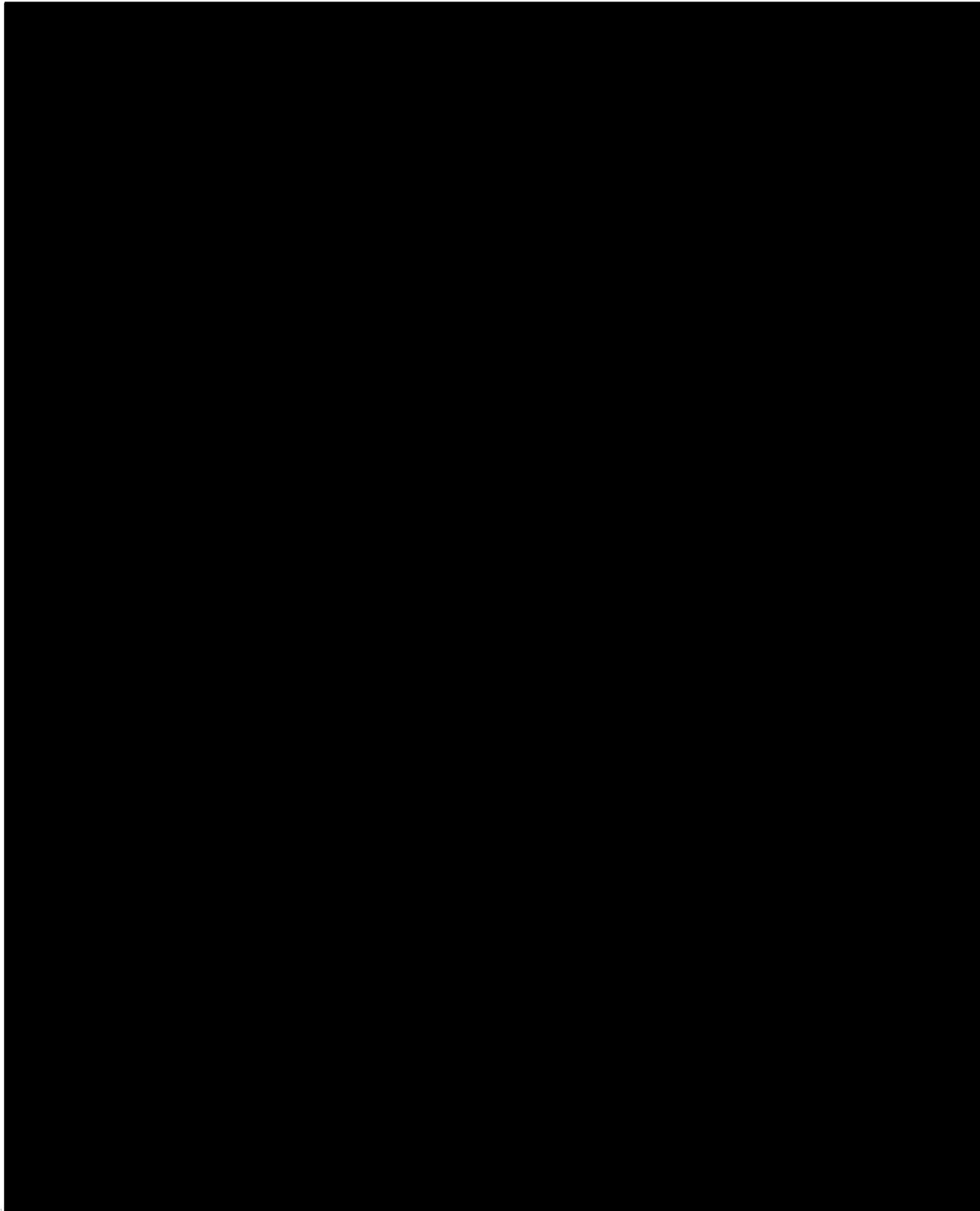
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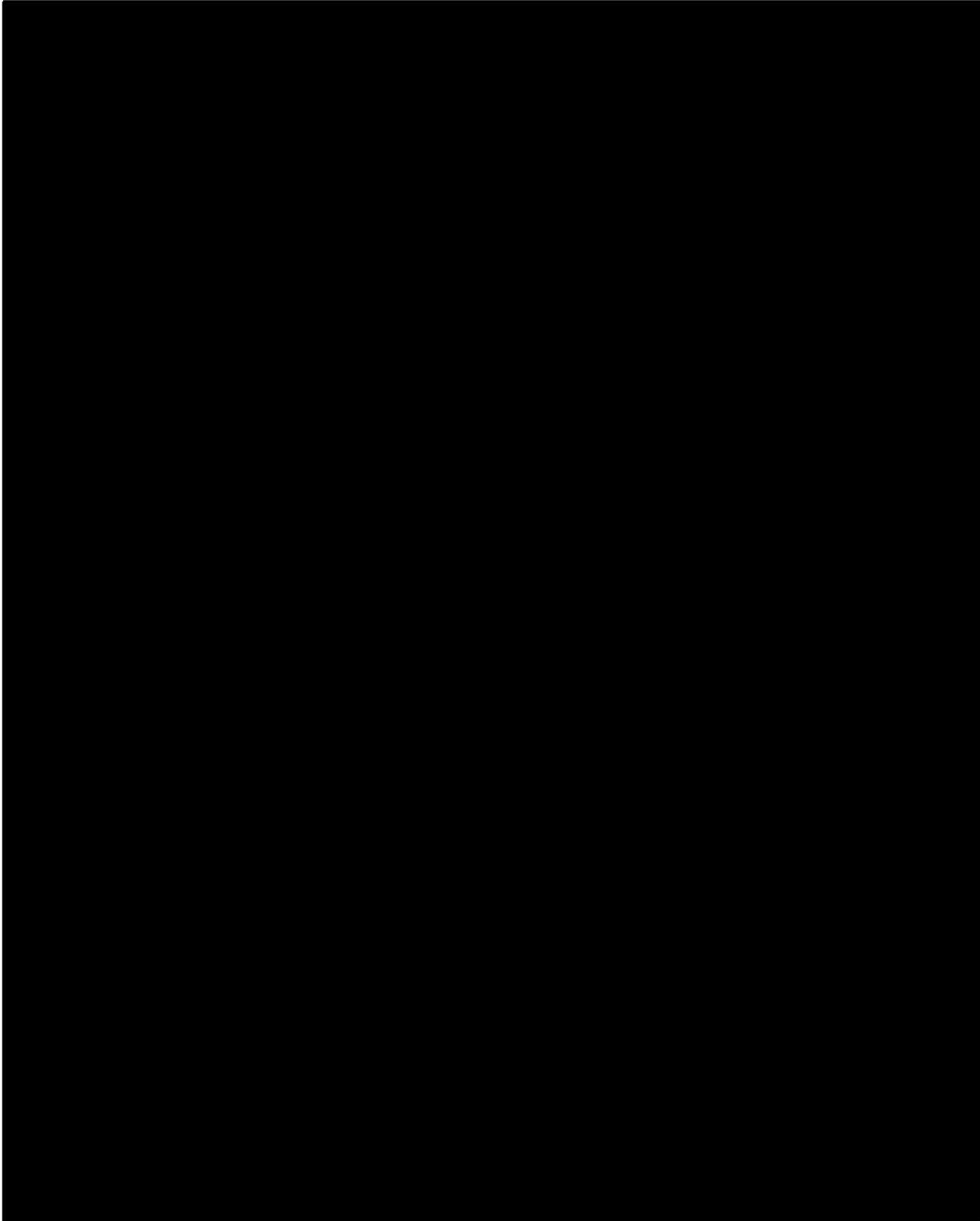
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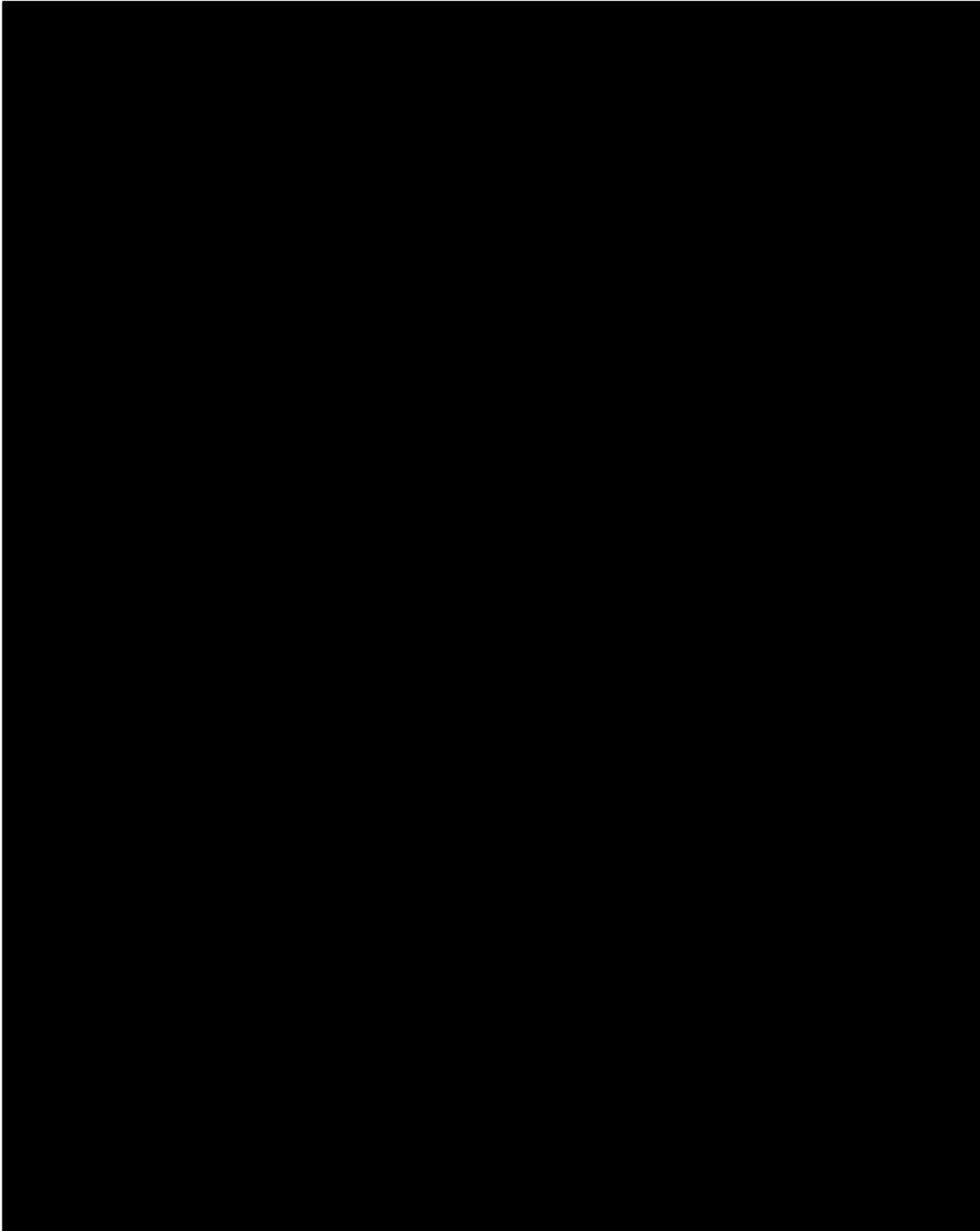
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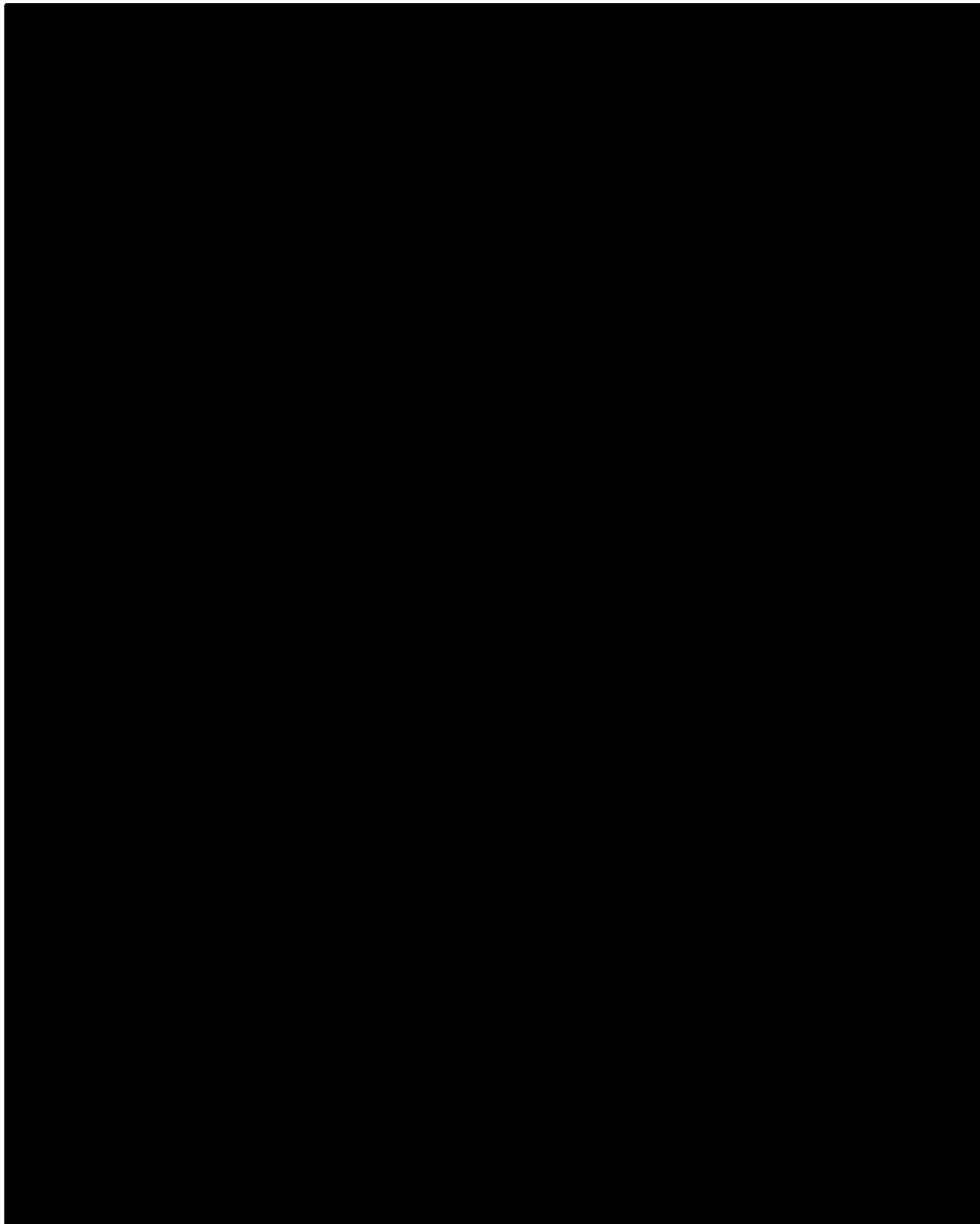
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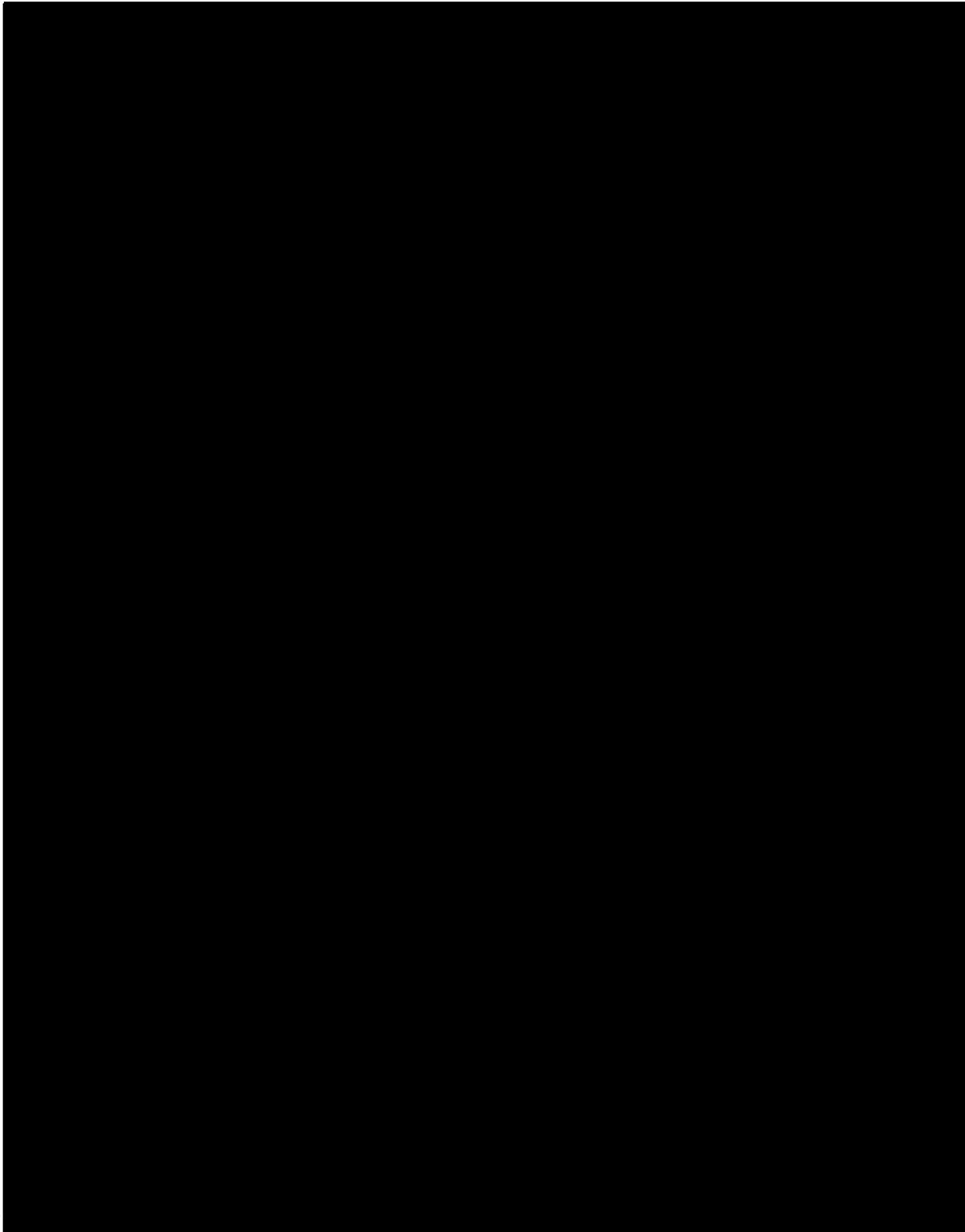
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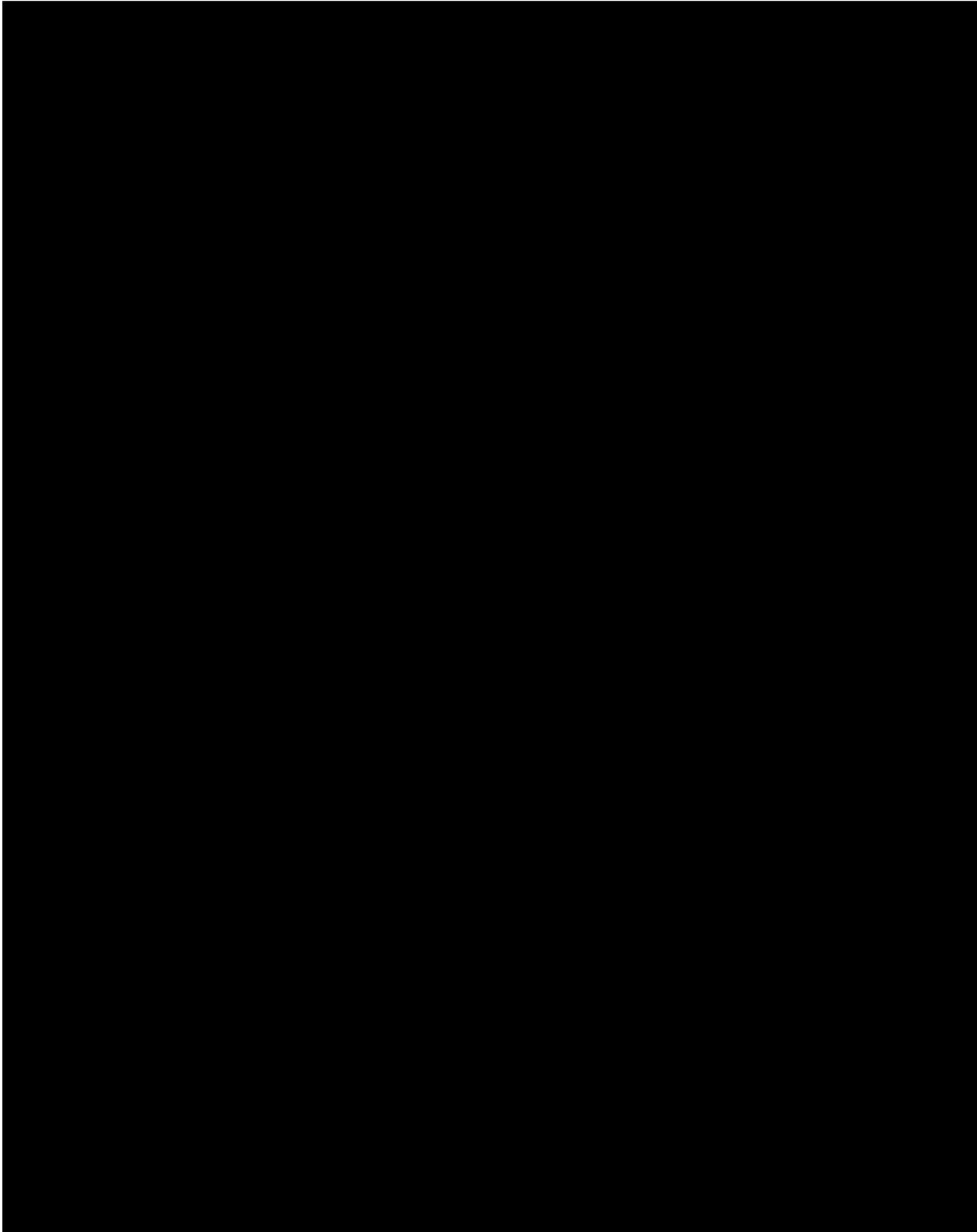
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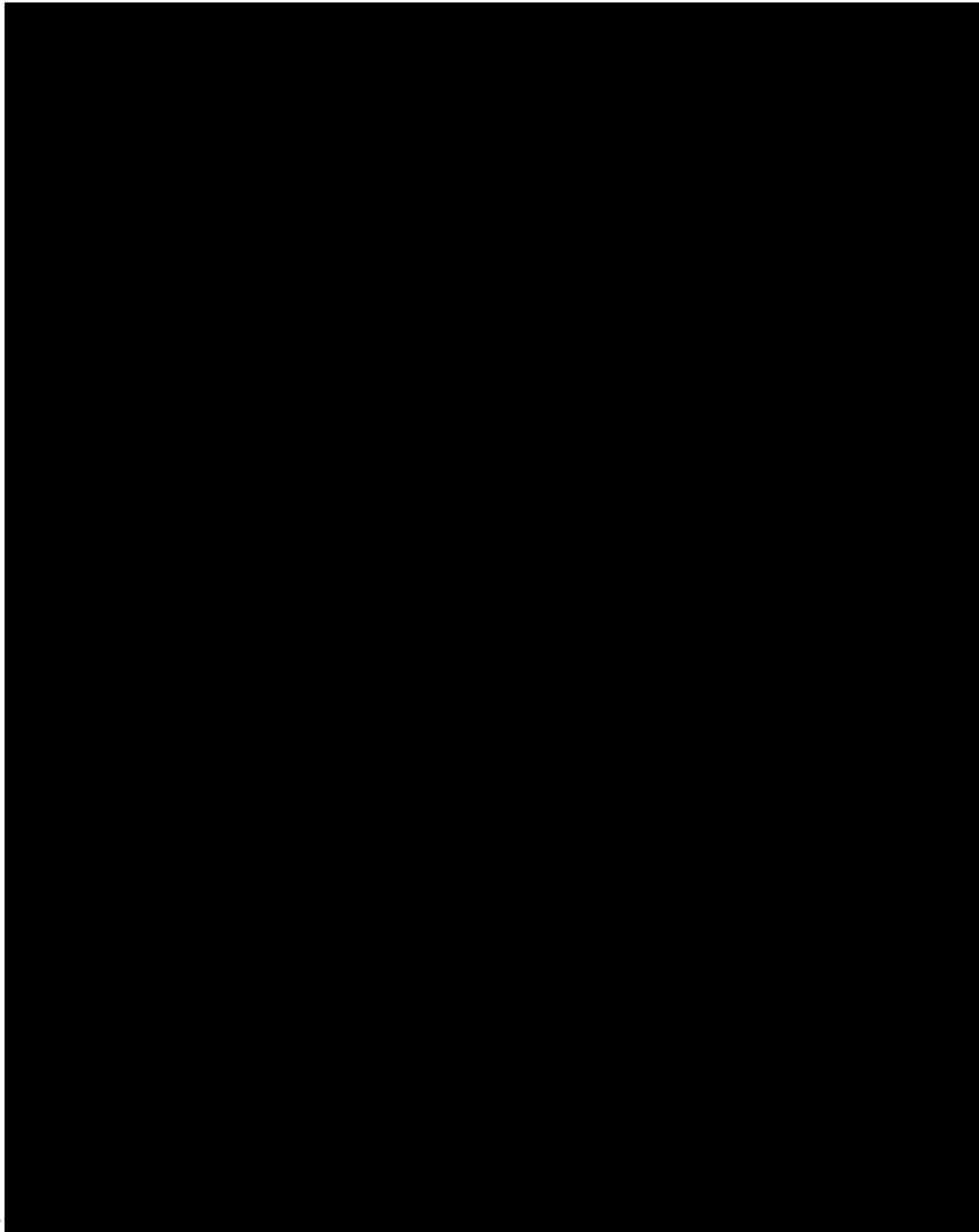
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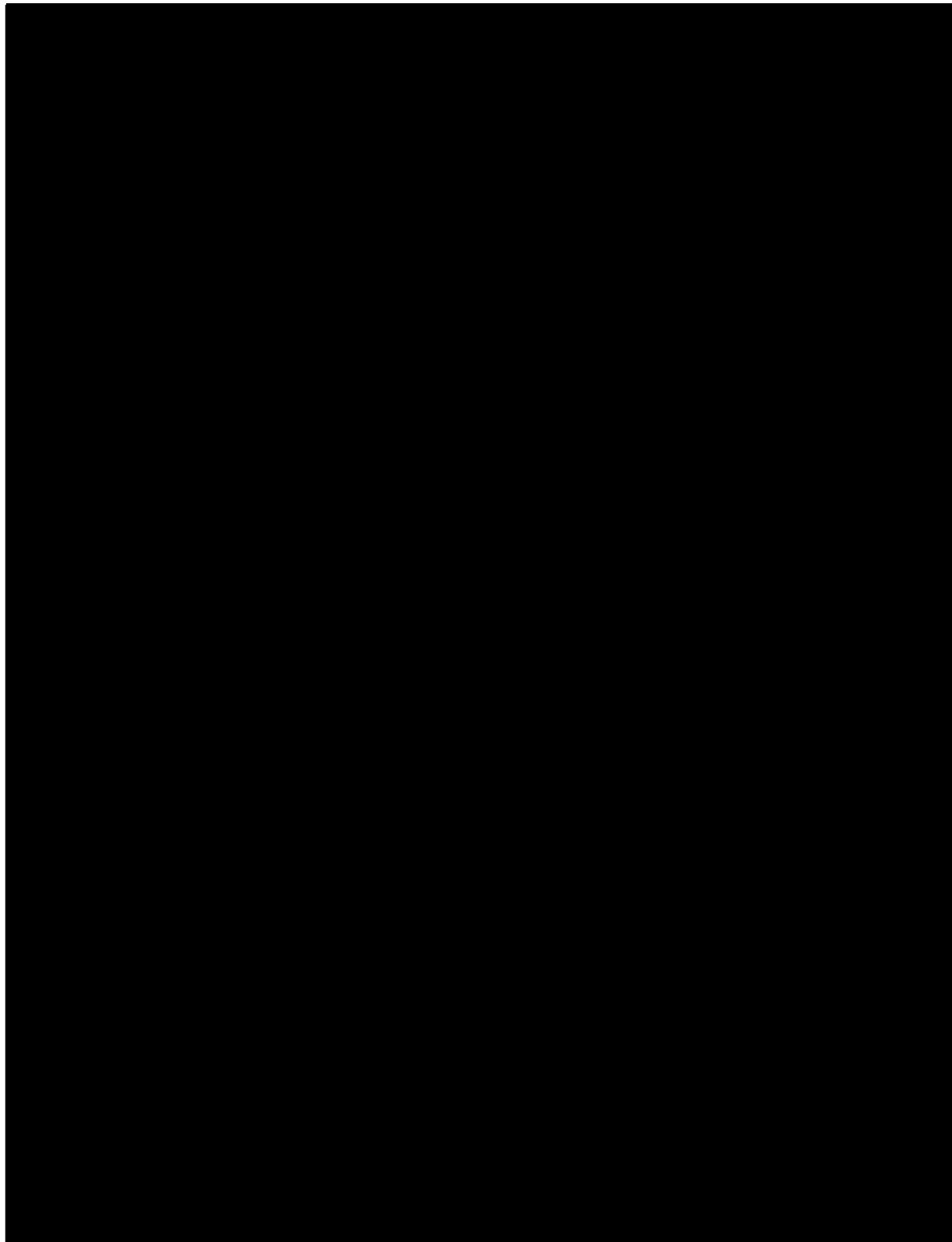
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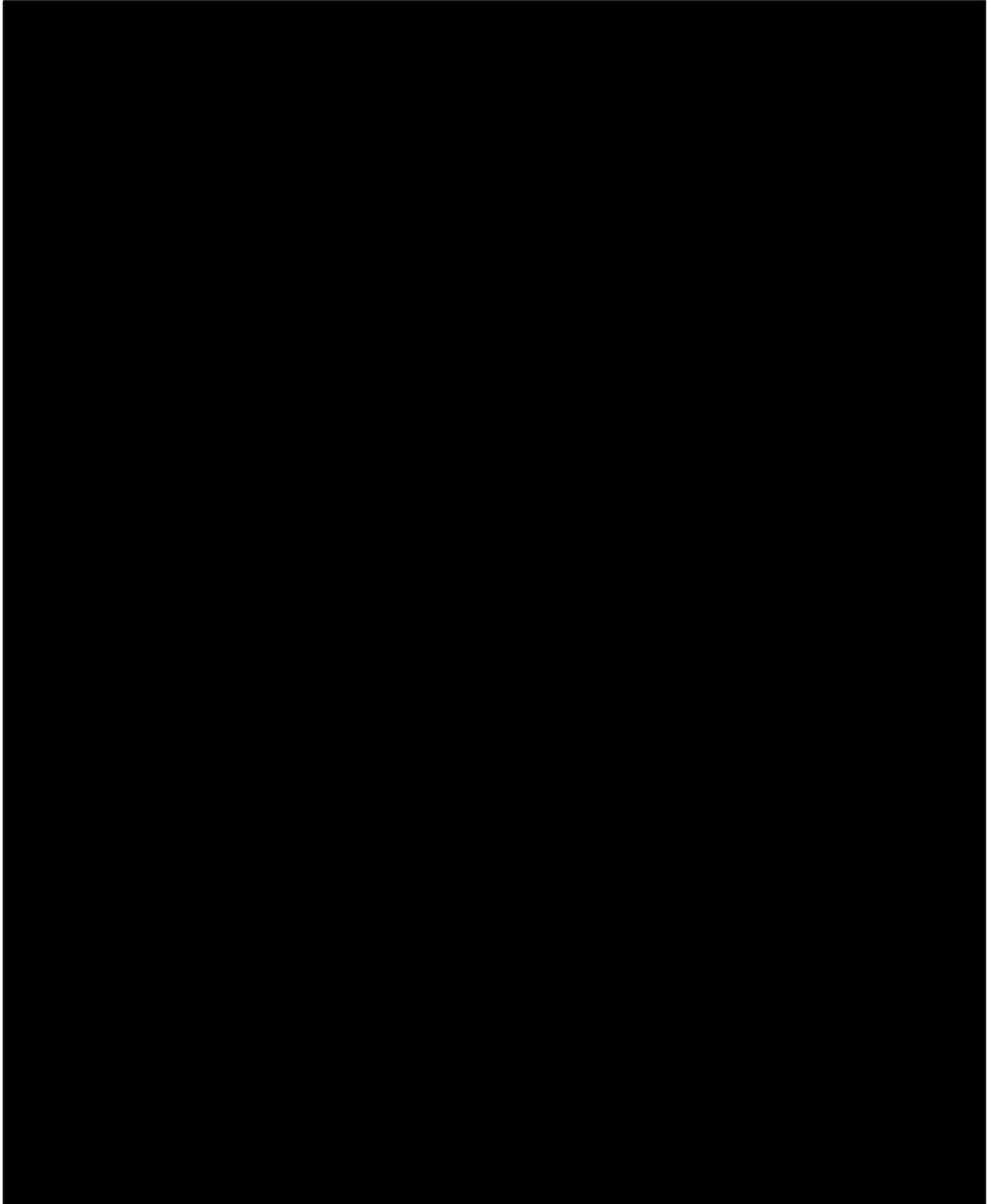
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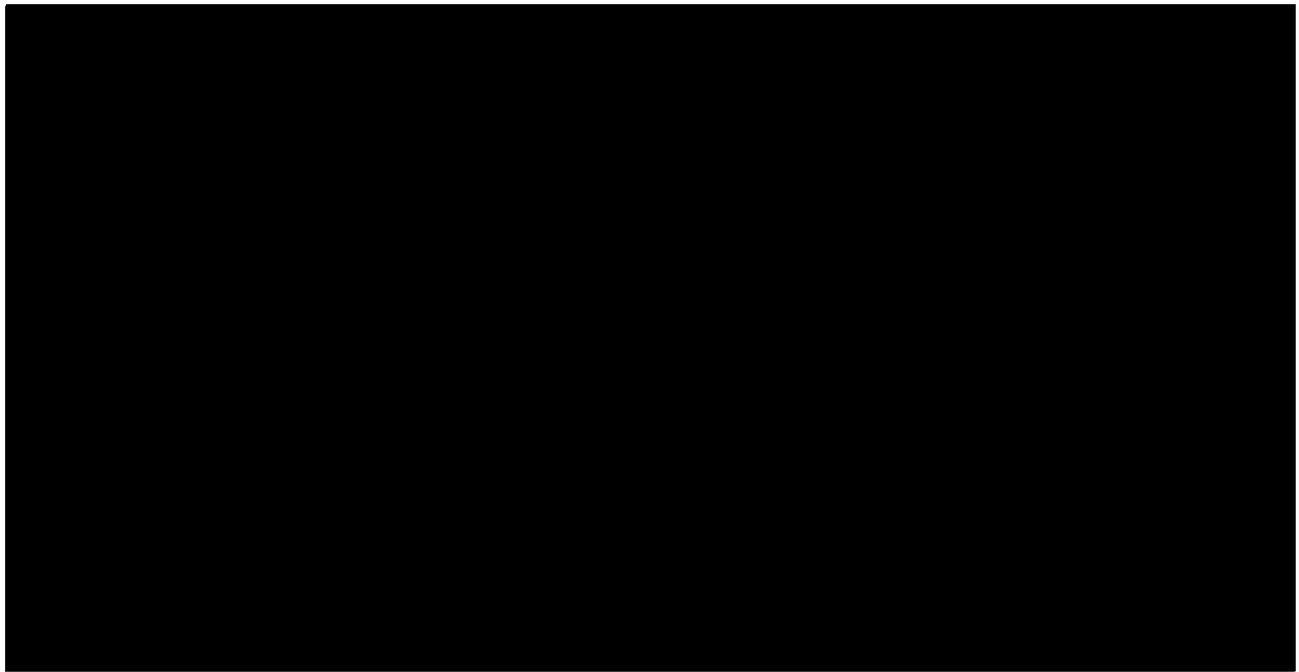
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APPENDIX I: CONFIDENTIALITY POLICY AND PROCEDURES

POLICY NUMBER 5.0: CALIFORNIA IMR AND IBR CONFIDENTIALITY AND RECORDS PROTECTION

AUTHOR: Compliance Officer

PURPOSE: This document contains standards for safeguarding privacy and protecting confidential information that MAXIMUS Federal reviews for the California Independent Medical Review (IMR) and Independent Bill Review (IBR) Projects.

SCOPE AND AUDIENCE: The privacy and confidentiality standards contained within apply to the MAXIMUS Federal California IMR and IBR Projects.

The audience for this policy is MAXIMUS Federal staff, associates and contractors associated with the MAXIMUS Federal California IMR and IBR Projects.

SUMMARY AND EXCLUSIONS: All confidential information received at MAXIMUS Federal in the course of the California IMR and IBR Projects will be maintained in accordance with the standards set forth herein.

REFERENCE CRITERIA: Reference materials for the standards contained herein: Utilization Review Accreditation Commission (URAC) Independent Review Organization (IRO) Standards, Federal law (e.g., HIPAA, Privacy Act) and regulations, Centers for Medicare and Medicaid (CMS) requirements, The California Insurance Information and Privacy Act, The California Confidentiality of Medical Information Act, Senate Bill 863, California Labor Code Sections 139.5, 4603.6, 4610.5, and 4610.6.

5.1 Policy Statement

MAXIMUS Federal will maintain confidentiality of information received for Independent Medical Review and Independent Bill Review. "Confidential information" includes:

- Medical Records, Including Notes, Reports, Orders, Test Results, Diagnoses, Treatments, Photographs, Videotapes, X-Rays, Billing Records, Results Of Independent Medical Examinations
- Personal Identifiers, Including Enrollee/Subscriber Names, Addresses, Social Security Numbers, Other Identifying Numbers, And All Other Data That Are Personally Identifiable
- Written Correspondence
- Electronically Transmitted Information
- Records Of Telephone Communications
- Computer reports and analyses

MAXIMUS Federal has established standards for protecting confidential information from unauthorized disclosure. MAXIMUS Federal will adopt the most stringent of Federal laws, state laws, or the National Commission on Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC) requirements. Protection of confidential information is incumbent upon all MAXIMUS Federal staff, associates and contractors, and every aspect of MAXIMUS Federal's Independent Medical Review and Independent Bill Review processes.

California Department of Industrial Relations



5.2 Duties of Staff, Associates and Contractors

All staff, associates, and contractors associated with the MAXIMUS Federal California Independent Medical Review and Independent Bill Review Projects will execute confidentiality agreements acknowledging that information relating to appeals reviewed in these projects is confidential, and agreeing to protect, physically, electronically, and otherwise, all confidential information considered in the course of business in accordance with MAXIMUS Federal policy.

5.3 Physical Security

MAXIMUS Federal's offices are located in secure buildings accessible only with key or code after regular business hours, offices are secured at all times, and entry to offices is restricted.

All case files received for Independent Medical Review and Independent Bill Review, including paper documents, films, written correspondence and any and all other documents added to the case file will be secured in file cabinets or records storage area when not under active review.

Documentation relating to active cases will be stored in a locked record's room, onsite at MAXIMUS Federal's office in Folsom, California, that will be secured outside of regular business hours.

All case file documentation will be scanned and uploaded into the case work flow management system for storage. After the IMR or IBR materials have been scanned and uploaded to the MAXIMUS Federal case work flow management system, they will be placed in the medical records room until the review process has been completed, at which time the materials will be destroyed by certified vendors. The electronic version of the IMR or IBR materials will be permanently retained in the MAXIMUS Federal case work flow management system.

Records will be secured through the implementation of security controls within the system of record for this scope of work. Our case work flow management system instantiation will have a number of access control safeguards implemented that include but are not limited to user authentication with password complexity requirements, session locking, application role-based access, audit and accountability controls, system use notifications and rules of behavior for every authorized user. Finally all authorized users of our case work flow management system will be subject to security controls as implemented by the system regardless of location.

All employees, associates, contractors and any other personnel authorized to handle or review confidential information are contractually prohibited via written agreement, including but not limited to a Business Associate Agreement from the unauthorized re-disclosure of that information.

5.4 Computer Systems Security

MAXIMUS Federal employs a secure "intranet" computer system protected from unauthorized access with multilevel security features ("firewall"); information relating to review of cases will be stored only in authorized company directories; automated systems track the location of case files; and computers will be "backed up" on a nightly basis to minimize loss.

California Department of Industrial Relations



Computer files will be closed when not under active review, and computers will be secured when the employee is not at work.

5.5 Release of Records

MAXIMUS Federal will release records pertaining to the IMR or IBR process or to an individual IMR or IBR case only in accordance with the terms of its contract with the Department of Industrial Relations.

5.6 Release of Information on the Telephone

MAXIMUS Federal staff shall release information by telephone only to (1) an injured employee who has requested IMR, (2) a physician who has joined with an injured employee in making an IMR request, (3) a provider that has requested IMR or IBR, (4) a claims administrator in an IMR or IBR case, or (5) an attorney or other representative or agent of any of the above parties. MAXIMUS Federal staff will establish the identity of a telephone caller by asking for (1) the DWC or MAXIMUS identifier for the case and (2) the names of the parties in the case. If there is any question about the identity of the caller, staff will consult the California IMR and IBR Project Manager for guidance.

Upon establishing that the caller has a right to information about a case, staff shall only provide factual answers regarding the following, where applicable: (1) date IMR or IBR request was filed; (2) dates that required or supporting documents were requested, due, and received; (3) date notice of ineligibility was sent, (4) date notice of assignment was sent; (5) date final determination was sent; (6) date case was closed. Staff shall document the release of any such information by telephone in the case work flow management system. Any inquiries that are not straightforward and not technical in nature shall be directed to the Division of Workers' Compensation (DWC).

5.7 Monitoring and Application

MAXIMUS Federal will monitor all aspects of operation to ensure that standards for privacy and confidentiality are adhered to consistently.

5.8 Enforcement

MAXIMUS Federal will enforce compliance with these confidentiality standards; this is the duty of the Compliance Officer, who delegates enforcement to Quality Assurance Auditors. The Compliance Officer and Quality Assurance Officers will routinely review policy and procedure, routinely and systematically conduct onsite reviews of all aspects of handling confidential information, oversee adherence to these policies, and remedy deviations and insufficiencies.

PROCEDURE 5.1: CALIFORNIA CONFIDENTIAL RECORDS PROTECTION

AUTHOR: California Project Manager

PURPOSE: This document contains procedures for safeguarding privacy and protecting confidential information that MAXIMUS Federal reviews in conduct of the California Independent Medical Review (IMR) and Independent Bill Review (IBR) projects.

SCOPE AND AUDIENCE: The privacy and confidentiality procedures contained herein apply to MAXIMUS Federal's California IMR and IBR projects. The audience for this policy is the California IMR and IBR staff, associates and contractors.

SUMMARY: Procedure documentation for privacy and confidentiality protection.

REFERENCE CRITERIA: Reference materials for the standards contained herein: Utilization Review Accreditation Commission (URAC) Independent Review Organization (IRO) Standards, Federal law (e.g., HIPAA, Privacy Act) and proposed regulations, Centers for Medicare and Medicaid (CMS) requirements, The California Insurance Information and Privacy Act, The California Confidentiality of Medical Information Act, Senate Bill 863, California Labor Code Sections 139.5, 4603.6, 4610.5, and 4610.6.

5.1 Confidential Records Protection

Procedures for ensuring that standards for privacy and confidentiality of information are met are set forth below.

5.2 Oversight

The MAXIMUS Federal Vice President, Operations will be responsible for assigning oversight duties to the California IMR and IBR Project Manager (Project Manager).

5.3 New Employees, Associates and Temporary Employees

MAXIMUS Federal will require new employees, associates and temporary employees to execute confidentiality agreements. The Project Manager will assure that such agreements have been executed and are on file.

5.4 Building Security

Building security policy and procedure is established and monitored by MAXIMUS Federal. MAXIMUS Federal California IMR and IBR Project staff and associates will comply with MAXIMUS Federal procedures.

5.5 Office Security

The Project Manager will routinely ensure that the office is secure at all times, and that identity of visitors is confirmed prior to admission. Only MAXIMUS Federal and MAXIMUS Federal staff and associates who have a legitimate need to conduct business, or designated representatives of the California Department of Industrial Relations will be admitted.

California Department of Industrial Relations



5.6 Records Storage Areas

Locked storage cabinets will be provided for on-site storage of all confidential case file information. The Project Manager and Administrative Assistant will routinely ensure that files are retained in the storage cabinets.

5.7 Secure Individual Work Areas

Files will not be left on individual work stations, unless the file is “active” and unless the staff or associate is present.

5.8 Additional Monitoring

MAXIMUS Federal will release records pertaining to the IMR or IBR process or to an individual IMR or IBR case only in accordance with the terms of its contract with the Department of Industrial Relations.

MAXIMUS Federal staff will establish the identity of a telephone caller by asking targeted questions related to the IMR or IBR case, including the caller’s name, relationship to the enrollee, affiliation, and reason for the inquiry. Upon establishing that the caller has a right to information about a case, the caller will be advised only of the status of a case. If there is any question as to the identity of the caller, staff will consult the Project Manager for guidance.

The Project Manager will regularly monitor Administrative Assistant and Appeal Officer Telephone response procedures to ensure that the identity of the caller is ascertained, that the reason for the inquiry is established, that the individual has a right to information about the case, and that only the status of the case is disclosed.

The Project Manager will regularly observe all aspects of operation to ensure compliance with standards for privacy and confidentiality.

APPENDIX J: CREDENTIALING POLICY AND PROCEDURES

Release Date:
12/31/2013

DOCUMENT INFORMATION AND APPLICATION	
Document Title: Medical Reviewer Credentialing	
Document Type: Procedure	Program(s): Medicare Appeals
Project(s): All Medicare QIC Projects, State Appeals	Document Owner: Director, Professional Relations

PURPOSE

This document describes the process for selecting, verifying and re-verifying professional credentials for MAXIMUS Federal Services' clinical reviewer panel.

DOCUMENT CONTENT

REQUIREMENTS OF THE PROCESS

The following contractual, regulatory, or standards requirements apply to this process:

SOURCE	LOCATION OR SECTION
ISO 9001:2008	7.4 – Purchasing
URAC Standards (Independent Review Organization)	CORE – 32 – Senior Clinical Staff Responsibilities
QIC Umbrella Statement of Work	IV.G.3 – Panel of Clinical Experts

TERMS AND DEFINITIONS

The following terms and definitions are covered in this document:

TERM OR ABBREVIATION	DEFINITION
Credential Committee	All applicable project Medical Directors, the QA Director and at least one MAXIMUS Federal Project Director/Project Manager.
Delegate (Credential Committee Meetings)	Members of the Credential Committee required to attend monthly credentialing meetings.
MPR	Acronym used for Medical Panel Review(er) or Medical Professional Review(er); a person that has been appointed to the credentialed panel or a medical review conducted by an appointed panel member.
Appoint/Appointed	Term used to describe the recommendation or final approval of a new candidate for membership on the MAXIMUS Federal Services Panel.

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TERM OR ABBREVIATION	DEFINITION
Terminate/Terminated	<p>Term used to describe the recommendation or final approval to remove an active member from the MAXIMUS Federal Services Panel who was not yet due to be re-credentialed (and whose resignation was <i>not</i> submitted voluntarily by the panel member).</p> <p>Termination is automatic if documented sanctions or violations of any of the following criteria are discovered:</p> <ul style="list-style-type: none"> • Active, valid, unrestricted license in the state of • practice • ABMS or American Osteopathic Recognized Board certification/ Board eligible • Valid DEA (if applicable) • No history of any disciplinary actions • Malpractice insurance coverage enforce <p>A termination may be considered for chronic quality and timeliness issues. A termination cannot be rendered solely due to lack of assigned cases.</p>
Deny Appointment/Re-Appointment	<p>Term used to describe the recommendation or final approval to reject a new candidate or current panel member due to be re-credentialed.</p> <p>A denial is automatic if documented sanctions or violations of any of the following criteria are discovered:</p> <ul style="list-style-type: none"> • Active, valid, unrestricted license in the state of • practice • ABMS or American Osteopathic Recognized Board certification/ Board eligible • Valid DEA (if applicable) • No history of any disciplinary actions • Malpractice insurance coverage enforce <p>A denial may be considered for chronic quality and timeliness issues. A denial cannot be rendered solely due to lack of assigned cases.</p>
Resigned	<p>Term used to identify a MAXIMUS Federal Services Panel member that has voluntarily asked to be removed from the panel of their own accord, or chosen not to seek re-credentialing.</p>
Suspend/Suspended	<p>Term used to change a current panel member's status or privilege from active to inactive. A suspension may be taken due to an investigation, missing or invalid credentialing documentation, or</p>

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	at the request of the panel member (i.e. sabbatical, vacation, etc.). A suspension shall be temporary in nature and should be resolved as expeditiously as possible following conclusion of the investigation.
Pend/Pending	Term indicating that no recommendation was made nor a final approval given regarding a MAXIMUS Federal Services Panel member; action is tabled until the next committee meeting. A pending status may be necessary if additional information is needed or required.

THE CREDENTIALING COMMITTEE

1. MAXIMUS Federal Services has determined Credential Committee membership shall include the follow:

- An employed Medical Director representing each project utilizing panel resources

NOTE: If a Medical Director employed through a MAXIMUS Federal subcontractor, then he/she is excluded from Committee membership.

- An employed Project Director or Project Manager representing each project utilizing panel resources
- The Quality Assurance Director representing the quality management program
- The Director of Professional Relations
- A Legal Counsel

NOTE: Legal counsel for the committee may be provided by a current committee member with adequate legal qualifications, such as J.D.

COMMITTEE MEETING DELEGATES

The Credentialing Committee convenes monthly based on the following criteria:

- Project Medical Directors, with voting rights
- At least one Project Director or Project Manager, with voting rights
- The Quality Assurance Director appointed to an unlimited term without voting rights
- A Legal Counsel representative to the Committee without voting rights

NOTE: This only applies if a separate Legal Counsel is assigned to the committee.

- The Director of Professional Relations appointed to an unlimited term without voting rights
 - Voting/non-voting privileges of the Committee Meeting delegates is intended to ensure objectivity

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INITIAL RECRUITMENT AND APPLICATION PROCESS

The Director of Professional Relations shall:

- Conduct panel member recruiting efforts based on need, requests, recommendations or project directives
- Send application forms to interested candidates
- Create and maintain an electronic file for credentialing of each potential candidate throughout the process
- Reviews a submitted application and all relevant supporting documentation that must accompany it:
 - Malpractice insurance certificate
 - DEA certificate (if applicable)
 - Copies of medical professional licenses
 - Specialty board certificates (if applicable)
 - Delineation of hospital privileges (if applicable)
 - Current CV
- Request in writing, any missing or omitted supporting documents from the applicant
- Verifies applicant credentials for accuracy and compliance
- Conducts an investigation of any identified discrepancies
- Inform and offer the applicant an opportunity to respond and resolve any issue that may prevent appointment to the panel

If the verification	Then...
Is not completed within 180 days...	Obtains refreshed Attestation Form from applicant or recommends dismissal.
Is successful...	Recommends applicant to Credential Committee.
Is not completed successfully...	Rejects and notifies candidate.
Identifies a discrepancy...	Works to resolve the discrepancy.

ONGOING REVIEW OF CREDENTIALS AND SANCTIONS

The Director of Professional Relations shall:

- Maintain and store a copy of all panel members' files, to include:
 - Completed application
 - All documents submitted with the application
 - Documentation of credential verification
 - Results of all database queries

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- Correspondence applicable to the current credentialing period between the consultant and MAXIMUS Federal Services
- Review the MPR Database monthly to identify professional licenses, DEA certifications, and board certifications that will expire within 30 days

The Credentialing Department shall:

- Obtain online primary source verification of all documents that are about to expire, or where the panel member indicates disciplinary action or a change in a credential
- Add updated credentials to panel members' file
- Update new expiration date in MPR database
- Verify a panel member's license standing and absence of sanctions at least quarterly through relevant **State** licensing web sites
- Verify panel member's **Federal** standing and absence of sanctions at least quarterly through the Office of the Inspector General (OIG) query

If the credential and sanction check...	Then...
Is satisfactory...	Updates panel member's records
Reveals a sanction, loss of license, or loss of privilege...	1. Suspend further case assignment and notify project Panel Schedulers; 2. Notify the Director of Professional Relations and the Panel Medical Director for referral to the Credential Committee.

The Director of Professional Relations shall:

- Refer sanctions, loss of license, and loss of privileges to the Credential Committee Meeting delegates
- Update the MPR database for all credentialing actions, and maintain all credentialing records

RE-CREDENTIALING PANEL MEMBERS

The Director of Professional Relations shall:

- Review the MPR Database monthly to identify panel members whose 3-year appointments will expire within 90 days
- Send a letter to the panel member indicating that re-appointment is due, and provide a copy of the original application for the panel member to make any changes
- Offer approved panel members the opportunity for re-appointment and provide a copy of their consultant application for revisions

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If re-appointment is...	Then...
Requested...	Proceeds to reviewing the application.
Not responded to...	Makes an additional attempt(s) to determine panel member interest
Declined by the panel member...	Panel membership allowed to expire, and is dismissed from panel as a resignation.

- Verify applicants credentials for accuracy and compliance

If verification...	Then...
Finds no issues...	Proceeds according to – Committee Meetings section
Identifies a discrepancy...	Resolves as in section – Initial Recruitment and Application Process.

COMMITTEE MEETINGS: REVIEW OF NEW PANEL APPOINTMENTS OR RE-CREDENTIALING EXISTING CANDIDATES

The Director of Professional Relations shall:

- Schedule and convene a regular Credentialing Committee Meeting
- State criteria at each meeting that all candidates must satisfy for a panel appointment:
 - Active, valid, unrestricted license in the state of practice
 - ABMS or American Osteopathic Recognized Board certification/Board eligible
 - Valid DEA (if applicable)
 - No history of any disciplinary actions
 - Malpractice insurance coverage enforce
- Provide a summary of compliance to these requirements to the Committee Meeting Delegates for each candidate presented
- Provide a summary of any additional documented adverse findings or issues that reflect positively or negatively upon a candidate. These may include the following:
 - Accuracy of signed and submitted credentialing documentation, including compliance with the terms of the Consultant Agreement
 - Willingness to accept assignments
 - Appropriate conduct when working with MAXIMUS Federal Services staff
 - News releases or articles
 - Feedback or complaints
 - Results of internal work measures (quality, timeliness, productivity

The Credentialing Committee shall:

- Review the information presented for each candidate appearing on the agenda

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- Make recommendations to appoint, re-appoint, deny appointment, suspend, pend, or terminate individual candidates:
 - Individual delegate recommendations should be based first on satisfaction of the criteria stated above, and second by consideration of any additional findings presented by the Director of Professional Relations
 - Recommendations from the meeting will be determined by majority opinion

The Director of Professional Relations shall:

- Document minutes of the completed meeting and distribute to committee members. Meeting minutes shall include the following:
 - Recommendations for each presented candidate

POST-COMMITTEE ACTIONS

The Director of Professional Relations shall:

- Send notice of appointment, a consultant agreement and required tax forms to appointed candidates or send notice or rejection to denied applicants
- Obtain Director of Federal Contracts' signature to execute the consultant agreement
- Forward a copy of required tax forms to the Finance Director
- Provide the applicant a copy of the executed consultant agreement
- Contact the Training Department for user ID and password(s) to access Data Security Training
- Update and store all related credentialing records
- Communicate the results of Committee Meeting actions and new consultants to all Panel Schedulers
- Notify project Medical Directors and Panel Schedulers in the event an adverse change in licensure and certification for a peer reviewer, that new assignments be suspended and previous assignments (if applicable) for the affected period be reviewed for quality

The Medical Director shall:

- Pull any completed peer reviews for the period in question in the event of notification due to adverse changes in licensure and certification
- Review such appeals for quality and compliance to all peer reviewer requirements, and submit for re-review to a new peer reviewer as needed

NOTE: In some instances, the Medical Director may end up being the resource that completes the new peer review.

PROVISIONAL PANEL APPOINTMENTS

The Director of Professional Relations shall:

- Handle situations or areas where panel membership is deficient for a required review
- Identify a potential candidate for provisional appointment to the panel

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- Verify the candidate's credentials:
 - License
 - AMA profile
- If the candidate is designated for assignment to approved Federal agency projects, query the National Practitioner Database (NPDB)

NOTE: NPDB queries cannot be used for candidates assigned solely to non-Federal agency or other client work.

- Submits provisional recommendation to the Medical Director

The Medical Director shall:

- Review the provisional recommendation
- Evaluate any adverse findings or negative evidence presented by the Director of Professional Relations
- Make a final determination on the application

If the Medical Director...	Then...
Rejects the candidate's application...	A rejection notice is sent by the Director of Professional Relations to the applicant.
Accepts the application...	Provisional appointment is granted. The Director of Professional Relations proceeds to post committee actions and completes all required documentation

The Director of Professional Relations shall:

- Send provisionally credentialed appointees a contract and tax form

TAKING CORRECTIVE ACTION FOR ADVERSE FINDINGS (LICENSURE, PRIVILEGES, SUSPENSION OR TERMINATION)

The Credentialed Peer Reviewer shall:

- Per executed Consultant Agreement, notify the Director of Professional Relations or Credentialing Department regarding any adverse change in licensure, certification or privileges, and excuse himself/herself from existing or future assignments pending the outcome of the credential committee's actions

The Director of Professional Relations shall:

- Notify the Panel Schedulers to suspend further assignments to the affected panel member

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- Notify the affected project Medical Directors of the adverse change in status, and the effective date(s) of the status change

The Medical Director shall:

- Determine what assignments were made to the panel member covering the period in question, and determine what impact the adverse status change has on the viability of any completed reviews
- In consultation with the Project Director and/or other stakeholders (i.e. client, appellant, parties to the appeal), determines whether a new review is needed and proceeds accordingly

MEDICAL DIRECTOR LICENSURE CORRECTIVE ACTION

The Medical Director shall:

- Per Employment Agreement, notify the Director of Professional Relations regarding any adverse change in licensure, certification or privileges, and excuse himself/herself from any existing or future assignments pending the outcome of the credential committee's actions

The Project Director shall:

- Designate an interim Medical Director, should the Medical Director's license and certification be subject to an adverse action, until the matter has been resolved through credentialing committee and/or Human Resources
- Ensure that all pending and future Medical Director cases are reassigned
- If necessary, assign the interim Medical Director to review any cases completed by the Medical Director during the affected period of adverse change in licensure and certification, to determine whether a re-review is appropriate and necessary

APPENDIX K: TRAINING MATERIALS

Independent Medical Review
State of California, DIR, DWC



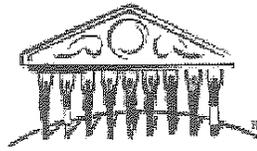
Appendix K. Training Materials

Provided in this section are the Independent Medical Review training materials.

- Training Instructions for Medical Review
- Course 1: General Information about IMR
- Course 2: MTUS Definition and the Hierarchy of Evidence
- Course 3: Completing an Independent Medical Review
- California DWC – Overview and Q&A for Physician Reviews

TRAINING INSTRUCTIONS FOR MEDICAL REVIEW

MAXIMUS
Federal Services



Re: Training Instructions for Medical Review

Dear <Insert Doctor's Name>;

Thank you for assisting us and the workers of California by agreeing to perform Independent Medical Reviews. Please use the following information for making decisions and completing the forms.

You receive the Review Packet on that same day that you accept a case. The packet contains:

1. The Independent Medical Review application;
2. the Utilization Review Denial letter from the Claims Administrator;
3. Documents the Claims Administrator used as the basis of denial or modification;
4. Medical Records available to the Claims Administrator;
5. Other relevant documents from the Employee, Applicant Attorney, or the Primary Treating Provider, if any, and;
6. If this is your first review for us, the Medical Treatment Utilization Schedule.

To help you through the review process, we have assembled this Training document so that you can prepare for reviewing a case. In this packet you will find the documents listed below. Clicking on a blue hyperlink in the online version takes you to the document.

1. [Attachment A](#) – General Directions for the IMR Program
2. [Attachment B](#) – Completing a Medical Review Form (MPR) showing a sample copy of the MAXIMUS Medical Provider Review Form (and a sample Attestation letter) including general instructions on how to craft your description of the:
 - a. Employee's medical condition,
 - b. Clinical findings relevant to the Disputed Issue, and
 - c. Rationale or reasoning leading to your decision;
3. [Attachment C](#) – Hierarchy Of Evidence-Basis For Decision Making;
4. [Attachment D](#) – Frequently Asked Questions (FAQs)

Thank you,


MAXIMUS
Paul Manchester, MD, MPH
Associate Medical Director
625 Coolidge Drive | Suite 100 | Folsom, CA 95630
916.673.4483 Office | 408.930.4255 Cell
PaulManchester@maximus.com

ATTACHMENT A – DIRECTIONS FOR THE IMR PROGRAM

Process of Accepting a Case

A Panel Scheduler will contact you through the Expert Gateway (email to you), Movelt (email to you), direct email, or phone call. The Panel Scheduler will give a brief description of the case and tell you whether the case is Expedited or Standard.

- Expedited Cases are due back within 24 hours
- Standard Cases are due back before 8 AM of the same day the next week.
 - For example, if you accept the case Tuesday, it is due to us no later than 8 AM the following Tuesday.

We mitigate against potential Conflict of Interest by not asking you to review a case within your same geographic area, or if you have a professional or personal connection with the Interested Parties. If you accept a case and find that you do have a conflict, please let the panel scheduler know as soon as possible.

Content of Packet Provided to You after Acceptance of Each Review

After you accept a case, you will receive the packet the same day. As stated in the welcome letter, this packet contains:

1. The Independent Medical Review application;
2. the Utilization Review Denial letter from the Claims Administrator;
3. Documents the Claims Administrator used as basis of denial or modification;
4. Medical Records available to the Claims Administrator;
5. Other relevant documents from the Employee, Applicant Attorney, or the Primary Treating Provider, if they did provide any, and;
6. If this is your first review for us, the Medical Treatment Utilization Schedule.

Completing the Medical Professional Review Form

This is covered in detail in [Attachment B](#).

If No Medical Records Are Provided

Please do not review the case. Return the case to the Scheduler who sent it to you.

The Case Summary

You will be asked to provide a clinical summary, diagnosis and findings relevant to the issues at dispute. The Case Summary need not be lengthy but should provide enough information to allow a reader to understand the clinical scenario and reasons why the disputed service was prescribed. For medication requests, your summary should provide a medication history including the duration of using the medication, and any results of use as documented in the medical reports. For other requests, your summary should include the clinical findings relevant to the disputed request. For example, your summary for a requested spine MRI should include

results of any prior spine imaging, any prior spine surgery, and specific signs and symptoms relevant to the spine.

How you may state your decision

Your decision must be that the disputed service “is” or “is not” medically necessary. Modifications of requests are not an option for IMR. “May” be medically necessary is also not an option. Your decision should be based on the medical necessity for the request as stated in its entirety. If the prior Utilization Review rendered a “modified” decision, your decision will still need to address the medical necessity for the request as stated in its entirety, with no consideration of the prior modification.

For example, if the disputed service is 24 visits of PT after surgery, your review should reference the MTUS recommendations and the necessity for 24 visits, not some portion of the 24 visits. You are asked to make your decision based on the records that we send you, even if you would like to have more extensive records.

What if You Have Questions

Contact the Panel Scheduler who assigned the case to you with any procedure questions.

Contact the Medical Director, Paul Manchester, MD, MPH, PaulManchester@maximus.com
Office: 916.673.4483 Cell: 408.930.4255., if you have questions regarding guidelines, medical analysis, or how to document your decision.

Process of Being Paid

When you return the completed Medical Professional Review Form, the completed Attestation Page will act as your invoice. MAXIMUS Federal Services reimburses independently contracted reviewers twice a month, with the intention of payment being received within 30 days of the day your Medical Professional Review Form is returned.

ATTACHMENT B: COMPLETING A MEDICAL REVIEW FORM (MPR)

1. The return date, type of case (standard or expedited) and the case number on the first page of the MPR will be filled in when it is sent out to you. You need to fill in your name and
2. Per the IMR contract with the State: "Each reviewer shall provide an individual assessment of the case that sets forth the reviewer's professional analysis and determination on whether the disputed medical treatment is medically necessary."

"Each analysis shall cite the injured employee's:

Medical condition,

Relevant documents reviewed in the process of making the determination,

Relevant findings associated with the standards to support the determination, (The above report requirements are to be in the Case Summary, on page one of the MPR. The reviewer should be able to provide the required case summary in about one paragraph.) and,

"Reasons supporting the analysis." (This is the rationale portion of your review, and should include direct references to the clinical findings in light of the applicable guidelines and medical evidence. The rationale for each of the disputed issue decisions should require no more than one paragraph.)

3. You are to address each Issue of Dispute separately, make an analysis, support your findings, and identify the evidence basis of your decision.
4. A section of the form for each Issue of Dispute will be included with the MPR.
5. Some areas of the MPR contain boxes to check. Please check all appropriate boxes.
6. Some areas of the MPR contain what appear to be gray boxes.
 - a. They are actually text fields.
 - b. Each gray box describes the type of information you are to enter.
 - c. Click on the description in the gray box and type your text into these boxes.
 - d. They expand with your key strokes to accommodate however much text you need to enter.
 - e. Entering text will overwrite the instructions showing in the gray box.
7. If you do not return a complete MPR (including the Attestation Page signed and dated) you will not be paid until all the signed documents are received.
8. Please do not pdf your MPR.

Note: Please see sample MPR starting on next page. In this sample, you will find two copies of the first page and two copies of the second page and two copies of the last page. The first of each set is the blank sample with instructions; the second copy is a sample which has been filled in to show you how information should be entered.

**MEDICAL PROFESSIONAL REVIEWER'S DECISION REPORT FORM
CALIFORNIA WORKERS' COMPENSATION
INDEPENDENT MEDICAL REVIEW**

**DATE AND TIME
DUE BACK TO
MAXIMUS:** January 14, 2014
08:00 AM (PST)

This information will be filled in for you.

Standard Medical Necessity

Medical Professional Reviewer: <MPR First Name Last Name, MPR Degree>

MAXIMUS Case Number: CM13-1234567

This information you need to fill in.

Please provide a one paragraph summary of the relevant clinical issues with a diagnosis or diagnoses relevant to the disputed issue(s). Your summary may be posted on the DWC website for public viewing so please avoid any inflammatory language or disparaging remarks about any aspect of the medical care or claims processes.

<Insert one paragraph summary here>

This summary must be supplied by you, the Physician Reviewer. It should be concise and in layperson's terms. This information will be sent out to the claims administrator and either the injured worker or the injured worker's attorney. It will also be posted on the DWC's website (with Personal Identification Information ((PII)) redactions)

Text with a gray background is an insert field. Tabbing through the document takes you to each field that requires information. The field allows you to enter as much text as you want into the gray area moving other text farther out in the document if necessary. It also erases the comment that informs you what sort of information should be entered.

**MEDICAL PROFESSIONAL REVIEWER'S DECISION REPORT FORM
CALIFORNIA WORKERS' COMPENSATION
INDEPENDENT MEDICAL REVIEW**

DATE AND TIME DUE BACK TO MAXIMUS:	January 14, 2014 08:00 AM (PST)
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Standard Medical Necessity

Medical Professional Reviewer:

Jake Tyson, MD

MAXIMUS Case Number:

CM13-1234567

Please provide a one paragraph summary of the relevant clinical issues with a diagnosis or diagnoses relevant to the disputed issue(s). Your summary may be posted on the DWC website for public viewing so please avoid any inflammatory language or disparaging remarks about any aspect of the medical care or claims processes.

The injured worker is 48 year old male who reported low back pain after lifting a barrel on 6/15/2010. His symptoms were confined to the low back without radiation to the extremities. He was treated with conservative methods during the first month after injury. Treatment included 10 visits of PT, daily Vicodin, daily Flexeril, and naproxen as needed. He was released to modified work, with limitations on lifting and stooping. Lumbar radiographs showed mild degenerative changes. During the fifth week after injury, the treating physician noted ongoing back pain, inability to increase activities at work, an overall lack of improvement, and ongoing use of all medications. He prescribed a lumbar MRI out of concern for a possible herniated disk causing ongoing back pain. There were no neurological deficits documented and the physical exam was notable only for local tenderness and limited range of motion.

MEDICAL PROFESSIONAL REVIEWER TO COMPLETE

1. Decision for Lumbar MRI:

Evidence-Basis for the Decision:

Evidence-Based Criteria Cited By Expert Reviewer:

MTUS Guidelines

- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) <Insert Chapter>, page(s) <Insert Page Number or Numbers>
- Chronic Pain Medical Treatment Guidelines <Insert Section>, page(s) <Insert Page Number or Numbers>
- Acupuncture Medical Treatment Guidelines
- Post-Surgical Treatment Guidelines <Insert Title of Surgery>, page(s) <Insert Page Number or Numbers>

Other Guidelines

- Official Disability Guidelines (ODG) <Insert Section (for example Knee)>, <Insert Topic (for example Total Knee Arthroplasty)>
- Other Medical Treatment Guideline or Medical Evidence: <Insert Other Basis/Criteria>

b) After a professional and thorough review of the documents, my analysis is that the above listed issue:

- Is/was NOT medically necessary
- I am reversing the prior UR decision. My decision is that the issue listed above IS medically necessary. The reasons for reversing the prior UR decision are listed in the rationale below.

c) My rationale for why the requested treatment/service is or is not medically necessary:

Insert Rationale

As with the Case Summary, this rationale should be concise and in layperson's terms. This information will be sent out to the claims administrator and either the injured worker or the injured worker's attorney. It will also be posted on the DWC's website (with Personal Identification Information ((PII)) redactions)

The second page of the document will list the first issue at Dispute for this review. There may only be one dispute, there may be many more. Each will have its own page for you to fill out.

Reviewer must fill in this information. First check the criteria used for your decision. Insert the Chapter or Section and the page number that you used from the guidelines for your decision.

Then check the box stating your decision as "not medically necessary" or as reversing the Claims Admin's decision.

Last but not least, include the rationale used in the making of your decision regarding medical

MEDICAL PROFESSIONAL REVIEWER TO COMPLETE

1. Decision for Lumbar MRI:

a) Evidence-Basis for the Decision:

Evidence-Based Criteria Cited By Expert Reviewer:

MTUS Guidelines

- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) 12, page(s) 304, 309
- Chronic Pain Medical Treatment Guidelines <Insert Section>, page(s) <Insert Page Number or Numbers>
- Acupuncture Medical Treatment Guidelines
- Post-Surgical Treatment Guidelines <Insert Title of Surgery>, page(s) <Insert Page Number or Numbers>

Other Guidelines

- Official Disability Guidelines (ODG) Low Back, Discography
- Other Medical Treatment Guideline or Medical Evidence: updated ACOEM Guidelines, Low Back, Discography, page 66 <Insert Other Basis/Criteria>

b) After a professional and thorough review of the documents, my analysis is that the above listed issue:

- Is/was **NOT** medically necessary
- I am reversing the prior UR decision. My decision is that the issue listed above **IS** medically necessary. The reasons for reversing the prior UR decision are listed in the rationale below.

c) My rationale for why the requested treatment/service is or is not medically necessary:

Per the MTUS-ACOEM Guidelines, chapter 12, recent studies do not support discography as a preoperative indication for either an IDET procedure or a fusion. Table 12-8 states that discography or CT discography is "not recommended." Although the 2nd edition of the ACOEM Guidelines does provide very limited endorsement for discography for some patients for which fusion is planned, it notes the necessity to review the latest studies. The updated ACOEM Guidelines and ODG review the latest studies and find no good support for discography. Based on guidelines and a review of the evidence, discography is not medically necessary.

REVIEWER'S ATTESTATION

[If you cannot attest to any of the following, please contact MAXIMUS immediately.]

Reviewer's Attestation I attest that I:

- **Am Board Certified in:** ~~BOARD CERTIFICATION(S)~~ Have a subspecialty Certificate in: ~~SUBSPECIALTY CERTIFICATE(S)~~
- **Have at least five years of experience** providing direct patient care;
- **Am in active clinical practice** at least 24 hours a week;
- **Have expertise** in the same or similar specialties and subspecialties that evaluate or treat the medical condition at issue or provide the type of medical treatment in dispute;
- **Am familiar with guidelines and protocols** in the area of the treatment under review;
- **Do not have an actual or potential material professional affiliation¹, material familial affiliation², or material financial relationship³** with regard to any of the following parties involved in this dispute, including but not limited to:
 - o The employer, workers' compensation insurer, claims administrator, or utilization review organization or an officer, director, or management employee of same;
 - o The Medical Provider Network of the insurer or claims administrator, unless at an academic medical center under contract to the insurer or claims administrator to provide services to employees and the center is neither going to provide the service nor is it the developer or manufacturer of the proposed treatment;
 - o The physician, the physician's medical group, the independent practice association (IPA) proposing the treatment, or the institution at which the treatment would be provided;
 - o The developer or manufacturer of the principle drug, device, procedure, or other therapy at dispute;
 - o The injured employee, the injured employee's immediate family, or the worker's representative; and/or,
 - o Any attorney or law firm representing the worker, employer, claims administrator or insurance company.
- **Have not had a change in my standing and status** in the practice of medicine since submission of information to MAXIMUS for credentialing, and specifically that I have not been subject to any disciplinary action by any health care institution, licensing authority, professional society, or government health care program;
- **Received and reviewed** all pertinent medical records and other appropriate information relevant to the case and listed in the Decision Report Form;
- **Found the record complete**;
- **Have rendered** an independent and impartial decision based upon application of relevant medical standards and medical scientific evidence to a California Workers' Compensation Independent Medical Review;
- **Have not accepted** compensation for review activities dependent in any way on the specific outcome of the case;
- **Do not have in my possession** copies of any case file documents associated with this review or will return the case file and all protected health information within three days of the date of this review;
- **Have affixed my signature** to this Attestation. If my case decision has been transmitted electronically to MAXIMUS Federal Services, the electronic signature that appears on my decision shall have the same validity and effect as if I had affixed my original signature by hand to this document.

Signature: _____

Date: _____

Name _____

Case Number: **CM13-1234567**

1 "Material professional affiliation" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any of the parties involved in this dispute.
 2 "Material familial affiliation" means any relationship such as a spouse, child, parent, sibling, spouse's parent, or child's spouse with any of the parties involved in this dispute.
 3 "Material financial affiliation" means any financial interest of more than 5 percent of total annual revenue or income from any of the parties involved in this dispute.

This ends
Dispute
information
and starts
Attestation for
all Disputes
information.

Reviewer must
fill in the
following
information.

Reviewer must
fill in the
following
information.

Case
number is
will be
filled in.

REVIEWER'S ATTESTATION

[If you cannot attest to any of the following, please contact MAXIMUS immediately.]

Reviewer's Attestation I attest that I:

- Am Board Certified in: PM&R; Have a subspecialty Certificate in: <SUBSPECIALTY CERTIFICATE(S)>
- Have at least five years of experience providing direct patient care;
- Am in active clinical practice at least 24 hours a week;
- Have expertise in the same or similar specialties and subspecialties that evaluate or treat the medical condition at issue or provide the type of medical treatment in dispute;
- Am familiar with guidelines and protocols in the area of the treatment under review;
- Do not have an actual or potential material professional affiliation¹, material familial affiliation², or material financial relationship³ with regard to any of the following parties involved in this dispute, including but not limited to:
 - The employer, workers' compensation insurer, claims administrator, or utilization review organization or an officer, director, or management employee of same;
 - The Medical Provider Network of the insurer or claims administrator, unless at an academic medical center under contract to the insurer or claims administrator to provide services to employees and the center is neither going to provide the service nor is it the developer or manufacturer of the proposed treatment;
 - The physician, the physician's medical group, the independent practice association (IPA) proposing the treatment, or the institution at which the treatment would be provided;
 - The developer or manufacturer of the principle drug, device, procedure, or other therapy at dispute;
 - The injured employee, the injured employee's immediate family, or the worker's representative; and/or,
 - Any attorney or law firm representing the worker, employer, claims administrator or insurance company.
- Have not had a change in my standing and status in the practice of medicine since submission of information to MAXIMUS for credentialing, and specifically that I have not been subject to any disciplinary action by any health care institution, licensing authority, professional society, or government health care program;
- Received and reviewed all pertinent medical records and other appropriate information relevant to the case and listed in the Decision Report Form;
- Found the record complete;
- Have rendered an independent and impartial decision based upon application of relevant medical standards and medical scientific evidence to a California Workers' Compensation Independent Medical Review;
- Have not accepted compensation for review activities dependent in any way on the specific outcome of the case;
- Do not have in my possession copies of any case file documents associated with this review or will return the case file and all protected health information within three days of the date of this review;
- Have affixed my signature to this Attestation. If my case decision has been transmitted electronically to MAXIMUS Federal Services, the electronic signature that appears on my decision shall have the same validity and effect as if I had affixed my original signature by hand to this document.

Signature:

John Tyson

Date:

1/13/14

Name

Duke Tyson

Case Number:

CM13-1234567

¹ "Material professional affiliation" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any of the parties involved in this dispute.

² "Material familial affiliation" means any relationship such as a spouse, child, parent, sibling, spouse's parent, or child's spouse with any of the parties involved in this dispute.

³ "Material financial affiliation" means any financial interest of more than 5 percent of total annual revenue or income from any of the parties involved in this dispute.

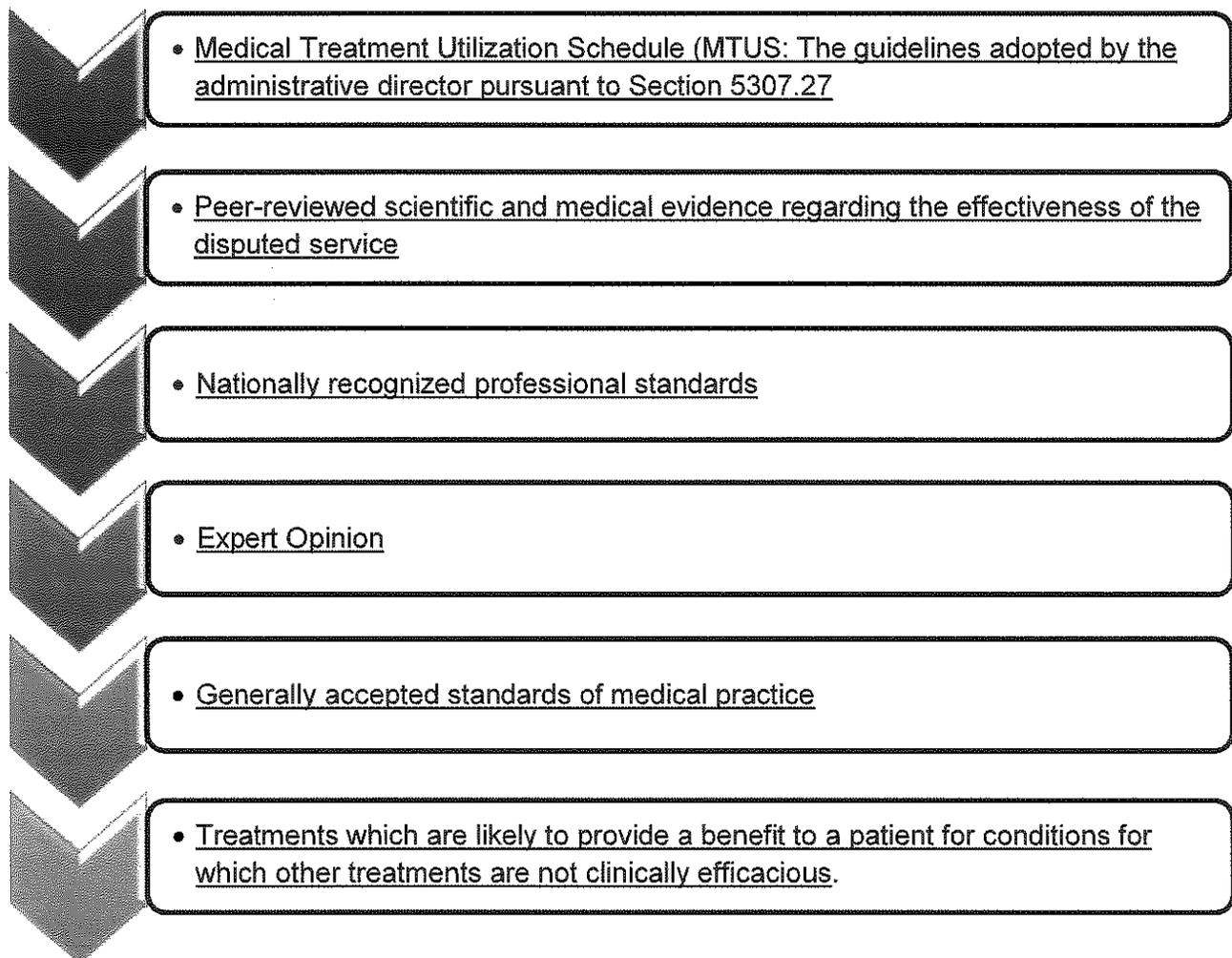
ATTACHMENT C: HEIRARCHY OF EVIDENCE-BASIS FOR DECISION MAKING

Medical Treatment Utilization Schedule (MTUS) LC §4604.5(a) – The recommended guidelines set forth in the medical treatment utilization schedule adopted by the administrative director pursuant to Section 5307.27 shall be presumptively correct on the issue of extent and scope of medical treatment 8 CCR §9792.25(a) – The MTUS is presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in the MTUS for the duration of the medical condition.

Hierarchy Pursuant To Labor Code §4610.5(c)(2)

Labor Code §4610.5(c)(2) – “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 following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee’s medical condition.

Hold CTRL and click each description for more details.



HIERARCHY OF EVIDENCE, THE MTUS

The purpose of your review is determination of medical necessity in light of the medical evidence hierarchy that has been described in the Review rules. A copy of the hierarchy description and the MTUS will be sent to you with your first set of review materials. Subsequent reviews will not contain them. The general principle for reviews with respect to the hierarchy is that the reviewer should use only one level of the hierarchy, and that level must be the highest level for which there is a relevant reference.

The last four levels in the hierarchy are not necessarily evidence-based, and should be viewed as last resort resources. Nearly all of the reviews which come to IMR can be evaluated in light of the first two tiers in the hierarchy.

Maximus does not currently provide access to medical evidence or other references in the hierarchy beyond the MTUS. Some of those alternative evidence sources may require a subscription fee.

- 1. The MTUS (Medical Treatment Utilization Schedule) in California is the first choice of medical evidence for every review, and whenever the MTUS has a reference for the request that you are reviewing, your review should make note of this.** No other guideline should be used in your review unless the MTUS is not adequate for determination of medical necessity. For cases in which you do not rely exclusively on the MTUS, your review should provide an explanation why the MTUS was not sufficient and why the other medical evidence was necessary.
- 2. The second tier of evidence in the hierarchy is described as “peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service”.** This includes guidelines like ODG (Official Disability Guidelines) and the updated ACOEM Guidelines (other than the updated ACOEM Guideline, Elbow chapter, which is part of the MTUS). Whenever you do use one of these alternative guidelines or other medical evidence, please provide a copy of the citation with your review decision, along with your rationale for using this alternative evidence.
- 3. Nationally Recognized Professional Standards** - No guideline within the MTUS was applicable and relevant to the clinical circumstances of the issue at dispute. You must identify the nationally recognized professional standard and state that it was the highest level of evidence applicable and relevant to the clinical circumstances of the issue at dispute.
- 4. Expert Opinion** - No guideline within the MTUS was applicable and relevant to the clinical circumstances of the issue at dispute. You must identify the expert opinion and state that it was the highest level of evidence applicable and relevant to the clinical circumstances of the issue at dispute.
- 5. Generally Accepted** - No guideline within the MTUS was applicable and relevant to the clinical circumstances of the issue at dispute. You must state that based on your years of experience with the clinical circumstances of the issue at dispute that the generally

accepted standard of medical practice was the highest level of evidence applicable and relevant to the clinical circumstances of the issue at dispute. You must also state the generally accepted standard of medical practice.

6. **Treatments which are likely to provide a benefit....** State that the employee's condition demonstrated a lack of response to evidence-based care, no other known treatments are clinically efficacious, and the treatment proposed by the Primary Treating Provider is likely to provide a benefit to the employee.

ATTACHMENT D: FREQUENTLY ASKED QUESTIONS (FAQs)

General Questions

Why do we have IMR?

What are the responsibilities of the medical reviewer as stated in the Maximus IMR contract?

MTUS Questions

How does the MTUS recommend using medical evidence for Utilization Review?

What parts of the ACOEM Guidelines are in the MTUS?

How does the MTUS recommend deciding when to transition from the ACOEM Guidelines 2nd Edition to the Chronic Pain Medical Treatment Guidelines?

Which section of the MTUS should be used to evaluate medical necessity for treatments of chronic pain?

How should the efficacy of treatment for chronic pain be measured?

How does the MTUS define "functional improvement"?

What does the MTUS recommend for an initial course of acupuncture?

What does the MTUS recommend for a follow-up course of acupuncture?

What does the MTUS recommend for manipulation to treat chronic pain?

What does the MTUS recommend for psychological and psychiatric treatment?

What are the recommendations of the MTUS for post-surgical physical therapy?

What does the MTUS recommend for physical therapy?

How does the MTUS address the medical necessity for medications?

What are some of the sources of medical evidence and guidelines that are not in the MTUS?

Why do we have IMR?

In September of 2012, the Governor of California signed SB 863, Workers' Compensation Reform, into law. One significant component of the reform was allowing injured employees to apply for binding Independent Medical Review of treatment/services requested by Primary or Secondary Treating Physicians and subsequently modified or denied as not medically necessary by Claims Administrators or Utilization Review Organizations.

What are the responsibilities of the medical reviewer as stated in the Maximus IMR contract?

Agreement Number 41230038

MAXIMUS Federal Services entered an agreement to perform Independent Medical Review (IMR) services to the California Department of Industrial Relations (DIR) and Division of Workers' Compensation (DWC). Exhibit A Section C.8. (c) of the agreement states:

"Each reviewer shall provide an individual assessment of the case that sets forth the reviewer's professional analysis and determination on whether the disputed medical treatment is medically necessary."

The same sub-section continues, "Each analysis shall cite the injured employee's: (numbers added for emphasis)

1. Medical condition,
2. Relevant documents reviewed in the process of making the determination,
3. Relevant findings associated with the standards to support the determination, and,
4. Reasons supporting the analysis."

Exhibit A Section C.8. (d) states, "A reviewer may make a conditional determination in favor of providing the disputed medical treatment based on further, scientifically described test or examination results of the injured employee."

How does the MTUS recommend using medical evidence for Utilization

Review? ([back to top](#))

Section 4610.5 of the Labor Code:

- (2) "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 following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:
- (A) The guidelines adopted by the administrative director pursuant to Section 5307.27.
 - (B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
 - (C) Nationally recognized professional standards.
 - (D) Expert opinion.
 - (E) Generally accepted standards of medical practice.
 - (F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

What parts of the ACOEM Guidelines are in the MTUS? ([back to top](#))

The Labor Code lists the following sections of the ACOEM Guidelines as incorporated into the MTUS. Note that the non body part specific chapters are 1-3 and 5. All of the body-part specific chapters from 2004 are included in the MTUS except Chapter 10, Elbow. The updated ACOEM Guidelines, 2007, Elbow chapter, was substituted for the original 2004 version of Chapter 10. The updated version is the chapter sent to you with your other materials for your IMR.

§ 9792.22. General Approaches

- a). The Administrative Director adopts and incorporates by reference into the MTUS specific guidelines set forth below from the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM Practice Guidelines) for the following chapters. A copy may be obtained from the American College of Occupational and Environmental Medicine, 25 Northwest Point Blvd., Suite 700, Elk Grove Village, Illinois, 60007-1030 (www.acoem.org).
 - (1) Prevention (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 1).
 - (2) General Approach to Initial Assessment and Documentation (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 2).
 - (3) Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3).

- (4) Cornerstones of Disability Prevention and Management (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 5).
Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.
Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.23. Clinical Topics

- a. The Administrative Director adopts and incorporates by reference into the MTUS specific clinical topic medical treatment guidelines in the series of sections commencing with 9792.23.1 et seq. Clinical topics apply to the initial management and subsequent treatment of presenting complaints specific to the body part.

How does the MTUS recommend deciding when to transition from the ACOEM Guidelines 2nd Edition to the Chronic Pain Medical Treatment Guidelines? ([back to top](#))

This citation is from the MTUS 9792.23.1 (page 4), neck and upper back section, but the same criteria are listed for each of the ACOEM Guideline chapters:

- (c) If recovery has not taken place with respect to pain by the end of algorithm 8-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.
- (d) If surgery is performed in the course of treatment for neck and upper back complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

Which section of the MTUS should be used to evaluate medical necessity for treatments of chronic pain? ([back to top](#))

9792.24.2. Chronic Pain Medical Treatment Guidelines replaces Chapter 6 of ACOEM Guidelines 2nd Edition

- (c) When a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections [*of the ACOEM Guidelines 2nd Edition*] but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment.
- (d) When the treatment is addressed in both the chronic pain medical treatment guidelines and the specific guideline found in the clinical topics section of the MTUS, the chronic pain medical treatment guideline shall apply.

8 C.C.R. 9792.20 – 9792.26, Chronic Pain Medical Treatment Guidelines

Page 1: “The chronic pain medical treatment guidelines apply when the patient has chronic pain as determined by following the clinical topics” section of the Medical Treatment Utilization Schedule (MTUS). In following the clinical topics section, the physician begins with an assessment of the presenting complaint and a determination as to whether there is a “red flag for a potentially serious condition” which would trigger an immediate intervention. Upon ruling

out a potentially serious condition, conservative management is provided. If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. If the patient continues to have pain that persists beyond the anticipated time of healing, without plans for curative treatment, such as surgical options, the chronic pain medical treatment guidelines apply. This provides a framework to manage all chronic pain conditions, even when the injury is not addressed in the clinical topics section of the MTUS.

“Chronic Pain: Chronic pain is defined as ‘any pain that persists beyond the anticipated time of healing.’”

Page 4: “As a practical matter, it is noted that “[t]he distinction between acute and chronic pain is somewhat arbitrary” and “chronicity may be reached from one to six months post injury.” ACOEM recognizes that the most clinically useful definition might be “chronic pain persists beyond the usual course of healing of an acute disease or beyond a reasonable time for an injury to heal.” (ACOEM Medical Treatment Guidelines Chapter 6 page 108.) The Division of Workers’ Compensation definition of chronic pain, “any pain that persists beyond the anticipated time of healing,” is derived from Bonica’s Management of Pain (Turk and Okifuji, 2001). Therefore, it is a clinical decision to recognize chronicity or persistence of pain when 1) the condition is not improving over time, 2) fails to improve with treatments directed to the specific injured body part (see Clinical Topics section of the MTUS), or 3) in the absence of a specifically correctable anatomic lesion (see Clinical Topics section of the MTUS). Often it takes a number of months for the clinician to recognize when pain becomes chronic.”

How should the efficacy of treatment for chronic pain be measured? ([back to top](#))

Chronic Pain Medical Treatment Guidelines 8 C.C.R. §§9792.20 – 9792.26 MTUS (Effective July 18, 2009) Page 9: Therapy for chronic pain ranges from single modality approaches for the straightforward patient to comprehensive interdisciplinary care for the more challenging patient. Therapeutic components such as pharmacologic, interventional, psychological and physical have been found to be most effective when performed in an integrated manner. All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement.

How does the MTUS define “functional improvement”? ([back to top](#))

9792.20. Medical Treatment Utilization Schedule-Definitions, Page 1

“Functional improvement” means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment.

What does the MTUS recommend for an initial course of acupuncture? ([back to top](#))

Title 8, California Code of Regulations, section 9792.202.24.1 page 8-9, Medical Treatment Utilization Schedule, Acupuncture Medical Treatment Guidelines

- (a) (1) “Acupuncture” is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for

a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm.

- (c) Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows:
1. Time to produce functional improvement: 3 to 6 treatments.
 2. Frequency: 1 to 3 times per week
 3. Optimum duration: 1 to 2 months

What does the MTUS recommend for a follow-up course of acupuncture? ([back to top](#))

Title 8, California Code of Regulations, section 9792.24.2 page 9, Medical Treatment Utilization Schedule, Acupuncture Medical Treatment Guidelines (d): Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(f).

What does the MTUS recommend for manipulation to treat chronic pain? ([back to top](#))

Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 – 9792.26 MTUS (Effective July 18, 2009) Page 58-60, Manual therapy & manipulation: Recommended for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. **Low back:** Recommended as an option. *Therapeutic care* – Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. *Elective/maintenance care* – Not medically necessary. *Recurrences/flare-ups* – Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. **Ankle & Foot, Carpal tunnel syndrome, Forearm, Wrist, & Hand, Knee:** Not recommended.

Treatment Parameters from state guidelines a. Time to produce effect: 4 to 6 treatments b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. Treatment beyond 4-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes.

What does the MTUS recommend for psychological and psychiatric treatment? ([back to top](#))

The Administrative Director adopts and incorporates by reference the Stress Related Conditions Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 15) into the MTUS from the ACOEM Practice Guidelines. [*This chapter provides general recommendations for evaluation and treatment of work-related psychological conditions.*]

Per the Medical Treatment Utilization Schedule 9792.20 – 9792.26 MTUS, Chronic Pain, pages 24 and 25, a limited course of biofeedback and cognitive behavioral therapy may be given for some patients. Page 101 of the MTUS, Chronic Pain section, provides a general

framework for the provision of psychological care to patients with chronic pain. Pages 13-16, 105, and 107 of the MTUS for Chronic Pain make specific recommendations for the use antidepressants to treat chronic pain, with assessment of results measured by functional improvement and other criteria.

What are the recommendations of the MTUS for post-surgical physical therapy? ([back to top](#))

9792.24.3. Postsurgical Treatment Guidelines

- (b) Application (1) The postsurgical treatment guidelines apply to visits during the postsurgical physical medicine period only and to surgeries as defined in these guidelines. At the conclusion of the postsurgical physical medicine period, treatment reverts back to the applicable 24- visit limitation for chiropractic, occupational and physical therapy pursuant to Labor Code section 4604.5(d)(1).

Title 8, California Code of Regulations, section 9792.20 et seq., 9792.24.3. Postsurgical Treatment Guidelines, Page 10,11,12

- (a)(2) "Initial course of therapy" means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section.
- (3) "Postsurgical physical medicine period" means the time frame that is needed for postsurgical treatment and rehabilitation services beginning with the date of the procedure and ending at the time specified for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section. For all surgeries not covered by these guidelines the postsurgical physical medicine period is six (6) months.
- (c) (3) If postsurgical physical medicine is medically necessary, an initial course of therapy may be prescribed. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery.
- (4) (B) In cases where no functional improvement is demonstrated, postsurgical treatment shall be discontinued at any time during the postsurgical physical medicine period.
- (5) Treatment is provided to patients to facilitate postsurgical functional improvement.
- (A) The surgeon who performed the operation, a nurse practitioner or physician assistant working with the surgeon, or physician designated by that surgeon, the therapist, and the patient should establish functional goals achievable within a specified timeframe.

[The MTUS contains recommendations for the quantity and duration of physical therapy after most of the common orthopedic surgeries. After an initial course, which is one half of the recommended total number of visits, further PT may be medically necessary if there is functional improvement. No other outcome measure is listed in the MTUS as a necessary criterion for continuing therapy.]

What does the MTUS recommend for physical therapy? ([back to top](#))

Each of the body part specific chapters in the ACOEM Guidelines 2nd Edition, recommends a few visits of physical therapy, primarily for instruction in self-care and exercise. The ACOEM Guidelines do not recommend a specific, maximum quantity of PT visits, although some

chapters recommend “1-2 visits for education, counseling, and evaluation of home exercise...”. The Chronic Pain section of the MTUS recommends the following:

Chronic Pain Medical Treatment Guidelines 9792.20 – 9792.26 MTUS (Effective July 18, 2009) Physical Medicine pages 98-99:

Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006)

Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)

Physical Medicine Guidelines – Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine.

Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks

Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks

Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks

When the patient can be categorized as having chronic pain (per the MTUS criteria), and is not in the post-surgical phase of care (per the MTUS criteria), the Physical Medicine section for chronic pain applies.

How does the MTUS address the medical necessity for medications? ([back to top](#))

The MTUS recommendations for medications to treat acute conditions are contained in the ACOEM Guidelines 2nd Edition. In general, acetaminophen and NSAIDs are recommended. Opioids may be indicated for two weeks or less. A short course of muscle relaxants may be indicated for neck or back pain. The Chronic Pain Medical Treatment Guidelines discuss many medications that might be used for chronic pain, including opioids. The reviewer is directed to the medication-specific citations. A general principle in the MTUS regarding all prescribing of medications for chronic pain is the following:

Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 – 9792.26 MTUS Page 60, Medications for chronic pain: *Only one medication should be given at a time, and*

interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. A record of pain and function with the medication should be recorded.

According to this citation from the MTUS, medications should not be initiated in a group fashion, and specific benefit with respect to pain and function should be documented for each medication.

What are some of the sources of medical evidence and guidelines that are not in the MTUS? ([back to top](#))

Official Disability Guidelines (ODG)

Updated ACOEM Guidelines (other than the Elbow chapter, which was adopted into the MTUS)

The American College of Radiology Appropriateness Criteria

The National Guideline Clearinghouse, found at www.guideline.gov

McKesson Interqual

Milliman Care Guidelines (MCG)

Medscape Reference, found at medscape.com

COURSE 1: GENERAL INFORMATION ABOUT IMR



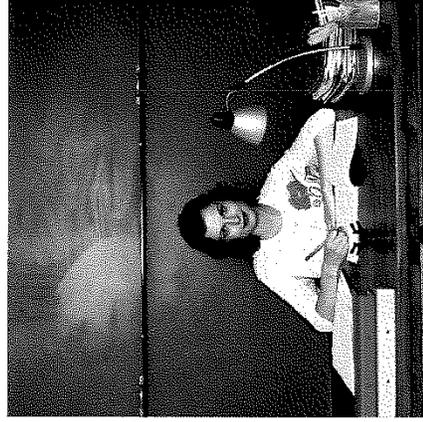
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Course 1 - General Information about IMR

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Learning Objectives

- Understand why there is an IMR process
- Understand the requirements for an Independent Medical Review
- Understand the basic documents used in the IMR Process
- Understand the process of receiving and accepting a case
- Learn the answers to common questions



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Purpose of IMR

- California Workers' Compensation system - each insurer may perform Utilization Review (UR) for any or all requests for treatment or testing
- UR is based on "medical necessity" rather than on a predefined list of benefits
- Prior to 2013, appeals for UR denials or modifications would be resolved through the legal system which sometimes used medical evaluators
- Beginning in 2013, appeals for UR denials or modifications were mandated to go through the Independent Medical Review (IMR) system, which is based on medical necessity

What is an IMR?

- IMR is performed by physicians without direction from judges or attorneys
- IMR determines “medical necessity” based on treatment guidelines and medical evidence
- Cost of the disputed issue does not enter into the IMR medical necessity determination
- All IMR decisions are anonymous with respect to the identity of the physician reviewer and the IMR physician does not contact the treating physician
- IMR results include the medical history, reviewer rationale, and cited guidelines
- IMR decisions are final, and there is no appeal absent evidence of significant misconduct
- The results of IMR are given to the injured worker and the State (Division of Workers Compensation, “DWC”).
- The results may be published for public viewing on the DWC website

Contract for IMR

- The Maximus contract with the State specifies that “each reviewer shall provide an individual assessment of the case that sets forth the reviewer’s professional analysis and determination on whether the disputed medical treatment is medically necessary.
- Each analysis shall cite the injured employee’s medical condition, relevant documents reviewed in the process of making the determination, relevant findings associated with the standards set forth in Labor Code section 4610.5(c)(2) to support the determination, and reasons supporting the analysis.”
- Based on these contractual requirements, the reviewer will be requested to provide a case summary, diagnoses, record review, guideline citation(s), and a rationale for the decision

Knowledge Check

Q1.

- 1. Medical necessity is determined by consulting a list of approved benefits for treatment of work-related medical conditions. True or False

Q2.

- 2. IMR decisions may be appealed if the injured worker or attorney do not agree with the decision. True or False.

3. The IMR physician is required to include which of the following in the review? (check all that apply):
- Clinical findings from the treating physician
 - Reasons for the decision
 - Diagnosis
 - Medical records used to make the review decision

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Lesson 2: Documents for IMR

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2013 IMR Application and Important Fields

State of California
Department of Industrial Relations
Division of Workers' Compensation
Application for Independent Medical Review
(All fields must be completed by the Claims Administrator)

Claim Number: 001263-0024631VC01
Date of Injury: Jun 15, 2010
Date of Onset: Dec 3, 2013
WCIS Jurisdictional Claim Number: 4971226371325421558731154
LAWC No (if applicable): ADJ5844815

Type of Review (Required): Expedited Regular

Injured worker information (Completion of this section is required)
Injured Worker First Name: [REDACTED] Injured Worker Last Name: [REDACTED]
Injured Worker Street Address/PO Box: [REDACTED] Injured Worker City: SACRAMENTO CA 95814 Zip Code: 95814

Medical provider information (Completion of this section is required)
Provider First Name: ROBERT
Provider Last Name: HAAS
Employer and Claims Administrator information (Completion of this section is required)
Employer Name: SACRAMENTO DISTILLERS
Employer Name (Please leave blank spaces between numbers, names or words):
Claims Administrator Company Name: APPLE A DAY HEALTH
Claims Administrator Company Name (Please leave blank spaces between numbers, names or words):
Diana Matuso
Claims Examiner Name:
750 N ST
Claims Administrator Street Address/PO Box (Please leave blank spaces between numbers, names or words):
SACRAMENTO CA 95814 Zip Code: 95814

Primary Diagnosis (Use ICD Codes where practical): Lumbar MRI
Indicate the treatment requested, attach additional pages if necessary:
Is the claim administrator disputing liability for the requested medical treatment besides the question of medical necessity?
 Yes No If yes, indicate why liability is being disputed

Consent to obtain medical records
I am asking for an independent medical review (IMR) to make a decision about the requested medical treatment that was delayed, denied, or modified by my claims administrator. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director of the Division of Workers' Compensation to review these records and information sent by my claims administrators and treating physician. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Date: 12-30-2013
THREDDYTYT
Signature: [Signature] (Print Name)
File this Application by mail by sending the form to: DWC-IMR, c/o MAXIMUS Federal Services, Inc.
625 Coolidge Drive, Suite 100, Folsom, CA 95630
You may also file this form by faxing the document to: Fax (916) 364-8134
DWC Form 954 (1/1/2013)

- 2013 IMR Application
- This document will be updated in 2014
- It is completed by the Claims Administrator and sent to the Employee or the Employee's Representative for review and signing
- Important fields described next

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2013 IMR Application Important Fields

State of California
Department of Industrial Relations
Division of Workers' Compensation
Application for Independent Medical Review
(All fields must be completed by the Claims Administrator)

Claim Number: 001263-002463WC01
 Date of Injury: Jun 15, 2010
 Date of UR Decision: Dec 3, 2013
 WCIS Jurisdictional Claim Number: 4971726371325421558741154
 EAMS No (if applicable): ADJ5844815

Type of Review (Required): Expedited Regular

Injured worker Information (Completion of this section is required)
 Injured Worker First Name: [Redacted] M Injured Worker Last Name: [Redacted]
 Injured Worker Street Address/PO Box: [Redacted] SACRAMENTO CA 95814
 Injured Worker City: State: Zip Code:

Medical provider information (Completion of this section is required)
 Provider First Name: ROBERT HAAS Provider Last Name: [Redacted]

Employer and Claims Administrator Information (Completion of this section is required)
 SACRAMENTO DISTILLERS
 Employer Name (Please leave blank spaces between numbers, names or words)
 APPLE A DAY HEALTH
 Claims Administrator Company Name (Please leave blank spaces between numbers, names or words)
 Dianna Martino
 Claims Examiner Name
 750 N ST
 Claims Administrator Street Address/PO Box (Please leave blank spaces between numbers, names or words)
 SACRAMENTO CA 95814
 Claims Administrator City: State: Zip Code:

“Date of UR” refers to the date of the UR decision for which this IMR is requested. If there are several UR decisions in the medical records, refer to the one with this date. The “Medical provider” listed should be the one that has requested the disputed service



2013 IMR Application Important Fields contd

“Treatment requested” should be treatments and/or tests denied or modified in the UR.

Unfortunately, IMR Applications often do not list the treatment/tests but instead refer to other documents in medical records or list something vague.

Maximus attempts to determine the denied treatment from the last UR. If the IMR physician feels that the request is not clear, the reviewer should contact Maximus for further

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APPLE A DAY HEALTH
 Claims Administrator Company Name (Please leave blank spaces between numbers, names or words)

Dianna Martino
 Claims Examiner Name

750 N ST.
 Claims Administrator Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO
 Claims Administrator City

CA - 95814
 State Zip Code

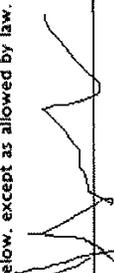
Lumbar MRI
 Indicate the treatment requested, attach additional pages if necessary

ongoing pain, lack of improvement, full meds
 Primary Diagnosis (Use ICD Code where practical)

Is the claims administrator disputing liability for the requested medical treatment besides the question of medical necessity?
 Yes No If yes, indicate why liability is being disputed

Consent to obtain medical records
 I am asking for an independent medical review (IMR) to make a decision about the requested medical treatment that was delayed, denied, or modified by my claims administrator. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. I allow the independent review organization designated by the Administrative Director of the Division of Workers' Compensation to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Date: 12/30/2013
 MM/DD/YYYY

Employee's Signature


File this Application by mail by sending the form to: **DWC-IMR, c/o MAXIMUS Federal Services, Inc.**
 625 Coolidge Drive, Suite 100, Folsom, CA 95630

You may also file this form by faxing the document to: **Fax (916) 364-8134**

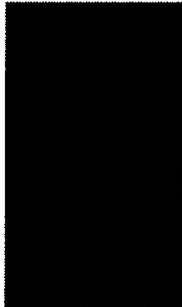
DWC form IMR (1/1/2013)

Typical UR Letter



GREEN APPLE HEALTH CARE SERVICES

December 3, 2013



Re: Lumbar MRI Request for Authorization
Claim #: 001263-002463WC01
Patient: [REDACTED]

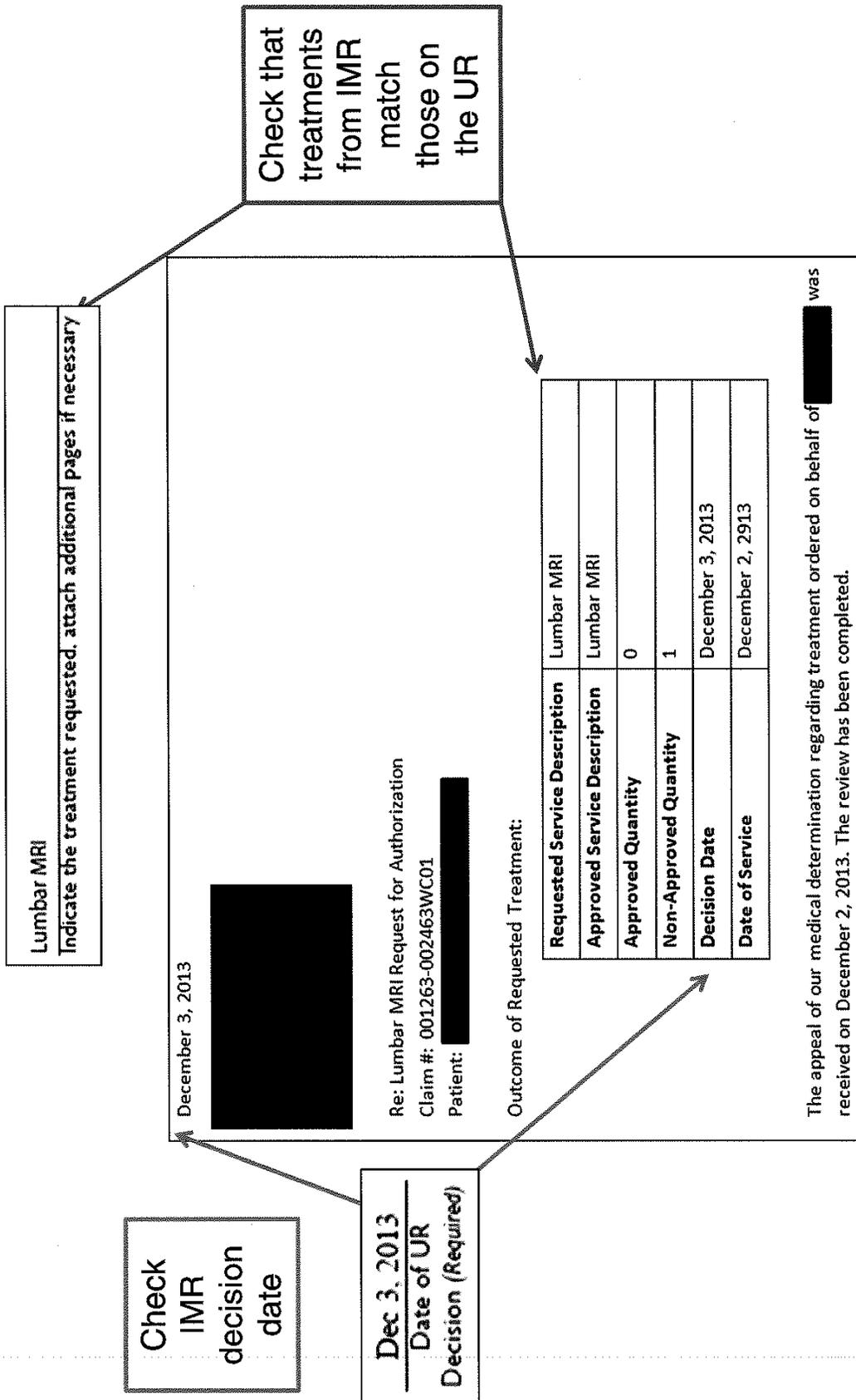
Outcome of Requested Treatment:

Requested Service Description	Lumbar MRI
Approved Service Description	Lumbar MRI
Approved Quantity	0
Non-Approved Quantity	1
Decision Date	December 3, 2013
Date of Service	December 2, 2013

The appeal of our medical determination regarding treatment ordered on behalf of [REDACTED] was received on December 2, 2013. The review has been completed.

- This is a typical UR letter from a Claims Administrator
- This UR denies the treatment
- Some UR decisions will modify the treatment request or provide a partial certification
- PHI fields have been redacted to protect privacy of the individual
- More detail follows

Comparing IMR to UR



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Additional Documents of the IMR – Medical Records

- Follow-up office visits in the California Workers Compensation system are usually documented on the “PR2” form, but may also be documented via narrative reports
- Treatment requests should be documented on the RFA form (Request for Authorization).
 - It is often helpful to see how the treatment was requested on the RFA compared to what was listed in UR (since the UR does not always accurately state the treatment request).
 - Unfortunately, the RFA is often not in the records.

Additional Documents of the IMR – Med-Legals

- Agreed Medical Evaluators (“AME”) and Qualified Medical Evaluators (“QME”) have an important legal role in the California Workers Compensation system but have no specific role or special authority in the IMR process.
- A recommendation from an AME or QME does not equate to medical necessity, and absent support from the MTUS or good medical evidence, should not be the basis for an IMR decision.
- The clinical evaluation (rather than treatment recommendations) from the AME or QME may be a good source of information in support of an IMR decision.

Additional Documents of the IMR – Attorney Letters

- Attorney letters or recommendations may be present in the medical records.
- Attorney requests or demands do not equate to medical necessity but may be used as background information by the IMR physician.

Additional Documents of the IMR – MTUS

- **The first time you review a case, a copy of the MTUS will be supplied in the packet sent to you.**
- **More detailed information on the MTUS and the hierarchy of evidence used in the review are detailed in Course 2: “The MTUS and Hierarchy of Evidence for Expert Review”**

Knowledge Check

Q1.

1. When an AME recommends a treatment, the IMR physician should assume that the treatment is medically necessary unless there is clear evidence to the contrary. True or False

Q2.

2. Documents which you may encounter in the medical records include (check all that apply):

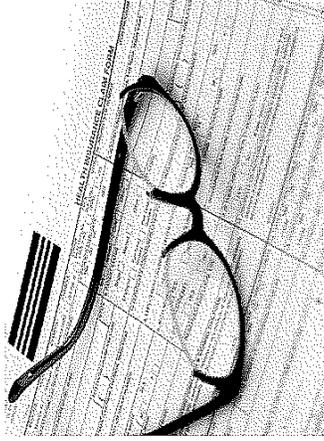
- PR2
- IMR Application
- RFA
- UR decisions
- Attorney demands

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Lesson 3: Overview of Receiving a Case, Applying Guidelines, Creating a Case Summary, and Writing Rationale

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Process of Accepting a Case



- Panel Scheduler will contact you:
 - through the Expert Gateway (email to you),
 - MoveIt (email to you),
 - direct email, or
 - phone call.
- You will receive a brief description of the case and whether it is Expedited or Standard
- Expedited Cases are due back within 24 hours
- Standard Cases are due back before 8 AM of the same day the next week.
 - For example, if you accept the case Tuesday, it is due to us no later than 8 AM the following Tuesday.
- We will not ask you to review a case:
 - if you have a professional or personal connection with the Interested Parties
 - If you have a Conflict of Interest, please let the panel scheduler know as soon as possible.

Content of Packet after You Accept a Review



- You receive the packet the same day you accept a case
- This packet contains:
 - The Independent Medical Review application;
 - Utilization Review Denial letter from the Claims Administrator;
 - Documents the Claims Administrator used as basis of denial or modification;
 - Medical Records available to the Claims Administrator;
 - Other relevant documents from the Employee, Applicant Attorney, or the Primary Treating Provider, if they did provide any, and;
 - If this is your first review for us, the Medical Treatment Utilization Schedule
- If no Medical Records are provided:
 - Please do not review the case - Return the case to the Scheduler who sent it to you

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What if You Have Questions

- Contact the Panel Scheduler who assigned the case to you with any procedure questions.
- If you have questions regarding guidelines, medical analysis, or how to document your decision, Contact the Medical Director, Paul Manchester, MD, MPH
 - PaulManchester@maximus.com
 - Office: 916.673.4483
 - Cell: 408.930.4255



How You Will Be Paid

- Return the completed Medical Professional Review Form, including the Attestation Page
- MAXIMUS Federal Services reimburses independently contracted reviewers twice a month, with the intention of payment being received within 30 days of the day your Medical Professional Review Form is returned.



Knowledge Check

Q1.

1. If the IMR physician is sent a case in which the treating physician is a member of his/her medical group, the reviewing physician should:

- -review the case as long as he/she has not seen this patient
- -return the case to the Panel Scheduler due to a Conflict of Interest
- - review the case as long as he/she does not discuss the case with treating physician

Q2.

2. If the reviewing physician receives a Standard case on Friday, it will be due on which day of the next week?

Wed

Thurs

Fri

Knowledge Check

Q3.

3. If the IMR physician receives a review with no medical records, the physician may perform the review if the medical necessity is clear according to the guidelines. True or False

Q4.

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Lesson 4: Common Questions

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What if I did not receive any medical records?

- If you receive no medical records other than UR decision(s), you should not perform IMR.
- Please notify the Panel Scheduler who sent you the case.

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What if UR provided a modified authorization (such as authorizing 12 of 18 requested PT visits)?

- **The IMR physician cannot provide a modified decision**
- **The IMR reviewer should address the medical necessity for the request as it was originally stated, and render an “is” or “is not” medically necessary decision based on the original request**
- **For 18 PT requested PT visits, the IMR reviewer should review guidelines and determine the medical necessity for 18 visits, not for a lesser portion of the 18 visits**
- **If a modification is medically necessary, the IMR decision does not prevent the Claims Administrator and treating physician from agreeing to a revised treatment plan in the future**

What if the IMR physician receives a review which lies outside of his or her specialty?

- If the reviewer feels that the subject lies outside of his/her field of expertise or experience, the reviewer should return the unreviewed case to the Scheduler with an explanation.
- Under no conditions should a reviewer perform IMR for requests which fall outside of the scope of one's licensure.
 - For example, a chiropractor should never review the medical necessity for medications.

What if the medical records contain medical information generated or received after the date of the last UR?

- The IMR physician may use all medical information contained in the medical records.
- However, the IMR physician may not cancel, change, or withdraw an IMR request based on information found in the medical records.
- The IMR physician should always address the medical necessity for the requests that were listed for him/her.
- The IMR physician may contact Maximus to clarify a disputed service which is not clear

Where do I find answers to Frequently Asked Questions?

- **Frequently asked questions are answered in detail at the end of your Training Packet in Attachment D**
 - If you are reviewing the document electronically, the answer to each question can be found by clicking the question itself listed at the top of Attachment D
 - Returning to the list of questions is as easy as clicking the [back to top link](#) at the end of each question

What if You Have Questions

- Contact the Panel Scheduler who assigned the case to you with any procedure questions.
- If you have questions regarding guidelines, medical analysis, or how to document your decision, Contact the Medical Director, Paul Manchester, MD, MPH
 - PaulManchester@maximus.com
 - Office: 916.673.4483
 - Cell: 408.930.4255



Knowledge Check

Q1.

1. If a portion of the disputed service is clearly medically necessary, the reviewing physician's decision should be that the disputed service is medically necessary in part, while the other portion of the request is not. True or False

Q2.

2. Although the IMR physician may not feel qualified to evaluate the medical necessity for a given disputed service, Maximus expects that the reviewer will provide a decision if the disputed service is clearly discussed in the MTUS. True or False

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Knowledge Check

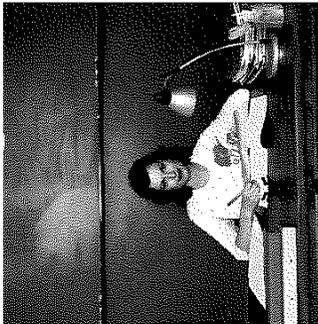
Q3.

3. If the IMR physician finds that additional medical records that were submitted after the last UR decision, the IMR physician may reverse the last UR decision based on these records that were not available to the UR physician. True or False

Q4.

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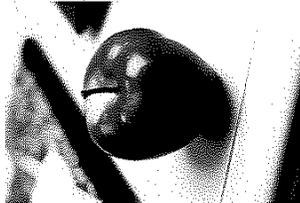
Review and Summary



- **Understand why there is an IMR Process**
 - IMR is a new program in California designed to resolve treatment disputes using medical necessity criteria only”
 - IMR physicians make decisions using medical evidence and guidelines.
 - IMR decisions are the final appeal for disputed services in the Workers Compensation system

Understand the requirements for an Independent Medical Review

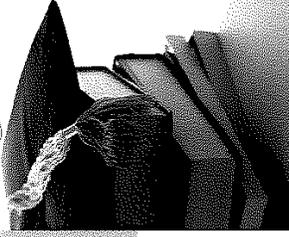
- Analysis/determination as to the medical necessity of the disputed medical treatment
- Reviewer to provide case summary, diagnoses, record review, guideline citation(s), and rationale for the decision



Review and Summary

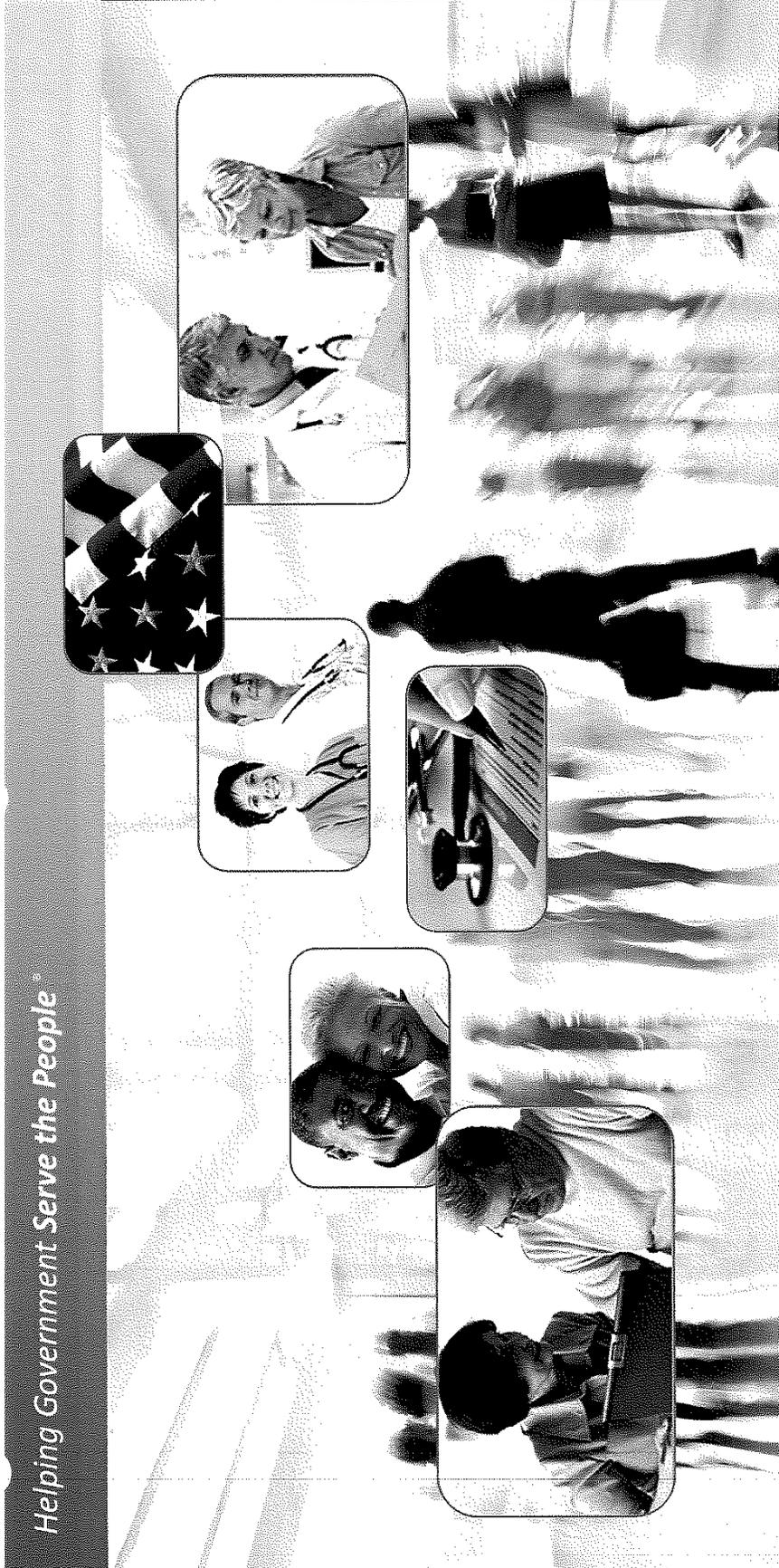
- **Understand the basic documents used in the MPR Process**
 - Application for IMR – primary document for IMR request, requests IMR for tests or treatments that were denied or modified
 - Utilization Review (UR) decision – documentation of the decision to deny or modify a treatment request”
 - Medical Records – can include medical reports (PR2s, RFAs, narratives), AMEs, QMEs, attorney letters
- **Understand the general process of accepting and receiving a case**
 - Contacted by panel scheduler
 - If accepted, receive full MPR packet same day
 - If no medical records received, do not accept, contact Panel Scheduler

Review and Summary



- **Learn the answers to common questions**
 - Answers to common questions can be found in this course
 - Frequently asked questions are answered in detail at the end of your Training Packet in Attachment D
 - Contact the Panel Scheduler who assigned the case to you with any procedure questions.
 - If you have questions regarding guidelines, medical analysis, or how to document your decision, contact the Medical Director, Paul Manchester, MD, MPH, Office: 916.673.4483, Cell: 408.930.4255, or PaulManchester@maximus.com

COURSE 2: MTUS DEFINITION AND THE HIERARCHY OF EVIDENCE



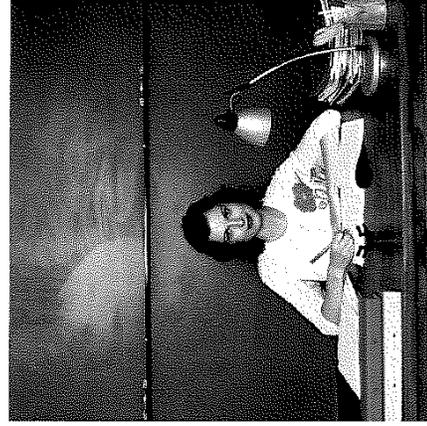
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Course 2 – MTUS Definition and the Hierarchy of Evidence

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Learning Objectives

- Understand what constitutes the MTUS
- Understand how to use and cite the MTUS and other evidence
- Understand what portions of the MTUS apply to chronic cases
- Understand “functional improvement” as defined and used in the MTUS



What is the MTUS?

- The MTUS (Medical Treatment Utilization Schedule) is a collection of treatment guidelines accepted by the State of California as authoritative for Workers Compensation
- There are four major sections of the MTUS:
 - acupuncture treatment guidelines,
 - chronic pain guidelines,
 - selected chapters from the ACOEM Guidelines second edition (chapters 1-3, 5, 8, 9, 11-16), 2007 updated Elbow chapter, and
 - the post-operative physical medicine guidelines.
- Maximus provides all its reviewers with an indexed version of the MTUS
- The DWC website has the acupuncture treatment guidelines, chronic pain, and the post-operative physical medicine guidelines available for download

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Lesson 1: Hierarchy of Evidence

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Hierarchy of Evidence per the Labor Code

Medical Treatment Utilization

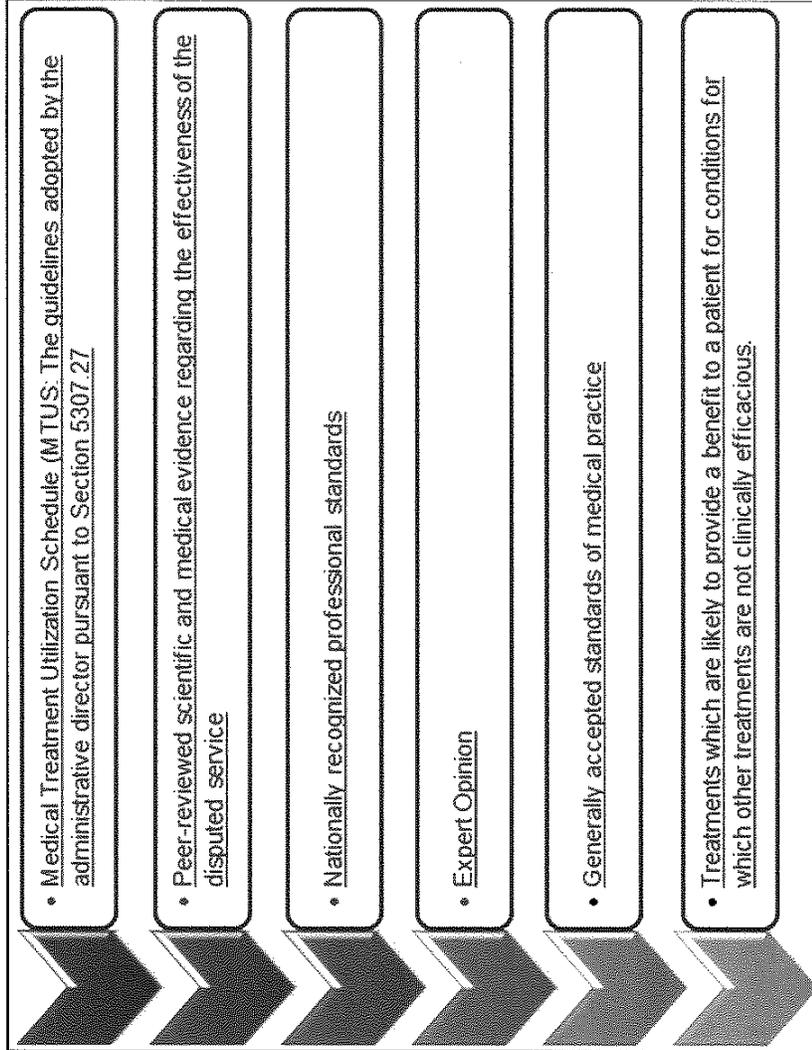
Schedule (MTUS) LC §4604.5(a) –

Recommended guidelines set forth in the medical treatment utilization schedule adopted by the administrative director pursuant to Section 5307.27 shall be presumptively correct on the issue of extent and scope of medical treatment 8 CCR §9792.25(a) – The MTUS is presumptively correct on the issue of extent and scope of medical treatment and diagnostic services addressed in the MTUS for the duration of the medical condition.

Hierarchy Pursuant To Labor Code

§4610.5(c)(2) Labor Code §4610.5(c)(2) –

“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 following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee’s medical condition.



HIERARCHY OF EVIDENCE, THE MTUS

- **The purpose of your review is determination of medical necessity in light of the medical evidence hierarchy that has been described in the IMR regulations.**
 - A copy of the hierarchy description and the MTUS will be sent to you with your first set of review materials. Subsequent reviews will not contain them.
 - The general principle for reviews with respect to the hierarchy is that the reviewer should use only one level of the hierarchy, and that level must be the highest level for which there is a relevant reference.
- The last four levels in the hierarchy are not necessarily evidence-based, and should be viewed as last resort resources.
- Nearly all of the reviews which come to IMR can be evaluated in light of the first two tiers in the hierarchy.
- Maximus does not currently provide access to medical evidence or other references in the hierarchy beyond the MTUS.
 - Some of those alternative evidence sources may require a subscription fee.

How is medical evidence to be used for IMR?

- All determinations of medical necessity require support from an evidence-based guideline or peer-reviewed medical evidence if at all possible, and the MTUS is considered as the presumptively correct authority.
- All IMR physicians should consult the MTUS for all IMR decisions.
- The hierarchy of evidence should be followed as described in the regulations.
- **If the MTUS (first tier of hierarchy) adequately addresses the disputed service, no other guideline or evidence is required.**
- Only when the MTUS is not sufficient may other evidence be used and the reviewer should explain why the alternative evidence was used.

Second and Third Tier Evidence

- The second tier of evidence in the hierarchy is described as “peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service”.
 - This includes guidelines like ODG (Official Disability Guidelines) and the updated ACOEM Guidelines (other than the updated ACOEM Guideline, Elbow chapter, which is part of the MTUS), as well as peer-reviewed journal articles.
 - Whenever you do use one of these alternative guidelines or other medical evidence, please provide a description of any journal citations in standard bibliographic form. For guidelines, please provide the name of the guideline, topic, and page (if there is one). You should also explain why the MTUS was not adequate for this review.”

Fourth through Sixth Tier

- The last four levels in the hierarchy are not necessarily evidence-based, and should be viewed as last resort resources. Nearly all of the reviews which come to IMR can be evaluated in light of the first two tiers in the hierarchy.
- The third tier is “Nationally Recognized Professional Standards” .
 - You must identify the nationally recognized professional standard and state that it was the highest level of evidence applicable and relevant to the clinical circumstances of the issue at dispute.
- The fourth tier is “Expert Opinion” .
 - You must identify the expert opinion and state that it was the highest level of evidence applicable and relevant to the clinical circumstances of the issue at dispute.
- The fifth tier is “Generally accepted standards of medical practice” .
 - You must identify the generally accepted standard of medical practice and the reason why.
- The sixth tier is “Treatments which are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious” .
 - State that the employee’s condition demonstrated a lack of response to evidence-based care, no other known treatments are clinically efficacious, and the treatment proposed by the Primary Treating Provider is likely to provide a benefit to the employee

What are some of the sources of medical evidence and guidelines that are not in the MTUS?

- **Official Disability Guidelines (ODG), subscription only, mostly online**
- **Updated ACOEM Guidelines (other than the Elbow chapter, which was adopted into the MTUS), subscription only, online**
- **The American College of Radiology Appropriateness Criteria, free, online**
- **The National Guideline Clearinghouse, found at www.guideline.gov, free, online**
- **McKesson Interqual, subscription only**
- **Milliman Care Guidelines (MCG), subscription only**
- **Medscape Reference, found at medscape.com, free**
- **UpToDate, subscription only, online**

- **Lesson 2: Chronic Pain and Functional Improvement, Definitions**

Which portion of the MTUS should be used for chronic conditions?

“Chronic Pain: Chronic pain is defined as ‘any pain that persists beyond the anticipated time of healing.’”

8 C.C.R. 9792.20 – 9792.26, Chronic Pain Medical Treatment Guidelines,

Page 1:

“The chronic pain medical treatment guidelines apply when the patient has chronic pain as determined by following the clinical topics” section of the Medical Treatment Utilization Schedule (MTUS). If the patient continues to have pain that persists beyond the anticipated time of healing, without plans for curative treatment, such as surgical options, the chronic pain medical treatment guidelines apply. This provides a framework to manage all chronic pain conditions, even when the injury is not addressed in the clinical topics section of the MTUS.”

- 9792.24.2. Chronic Pain Medical Treatment Guidelines replaces Chapter 6 of ACOEM Guidelines 2nd Edition:
 - (c) When a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections [of the ACOEM Guidelines 2nd Edition] but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment.
 - (d) When the treatment is addressed in both the chronic pain medical treatment guidelines and the specific guideline found in the clinical topics section of the MTUS, the chronic pain medical treatment guideline shall apply.

Chronic Pain contd

This citation is from the MTUS 9792.23.1 (page 4), neck and upper back section, but the same criteria are listed for each of the ACOEM Guideline chapters:

- (c) If recovery has not taken place with respect to pain by the end of algorithm 8-5, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.
- (d) If surgery is performed in the course of treatment for neck and upper back complaints, the postsurgical treatment guidelines in section 9792.24.3 for postsurgical physical medicine shall apply together with any other applicable treatment guidelines found in the MTUS. In the absence of any cure for the patient who continues to have pain that persists beyond the anticipated time of healing, the chronic pain medical treatment guidelines in section 9792.24.2 shall apply.

Functional Improvement

- The MTUS, 9792.20. Medical Treatment Utilization Schedule—Definitions, page 1, defines functional improvement very specifically: '(f) "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment.' This definition does not include pain relief.
- In the MTUS, "functional improvement" is used to measure outcomes and determine the medical necessity for further treatment in cases of post-operative PT, medications, acupuncture, chiropractic, and other treatment modalities.
- The MTUS, chronic pain section, page 9, states that "all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement".
- Whenever possible, the IMR physician should refer to the presence or absence of functional improvement when determining the medical necessity for further treatment of chronic pain.

Q1

The MTUS includes which of the following (check all that apply):

- acupuncture treatment guidelines
- Chapter 7 of the ACOEM Guidelines
- Chapter 15 of the ACOEM Guidelines
- Chronic pain medical treatment guidelines
- Chapter 10 of the ACOEM Guidelines
- Post-operative physical medicine guidelines

Q2

- In which tier of the medical evidence hierarchy does the updated ACOEM Guideline for the elbow reside?

Q3

- In which tier of the medical evidence hierarchy do the Official Disability Guidelines reside?

Q4

The ACOEM Guidelines portion of the MTUS is for acute conditions and does not apply to chronic pain conditions, as per direction from the Chronic Pain Medical Treatment Guidelines portion of the MTUS. True or False.

Q5

Which of the following is true for chronic pain conditions, as per the Chronic Pain Medical Treatment Guidelines portion of the MTUS? (choose all that are true)

- -Chronic pain is pain that persists beyond the anticipated time of healing, without plans for curative treatment.
- -Treatments for pain that are covered in the ACOEM Guidelines "clinical topics" sections are not applicable to treating chronic pain
- -If surgery is performed on a patient with chronic pain, the chronic pain section of the MTUS is the most applicable section of the MTUS for evaluating medical necessity of post-operative PT
- -If a treatment for chronic pain is prescribed and that treatment is not listed in the MTUS, the treatment can be presumed to be not medically necessary

Q6

"Functional improvement" as defined in the MTUS includes which of following (check all that apply):

- -greater than 50% reduction in pain
- -restriction from lifting more than 10 pounds changed to allow lifting up to 50 pounds
- -change from monthly office visits to "prn" visits due to decrease in pain
- -improved range of motion after surgery
- -decrease in Vicodin prescribing from 90 per month to 10 per month

Q7

- . Successful treatment of chronic pain should be apparent by documentation of functional improvement. True or False

Q2

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COURSE 3: COMPLETING AN INDEPENDENT MEDICAL REVIEW

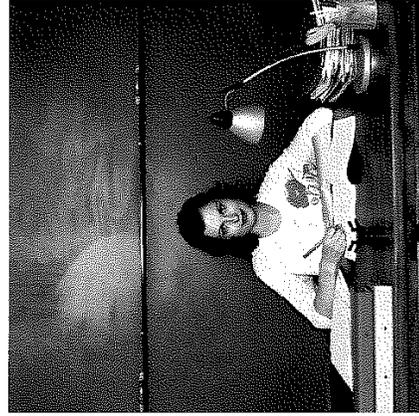
Helping Government Serve the People®

Course 3 – Completing an
Independent Medical Review

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Learning Objectives

- Focus on essential task of writing review
- See the process of writing a review using an example



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In this sample disputed service...

- **First, review the relevant documents:**
 - IMR Application
 - Utilization Review letter
 - Medical records
 - guidelines

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Directions for the Review

- Maximus wants to assure the proper use of guidelines and evidence rather than directing the physician reviewer to a yes or no decision in a given case
- The guideline should be selected first, with review details selected based on guideline requirements.
- The Case Summary need not be lengthy but should provide enough information to allow a reader to understand the clinical scenario and reasons why the disputed service was prescribed. If the information that you hope to see in the physician's reports (such as indications for the disputed service) is not present, please state this pertinent negative.
- For medication requests, your summary should provide a medication history which includes the duration of use, indications for the medication, and any results of use as documented in the medical reports.
- For other requests, your summary should include the clinical findings relevant to the disputed request.
 - For example, your summary for a requested spine MRI should include results of any prior spine imaging, any prior spine surgery, and specific signs and symptoms relevant to the spine.

Checklist for the Reviewer

- **What is the disputed service?**
 - Lumbar MRI [as listed on the MPR, and should also be listed on the IMR application and last UR decision]
- **Which guideline is the most relevant?**
 - ACOEM Guidelines 2nd edition, pages 303-304, 309.
 - The IMR physician does not need to provide the text of the guideline or evidence, just the title, section, topic, and page.

Checklist for Reviewer

- What was the UR decision and how was the decision supported?
 - look at the last UR decision documents in the medical records

CREATING A CASE SUMMARY

- Per the IMR contract with the State: “Each reviewer shall provide an individual assessment of the case that sets forth the reviewer’s professional analysis and determination on whether the disputed medical treatment is medically necessary.” “Each analysis shall cite the injured employee’s”:
 - “Medical condition”,
 - “Relevant documents reviewed in the process of making the determination”,
 - “Relevant findings associated with the standards to support the determination”, (The above report requirements are to be in the Case Summary, on page one of the MPR. The reviewer should be able to provide the required case summary in one to two paragraphs.) and,
 - “Reasons supporting the analysis.” (This the rationale portion of your review, and should include direct references to the clinical findings in light of the applicable guidelines and medical evidence. The rationale for each of the disputed issue decisions should require no more than one paragraph.)

Creating a Case Summary, continued

- Review the records and compose the clinical summary with the guideline in mind.
 - Case summary: The injured worker is 48 year old male who reported low back pain after lifting a barrel on 6/15/2010. His symptoms were confined to the low back without radiation to the extremities. He was treated with conservative methods during the first month after injury. Treatment included 10 visits of PT, daily Vicodin, daily Flexeril, and naproxen as needed. He was released to modified work, with limitations on lifting and stooping. Lumbar radiographs showed mild degenerative changes. During the fifth week after injury, the treating physician noted ongoing back pain, inability to increase activities at work, an overall lack of improvement, and ongoing use of all medications. He prescribed a lumbar MRI out of concern for a possible herniated disk causing ongoing back pain. There were no neurological deficits documented and the physical exam was notable only for local tenderness and limited range of motion.

Completing a Medical Review Form

- The demographic information on the first page of the MPR will be filled in when it is sent out to you.
- A section of the form for each Issue of Dispute will be included with the MPR. Address each Issue of Dispute separately, make an analysis, support your findings, and identify the evidence basis of your decision.
- Some areas of the MPR contain boxes to check. Please check all appropriate boxes.
- Some areas of the MPR contain what appear to be gray boxes.
 - They are actually text fields.
 - Each gray box describes the type of information you are to enter.
 - Click on the description in the gray box and type your text into these boxes.
 - They expand with your key strokes to accommodate however much text you need to enter.
 - Entering text will overwrite the instructions showing in the gray box.
- If you do not return a complete MPR (including the Attestation Page signed and dated) you will not be paid until all the signed documents are received.
- Please do not pdf your MPR.

First Page of the MPR form

MEDICAL PROFESSIONAL REVIEWER'S DECISION REPORT FORM
CALIFORNIA WORKERS' COMPENSATION
INDEPENDENT MEDICAL REVIEW
REVISED 12/19/13

DATE AND TIME DUE BACK TO MAXIMUS: January 14, 2014 08:00 AM (PST)

Standard Medical Necessity

Medical Professional Reviewer: <MPR First Name Last Name, MPR Degree>

MAXIMUS Case Number: CM13-1234567

Please provide a one paragraph summary of the relevant clinical issues with a diagnosis or diagnoses relevant to the disputed issue(s). Your summary may be posted on the DWC website for public viewing so please avoid any inflammatory language or disparaging remarks about any aspect of the medical care or claims processes.

<Insert one paragraph summary here>

This information will be filled in for you.

This information you need to fill in.

MAXIMUS

What you need to do on this first page

**MEDICAL PROFESSIONAL REVIEWER'S DECISION REPORT FORM
CALIFORNIA WORKERS' COMPENSATION
INDEPENDENT MEDICAL REVIEW
REVISED 12/19/13**

**DATE AND TIME
DUE BACK TO
MAXIMUS:**

January 14, 2014
08:00 AM (PST)

Standard Medical Necessity

Medical Professional Reviewer: Jake Tyson, MD

MAXIMUS Case Number: CM13-1234567

Please provide a one paragraph summary of the relevant clinical issues with a diagnosis or diagnoses relevant to the disputed issue(s). Your summary may be posted on the DWC website for public viewing so please avoid any inflammatory language or disparaging remarks about any aspect of the medical care or claims processes.

The injured worker is 48 year old male who reported low back pain after lifting a barrel on 6/15/2010. His symptoms were confined to the low back without radiation to the extremities. He was treated with conservative methods during the first month after injury. Treatment included 10 visits of PT, daily Vicodin, daily Flexeril, and naproxen as needed. He was released to modified work, with limitations on lifting and stooping. Lumbar radiographs showed mild degenerative changes. During the fifth week after injury, the treating physician noted ongoing back pain, inability to increase activities at work, an overall lack of improvement, and ongoing use of all medications. He prescribed a lumbar MRI out of concern for a possible herniated disk causing ongoing back pain. There were no neurological deficits documented and the physical exam was notable only for local tenderness and limited range of motion.

Note that as you type into the gray field, the instructions in the field vanish.

For each Dispute page received

MEDICAL PROFESSIONAL REVIEWER TO COMPLETE

This information will be filled in for you for each dispute. The remainder of the page is for you to complete. This case only has one issue at dispute so this is the only dispute page that will be contained in the MPR.

1. Decision for Lumbar MRI:

a) Evidence-Basis for the Decision:

Evidence-Based Criteria Cited By Expert Reviewer:

MTUS Guidelines

- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) <Insert Chapter>, page(s) <Insert Page Number or Numbers>
- Chronic Pain Medical Treatment Guidelines <Insert Section>, page(s) <Insert Page Number or Numbers>
- Acupuncture Medical Treatment Guidelines
- Post-Surgical Treatment Guidelines <Insert Title of Surgery>, page(s) <Insert Page Number or Numbers>

Other Guidelines

- Official Disability Guidelines (ODG) <Insert Section (for example Knee)>, <Insert Topic (for example Total Knee Arthroplasty)>
- Other Medical Treatment Guideline or Medical Evidence: <Insert Other Basis/Criteria>

b) After a professional and thorough review of the documents, my analysis is that the above listed issue:

- is/was NOT medically necessary
- I am reversing the prior UR decision. My decision is that the issue listed above IS medically necessary. The reasons for reversing the prior UR decision are listed in the rationale below.

c) My rationale for why the requested treatment/service is or is not medically necessary:

Insert Rationale

Choosing a Guideline

- The only portion of the MTUS which addresses imaging is the ACOEM Guideline section
- Each of the body part chapters of the MTUS has some instruction regarding imaging of that body part
- Not all imaging is adequately covered in the MTUS and additional guidelines are appropriate when the MTUS does not adequately cover the issue in dispute. Typical alternative guidelines are the Official Disability Guidelines and the American College of Radiology Appropriateness Criteria.
- For this case, the relevant sections of the MTUS are shown in subsequent slides. The MTUS is clear that an MRI is indicated primarily for further investigation when the clinical presentation provides good evidence of underlying significant pathology. This is consistent with recent evidence that continues to recommend against obtaining an MRI of the low back for uncomplicated low back pain. No additional guidelines are needed in this case.

MTUS ACCOEM Guidelines 2nd Ed, p. 303

Special Studies and Diagnostic and Treatment Considerations

Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management.

Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures).

Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. Diskography is not recommended for assessing patients with acute low back symptoms.

Low Back Complaints

303
.....

MTUS ACCOEM Guidelines 2nd Ed, pp. 304-305

Table 12-7 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. An imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for one month or more to further evaluate the possibility of potentially serious pathology, such as a tumor.

Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great.

Magnetic resonance (MR) neurography may be useful in isolating diagnoses that do not lend themselves to back surgery, such as sciatica caused by piriformis syndrome in the hip. However, MR neurography is still new and needs to be validated by quality studies.

Recent studies on diskography do not support its use as a preoperative indication for either intradiscal electrothermal (IDET) annuloplasty or fusion. Diskography does not identify the symptomatic high-intensity zone, and concordance of symptoms with the disk injected is of limited diagnostic value (common in non-back issue patients, inaccurate if chronic or abnormal psy-

chosocial tests), and it can produce significant symptoms in controls more than a year later. Tears may not correlate anatomically or temporally with symptoms. Diskography may be used where fusion is a realistic consideration, and it may provide supplemental information prior to surgery. This area is rapidly evolving, and clinicians should consult the latest available studies. Despite the lack of strong medical evidence supporting it, diskography is fairly common, and when considered, it should be reserved only for patients who meet the following criteria:

Table 12-7. Ability of Various Techniques to Identify and Define Low Back Pathology

Technique	LS Strain	Disk Protrusion	Cauda Equina Syndrome	Spinal Stenosis	Post-laminectomy Syndrome
History	++	++	++	++	+++
Physical examination	++	+++	+++	++	+++
Laboratory studies	0	0	0	0	0
Imaging studies					
Radiography ¹	0	+	+	++	+
Computerized tomography (CT) ^{1,2}	0	+++	+++	+++	++
Magnetic resonance imaging (MRI) ^{1,2}	0	+++	+++	+++	+++
Electromyography (EMG), sensory evoked potentials (SEPs)	0	+++	+	+	+

¹ Risk of complications (e.g., infection, radiation) highest for myeloCT, second highest for myelography, and relatively less for bone scan, radiography, and CT.

² False-positive results in up to 30% of people over age 30 who do not have symptoms and up to 50% in those over age 40.

Note: Number of plus signs indicates relative ability of technique to identify or define pathology.

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OCCUPATIONAL MEDICINE PRACTICE GUIDELINES

- Back pain of at least three months duration.
- Failure of conservative treatment.
- Satisfactory results from detailed psychosocial assessment. (Diskography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided.)
- Is a candidate for surgery.
- Has been briefed on potential risks and benefits from diskography and surgery. *Low Back Complaints*

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MTUS ACOEM Guidelines 2nd Ed, p. 309

Table 12-8. (continued)

<i>Clinical Measure</i>	<i>Recommended</i>	<i>Optional</i>	<i>Not Recommended</i>
Imaging	CT or MRI when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative (C) MRI test of choice for patients with prior back surgery (D) Assure quality criteria for imaging tests (B)	Mycelography or CT myelography for preoperative planning if MRI is unavailable (D) MR neurography (D)	Using imaging test before 1 month in absence of red flags (B) Diskography or CT diskography (C)

What must be completed for each dispute

MEDICAL PROFESSIONAL REVIEWER TO COMPLETE

1. Decision for lumbar MRI:

a) Evidence-Basis for the Decision:

Evidence-Based Criteria Cited By Expert Reviewer:

MTUS Guidelines

- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 12, page(s) 303-305, 309
- Chronic Pain Medical Treatment Guidelines <Insert Section>, page(s) <Insert Page Number or Numbers>
- Acupuncture Medical Treatment Guidelines
- Post-Surgical Treatment Guidelines <Insert Title of Surgery>, page(s) <Insert Page Number or Numbers>

Other Guidelines

- Official Disability Guidelines (ODG) <Insert Section (for example Knee)>, <Insert Topic (for example Total Knee Arthroplasty)>
- Other Medical Treatment Guideline or Medical Evidence: <Insert Other Basis/Criteria>

b) After a professional and thorough review of the documents, my analysis is that the above listed issue:

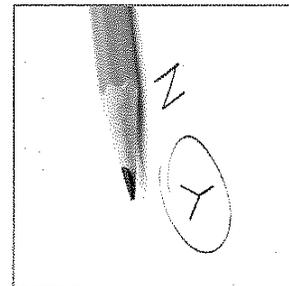
- Is/was **NOT** medically necessary
- I am reversing the prior UR decision. My decision is that the issue listed above **IS** medically necessary. The reasons for reversing the prior UR decision are listed in the rationale below.

c) My rationale for why the requested treatment/service is or is not medically necessary:

Insert Rationale

How you may state your decision

- **Your decision must be that the disputed service “is” or “is not” medically necessary.**
 - Modifications of requests are not an option for IMR.
 - “May” be medically necessary is also not an option.
 - Your decision should be based on the medical necessity for the request as stated in its entirety.
 - If the prior Utilization Review rendered a “modified” decision, your decision will still need to address the medical necessity for the request as stated in its entirety, with no consideration of the prior modification.
 - For example, if the disputed service is 24 visits of PT after surgery, your review should reference the MTUS recommendations and the necessity for 24 visits, not some portion of the 24 visits.
 - You are asked to make your decision based on the records that we send you, even if you would like to have more extensive records.



- Make your decision as “is” or “is not medically necessary”

b) After a professional and thorough review of the documents, my analysis is that the above listed issue:

Is/was **NOT** medically necessary

I am reversing the prior UR decision. My decision is that the issue listed above **IS** medically necessary. The reasons for reversing the prior UR decision are listed in the rationale below.

Rationale

- Describe the diagnosis and reasons supporting your decision. The reviewer should note the specific indications for the disputed service that are or are not met in this case.
 - The injured worker has non-specific back pain best classified as a strain without radiculopathy. The MTUS citation listed provides specific indications for imaging in cases of low back pain. The treating physician has not described the clinical evidence of significant pathology, such as “*Unequivocal objective findings that identify specific nerve compromise on the neurologic examination*”. No “red flag” conditions are identified. Specific indications for surgery are not present. The radiographs did not show any significant pathology. The MRI is not medically necessary as the injured worker does not meet the criteria described in the MTUS.

What must be completed for each dispute - rationale

c) My rationale for why the requested treatment/service is or is not medically necessary:

The injured worker has non-specific back pain best classified as a strain without radiculopathy. The MTUS citation listed provides specific indications for imaging in cases of low back pain. The treating physician has not described the clinical evidence of significant pathology, such as "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination". No "red flag" conditions are identified. Specific indications for surgery are not present. The radiographs did not show any significant pathology. The MRI is not medically necessary as the injured worker does not meet the criteria described in the MTUS.

Reviewer's Attestation Page

REVIEWER'S ATTESTATION
[If you cannot attest to any of the following, please contact MAXIMUS immediately.]

Reviewer's Attestation [attest that I]
 Am Board Certified in PM&R Have a subspecialty Certificate in: SUBSPECIALTY

CERTIFICATES:

- Have at least five years of experience providing direct patient care;
- Am in active clinical practice at least 24 hours a week;
- Have expertise in the same or similar specialties and subspecialties that evaluate or treat the medical condition at issue or provide the type of medical treatment in dispute;
- Am familiar with guidelines and protocols in the area of the treatment under review;
- Do not have an actual or potential material professional affiliation¹, material familial affiliation², or material financial relationship³ with regard to any of the following parties involved in this dispute, including but not limited to:
 - The employer, workers' compensation insurer, claims administrator, or utilization review organization or an officer, director, or management employee of same;
 - The Medical Provider Network of the insurer or claims administrator, unless at an academic medical center under contract to the insurer or claims administrator to provide services to employees and the center is neither going to provide the service nor is it the developer or manufacturer of the proposed treatment;
 - The physician, the physician's medical group, the independent practice association (IPA) proposing the treatment, or the institution at which the treatment would be provided;
 - The developer or manufacturer of the principle drug, device, procedure, or other therapy at dispute;
 - The injured employee, the injured employee's immediate family, or the worker's representative; and/or,
 - Any attorney or law firm representing the worker, employer, claims administrator or insurance company.
- Have not had a change in my standing and status in the practice of medicine since submission of information to MAXIMUS for credentialing, and specifically that I have not been subject to any disciplinary action by any health care institution, licensing authority, professional society, or government health care program;
- Received and reviewed all pertinent medical records and other appropriate information relevant to the case and listed in the Decision Report Form;
- Found the record complete;
- Have rendered an independent and impartial decision based upon application of relevant medical standards and medical scientific evidence to a California Workers' Compensation Independent Medical Review;
- Have not accepted compensation for review activities dependent in any way on the specific outcome of the case;
- Do not have in my possession copies of any case file documents associated with this review or will return the case file and all protected health information within three days of the date of this review;
- Have affixed my signature to this Attestation. If my case decision has been transmitted electronically to MAXIMUS Federal Services, the electronic signature that appears on my decision shall have the same legal effect as if I had affixed my original signature by hand to this document.

Signature: [Signature] Date: 1/23/14
 Name: Jack Tyler Case Number: CM13-1234567

1 "Material professional affiliation" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any of the parties involved in this dispute.
 2 "Material familial affiliation" means any relationship such as a spouse, child, parent, sibling, spouse's parent, or child's spouse with any of the parties involved in this dispute.
 3 "Material financial affiliation" means any financial interest of more than 5 percent of total annual revenue or income from any of the parties involved in this dispute.

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Knowledge Check

Q1

The required components of the physician's Independent Medical Review must include (choose all that apply):

- a diagnosis,
- the rationale from the last UR decision,
- clinical findings,
- discussion of guideline recommendations

Q2

"MPR" refers to:

- Medical Physician Report
- Medical Professional Report
- Medical Professional Reviewer

Which of the following citations from the MTUS are adequate evidence citations? (choose all that apply):

- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Low Back, chapter 12
- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) knee chapter, page 337
- Chronic Pain Medical Treatment Guidelines, epidural injections
- Chronic Pain Medical Treatment Guidelines, topical analgesics, pages 114-116
- Post-Surgical Treatment Guidelines, low back, pages 25-26

If the IMR physician reviewer makes a decision which does not uphold the decision of the last Utilization Review, the IMR physician will therefore make a decision that the disputed service is:

- Medically necessary, or
- NOT medically necessary

COMPLETING AN INDEPENDENT MEDICAL REVIEW

Case Reviews – Recommendations for Reviewers (1)

- Do not include PHI in reviews (especially names) – use “injured worker” and “treating physician”
- Audience is the general public – complete sentences, grammar, avoid abbreviations
- You can and should use records in decision that UR physician may not have had
 - Intent of IMR is to determine medical necessity, not engage in a legal contest
 - If new records result in overturning UR decision, explain that
- No medical records? DO NOT PROCEED! Contact the Panel Scheduler via MoveIt
- When you overturn a UR decision, explain why – your review should be as good as last UR review
- Vague quantity or frequency requests
 - If you find medically necessary, you’re approving an unlimited quantity for unlimited duration
 - If you believe some part is medically necessary, but believe it should be more specific, decision should be to find the request as stated is not medically necessary
 - It is responsibility or treating physician to provide adequate treatment plan and request
- If you are assigned a case with any request outside of your scope of practice or licensure, OR you cannot complete the entire review – RETURN THE REVIEW... DO NOT COMPLETE ANY PORTION!!
 - We cannot accept and will not reimburse a partial review

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Case Reviews – Recommendations for Reviewers (2)

- **Tips to an efficient review or records**
 - Choose your guideline first, based on disputed service/request
 - Then look for information in the records that are pertinent to the guideline recommendations
 - You **DO NOT** need to make a comprehensive review and summary of the entire medical records
- **Procedures and associated services reviews**
 - You do not need to separately review and cite guidelines for each of the associated services IF you find primary procedure not medically necessary
 - Example: Shoulder surgery includes DME, surgical assistant, post-op PT, medical clearance, and medications – if surgery not medically necessary, the rest are not medically necessary
- **Clinical summary portion of the review should be in your own words – NOT a copy of the UR or other report in records**
 - Include the reason why disputed service was prescribed (if stated) and date prescribed
- **For each medication reviewed, provide duration of use and results of use**
 - If such information is not provided, state that
- **Always cite evidence-based guideline or peer-reviewed evidence to support decision**
 - ALWAYS search MTUS for relevant references
 - ALWAYS explain why a non-MTUS reference was used
 - In nearly all reviews, MTUS or other medical evidence is available
 - Avoid using terms “in my opinion”, “community standards”, “medically reasonable care”

MAXIMUS

Case Reviews – Recommendations for Reviewers (3)

- No need to paste content of guidelines into your review
 - Pasted guidelines are no substitute for solid rationale
 - Use your own words and discuss the relevant portions of the guideline
 - A pasted guideline with a statement that the injured worker does not meet the guideline recommendations is NEVER ADEQUATE!
- Guideline citations
 - ALWAYS include name of guideline, chapter or section, topic, and page
 - MAXIMUS-provided PDF of MTUS has two sets of page numbers
 - PDF page numbers at the top of each page
 - Page numbers from various MTUS sections (ACOEM, chapters, chronic pain, etc.)
 - DO NOT USE THE PDF PAGE NUMBERING – use the page numbers from the original document only
- Even if MTUS includes what appears to be a quote from ODG, your citation should be the MTUS (not ODG)

Business Process Management for Government

CA DWC – MAXIMUS Federal Contacts

MAXIMUS Federal Services Physician Review

Physician Review Subject Matter

- Dr. Paul Manchester
 - Medical Director, MAXIMUS Federal
 - PaulManchester@maximus.com
 - Office: 916-673-4483



Movelt and Panel Scheduling

- Kevin Gregory
 - Director, MAXIMUS Federal
 - kevingregory@maximus.com
 - Office: 585-348-3135

MAXIMUS

Recommendations for Independent Medical Reviewers – Details

Protected Health Information in your reviews: do not include names of the injured worker or treating physician, or any other possible PHI, as these will be redacted in the final version. You may use terms like “injured worker” and “treating physician”.

The audience for your reviews is the general public, not physicians exclusively. You should avoid all abbreviations other than those that are very commonly understood by the lay public (MD, MRI). Sentences should be complete and grammar should be correct.

If the medical records that you have include items not available to the UR physician, including records generated or received after the UR decision, you should use these records in making your decision. The intent of IMR is to determine medical necessity, not engage in a legal contest. If you have records that UR did not, and those records result in your overturning the UR decision, you should explain this.

If you have no medical records, do not proceed with the review. Notify the scheduler and ask if you should return the review. Sometimes the records are available and can be sent to you.

Whenever you overturn a UR decision, you should explain why. Your review should be at least as good as the last UR.

If you review a vague request (“naproxen”, with no quantity; “medication management”, with no frequency or quantity), please be aware that if you find this medically necessary, you are approving an unlimited quantity for an unlimited duration. If you believe that some quantity is medically necessary but also believe the request needs to be more specific, the proper decision is to find the request as stated to be not medically necessary. It is the responsibility of the treating physician to provide an adequate treatment plan and request.

If you receive a review with any request which does not fall within your scope of practice or licensure, please return the review and do not complete any of it. Some reviewers like to complete part of the review and return the review only partially completed. This is of no use to us.

If for any reason you cannot complete the entire review, addressing all the requests, please return the review without performing any review. We cannot use a partially completed review.

The most efficient way to review records is to choose your guideline first, based on the disputed service/request. You will then look for information in the records pertinent to the guideline recommendations. There is no need to make a comprehensive review and summary of the entire medical records.

If you review for a procedure and its associated services, you do not need to separately review and cite guidelines for each of the associated services IF you find the primary procedure to be not medically necessary. For example, a request for a shoulder surgery may also include DME, a surgical assistant, post-op PT, medical clearance, and medications. If the shoulder surgery is not medically necessary, the

rest of the items can be listed as not medically necessary with the following rationale: Since the primary procedure is not medically necessary, this associated service is also not medically necessary.

The clinical summary portion of your review should be in your own words and not a copy of the UR or some other report in the records. The clinical summary should include the reason why the disputed service was prescribed (if this is stated) and the date prescribed.

For each of the medications reviewed, the reviewer should provide the duration of use and results of use. If this information is not available, this should be stated. Medical necessity for medications should be based on the indications AND the results of use.

Always cite an evidence-based guideline or peer-reviewed evidence in support of your decision. Always search the MTUS for relevant references, and use other sources only if necessary. Always explain why a non-MTUS reference was used. In nearly all reviews, the MTUS or other medical evidence is available and relevant. You should be wary of ever using terms like “in my opinion”, “community standards”, “medically reasonable care”, etc.

There is no need to paste the content of guidelines into your reviews, and a pasted guideline is never a substitute for a rationale which is in your own words and which discusses the relevant portions of the guideline. A pasted guideline with a statement that this injured worker does not meet the guideline recommendations is never adequate.

A guideline citation should always include the name of guideline, the chapter or section, the topic, and page. Note that the 611-page MTUS compilation that Maximus provided to the reviewers has PDF page numbers at the top of the packet as well as page numbers in the various MTUS sections (ACOEM chapters, chronic pain, etc). Do not use the PDF page numbers; use the page numbers from the original document only.

Even if the MTUS includes what appears to be a quote from ODG, your citation should be to the MTUS, not ODG.

***APPENDIX L: SAMPLE REDACTED CASE
SUMMARY FORM***

Independent Medical Review
State of California, DIR, DWC



Sample Redacted Case Summary

Date Assigned:	10/03/2013	Date of Injury:	08/23/2013
Decision Date:	11/01/2013	UR Denial Date:	09/14/2013
Priority:	Standard	Application Received:	10/01/2013
Disputed Body Parts:	Lumbar spine		
Reviewing Physician Board Certifications	Pain Management and Rehabilitation		
Reviewing Physician State(s) of Licensure:	California		

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is 48 year old male who reported low back pain after lifting a barrel on 6/15/2010. His symptoms were confined to the low back without radiation to the extremities. The working diagnosis was a strain without radiculopathy. He was treated with conservative methods during the first month after injury. Treatment included 10 visits of PT, daily Vicodin, daily Flexeril, and naproxen as needed. He was released to modified work, with limitations on lifting and stooping. Lumbar radiographs showed mild degenerative changes. During the fifth week after injury, the treating physician noted ongoing back pain, inability to increase activities at work, an overall lack of improvement, and ongoing use of all medications. He prescribed a lumbar MRI out of concern for a possible herniated disk causing ongoing back pain. There were no neurological deficits documented and the physical exam was notable only for local tenderness and limited range of motion.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Lumbar MRI is not medically necessary and appropriate.

Claims Administrator rule cited: American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, pages 289-290, 303-304, recommendations for further testing and imaging.

MAXIMUS rule cited: American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, pages 289-290, 303-304, recommendations for further testing and imaging.

Rule statement: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant

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surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures).

Decision rationale: The treating physician has not provided evidence of specific nerve compromise on neurologic examination. There is no physiologic evidence in the medical records to indicate nerve insult or nerve impairment. No “red flag” conditions are identified. Specific indications for surgery are not present. The radiographs did not show any significant pathology. MTUS criteria for an MRI Lumbar Spine have not been met.

APPENDIX M: CA BUSINESS LICENSE

State of California
Secretary of State

CERTIFICATE OF STATUS

ENTITY NAME:

MAXIMUS FEDERAL SERVICES, INC.

FILE NUMBER: C3014438
REGISTRATION DATE: 08/30/2007
TYPE: FOREIGN CORPORATION
JURISDICTION: VIRGINIA
STATUS: ACTIVE (GOOD STANDING)

I, DEBRA BOWEN, Secretary of State of the State of California,
hereby certify:

The records of this office indicate the entity is qualified to
transact intrastate business in the State of California.

No information is available from this office regarding the financial
condition, business activities or practices of the entity.



IN WITNESS WHEREOF, I execute this certificate
and affix the Great Seal of the State of
California this day of April 30, 2014.

Debra Bowen

DEBRA BOWEN
Secretary of State

APPENDIX N: CURRENT REPORTS

Independent Medical Review
State of California, DIR, DWC



Sample Current Reports

The following report samples represent only a fraction of the reports provided regularly to DWC and are for example purposes only. These reports will be replaced with the MAXDat reporting solution as described in *Section 4.2.8: Case Workflow Tracking Reports* and include all the data elements required in Appendix A, B, C, and D.

Daily Report Example

Case Creation Completed					Total Cases Created
Date		Expedited Appeals Created	Standard Appeals Created routed to Preliminary Review	Standard Appeals Created - Missing UR	
3/1/2014	Saturday	0	200	62	262
3/2/2014	Sunday				0
3/3/2014	Monday	6	388	46	440
3/4/2014	Tuesday	5	625	142	772
3/5/2014	Wednesday	4	620	133	757
3/6/2014	Thursday	9	137	652	798
3/7/2014	Friday	4	544	121	669
3/8/2014	Saturday	0	219	16	235

Independent Medical Review
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Weekly Report IMR Life-to-Date Listing of Closed Cases Example

MFS IMR Case #	DWC Case #	IMR Year	IMR Number	Case Status	Decision	Decision Date	Dec Letter Mailed Date	Review Type	App Received Date	Date Assigned	First Med Record
C	I	13	1	Closed - Final Determination Issued	Partial Overturn	04/30/14	04/30/14		07/26/13	03/03/14	03/24/14
C	I	13	1	Closed - Final Determination Issued	Partial Overturn	05/05/14	05/06/14		08/09/13	03/07/14	03/25/14
C	I	13	1	Closed - Final Determination Issued	Partial Overturn	04/23/14	04/24/14		08/05/13	03/03/14	03/18/14
C	I	13	1	Closed - Final Determination Issued	Partial Overturn	04/21/14	04/22/14		09/16/13	02/07/14	02/18/14
C	I	13	1	Closed - Final Determination Issued	Partial Overturn	04/03/14	04/04/14		10/10/13	12/06/13	12/20/13
C	I	13	1	Closed - Final Determination Issued	Partial Overturn	04/30/14	04/30/14		10/15/13	03/21/14	04/01/14
C	I	13	1	Closed - Final Determination Issued	Partial Overturn	04/30/14	04/30/14		10/16/13	03/28/14	04/09/14

Use or disclosure of data contained on this sheet is subject to the restrictions on the title page of this proposal

Independent Medical Review
State of California, DIR, DWC



Monthly Report Summary Example

Data Element	
Number of IMR requests received	11,571
Number designated as potentially ineligible for IMR	1,258
Number determined to be ineligible for IMR	31
Number deemed eligible for IMR	1,227
Number of IMR determinations completed	6,065
Number of standard IMR determinations completed	6,051
Number of standard IMR determinations completed within required timeframe	19
Number of standard IMR determinations completed outside required timeframe	6,032
Average number of days to complete standard IMR determination	82.80
Number of expedited IMR determinations complete	14
Number of expedited IMR determinations completed within required timeframe	8
Average number of days to complete an expedited IMR determination	7.21
Number of UR decisions overturned	805
Number of completed determinations involving a single reviewer	6,065
Number of completed determinations involving multiple reviewers	0
Fees charged for IMR, total	\$X
Average fee charged per IMR case	\$X

Use or disclosure of data contained on this sheet is subject to the restrictions on the title page of this proposal

EXHIBIT B

BUDGET DETAIL AND PAYMENT PROVISIONS

1. Invoicing and Payment

Contractors shall submit invoices directly to Claims Administrators. Contractor shall not submit invoices to the State.

2. Budget Contingency Clause

It is mutually agreed that the Budget Act of the current year or any subsequent years covered under this Agreement has no effect on this Agreement. The State shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under the Agreement.

3. Prompt Payment Clause

Government Code Chapter 4.5, commencing with section 927, is not applicable to this Agreement.

4. Budget

The total budget is \$0.00 (zero dollars and zero cents).

EXHIBIT C

General Terms and Conditions – GTC 610

GTC 610 is hereby incorporated by reference and made part of this agreement as if attached hereto.
This document can e viewed at

<http://www.ols.dgs.ca.gov/Standard+Language/default>

EXHIBIT D

SPECIAL TERMS AND CONDITIONS

1) RESOLUTION OF DISPUTES:

Notwithstanding the General Terms and Conditions (Exhibit C), and in compliance with Public Contract Code 10381, DIR adds:

Contractor should first discuss the problem informally with the Division of Worker's Compensation (DWC) Project Manager. If the problem cannot be resolved at this stage, Contractor must direct the grievance together with any evidence, in writing, to the Administrative Director of the DWC. The grievance must state the issues in dispute, the legal authority or other basis for Contractor's position and the remedy sought. The Administrative Director must make a determination on the problem within ten (10) working days after the receipt of the written communication from Contractor. The Administrative Director shall respond in writing to Contractor indicating the decision and reasons therefore. Should Contractor disagree with the Administrative Director's decision, the Contractor may appeal to the next level.

Contractor must prepare a letter indicating why the Administrative Director's decision is unacceptable, attaching to it Contractor's original statement of the dispute with supporting documents along with a copy of the Administrative Director's response. This letter shall be sent to the Director of DIR or designee within ten (10) working days from receipt of the Administrative Director's decision. The Director of DIR or designee shall meet with Contractor to review the issues raised. A written decision signed by the Director of DIR or designee shall be returned to Contractor within twenty (20) working days of receipt of Contractor's letter.

Authority to terminate performance under the terms of this Agreement is not subject to appeal under this section. All other issues including, but not limited to, the amount of any equitable adjustment and the amount of any compensation or reimbursement that should be paid to Contractor shall be subject to the disputes process under this section. (Public Contract Code (PCC) Sections 10240.5, 10381, 22200, et seq.)

2) RIGHTS IN DOCUMENTS AND DATA:

Contractor agrees that all documents, data plans, drawings, specifications, reports, computer programs, operating manuals, notes, and other written or graphic work produced in the performance of this Agreement are subject to the rights of the State as set forth in this section. The State shall have the right to reproduce, publish, and use all such work, or any part thereof, in any manner and for any purposes whatsoever and to authorize others to do so, on its behalf.

If any Deliverable Work set forth in the Scope of Work is copyrightable, Contractor, through this Agreement transfers ownership of that copyright to the State, and the State may, as an illustration but not a limitation, reproduce, publish, and use such work, or any part thereof, and authorize others to do so (40 CFR 31.34, 31.36). The State grants Contractor a royalty-free, nonexclusive, nontransferable, irrevocable license to reproduce, publish and prepare derivative works of the copyrightable work, for noncommercial research and noncommercial educational purposes.

Any material that does not conform to the requirements of this Agreement may be rejected by the State at its discretion. Notice of such a rejection shall be given to Contractor by the State within ten (10) days of receipt of the materials, and final payment shall not be made for such material until substantial compliance has been obtained within the time and manner determined by the State.

3) CONTRACTOR'S STATUS RIGHTS AND OBLIGATIONS:

Notwithstanding the General Terms and Conditions (Exhibit C), Contractor has been delegated certain authority under the Scope of Work (Exhibit A) to make and issue determinations which are deemed the final determinations of the Administrative Director of DWC pursuant to Labor Code section 4603.6(f)). Contractor has the status of and Independent Bill Review Organization (IBRO) under Labor Code sections 139.5 and 4603.6, and has such authority as is conferred on an IBRO by those statutes, as further delimited by this Agreement.

Public Contract Code Sections 10335-10381 contain language describing Contractor's duties, obligations, and rights under this Agreement. By signing this Agreement, Contractor certifies that it has been fully informed regarding these provisions of the Public Contract Code.

4) CONTRACTOR EVALUATION:

Contractor's performance under this Agreement shall be evaluated within sixty (60) days after completion. For this purpose a form designated by the Department of General Services (the "Contract/Contractor Evaluation," Form STD.4: shall be used. Post evaluations shall remain on file for a period of thirty-six (36) months. If Contractor did not satisfactorily perform the work or service specified in the Agreement, DIR's Contract Manager shall place one copy of the evaluation form in the Agreement file and send one copy of the form to the Department of General Services within five (5) working days of the completion of the evaluation. Upon filing an unsatisfactory evaluation with the Department of General Services, the Contract Manager shall notify and send a copy of the evaluation to the Contractor within fifteen (15) days. Contractor shall have thirty (30) days to prepare and send statement of the Contract Manager and the Department of General Services defending its performance under the Agreement. Contractor's statement shall be filed with the evaluation in the Contract Manager's file and at the Department of General Services. (PCC 10369

5) DISCLOSURE REQUIREMENTS:

Contactors shall acknowledge the support of DIR and DWC when publicizing the work performed under this Agreement. Materials developed with contract funds shall contain an acknowledgement of the use of State funds in the development of materials and a disclaimer that the contents do not necessarily reflect the position or policy of DIR or DWC.

If Contractor or subcontractor(s) are required to prepare multiple documents or written reports, the disclosure statement may also contain a statement indicating that the total Agreement amount represents compensation for multiple documents or written reports.

Contractor shall include in each of its subcontracts for work under this Agreement a provision which incorporates the requirements stated within this Section.

6) LICENSES AND PERMITS:

Contactors are firms licensed to do business in California and shall obtain at its own expense all license(s) and permit(s) required by law for accomplishing any work required in connection with this Agreement.

Contractor shall submit evidence showing that it is an active corporation in good standing in the state where incorporated.

In the event any license expires at any time during the term of this Agreement, Contractor agrees to provide the State with a copy of the renewed license within 30 days following the expiration date. In the event Contractor fails to keep in effect at all times all required license(s) and permit(s), the State may, in addition to any other remedies it may have, terminate this Agreement upon occurrence of such event.

7) INSURANCE REQUIREMENTS:

When Contractor submits a signed agreement to the State, contractor shall furnish a certificate of insurance, stating that there is liability insurance presently in effect of not less than \$2,000,000 per occurrence for bodily injury and property damage liability combined.

The Certificate of Insurance will include provisions a, b, c in their entirety:

- a. The insurer will not cancel insured's coverage without 30 days prior written notice to the State.
- b. The State of California, its officers, agents, employees, and servants are included as additional insureds, but only insofar as operations under this Agreement are concerned.
- c. The State will not be responsible for any premiums or assessments on the policy.
Contractor agrees that the bodily injury liability insurance herein provided for shall be in

effect at all times during the term of this Agreement. In the event said insurance coverage expires at any time during the term of this Agreement, Contactor agrees to provide at least 30 days prior to said expiration date, a new certificate of insurance evidencing insurance coverage as provided for herein for not less than the remainder of the term of the Agreement, or for a period of not less than one year. New certificates of insurance are subject to the approval of the Department of General Services and the Contractor agrees that no work or services shall be performed prior to the giving of such approval. In the event the Contractor fails to keep in effect at all times insurance coverage as herein provided, the State may in addition to other remedies it may have, terminate this Agreement upon occurrence of such event.

The State will not provide for nor compensate the Contractor for any insurance premiums or costs for any type or amount of insurance.

Automobile Liability

Contractor shall maintain commercial auto liability insurance with limits not less than \$1,000,000 per accident. Such insurance shall cover liability arising out of a motor vehicle including owned, hired and non-owned motor vehicles. Should the scope of the Agreement involve transportation of hazardous materials, an MCS-90 endorsement is required.

Commercial General Liability

Contractor, along with any of its subcontractors engaged to perform work pursuant to this Agreement, shall maintain Commercial Liability insurance with limits of at least \$2,000,000 covering any damages caused by an error, omission, or negligent act of the Contractor in connection with the work provided such claims arise during the period commencing upon the preparation of the project work documents and ending 5 years following substantial completion.

Workers' Compensation

Contractor certifies and is aware of the provisions of Section 3700 of the Labor Code which requires every employer to be insured against liability for Workers' Compensation or to undertake self-insurance in accordance with the provisions of that Code and Contractor agrees to comply with such provisions before commencing performance of the work on this Agreement.

By signing this Agreement, Contractor hereby warrants that it carries Workers' Compensation insurance on all of its employees, as defined under Labor Code section 3351, who will be engaged in the performance of this Agreement.

8) TERMINATION WITHOUT CAUSE:

Notwithstanding the General Terms and Conditions termination clause, DIR adds the following:

DIR may terminate this Agreement for any or no reason whatsoever, upon giving Contractor thirty (30) calendar days prior written notice.

Any termination shall be effected by written notice to Contractor, either hand-delivered to Contractor or sent certified mail, return receipt requested. The notice of termination shall specify the effective date of termination.

Upon receipt of notice of termination, and except as otherwise directed in the notice, Contractor shall:

- a. Stop work on the date specified in the notice;
- b. Place no further orders or enter into any further subcontracts for materials, services or facilities except as necessary to complete work under the Agreement up to effective date of termination;
- c. Terminate all orders and subcontracts;
- d. Promptly take all other reasonable and feasible steps to minimize any additional cost, loss, or expenditure associated with work terminated, including, but not limited to reasonable settlement of all outstanding liability and claims arising out of termination of orders and subcontracts;
- e. Immediately deliver to DIR or to any person or entity designated by DIR, all documentation and records pertaining to any case that has been submitted or assigned to Contractor for Independent Bill Review (IBR) under this Agreement and for which the IBR has not been completed or was completed within the one year period immediately preceding the date of receipt of notice of termination;
- f. Meet and confer with DIR to determine whether additional records and documentation from IBR cases completed more than a year prior to receipt of the notice of termination shall be delivered to DIR or a person or entity designated by DIR, destroyed, or retained by Contractor for the time specified in Exhibit A, Section 12(a) of this Agreement.
- g. Deliver or make available to the DIR all other data, drawings, specifications, reports, estimates, summaries, and such other information and material as may have been accumulated by Contractor under this Agreement, whether completed, partially completed, or in progress.

9) COMPUTER SOFTWARE COPYRIGHT COMPLIANCE:

By signing this Agreement, Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

10) BACKGROUND INVESTIGATION:

Due to the nature of the services to be performed, DIR reserves the right to conduct a thorough background investigation of Contractor, its agents, subcontractors and individual employees who will have access to medical information as part of their duties under this Agreement; and reserves the right to disapprove any individual from performing under the scope of this Agreement. Each Contractor, agent, subcontractor and individual employee who is to perform services under this Agreement must voluntarily consent to a background investigation, except for those persons who have had a background investigation as a condition of securing and maintaining licensure or certification as a medical professional. Previous clearances or investigations conducted by other agencies will not be accepted as an alternative to DIR's background investigation, with the exception that DIR may in its discretion accept a recent background investigation completed for purposes of performing services for the State of California's Department of Managed Health Care pursuant to Health and Safety Code sections 1370.4 and 1374.36. It is Contractor's responsibility to notify DIR when an employee working under this Agreement is terminated, not hired or reassigned to other work.

11) CONFLICT OF INTEREST:

No Contractor shall participate in the making of, or in any way attempt to influence, a decision in which Contractor knows, or has a reason to know, that it has a financial interest. Contractor shall notify DIR's Contract Manager immediately in writing if Contractor has a potential, or actual, conflict of interest relating to this Agreement.

Contractor shall abide by the provisions of Government Code Sections 1090, 81000 et seq., 82000 et seq., 87100 et seq., and 87300 et seq., Public Contract Code (PCC) Sections 10335 et seq. and 10410 et seq., California Code of Regulations, Title 2, Section 18700 et seq., and DIR's Incompatible Activities Policy

Every employee who participates in the process of making an IBR determination, with the exception of employees who perform purely ministerial, secretarial, manual, or clerical work, shall file a Statement of Economic Interests (Fair Political Practices Commission Form 700) within thirty (30) days of commencing work, annually during the life of the Agreement, and within thirty (30) days after leaving work or the expiration of the Agreement. Reports shall be filed with DIR and shall be in accordance with Political Reform Act requirements as well as the disclosure categories set for the in DIR's Conflict of Interest Code.

Contractor shall have a continuing duty to disclose to DIR, in writing, all interests and activities that create an actual or potential conflict of interest in performance of the Agreement.

Contractor shall have a continuing duty to keep DIR timely and fully apprised in writing of any material changes in Contractor's business structure or status. This includes any changes in business form, such as a change from sole proprietorship or partnership into a corporation or

vice-versa; any changes in company ownership; any dissolution of the business; any change of the name of the business; any filing in bankruptcy; any revocation of corporate status by the Secretary of State; and any other material changes in Contractor's business status or structure that could affect the performance of Contractor's duties under the Agreement.

If Contractor violates any provision of the above paragraphs, such action by Contractor shall render this Agreement void.

12) POTENTIAL SUBCONTRACTORS:

Nothing contained in this Agreement or otherwise, shall create any contractual relationship between the State and any subcontractors, and no subcontract shall relieve Contractor of responsibilities and obligations hereunder. Contractor agrees to be as fully responsible to the State for the acts and omissions of its subcontractors and of persons either directly or indirectly employed Contractor. Although the State shall have no obligation to pay any moneys directly to any subcontractor, Contractor is encouraged to make timely payment to its subcontractors under all applicable State laws, rules and regulations.

13) FORCE MAJEURE:

Except for defaults of subcontractors at any tier, Contractor shall not be liable for any excess costs if the failure to perform the contract arises from causes beyond the control and without the fault or negligence of Contractor. Examples of such causes include, but are not limited to:

- Acts of nature or of the public enemy, and
- Acts of the federal or State government in either its sovereign or contractual capacity

If the failure to perform is caused by the default of a subcontractor at any tier, and if the cause of the default is beyond the control of both Contractor and subcontractor, and without the fault or negligence of either, Contractor shall not be liable for any excess costs for failure to perform.

14) PROGRESS REPORTS:

Contractor shall submit progress reports to the State representative as required, describing work performed, work status, work progress, difficulties encountered, remedial action, and statement of activity anticipated subsequent to reporting period for approval prior to payment of invoices. Contractor to be reimbursed by invoicing, in detail, all costs and charges with Contract Number and sending to designated address.

15) AUDIT:

Notwithstanding the Audit clause in Exhibit C, Contractor is required under this Agreement to keep records for three years after final payment unless a longer period of records retention is stipulated in writing by the State.

16) WAIVER OF RIGHTS:

Any action or inaction by the State or the failure of the State on any occasion to enforce any right or provision of the contract, shall not be construed to be a waiver by the State of its rights hereunder and shall not prevent the State from enforcing such provision or right on any future occasion. The rights and remedies of the State herein are cumulative and are in addition to any other rights or remedies that the State may have at law or in equity.

17) BUSINESS CONTINUITY AND DATA RECOVERY PLANS:

Contractor represents and warrants that (a) it has a detailed written plan to address the situation in which there is any incident or event affecting the security, integrity or existence of any and all data, in whatever form, including Confidential Information specified in Exhibit E, that is in the possession or control of Contractor and is needed to fulfill Contractor's obligation under the Agreement. Contractor further represents and warrants that such plan includes industry standard practices such as daily copying of digitalized data (24 hour backup). In addition, Contractor represents and warrants that it has a detailed written plan to address the situation in which there is any incident or event that makes it commercially impossible for Contractor to continue to fulfill its obligations under this agreement for a period of more than 72 (seventy-two) hours, and that such plan includes specific steps for the resumption of the performance of Contractor's obligation under the Agreement. Contractor agrees to provide DIR with a copy of both plans no later than 15 (fifteen) business days after commencement of the Agreement.

EXHIBIT E – Additional Provisions

INFORMATION SECURITY, INTEGRITY, AND CONFIDENTIALITY

Where access to personal^[1], confidential^[2], and/or sensitive^[3] information assets^[4] (hereafter, collectively referred to as Confidential Information) is required in the performance of this Agreement for the Department of Industrial Relations (DIR); or access to such information is not required but physical access to facilities or computer systems is required and such access presents the potential for incidental access and/or inadvertent disclosure of such information, Contractor agrees to the following:

1. **General Confidentiality of Data Provision:** Contractor shall protect all Confidential Information from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the State. This includes, but is not limited to, the secure transport, transmission and storage of data used or acquired in the performance of this Agreement. No reports, information, discoveries or data obtained, assembled or developed by Contractor in the performance of this Agreement may be released, published or made available to any individual or entity without prior written approval from the Department. Contractor shall retain as confidential all work performed under this Agreement, recommendations or reports made to DIR, and all discussions between Contractor and DIR staff, including all communications, whether oral, written or electronic. DIR may deem non-confidential part or all of the work or other information referenced in this paragraph without prior permission of Contractor.
2. Contractor warrants and certifies that in the performance of this Agreement, it will comply with all applicable statutes, rules, regulations and orders of the United States and the State of California and agrees to indemnify the State against any loss, cost, damage or liability by reason of Contractor's violation of this provision, including but not limited to information handling and confidentiality requirements outlined in the California Information Practices Act (Civil Code sections 1798 et seq.).
3. No reports, information, discoveries or data obtained, assembled or developed by Contractor in the performance of this Agreement, including any Confidential Information, may be released, published, orally disclosed, or made available to any individual or entity without prior written approval from the Department. In the event Contractor receives a request under California's Public Records Act (Government Code sections 6250 et seq.) for inspection or copies of any records or information pertaining to its work under this Agreement, Contractor shall notify DWC of the request by no later than the next business day following receipt of the request. Contractor shall include with the notification a copy of the request, if made in writing, or a full description of the request, including the identity and contract information of the requester, if made orally. Contractor shall cooperate fully with DWC in responding to the Public Records Act request, and shall not disclose in any manner (inspection, copy, description) any requested information, documents, data or records to the requestor absent explicit written instructions from DWC. Contractor shall maintain a log of all authorized disclosures made in response to a Public Records Act request.

[1] Information that identifies or describes an individual, including but not limited to, name, social security number, physical description, home address, home telephone number, education, financial account numbers, employment history and individually identifiable health information. (See California State Administrative Manual, sections 5300.4 and 5320.5).

[2] Information that is exempt from disclosure under the provisions of the California Public Records Act (GC 6250-6265) or other applicable state or federal laws. (See California State Administrative Manual, sections 5300.4 and 5320.5).

[3] Information, either public or confidential, maintained by the Department that requires special precautions to protect from unauthorized use, access, disclosure, modification, loss, or deletion. Sensitive information includes, but is not limited to, records of the Department's financial transactions and regulatory actions. (See California State Administrative Manual, sections 5300.4 and 5320.5).

[4] All categories of automated information, including but not limited to records, files, statistics and databases; and information technology facilities, equipment (including personal computer systems), and software owned or leased by the Department. (See California State Administrative Manual, section 5300.4).

In the event Contractor is served with a subpoena, court order or other written demand issued upon or by the authority of a law enforcement or regulatory agency for Confidential Information, or any records or data pertaining to its performance of the Agreement, Contractor shall provide the DIR Contract Manager a copy of such demand no later than the close of business on the day Contractor receives the demand, and shall cooperate fully with the State in responding to the demand. State shall have the right to oppose any such demand or participate in any resolution, mediation, or adjudication of a dispute regarding such demand at its own expense with respect to attorneys' fees and costs. Contractor shall not, except as authorized or required by his or her duties by law, reveal or divulge to any person or entity any of the Confidential Information concerning DIR, the Division of Workers' Compensation, the Workers' Compensation Appeals Board, and their affiliates which becomes known to him or her during the term of this Agreement.

4. Contractor shall not use or attempt to use, nor shall it enable or authorize any subcontractor or third party to sue, any such Confidential Information in any manner or for any purpose not authorized under this agreement.
5. Contractor shall comply, and shall cause its agents, subcontractors and individual employees to comply, with such directions as DIR shall make to ensure the safeguarding, including the confidentiality and only authorized access and use, of Confidential Information and DIR resources.
6. DIR reserves the right to require that, prior to commencing work on this contract, Contractor, its agents, subcontractors and individual employees who will be involved in the performance of this Agreement, sign an information security and confidentiality statement, in a form to be provided by DIR. In such cases, Contractor shall attest that its agents, subcontractors and individual employees who will be involved in the performance of this Agreement are bound by terms of a confidentiality agreement with Contractor similar in nature to this statement.
7. Upon discovery of a breach in security that has or may have resulted in compromise to Confidential Information, Contractor shall, at its own expense, comply with all federal and California law, and all State of California policies, guidelines, standards, memoranda and directives that govern or relate to responsibilities arising in the event of known or reasonably suspected breaches of any information or data (in whatever form and whether or not encrypted), including but limited to the obligation to issue timely notification of such breach to affected individuals. Contractor shall also notify DIR within two (2) hours of discovery. DIR's contacts for such notification is as follows:

James Culbeaux, Chief Information Technology Officer
Department of Industrial Relations
1515 Clay Street, Suite 1900
Oakland, California 94612
Phone: (510) 286-6801
Fax: (510) 286-6800

Susan M. Marsh, Counsel and Privacy Officer
Department of Industrial Relations
Office of the Director, Legal Unit
1515 Clay Street, Suite 701
Oakland, California 94612
Phone: (510) 286-3811
Fax: (510) 286-1220

Tim Ung, Information Security Officer
Department of Industrial Relations
1515 Clay Street, Fourth Floor
Oakland, California 94612
Phone: (510) 286-0948

Within 48 hours of discovery Contractor shall further provide to DIR, on a form provided by DIR, a description of the nature of the breach or potential breach in security, including the following information: the dates the incident occurred and was detected, the location, a general description of the incident including the nature of the data or information involved, the media or device type involved (e.g., computer, flash drive, PDA, hard copy of document), and whether the incident involved personal information protected under State or federal law. The notification shall also identify staff of Contractor (name, title and contact information) who discovered breach. Contractor shall also provide DIR with written notification of what corrective action it will take to prevent like incidents in the future. In addition, Contractor agrees to cooperate fully with any action the State takes in response to such breach, including an investigation of Contractor by the State. Contractor shall indemnify and hold harmless the State in the event of any third party claims or lawsuits arising from such breach.

8. Contractor agrees to properly secure and maintain any computer systems (hardware and software applications) that Contractor will use in the performance of this Agreement. This includes ensuring that all security patches, upgrades, and anti-virus updates are applied appropriately to secure data that may be used, transmitted, or stored on such systems in the performance of this Agreement.
9. Whenever Contractor utilizes non-State issued equipment in the performance of this Agreement, Contractor agrees, in addition to Paragraphs 1 through 8 above, to:
 - a. Access and use Confidential Information only for performing Agreement duties for DIR;
 - b. Install encryption technology on all equipment, including but not limited to, personal laptops, computers, handheld devices, and removable storage devices; e.g., flash drives, CDs, and DVDs;
 - c. Store and transmit Confidential Information using encryption technology;
 - d. Pay all costs associated with complying with the encryption requirements within this section whenever utilizing non-State issued equipment;
 - e. Have fully functional and operating encryption technology in place prior to commencing work on this Agreement;
 - f. Set the lock computer feature on personal laptops or PCs to automatically engage after no more than 15 minutes of keyboard and/or mouse inactivity;
 - g. Not remove Confidential Information from any Department-controlled work area without prior authorization from Department staff authorized to provide such authorization; and
 - h. Consent to DIR's monitoring of Contractor's activities involving use of DIR's systems, applications or network.

ATTACHMENT I

LABOR CODE EXCERPTS (as amended effective January 1, 2013)

Section 139.5

(a) (1) The administrative director shall contract with one or more independent medical review organizations and one or more independent bill review organizations to conduct reviews pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4. The independent review organizations shall be independent of any workers' compensation insurer or workers' compensation claims administrator doing business in this state. The administrative director may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4, that an organization shall be required to meet in order to qualify as an independent review organization and to assist the division in carrying out its responsibilities.

(2) To enable the independent review program to go into effect for injuries occurring on or after January 1, 2013, and until the administrative director establishes contracts as otherwise specified by this section, independent review organizations under contract with the Department of Managed Health Care pursuant to Section 1374.32 of the Health and Safety Code may be designated by the administrative director to conduct reviews pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4. The administrative director may use an interagency agreement to implement the independent review process beginning January 1, 2013. The administrative director may initially contract directly with the same organizations that are under contract with the Department of Managed Health Care on substantially the same terms without competitive bidding until January 1, 2015.

(b) (1) The independent medical review organizations and the medical professionals retained to conduct reviews shall be deemed to be consultants for purposes of this section.

(2) There shall be no monetary liability on the part of, and no cause of action shall arise against, any consultant on account of any communication by that consultant to the administrative director or any other officer, employee, agent, contractor, or consultant of the Division of Workers' Compensation, or on account of any communication by that consultant to any person when that communication is required by the terms of a contract with the administrative director pursuant to this section and the consultant does all of the following:

(A) Acts without malice.

(B) Makes a reasonable effort to determine the facts of the matter communicated.

(C) Acts with a reasonable belief that the communication is warranted by the facts actually known to the consultant after a reasonable effort to determine the facts.

(3) The immunities afforded by this section shall not affect the availability of any other privilege or immunity which may be afforded by law. Nothing in this section shall be construed to alter the laws regarding the confidentiality of medical records.

(c) (1) An organization contracted to perform independent medical review or independent bill review shall be required to employ a medical director who shall be responsible for advising the contractor on clinical issues. The medical director shall be a physician and surgeon licensed by the Medical Board of California or the California Osteopathic Medical Board.

(2) The independent review organization, any experts it designates to conduct a review, or any officer, director, or employee of the independent review organization shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:

(A) The employer, insurer or claims administrator, or utilization review organization.

(B) Any officer, director, employee of the employer, or insurer or claims administrator.

(C) A physician, the physician's medical group, the physician's independent practice association, or other provider involved in the medical treatment in dispute.

(D) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer, would be provided.

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee whose treatment is under review, or the alternative therapy, if any, recommended by the employer.

(F) The employee or the employee's immediate family, or the employee's attorney.

(d) The independent review organizations shall meet all of the following requirements:

(1) The organization shall not be an affiliate or a subsidiary of, nor in any way be owned or controlled by, a workers' compensation insurer, claims administrator, or a trade association of workers' compensation insurers or claims administrators. A board member, director, officer, or employee of the independent review organization shall not serve as a board member, director, or employee of a workers' compensation insurer or claims administrator. A board member, director, or officer of a workers' compensation insurer or claims administrator or a trade association of workers' compensation insurers or claims administrators shall not serve as a board member, director, officer, or employee of an independent review organization.

(2) The organization shall submit to the division the following information upon initial application to contract under this section and, except as otherwise provided, annually thereafter upon any change to any of the following information:

(A) The names of all stockholders and owners of more than 5 percent of any stock or options, if a publicly held organization.

(B) The names of all holders of bonds or notes in excess of one hundred thousand dollars (\$100,000), if any.

(C) The names of all corporations and organizations that the independent review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business.

(D) The names and biographical sketches of all directors, officers, and executives of the independent review organization, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with any employer, workers' compensation insurer, claims administrator, medical provider network, managed care organization, provider group, or board or committee of an employer, workers' compensation insurer, claims administrator, medical provider network, managed care organization, or provider group.

(E) (i) The percentage of revenue the independent review organization receives from expert reviews, including, but not limited to, external medical reviews, quality assurance reviews, utilization reviews, and bill reviews.

(ii) The names of any workers' compensation insurer, claims administrator, or provider group for which the independent review organization provides review services, including, but not limited to, utilization review, bill review, quality assurance review, and external medical review. Any change in this information shall be reported to the department within five business days of the change.

(F) A description of the review process, including, but not limited to, the method of selecting expert reviewers and matching the expert reviewers to specific cases.

(G) A description of the system the independent medical review organization uses to identify and recruit medical professionals to review treatment and treatment recommendation decisions, the number of medical professionals credentialed, and the types of cases and areas of expertise that the medical professionals are credentialed to review.

(H) A description of how the independent review organization ensures compliance with the conflict-of-interest requirements of this section.

(3) The organization shall demonstrate that it has a quality assurance mechanism in place that does all of the following:

(A) Ensures that any medical professionals retained are appropriately credentialed and privileged.

(B) Ensures that the reviews provided by the medical professionals or bill reviewers are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensures that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions and the medical necessity of treatments or therapies in question.

(D) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensures the independence of the medical professionals or bill reviewers retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts of interest, pursuant to paragraph (5).

(4) Medical professionals selected by independent medical review organizations to review medical treatment decisions shall be licensed physicians, as defined by Section 3209.3, in good standing, who meet the following minimum requirements:

(A) The physician shall be a clinician knowledgeable in the treatment of the employee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

(B) Notwithstanding any other provision of law, the physician shall hold a nonrestricted license in any state of the United States, and for physicians and surgeons holding an M.D. or D.O. degree, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. The independent medical review organization shall give preference to the use of a physician licensed in California as the reviewer.

(C) The physician shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

(D) Commencing January 1, 2014, the physician shall not hold an appointment as a qualified medical evaluator pursuant to Section 139.32.

(5) Neither the expert reviewer, nor the independent review organization, shall have any material professional, material familial, or material financial affiliation with any of the following:

(A) The employer, workers' compensation insurer or claims administrator, or a medical provider network of the insurer or claims administrator, except that an academic medical center under contract to the insurer or claims administrator to provide services to employees may qualify as an independent medical review organization provided it will not provide the service and provided the center is not the developer or manufacturer of the proposed treatment.

(B) Any officer, director, or management employee of the employer or workers' compensation insurer or claims administrator.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment.

(D) The institution at which the treatment would be provided.

(E) The development or manufacture of the treatment proposed for the employee whose condition is under review.

(F) The employee or the employee's immediate family.

(6) For purposes of this subdivision, the following terms shall have the following meanings:

(A) "Material familial affiliation" means any relationship as a spouse, child, parent, sibling, spouse's parent, or child's spouse.

(B) "Material financial affiliation" means any financial interest of more than 5 percent of total annual revenue or total annual income of an independent review organization or individual to which this subdivision applies. "Material financial affiliation" does not include payment by the employer to the independent review organization for the services required by the administrative director's contract with the independent review organization, nor does "material financial affiliation" include an expert's participation as a contracting medical provider where the expert is affiliated with an academic medical center or a National Cancer Institute-designated clinical cancer research center.

(C) "Material professional affiliation" means any physician-patient relationship, any partnership or

employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent review organization. "Material professional affiliation" does not include affiliations that are limited to staff privileges at a health facility.

(e) The division shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the administrative director, filed with it by an independent review organization under contract pursuant to this section. The division may charge a fee to the interested person for copying the requested information.

(f) The Legislature finds and declares that the services described in this section are of such a special and unique nature that they must be contracted out pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code. The Legislature further finds and declares that the services described in this section are a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130 of the Government Code.

Section 4610

(a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

- (1) Developed with involvement from actively practicing physicians.
- (2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.
- (3) Evaluated at least annually, and updated if necessary.
- (4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.
- (5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements shall be met:

- (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the 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. In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.
- (2) When the employee's condition is such that the employee 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, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.
- (3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the

request is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer

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 Section 4610.5, if applicable, or otherwise pursuant to Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny or delay a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(6) A utilization review decision to modify, delay, 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 any further recommendation by the same physician 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.

(7) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(8) If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

Section 4610.1

An employee shall not be entitled to an increase in compensation under Section 5814 for unreasonable delay in the provision of medical treatment for periods of time necessary to complete the utilization review process in compliance with Section 4610. A determination by the appeals board or a final determination of the administrative director pursuant to independent medical review that medical treatment is appropriate shall not be conclusive evidence that medical treatment was unreasonably delayed or denied for purposes of penalties under Section 5814. In no case shall this section preclude an employee from entitlement to an increase in compensation under Section 5814 when an employer has unreasonably delayed or denied medical treatment due to an unreasonable delay in completion of the utilization review process set forth in Section 4610.

Section 4610.5

4610.5. (a) This section applies to the following disputes:

(1) Any dispute over a utilization review decision regarding treatment for an injury occurring on or after January 1, 2013.

(2) Any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(b) A dispute described in subdivision (a) shall be resolved only in accordance with this section.

(c) For purposes of this section and Section 4610.6, the following definitions apply:

(1) "Disputed medical treatment" means medical treatment that has been modified, delayed, or denied by a utilization review decision.

(2) "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 following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:

(A) The guidelines adopted by the administrative director pursuant to Section 5307.27.

(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(3) "Utilization review decision" means a decision pursuant to Section 4610 to modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402.

(4) Unless otherwise indicated by context, "employer" means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

(d) If a utilization review decision denies, modifies, or delays a treatment recommendation, the employee may request an independent medical review as provided by this section.

(e) A utilization review decision may be reviewed or appealed only by independent medical review pursuant to this section. Neither the employee nor the employer shall have any liability for medical treatment furnished without the authorization of the employer if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review in accordance with this section.

(f) As part of its notification to the employee regarding an initial utilization review decision that denies, modifies, or delays a treatment recommendation, the employer shall provide the employee with a one-page form prescribed by the administrative director, and an addressed envelope, which the employee may return to the administrative director or the administrative director's designee to initiate an independent medical review. The employer shall include on the form any information required by the administrative

director to facilitate the completion of the independent medical review. The form shall also include all of the following:

(1) Notice that the utilization review decision is final unless the employee requests independent medical review.

(2) A statement indicating the employee's consent to obtain any necessary medical records from the employer or insurer and from any medical provider the employee may have consulted on the matter, to be signed by the employee.

(3) Notice of the employee's right to provide information or documentation, either directly or through the employee's physician, regarding the following:

(A) The treating physician's recommendation indicating that the disputed medical treatment is medically necessary for the employee's medical condition.

(B) Medical information or justification that a disputed medical treatment, on an urgent care or emergency basis, was medically necessary for the employee's medical condition.

(C) Reasonable information supporting the employee's position that the disputed medical treatment is or was medically necessary for the employee's medical condition, including all information provided to the employee by the employer or by the treating physician, still in the employee's possession, concerning the employer's or the physician's decision regarding the disputed medical treatment, as well as any additional material that the employee believes is relevant.

(g) The independent medical review process may be terminated at any time upon the employer's written authorization of the disputed medical treatment.

(h) (1) The employee may submit a request for independent medical review to the division no later than 30 days after the service of the utilization review decision to the employee.

(2) If at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit a request for independent medical review to the administrative director or administrative director's designee is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

(3) If the employer fails to comply with subdivision (f) at the time of notification of its utilization review decision, the time limitations for the employee to submit a request for independent medical review shall not begin to run until the employer provides the required notice to the employee.

(4) A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit a request for independent medical review on its own behalf. A request submitted by a provider pursuant to this paragraph shall be submitted to the administrative director or administrative director's designee within the time limitations applicable for an employee to submit a request for independent medical review.

(i) An employer shall not engage in any conduct that has the effect of delaying the independent review process. Engaging in that conduct or failure of the employer to promptly comply with this section is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount

determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars (\$5,000) for each day that proper notification to the employee is delayed. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(j) For purposes of this section, an employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf. A designation of an agent executed prior to the utilization review decision shall not be valid. The requesting physician may join with or otherwise assist the employee in seeking an independent medical review, and may advocate on behalf of the employee.

(k) The administrative director or his or her designee shall expeditiously review requests and immediately notify the employee and the employer in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the employer agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred if at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity.

(l) Upon notice from the administrative director that an independent review organization has been assigned, the employer shall provide to the independent medical review organization all of the following documents within 10 days of notice of assignment:

(1) A copy of all of the employee's medical records in the possession of the employer or under the control of the employer relevant to each of the following:

(A) The employee's current medical condition.

(B) The medical treatment being provided by the employer.

(C) The disputed medical treatment requested by the employee.

(2) A copy of all information provided to the employee by the employer concerning employer and provider decisions regarding the disputed treatment.

(3) A copy of any materials the employee or the employee's provider submitted to the employer in support of the employee's request for the disputed treatment.

(4) A copy of any other relevant documents or information used by the employer or its utilization review organization in determining whether the disputed treatment should have been provided, and any statements by the employer or its utilization review organization explaining the reasons for the decision to

deny, modify, or delay the recommended treatment on the basis of medical necessity. The employer shall concurrently provide a copy of the documents required by this paragraph to the employee and the requesting physician, except that documents previously provided to the employee or physician need not be provided again if a list of those documents is provided.

(m) Any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The employer shall concurrently provide a copy of medical records required by this subdivision to the employee or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

(n) If there is an imminent and serious threat to the health of the employee, as specified in subdivision (c) of Section 1374.33 of the Health and Safety Code, all necessary information and documents required by subdivision (l) shall be delivered to the independent medical review organization within 24 hours of approval of the request for review.

(o) The employer shall promptly issue a notification to the employee, after submitting all of the required material to the independent medical review organization, that lists documents submitted and includes copies of material not previously provided to the employee or the employee's designee.

Section 4610.6

4610.6. (a) Upon receipt of a case pursuant to Section 4610.5, an independent medical review organization shall conduct the review in accordance with this article and any regulations or orders of the administrative director. The organization's review shall be limited to an examination of the medical necessity of the disputed medical treatment.

(b) Upon receipt of information and documents related to a case, the medical reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the employee, provider reports, and any other information submitted to the organization or requested from any of the parties to the dispute by the reviewers. If the reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (c).

(c) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the employee and the standards of medical necessity as defined in subdivision (c) of Section 4610.5.

(d) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director. If the disputed medical treatment has not been provided and the employee's provider or the administrative director

certifies in writing that an imminent and serious threat to the health of the employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the employee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

(e) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the employee's medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (c) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(f) The independent medical review organization shall provide the administrative director, the employer, the employee, and the employee's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(g) The determination of the independent medical review organization shall be deemed to be the determination of the administrative director and shall be binding on all parties.

(h) A determination of the administrative director pursuant to this section may be reviewed only by a verified appeal from the medical review determination of the administrative director, filed with the appeals board for hearing pursuant to Chapter 3 (commencing with Section 5500) of Part 4 and served on all interested parties within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:

(1) The administrative director acted without or in excess of the administrative director's powers.

(2) The determination of the administrative director was procured by fraud.

(3) The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.

(4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.

(5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion.

(i) If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent medical review by a different independent review organization. In the event that a different independent medical review organization is not available after remand, the administrative director shall submit the dispute to the original medical review organization for review by a different reviewer in the organization. In no event shall a workers' compensation administrative law judge, the appeals board, or any higher court make a determination of medical necessity contrary to the determination of the independent medical review organization.

(j) Upon receiving the determination of the administrative director that a disputed health care service is medically necessary, the employer shall promptly implement the decision as provided by this section unless the employer has also disputed liability for any reason besides medical necessity. In the case of reimbursement for services already rendered, the employer shall reimburse the provider or employee, whichever applies, within 20 days, subject to resolution of any remaining issue of the amount of payment pursuant to Sections 4603.2 to 4603.6, inclusive. In the case of services not yet rendered, the employer shall authorize the services within five working days of receipt of the written determination from the independent medical review organization, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the authorization.

(k) Failure to pay for services already provided or to authorize services not yet rendered within the time prescribed by subdivision

(l) is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars (\$5,000) for each day the decision is not implemented. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(l) The costs of independent medical review and the administration of the independent medical review system shall be borne by employers through a fee system established by the administrative director. After considering any relevant information on program costs, the administrative director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews and the cost of administering the independent medical review system, which may vary depending on the type of medical condition under review and on other relevant factors.

(m) The administrative director may publish the results of independent medical review determinations after removing individually identifiable information.

(n) If any provision of this section, or the application thereof to any person or circumstances, is held invalid, the remainder of the section, and the application of its provisions to other persons or circumstances, shall not be affected thereby.

STATE OF CALIFORNIA
AGREEMENT SUMMARY
 STD. 215 (REV. 1-2014)

AGREEMENT NUMBER 41430056	AMENDMENT NUMBER
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CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED

1. CONTRACTOR'S NAME MAXIMUS FEDERAL SERVICES, INC.		2. FEDERAL I.D. NUMBER 20-2998066
3. AGENCY TRANSMITTING AGREEMENT DEPARTMENT OF INDUSTRIAL RELATIONS	4. DIVISION, BUREAU OR OTHER UNIT DIV. OF WORKERS' COMPENSATION	5. AGENCY BILLING CODE 37390
6. NAME AND TELEPHONE NUMBER OF CONTRACT ANALYST FOR QUESTIONS REGARDING THIS AGREEMENT Matthew Shiroma (510)286-6844		
7. HAS YOUR AGENCY CONTRACTED FOR THESE SERVICES BEFORE? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <small>(If YES, enter prior contractor name and Agreement Number)</small> Maximus Federal Services, Inc. Contract #41230038		

8. BRIEF DESCRIPTION OF SERVICES - LIMIT 72 CHARACTERS INCLUDING PUNCTUATION AND SPACES
 Contractor will provide Independent Medical Review (IMR) used to decide disputes regarding medical treatment in Workers' Compensation cases.

9. AGREEMENT OUTLINE *(Include reason for Agreement; Identify specific problems, administrative requirement, program need or other circumstances making the Agreement necessary; include special or unusual terms and conditions.)*
 Senate Bill 863 was signed into law by Governor Brown on September 18, 2012. The Bill requires Independent Medical Review to be used to decide disputes regarding medical treatment in Workers' Compensation cases. This agreement is necessary to establish a pool of qualified reviewers without increasing the State's personnel costs and to establish an IMR process which takes approximately 40 (or fewer) days to arrive at a determination so that the approximate treatment can be obtained for injured workers.

10. PAYMENT TERMS (More than one may apply.)

MONTHLY FLAT RATE QUARTERLY ONE-TIME PAYMENT PROGRESS PAYMENT
 ITEMIZED INVOICE WITHHOLD ADVANCED PAYMENT NOT TO EXCEED
 REIMBURSEMENT/REVENUE or

OTHER *(Explain)* No payment terms. This is a zero dollar agreement.

11. PROJECTED EXPENDITURES FUND TITLE	ITEM	F.Y.	CHAPTER	STATUTE	PROJECTED EXPENDITURES
GENERAL FUND	7350-001-0001	14/15	25	2014	\$0.00
GENERAL FUND	7350-001-0001	15/16		2015	\$0.00
GENERAL FUND	7350-001-0001	16/17		2016	\$0.00
GENERAL FUND	7350-001-0001	17/18		2017	\$0.00

OBJECT CODE	AGREEMENT TOTAL
OPTIONAL USE PCA/Index: 36300/3851	AMOUNT ENCUMBERED BY THIS DOCUMENT \$0.00
I CERTIFY upon my own personal knowledge that the budgeted funds for the current budget year are available for the period and purpose of the expenditure stated above.	PRIOR AMOUNT ENCUMBERED FOR THIS AGREEMENT

ACCOUNTING OFFICER'S SIGNATURE: Suzanne D. Carbo DATE SIGNED: 12/12/2014 TOTAL AMOUNT ENCUMBERED TO DATE

12. AGREEMENT	TERM		TOTAL COST OF THIS TRANSACTION	BID, SOLE SOURCE, EXEMPT
	From	Through		
Original	01/01/2015	12/31/2017	\$0.00	DIR DWC RFP 14-001
Amendment No. 1				
Amendment No. 2				
Amendment No. 3				
Amendment No. 4				
Amendment No. 5				
	TOTAL		\$0.00	

(Continue)

13. BIDDING METHOD USED:

- REQUEST FOR PROPOSAL (RFP) INVITATION FOR BID (IFB) USE OF MASTER SERVICE AGREEMENT
(Attach justification if secondary method is used)
- SOLE SOURCE CONTRACT EXEMPT FROM BIDDING OTHER *(Explain)*
(Attach STD. 821) *(Give authority for exempt status)*

NOTE: Proof of advertisement in the State Contracts Register or an approved form STD. 821, Contract Advertising Exemption Request, must be attached

DIR DWC RFP 14-001

14. SUMMARY OF BIDS *(List of bidders, bid amount and small business status) (If an amendment, sole source, or exempt, leave blank)*

CID - 81% and didn't pass for Phase II Peer Review - 45% and didn't pass for Phase II
 Claims Eval - 79% and didn't pass for Phase II ExamWorks - 85% and had a final score of 58%
 DC Risk - 39% and didn't pass for Phase II Maximus - 89% and had a final score of 89%

15. IF AWARD OF AGREEMENT IS TO OTHER THAN THE LOWER BIDDER, PLEASE EXPLAIN REASON(S) *(If an amendment, sole source, or exempt, leave blank)*

16. WHAT IS THE BASIS FOR DETERMINING THAT THE PRICE OR RATE IS REASONABLE?

Maximus and ExamWorks passed the Phase I (meets the requirement stated in the RFP). In Phase II (cost proposals), Maximus offered the lowest pricing compared to Examworks. In summary, Maximus offered \$347.55 per review compared to ExamWorks for \$505.50 per review.

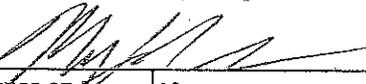
17 (a) JUSTIFICATION FOR CONTRACTING OUT *(Check one)*

- Contracting out is based on cost savings per Government Code 19130(a). The State Personnel Board has been so notified. Contracting out is justified based on Government Code 19130(b). Justification for the Agreement is described below.

Justification: The contractor will provide equipment, materials, facilities, or support services that could not feasibly be provided by the state in the location where the services are to be performed. The services contracted for reviewing/evaluating workplace injuries and medical determination, cannot be performed satisfactorily by civil service employee, and are highly specialized or of technical nature that the necessary expert knowledge, experience, and ability are not available through the civil service system.

17 (b) EMPLOYEE BARGAINING UNIT NOTIFICATION

By checking this box, I hereby certify compliance with Government Code section 19132(b)(1)

AUTHORIZED SIGNER: 

DATE: 12/12/2014

18. FOR AGREEMENTS IN EXCESS OF \$5,000, HAS THE LETTING OF THE AGREEMENT BEEN REPORTED TO THE DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING?

- NO YES N/A

19. HAVE CONFLICT OF INTEREST ISSUES BEEN IDENTIFIED AND RESOLVED AS REQUIRED BY THE STATE CONTRACT MANUAL SECTION 7.10?

- NO YES N/A

20. FOR CONSULTING AGREEMENTS, DID YOU REVIEW ANY CONTRACTOR EVALUATIONS ON FILE WITH THE DGS LEGAL OFFICE?

- NO YES NONE ON FILE N/A

21. IS A SIGNED COPY OF THE FOLLOWING ON FILE AT YOUR AGENCY FOR THIS CONTRACTOR?

A. CONTRACTOR CERTIFICATION CLAUSES

- NO YES N/A

B. STD.204, VENDOR DATA RECORD

- NO YES N/A

22. REQUIRED RESOLUTIONS ARE ATTACHED

- NO YES N/A

23. ARE DISABLED VETERANS BUSINESS ENTERPRISE GOALS REQUIRED? *(If an amendment, explain changes, if any)*

- NO *(Explain below)* YES *(If YES complete the following)*

DISABLED VETERAN BUSINESS ENTERPRISES: _____ OF AGREEMENT

Explain: The total budget is \$0.00 (zero dollars and zero cents).

24. IS THIS A SMALL BUSINESS CERTIFIED BY OSBCR?

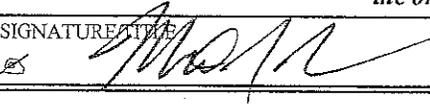
- NO YES *(Indicate Industry Group)* _____

SMALL BUSINESS REFERENCE NUMBER

25. IS THIS AGREEMENT (WITH AMENDMENTS) FOR A PERIOD OF TIME LONGER THAN TWO YEARS? *(If YES, provide justification)*

- NO YES Pursuant to legislative mandate in labor code section 139.5, subdivisions (a)(1) and (d & e) [Stats. 2012, Chap. 363 (SB 863), sec. 7. This contract has a budget of \$0.00.

I certify that all copies of the referenced Agreement will conform to the original Agreement sent to the Department of General Services.

SIGNATURE: 

DATE SIGNED: 12/12/2014