

**41430054**

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	12	page(s)
Exhibit A-1 - Maximus Response to DIR DWC RFP 14-002	213	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	8	page(s)
Exhibit E - Additional Provisions	3	page(s)
Attachment I - Labor Code Excerpts	10	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](http://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)

12/11/2014

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)

12/12/2014

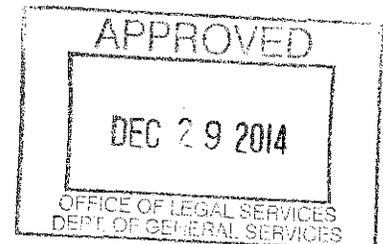
PRINTED NAME AND TITLE OF PERSON SIGNING

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



Exempt per:

## EXHIBIT A SCOPE OF WORK

Contractor MAXIMUS Federal Services, Inc. ("Contractor") agrees to provide independent bill review ("IBR") 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 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 (2) 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 the person or entity that made, or on whose behalf another person or entity made, a decision to deny all or part of the payment requested by the Provider for services rendered. Claims Administrator may be 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).

“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 IBR RFP, and incorporated herein except as noted below, may 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.

“IBR” means independent bill review, and specifically, the independent bill review authorized by Labor Code sections 4603.6 and 139.5 (as added by Stats. 2012, Ch. 363 (Senate Bill 863)) and their related regulations.

“Interested IBR Parties” means those individuals or entities that have an interest in the matter of the Independent Bill Review. Examples of Interested IBR Parties include the provider of medical or other authorized services, the injured worker, the injured worker’s employer, and the facility where health care services were rendered.

“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 a provider of medical treatment services or medical-legal services that has requested an independent bill review (IBR) to resolve a dispute over the amount of payment for services according to either a fee schedule established by the Administrative Director, including a fee schedule that is adopted or amended by the Administrative Director during the term of this agreement, or a contract for reimbursement rates under Labor Code section 5307.11. (The billing processes of providers of medical treatment services are governed by Labor Code section 4603.2. The billing processes of providers of medical-legal services are governed by Labor Code sections 4620 and 4622.) Providers may include, but are not limited to, physicians, hospitals, pharmacies, interpreters, copy services (after adoption of a fee schedule), and home care services (after adoption of a fee schedule). Interpretation services subject to IBR include interpretation at medical visits and medical-legal evaluations, but do not include interpretation at hearings or depositions. Copy services subject to IBR include copying of medical records, but do not include copying of employment and other non-medical claims records.

“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.

#### **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 Bill 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 IBR reviews, 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 IBR process, including oversight for compliance with 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 IBR or the information submitted with the application is insufficient to begin the IBR process, and making an independent determination as to whether the case is eligible for IBR.
- 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 IBR 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 IBR 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 14-002, "Independent Bill Review", submitted by MAXIMUS Federal Services, Inc. ("the Response") and incorporated herein. DIR/DWC and Contractor agree that:

- A. In the Response on page 4-14 at section 4.2.6, "Case Workflow Tracking Reports," the last sentence of the first paragraph which reads,

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 in Appendix A.

***Is revised so it shall read,***

We understand that the requirements include the reporting elements listed in RFP Appendices B and C, the required case data elements provided as part of the submitted determination letters in Appendix A, and additional data elements that may be specified by DIR/DWC during the term of the Agreement.

- B. In the Response on page 4-23 at section 4.3.1, "Case Tracking System Technical Support", the following language ***shall be added*** 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.":

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 DIR/DWC 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.

C. In the Response on page 4-23, at section 4.3.2, "Case Tracking User Training and Materials, the language of the first paragraph, which reads,

Since the IBR 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. 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 along 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's program 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.

D. In the Response on page 4-24, at section 4.3.3, "Case Workflow Tracking System Updates and Changes," in the last paragraph, the following language ***shall be added*** after the sentence which reads, "Future case workflow tracking system updates determined to be reasonable have been incorporated into our per unit pricing structure and will not lead to additional costs.":

Such updates or enhancements shall include those made regularly to address needs presented by DIR/DWC.

and the following language **shall be added** after the last sentence, which reads, “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.”:

In addition to providing DIR/DWC with the system impact assessment and system documentation prior to the implementation of a case workflow tracking system change, MAXIMUS shall provide DIR/DWC with training on the updates or enhancements at least two (2) weeks prior to implementation of the update or enhancement.

***Such that the last paragraph of this section shall read, in its entirety, as follows:***

The system documentation that is provided to DWC will include both detailed system documentation and a non-technical summary of the upgrade. Future case workflow tracking system updates determined to be reasonable have been incorporated into our per unit pricing structure and will not lead to additional costs. Such updates or enhancements shall include those made regularly to address needs presented by DIR/DWC. Additional information regarding the costs to accommodate reasonable future modifications is included in our Cost Proposal. 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. In addition to providing DIR/DWC with the system impact assessment and system documentation prior to the implementation of a case workflow tracking system change, MAXIMUS shall provide DIR/DWC with training on the updates or enhancements at least two (2) weeks prior to implementation of the update or enhancement.

E. In the Response on page 4-25 at section 4.3.4, “Additional Functionality Requested,” the following language **shall be added** 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.

F. In the Response on page 4-34 at section 4.4.5.1, “Maintain a Case Work-flow Tracking System,” at the second paragraph, the first and second sentences that read,

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. DWC staff members receive a system-generated alert when assigned to complete eligibility review of an IBR case.

***Are revised and language is added 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 DCW 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 IBR 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.

G. In the Response on page 4-37 at section 4.4.6.1, "Reviewers Experience," the following language at the last bullet ***shall be deleted***:

Proficient in CPT, ICD9 or 10, HCPCS, and DSM-I-V coding, Medicare Correct Coding Initiatives, and the application of medical protocols in claims processing, including but not limited to multiple surgeries and bundling rules.

***And the following language shall be added in its place and govern:***

Proficient in CPT, ICD9 and, prior to the time that it becomes adopted as the industry standard, ICD 10, HCPCS, and DSM-I-V coding, Medicare Correct Coding Initiatives, and the application of medical protocols in claims processing, including but not limited to multiple surgeries and bundling rules.

H. In the Response on page 4-41 at section 4.4.11, "Confidentiality of Records and Information," under subsection 'MAXIMUS Federal Staff and Vendor Confidentiality Agreements,' the first sentence, which reads

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.

***Is revised so it shall read:***

MAXIMUS Federal requires that all staff, reviewers, subcontractors, and vendors sign confidentiality agreements acknowledging that all information relating to clinical review is

confidential; and agreeing to not make any unauthorized use or disclosure of any information relating to clinical review, and agreeing to prevent any unauthorized use or disclosure of any information relating to clinical review.

I. In the Response on page 4-43 at section 4.4.11.2, "Records and Information Provided," the first sentence which reads,

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

***Is revised so it shall read:***

MAXIMUS Federal understands that all records and information provided to, obtained by, or prepared by MAXIMUS Federal in connection with any IBR performed are DWC records and cannot be used for any purpose not specified under this agreement.

***And the following language is added immediately thereafter:***

Further, all records and information provided to or obtained by MAXIMUS Federal in connection with any IBR performed shall be considered DIR designated "Confidential Information" under the Agreement.

J. In the Response on page 4-43 at section 4.4.11.4, "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 DWC's operations made available to MAXIMUS Federal in order to carry out this agreement, or which become available to MAXIMUS Federal in carrying out this agreement, shall be considered designated "DIR Confidential Information" and shall be protected by MAXIMUS Federal from unauthorized use or disclosure.

K. In the Response on page 4-45 at section 4.4.12, "Quality Assurance," at the end of subsection 4.4.12.1, "Overview," and before the heading, "Quality Assurance Program," the following language ***shall be inserted:***

MAXIMUS shall notify DIR/DWC in writing in the event that there is a change to any of the following, which writing shall specify the nature of the change and the steps proposed to remedy the change:

- The MAXIMUS Federal Qualifications described for Levels 1 through 4 of the ‘Four Level Quality Assurance/Quality Control Process for IBR Decisions’ identified in Exhibit 2.2, “Key Features,” in the Response on page 2-5;
- In the Response on page 2-5 at ‘Experience and Familiarity with Workers’ Compensation Fee Schedules,’ the representation that “Our certified coders are required to maintain current knowledge, including updates, of the fee schedule as adopted by the DWC.”
- In the Response on page 2-7 under ‘Quality Management and URAC Accreditation’, the representation that MAXIMUS has obtained “full accreditation from URAC as an external review organization.”

L. In the Response on page 4-57 at section 4.4.24, “Monitoring of Contract Performance,” the last sentence of this section 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:***

We agree to revise and deliver to the Department Project Manager any report, as described at sections 4.4.12.5 and 4.4.12.6, or product, as identified in the exhibit “Intended Products” at section 1.4, that the Project Manager has deemed unacceptable within 15 working days of such designation.

M. In the Response on page 4-51 at section 4.4.12.5, “Within 15 Days of Each Month-end, Prepare a Summary Report of Work Completed the Previous Month,” the first sentence of the section which reads,

Within 15 days of the end of each month, our QA team will prepare a summary report of the work completed the prior month and submit it to DWC.

***Is revised so it shall read:***

Within the timeframe negotiated between DIR and MAXIMUS, MAXIMUS’s QA team will prepare a summary report of the work completed the prior month and submit it to DWC.

N. In the Response at Exhibit 5, “Management and Staffing”, on pages 5-4 and following, the “Staff Organization Plan” at section 5.1:

1) The biography of Natasha Miller on page 5-5 ***shall be deleted***. On page 5-7, in exhibit 5.1-1, “IBR Organization Chart,” “N. Miller” ***shall be deleted***. The name “Natasha Miller” and all text following her name under “Experienced Staff” at “Chief Coding Specialist/Reviewer,” on page 5-8 ***shall be deleted***.

2) The reference to J. Davalos in exhibit 5.1-1, “IBR Organization Chart,” on page 5-7 **shall be deleted**. In the table on page 5-9, the name, “Jorge Davalos” under “Experienced Staff at “Senior Operations Manager” **shall be deleted**.

O. In the Response at Exhibit 5. “Management and Staffing,” on page 5-6, after the biographical description of Director of Information Systems- Richard Brunner, the following language **shall be added**:

As of the date of execution of this agreement, this table identifies under “IBR” 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 performing 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 Bruner	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	.75	Director of Training	.25
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

Team Member	California Operations	IMR		IBR	
	FTE Equivalency	Project Role	FTE Equivalency	Project Role	FTE Equivalency
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, Providers must submit payment in advance to the Contractor. Direct payment is not intended to constitute a material affiliation between Contractor and Provider.

B. Payment shall be based on the fees proposed by the Contractor and agreed to by DIR/DWC. As of January 1, 2015, payment for IBR services by Contractor shall be as set forth below. The Parties agree that fees for Contractor's IBR 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.

<b>IBR Service:</b>	<b>Base Contract Period Fee*</b>
Completed IBR Review	\$ 195.00
Ineligible IBR Application**	\$ 47.50
Withdrawn IBR Review***	\$ 195.00

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

\*\*Case is determined ineligible or withdrawn prior to being sent to review.

\*\*\*Case is withdrawn after being sent to review.

[remainder of page intentionally left blank]

## **VII. Limitation of Liability**

The Parties acknowledge that Labor Code section 139.5(b) provides a limitation of monetary liability subject to the conditions therein. MAXIMUS Federal has determined that it is a consultant as defined in subdivision (b)(1) for the services provided under this agreement. Subdivision (b)(2) of section 139.5 provides that 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 DWC, or on account of any communication by that consultant to any person when that communication is required by the terms of an agreement pursuant to section 139.5, 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.

Section 139.5(b)(3) further provides that any 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, and that it shall not be construed to alter the laws regarding the confidentiality of medical records.

**Exhibit A-1 – Maximus Response to DIR DWC RFP 14-002**

Independent Bill Review  
State of California, DIR, DWC



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# 1. Introduction

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

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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 established the Independent Bill Review (IBR) process which resolves medical treatment regarding the amount to be paid to medical providers. IBR is effective for all dates of service on or after January 1, 2013 and is limited to disputes involving services of goods covered by fee schedules adopted by DWC or contract for reimbursement under Labor Code section 5307.11. IBR does not apply to billing disputes involving services or goods that are not covered under adopted fee schedules, disputes regarding treatment authorization or cases where the injury itself is in dispute.

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 IBR program. Throughout this process and the operation of IBR program over the last two years we developed an expert understanding of requirements of the program and to provide California's workers' compensation health care providers an independent, equitable program that helps to ensure fairness, and appropriate medical coding and reimbursement expertise.

## 1.2 Purpose

We understand that the purpose of this Request for Proposal (RFP) is the Department of Industrial Relations Division of Workers' Compensation to contract with an independent bill review organization (IBRO) to conduct independent bill reviews submitted to the IBRO by DWC by providers under Labor Code section 4603.6 and California Code of Regulations, title 8 (8 C.C.R.), section 9792.5.7, et seq. Essential to fulfilling this purpose the IBRO must be absolutely independent and free from conflict of interest.

It is our belief and understanding that there is only one IBRO that can fulfill this essential goal, MAXIMUS Federal. MAXIMUS Federal is the only IBRO that exclusively provides IMR services on behalf of state and federal government agencies. Meaning we do not provide any IBRO or related services to any claims administrator, state compensation insurance fund, workers' compensation, disability or

**?** did you **KNOW**

MAXIMUS Federal is ...

- The only vendor with an in-depth working knowledge of Senate Bill 863, Labor Code section 139.5 and 4603.7, and 8 CCR 9792.5.7, et al.
- The only IBRO that has California Government IBR experience
- The only IBRO 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

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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 IBRs to California providers.

	IBRO that exclusively provides government sponsored IBR services	Commercial Bill Review Organization (URO)
Organizational Independence	Yes	No
Utilization of Certified Coding Specialists who also hold Bachelor’s Degrees	Yes	Sometimes
Utilization of Bill Review Software with pre-determined coding edits	No	Yes
Use of applicable fee schedules and applicable rules from the National Correct Coding Initiative	Yes	Sometimes
Experience providing more than 100,000 conflict free independent bill reviews a year	Yes	No

**Exhibit 1.2-1: MAXIMUS Federal Advantages.** This table clearly illustrates why MAXIMUS Federal is the best option to support DWC’s stated purpose to provide unbiased, accurate, and timely IBRs to California providers.

### 1.3 Objective

As stated by DWC in their Initial Statement of Reasons in January 2013, the purpose of the DWC IBR program is to ensure that billing disputes in workers’ compensation cases will be resolved by a conflict-free medical billing and payment expert utilizing fee schedules adopted by the DWC Administrative Director. MAXIMUS Federal is the only IBRO with California IBR experience and that can provide DWC with conflict-free decision 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	Coding Specialists	10 days
2. Assignment of Cases for IBR	IBR Supervisor	1 day
3. Additional Information to Determine Eligibility	Coding Specialists	15 days (mail); 12 days (e-mail)
4. Timeframes for Completing Reviews	All Staff	30 days
5. Case Information and Changes in Case Status	Coding Specialists	30 days
6. Number and Type of Reviewers	IBR Supervisor and Recruitment Department	Ongoing
7. Content of Reviews	Chief Coding Reviewer	3-5 days
8. Distribution of Completed Reviews	Coding Specialists	1 day
9. Appeal and Review of Remanded Cases	IBR Supervisor and Coding Specialists	60 days

**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
10. Confidentiality of Records and Information	All Staff	Ongoing
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 IBR partner and features a team of certified coding professionals that are expert in the correct interpretation and application of the Official Medical Fee Schedule (OMFS). As a testament to our commitment to making the IBR 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 forgoing MAXIMUS Federal Services is confident that we can provide DWC with a conflict free, cost-effective, low-risk IBR service solution. We are positioned to implement this program immediately upon contract award without any organizational conflicts of interests to mitigate.

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Set forth below, based upon our understanding of the RFP instructions, please find an outline of our proposal design as well as information related to our general approach to meeting DWC's requirements for the provision of IBR services.

### Proposed Design

*Exhibit 2-1: Proposed Design* provides a brief overview of our proposed design for our proposal. Our proposal carefully tracks the requirements set forth in DWC's Request for Proposal (RFP) 14-002: Independent Bill 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, certified coding, and medical professional reviewer resources with direct California IMR experience that are ready to support the DWC IBR Project come January 1, 2015.

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did you  
KNOW

MAXIMUS Federal has ...

- A scalable workflow system, a team of certified coding professionals with the capacity to address 1,000 IBRs a month, and existing in-house resources available to address 10,000 IBRs a month
- Provided more than 200,000 IBRs in 2014 for government programs
- More than 10 years of California IBR experience and currently the only provider government sponsored IBR programs in the United States.
- No relationship with any claims administrator, workers' compensation, health or disability insurer or employer or medical provider 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 of 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 Bill 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.** *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 Bill Review Project (DWC IBR Project). We are committed to applying our knowledge and experience of the existing DWC IBR 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 IBR program experience with DWC and DMHC our experienced staff of certified Coding Specialists, 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 Bill Review Organization (IBRO) for the DWC IBR Project. Our objective is to continue to operate the DWC IBR Project in the most cost efficient manner while ensuring the highest quality of IBRs and continually striving to identify areas of innovation and improvement. MAXIMUS Federal is the only contractor who understands DWC, their IBR process and possesses practical experience in operating the DWC IBR Project.

For the past 10 years, we have successfully provided IBR services to a variety of California agencies, including DWC, and DMHC. As discussed above, MAXIMUS Federal is the only IBRO that is truly independent, can offer DWC first-hand IBR experience, and has the ability to leverage best practices and

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lessons learned developed in close collaboration with DWC to improve Project performance and outcomes. 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 DWC IBR 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.

Key Features	MAXIMUS Federal Qualifications
Capacity to perform over 10,000 IBRs per month by January 1, 2015	<ul style="list-style-type: none"> <li>■ Currently have seven full-time staff expert in all areas of IBR with 10 trained back office staff available as necessary and recruitment efforts are in place for additional full time staff to begin work prior to January 2015</li> </ul>
Access to Any Necessary Clinical Specialist	<ul style="list-style-type: none"> <li>■ Panel of 350 California licensed Medical Professional Reviewers available to provide clinical input as necessary on IBRs</li> <li>■ Access to another 600 California-licensed MPRs in active practice through subcontracting agreements with URAC accredited IROs</li> </ul>
Four-level Quality Assurance/Quality Control Process for IBR decisions	<ul style="list-style-type: none"> <li>■ Level 1: Orientation and ongoing training for Coding Specialists to ensure they understand program requirements. This onboarding process involves a direct interface with the Chief Coding Specialist and Senior Coding Consultant</li> <li>■ Level 2: Prospective, initial assessment of all new Coding Specialists with detailed feedback from the Chief Coding Specialist and Senior Coding Consultant until they are deemed ready to review on their own</li> <li>■ Level 3: Final decision letter quality assessment of summary, rationale and outcome that involves a daily random sample covering 24 technical and substantive elements</li> <li>■ Level 4: Each final decision letter undergoes an audit performed by to ensure legibility, completeness, and accuracy prior to distribution</li> </ul>
Experienced Project Management Staff	<ul style="list-style-type: none"> <li>■ Continued Project Oversight by existing Medical Director, Project Director, and IBR Supervisor</li> </ul>

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

We understand DWC is seeking a firm to conduct medical billing disputes referred to us by DWC under California Labor Code Section 4603.6, and California Code of Regulations, Title 8 (8 CCR), §9792.5.7, 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 state and federal agencies to provide IBR services. We have been providing IBR services for state IBR programs since 2001 and for more than 20 years for the Centers for Medicare & Medicaid Services (CMS). Since 2004 we have provided IBR services for the California Department of Managed Health Care and as DWC IBR contractor since 2012 we are the only organization with IBR experience in California.

In addition to our work with DWC and the other California agencies, we have successfully implemented health care IBR programs for more a number of state and Federal agencies including the Centers for Medicare & Medicaid. Our overall experience in state and federal government independent bill review programs sets us far apart from the competition. In 2013 alone we rendered more than 200,000

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independent bill review decisions addressing the full spectrum of health care claims including worker's compensation, Medicare, Medicaid, and group health while addressing such issue as appropriate application of fee schedules, correct coding (bundling and unbundling), and reasonable and customary reimbursement for non-contracted 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 160,000 IBRs for our Medicare Part A project, more than 15,000 IBRs for our Medicare Part C project, more than 20,000 IBRs for our Medicare Part B project and more than 5,000 IBRs for our state IBR programs. Based upon the two year history of the IBR program having less than 2,000 cases, we believe we are prepared to handle any expected increases in IBR volume in 2015. References for these projects are contained in *Section 6.2.12* of our proposal.

### **Commitment to California Based Operations**

We are licensed to do business in the State of California (please see *Appendix G: 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 DWC IMR Project. We believe our scalable system is the best solution to meet increasing IBR volumes. We continue to work closely with DWC to improve and upgrade *entellitrak* through regular system releases. To complement the *entellitrak* system and to enhance our ability to process IBRs 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

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

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## Medical Director

Paul Manchester, MD, MPH (California License #52883) will continue to serve as the Medical Director for the DWC IBR Project. In this capacity Dr. Manchester will continue to advise the IBR team on clinical issues which arise in IBRs. In addition, Dr. Manchester will provide assistance in assigning necessary medical professional reviewers to IBRs for cases that may require specialty clinical input such instances where payment for utilization of assistant surgeons is at issue or the intensity of the required services is at issue. With our panel of 350 California physicians we are in an excellent position to ensure all issues (reimbursement, coding, and clinical) are addressed in all IBRs.

## Experience Managing Electronic Submissions

We have significant experience receiving electronic IBR cases from all stakeholders for our IBR services for government agencies, individuals, and providers. For example, *entellitrak* features a secure 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 IBR projects we currently receive in excess of 15,000 electronic IBR cases a month.

## Experience and Familiarity with Workers' Compensation Fee Schedules

As set forth in *Section 6.2.3* of our proposal MAXIMUS Federal has extensive experience and familiarity with California workers' compensation fees schedules. Our reviewers are experts in the areas of interpretation and application of the Official Medical Fee Schedule (OMFS). Our certified coders are required to maintain current knowledge, including updates, of the fee schedule as adopted by the DWC.

MAXIMUS Federal reviews disputes involving the various fee schedules as described in the OMFS and Title 8 California Code of Regulations, including:

- Physician Services are reviewed using the following: Labor Code sections 4600, 4603.2, 5307.1 and 5307.11; and Regulations Title 8 California Code Regulations 9789.10, 9789.11, 9789.12.1 – 9789.19, 9791, 9791.1, 9792, and 9792.5
- Ambulance services are reviewed using Regulations Title 8 CCR § 9789.70, 9789.110 and 9789.111
- Clinical Laboratory services are reviewed using Regulations Title 8 CCR §9789.50
- Durable Medical Equipment Prosthetic Orthotics and Supplies (DMEPOS) services are reviewed using the following: Labor Code 5307.1; and Regulations Title 8 CCR §9789.60
- Inpatient Hospital services are reviewed using Regulations Title 8 CCR §9789.20-9789.25
- Outpatient Hospital services are reviewed using Regulations Title 8 CCR §9789.30-9789.39
- Pharmaceutical services are reviewed using the following: Labor Code 5307.1; and Regulations Title 8 CCR §9789.40
- Medical-Legal services are reviewed using the following resources: Labor Code 5400, 5401, 5402, 4650, 4628 and 139.2; and Regulations Title 8 CCR § 9793 -9795

## Existing Dedicated and Knowledgeable IBR Staff

We will leverage our current DWC IBR 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. We currently have a team of seven certified Coding Specialists dedicated to the IBR project with over 100 person years of coding experience. Our Coding Specialists are responsible for managing IBRs from

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receipt of an IBR application to closing the case. This current level of staffing is set for addressing 1,000 IBRs a month – the current volume of IBRs is approximately 100 a month. In preparation for anticipated higher volume we have also trained ten back up Coding Specialists who are available on an as needed basis and we are currently recruiting for additional full-time coding resources to be fully dedicated to the IBR program.

### **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 IBR 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 real-time access to data in August 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 available reports and dashboards are contained in *Section 4.2: Case Workflow Tracking System*.

In order to ensure we are collecting the most appropriate data a classifying the data correctly we have recently engaged Frank Neuhauser to serve as an expert consultant in reporting and data analysis. Mr. Neuhauser has more than 20 years of public policy research experience and has previously assisted DWC with the UC DATA project.

### **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, or disability insurer, medical provider network or any other type of payor. Simply put we can guarantee DWC that we will never contract with an entity that would create even a perceived conflict of interest with the IBR program. As such, we can guarantee DWC that we have no existing relationships and will have no relationship of any kind with any California claims administrator, workers' compensation, health or disability insurer or health care provider or medical provider network or any other entity that could create even a perceived conflict of interest for the IBR program. Moreover, we have no relationship with any national organization that is doing business in California (for example, Liberty Mutual, Anthem, Travelers, 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).

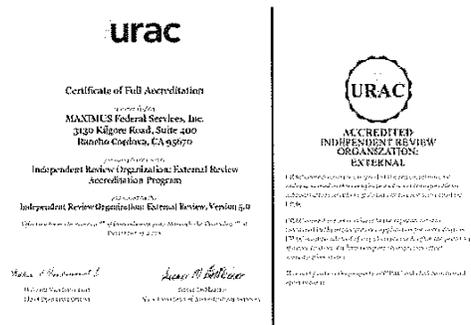
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**Our QMS:**

- 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.)

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 six times received full re-accreditation 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 IBR 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 bill reviews (IBR) on behalf of DWC is based upon on best practices and lessons learned as DWC's IBR partner since the program's inception. It is supported by a proven case management tool, *entellitrak*, and team of certified coders experienced in providing DWC IBR. As a testament to our IBR methodology, in a 2013 Customer Survey, DWC rated MAXIMUS Federal's quality of products as "high quality". Based on the foregoing we are confident we can provide DWC with a cost-effective, scalable, low-risk IBR 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 be used in conducting independent bill review. Please see *Section 4.2.1: Case Tracking Reporting* for a discussion of our analysis and reporting plans.

Having received more than 1,600 California IBRs since the program's inception, MAXIMUS Federal and its staff have a full and complete understanding of the California IBR program. Our experience provides us with an expert understanding of the workers' compensation and bill review industry and the role of IBRs for Providers and Claims Administrators. Since the implementation of the DWC IBR Program we have been able to continually leverage this unique experience and incorporate into our IBR methodology in the form of lessons learned and best practices.

All actions taken by MAXIMUS Federal during the IBR review process are updated in *entellitrak*. *Entellitrak* allows MAXIMUS Federal Project Staff to perform all actions required to assign and track a case through the various stages of the IBR process. This system was developed and customized specifically for DWC. We have been utilizing this and refining this system since January 2013 to meet DWC IBR requirements. It also allows DWC real-time access to case status and updates as we work side-by-side to ensure program success.

Through our IBR methodology we can ensure that our Coding Specialists, Chief Coding Reviewer, and MPRs (where applicable) promptly review all pertinent medical records and other appropriate information submitted relevant to the IBR and that the determinations and analyses are conducted professionally, thoroughly, and in a timely manner. We also have access to California-licensed attorneys who are expert in the legal issues that sometimes occur on IBRs, such as contract interpretations. If needed, we can provide DWC access to our attorney resources to assist with these cases.

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 supporting documentation. The purpose of this IBR program is to resolve medical billing disputes referred to the by DWC under Labor Code section 4603.6 and California Code of Regulations, Title 8 CCR, Section 9792.5.7, et al. is to decide disputes between physicians and Claims Administrators regarding the amount

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MAXIMUS Federal can offer ...:

- A proven scalable IBR workflow methodology that will support new innovations, including the online IBR application
- Proven management staff, including certified coders, experienced in performing DWC IBRs
- Only URAC accredited IBRO with direct experience providing DWC IBRs, which is continually leverage to incorporate best practices and lessons learned into our IBR workflow methodology

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of payment made by the Claims Administrator on a bill for medical treatment services or good rendered on or after January 1, 2013.

### 3.1 IBR Staff Resources

*Exhibit 3.1-1: IBR Staff Resources* describes the roles of the of the various IBR staff that support our IBR case methodology.

Staff Resource	Responsibilities
Administrative Staff	<ul style="list-style-type: none"> <li>■ Responsible for receiving IBR applications from Providers via online submission or mail</li> <li>■ Create a new case by data entering relevant case information into <i>entellitrak</i> and assign a unique internal case number for tracking and monitoring purposes</li> <li>■ Ensure that each IBR Application includes filing fee and supporting documents</li> </ul>
Coding Specialists	<ul style="list-style-type: none"> <li>■ Performs the Preliminary Review of cases</li> <li>■ Identifies potential eligibility issues</li> <li>■ Routes cases with potential eligibility issues to DWC for review</li> <li>■ Responsible for securing additional information to conduct IBR as necessary</li> <li>■ Request additional information from the Claims Administrator and other parties as necessary</li> <li>■ Identifies appropriate California Official Medical Fee Schedule (OMFS) sections to be applied</li> <li>■ Responsible for the appeal and review of remanded cases</li> <li>■ responsible for the distribution of completed reviews</li> <li>■ Initiates mailing of final determination letter</li> <li>■ Maintains the confidentiality of medical records and other data</li> </ul>
IBR Supervisor	<ul style="list-style-type: none"> <li>■ Determine the appropriate Chief Coding Reviewer, Coding Specialist, or MPR (as necessary) to review the case</li> <li>■ Ensure the Chief Coding Reviewer, Coding Specialist or MPR (as necessary) is qualified and available to review the case</li> <li>■ Perform a Chief Coding Reviewer, Coding Specialist or MPR (as necessary) conflict of interest check to ensure the review is conflict free</li> <li>■ Upload final determination letter and case file into Expert Gateway for MPR retrieval</li> </ul>
Chief Coding Reviewer	<ul style="list-style-type: none"> <li>■ Provides final quality control check on case information and letter contents prior to sending final determination letter</li> <li>■ Reviews completed IBRs and mentors Coding Specialists as required</li> <li>■ Maintains the confidentiality of medical records and other data</li> <li>■ Completes IBRs as an additional Coding Specialist, as needed</li> </ul>

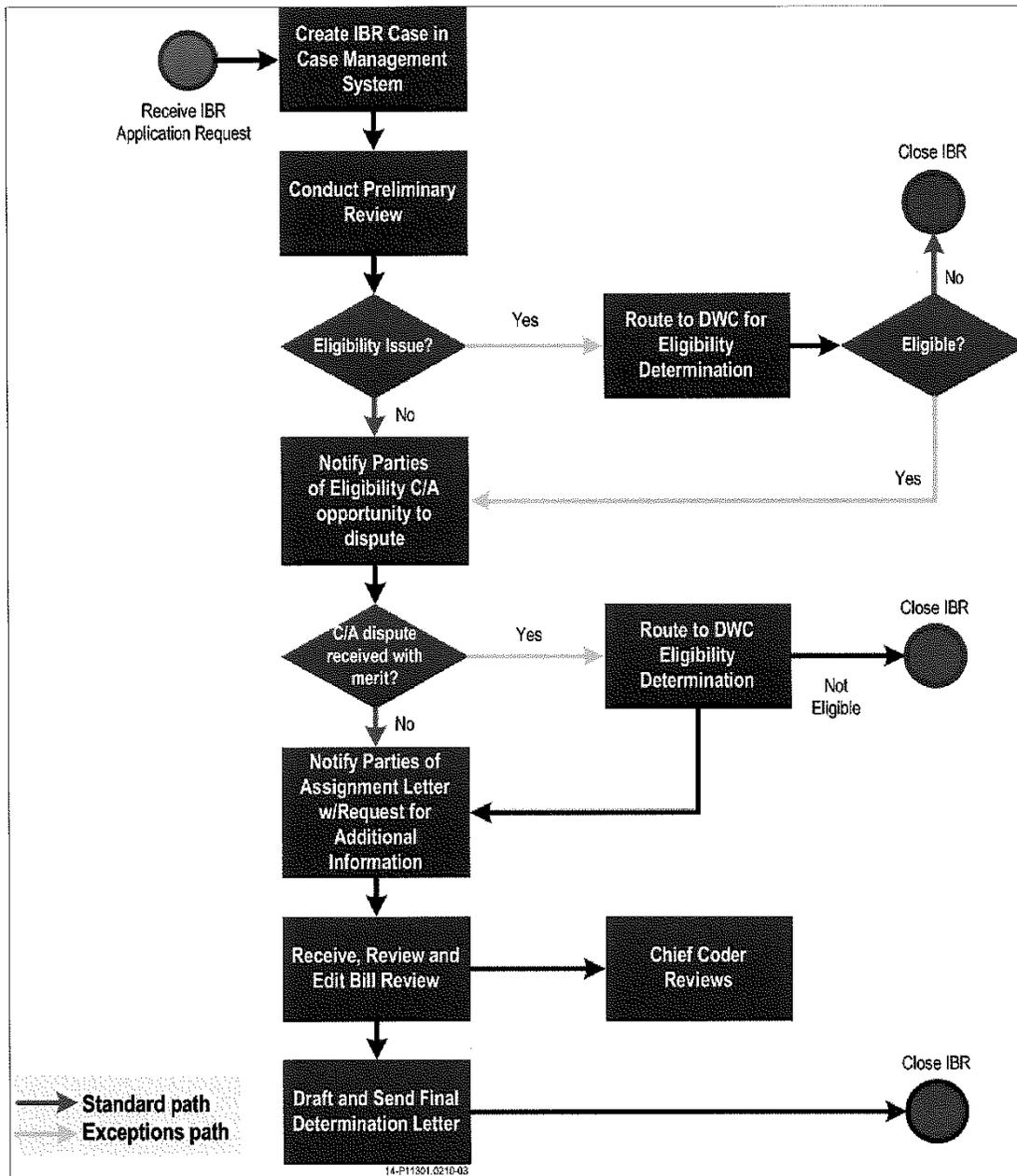
**Exhibit 3.1-1: IBR Staff Resources.** *This table describes the roles of the of the various IBR staff that support our IBR case methodology.*

We are confident our proven methodologies will allow us to continue to complete IBRs within 60 days as required by DWC.

### 3.2 Proposed IBR Workflow Process

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

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

Our IBR process will include the following steps:

- Case Creation
- Preliminary Review Process
- Requesting Additional Information
- IBR Case Assignment Process

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- Coding Specialist/MPR Review
- Case Closing Process

We are confident our IBR methodology will ensure we are able to maintain a 95 percent timeliness rate for the completion of DWC IBRs within the mandated timeframe of 60 days post assignment.

### **Case Creation**

Upon receipt of an IBR application and filing fee from the Providers, our administrative staff will enter the appropriate IBR case data and will create a new IBR case in *entellitrak*. Our administrative staff will automatically reject those IBR requests that are not accompanied by the appropriate filing fee or supporting documents.

If we reject the IBR request for either of these reasons our administrative staff will generate a notice via *entellitrak* notifying the provider that their request was not accepted, including the reasons for the rejection. Please see *Exhibit 3.2-2: IBR Application* illustrates that the Provider completes to begin the IBR. This form is accessed through the DWC website. Once all IBR review data is captured in *entellitrak*, an IBR Tracking Number is assigned to the case.

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The screenshot displays the 'Request for Independent Bill Review' form on the DIR website. Key sections include:

- Provider Information:** Fields for Provider Name (First, Middle, Last, Suffix), DBA, Contact Name, Street Address, PO Box, City, State (California), ZIP Code, Phone, Email, NPI, and License No.
- Provider's Agent/Representative Information:** Fields for Claims Administrator City, State (California), ZIP Code, Phone, Email, and Fax.
- Injured Worker:** Fields for Name (First, Last, Suffix), Date of Birth, Date of Injury, and SSN.
- Independent Bill Review Summary:** Includes 'Please select applicable Fee Schedules' (Physical Services), 'Claims Administrator Claim Number', 'Was the treatment in dispute authorized by Employer?', 'Reason for denial of full payment', 'Start Date of Service (MM/DD/YYYY)', 'End Date of Service (MM/DD/YYYY)', 'Amount in Dispute \$', and 'Date of Second Bill Review (MM/DD/YYYY)'. It also has a checkbox for 'Does the IBR request include consideration of multiple claims?'.

**Exhibit 3.2-2: IBR Application.** This screen depicts IBR Application that Providers can complete to begin the IBR Application.

This is an internal number that includes the DWC IBR number that is used to monitor the progress of the IBR throughout the review process and to ensure that DWC's timeframes are met.

**Preliminary Review**

For those IBRs that are deemed complete, a Coding Specialist will be assigned to conduct a preliminary review of the IBR application and supporting documentation. We understand that we have no more than 10 days from receipt of a complete application to complete the preliminary review. Upon completion of our preliminary review we will update *entellitrak* and notify DWC of the following preliminary review findings, as applicable:

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- There is a dispute over eligibility for IBR
- The application was not timely filed
- The application is a duplicate submission
- A second bill review was not timely requested or completed
- The medical treatment for which the bill was submitted was not authorized
- The service or good billed is not covered under a fee scheduled adopted by the DIR/DWC or contract for reimbursement under Labor Code section 5307.11
- The dispute involves the selection of an analogous procedure code or formula under a method not authorized by an adopted fee schedule
- There may be another reason why the case currently may be ineligible for IBR.

The assigned Coding Specialist will also notify DWC within the 10-day period if the information submitted with the IBR application is insufficient to begin the IBR process and initiate the request for additional information process, as applicable.

If this process identifies potential eligibility issues with the IBR it is routed to DWC for an eligibility determination. If DWC determines the case is ineligible the IBR is terminated. DWC will notify us of the termination. If DWC determines the case is eligible, it will continue through our IBR workflow process.

If DWC determines the IBR is ineligible by DWC, we will reimburse the provider at least 80 percent of the filing fee for a complete IBR review. Pursuant to 8 C.C.R. Section 9792.5.11, if a provider withdraws their IBR request prior to the assignment to a reviewer, we will reimburse the provider at least 80 percent of the filing fee.

### **Requesting Additional Information**

After preliminary review of a case, our Coding Specialist will request any additional information from the Provider or Claims Administrator that we determine is necessary to make a determination in the case in accordance with 8 C.C.R. Section 9792.5.10(b). The Coding Specialist will also request additional information from DIR/DWC as necessary.

All such requests and related information received will be updated in *entellitrak* and noted in our case summary. Our Coding Specialist is responsible for reviewing all information received from DWC, the Provider, and the Claims Administrator for legibility, completeness, and relevance to the case before forwarding it to the selected reviewer.

Once the case is deemed eligible, as outlined below:

- Our preliminary review discloses no reason why the case is ineligible for IBR and the information submitted with the application appears sufficient to begin the IBR review process, or
- We receive notification from DWC that the case is appears to be eligible for IBR

The Coding Specialist has one business day to provide written notification to the interested parties, under 8 C.C.R. Section 9792.5.9(b), that the Claims Administrator has the opportunity to dispute both the eligibility of the IBR request and the provider's reason for requesting IBR.

Upon receipt of this notice the Claims Administrator has 15 days from the notice date (by mail) or 12 days from the notice date if provided electronically to submit a disputing statement with supporting

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documentation. This notification also informs the parties of the Claims Administrator's obligation concurrently to send the Provider a copy of any information submitted to us and copies of any supporting documents not previously sent to the Provider.

**IBR Case Assignment**

An IBR is deemed ready for assignment when the following conditions have been met:

- When our preliminary review of documents submitted by the Provider and the Claims Administrator do not indicate any reason that the case can be considered ineligible
- The information submitted is sufficient to begin the IBR process
- DWC can also deem a case to be eligible for IBR

Within one business day after assignment, The Coding Specialist will generate a notice to alert the Provider and Claims Administrator that the case has been assigned for IBR. *Exhibit 3.2-3: Assignment Notice* illustrates the current content of the assignment notice.

**MAXIMUS FEDERAL SERVICES, INC.**  
Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
(855) 865-8873 Fax: (916) 605-4280

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**Assignment of Independent Bill Review with Request for Additional Documents**

Click here to enter a date.

<PROVIDER NAME, TITLE>  
<PROVIDER ADDRESS>  
<PROVIDER CITY, STATE, ZIP CODE>

IBR Case Number:	CB13 or 14-xxxxxxx	Date of Injury:	<MM/DD/YYYY>
Claim Number:	<CLAIM NUMBER>	Application Received:	<MM/DD/YYYY>
Claims Administrator:	<CLAIMS ADMIN>		
Date(s) of service:	<MM/DD/YYYY> - <MM/DD/YYYY>		
Provider Name:	<PROVIDER/GROUP NAME>		
Employee Name:	<EMPLOYEE NAME>		
Disputed Codes:	<CODES IN DISPUTE>		

Dear <PROVIDER NAME, TITLE>:

A Request for Independent Bill Review (IBR) pursuant to California Labor Code section 4603.6 was received by MAXIMUS Federal Services on <DATE>. The Administrative Director, Division of Workers' Compensation, has assigned MAXIMUS Federal Services to review requests for IBR and, if eligible, to impartially and independently perform the reviews.

Additional information is necessary to make a determination in the Independent Bill Review (IBR). Pursuant to California Labor Code section 4603.6, further documentation is needed in order to provide an accurate analysis and determination. Please provide the following additional documents:

Medical Records      Specify documents:  
 Contracted/Negotiated Rate      Specify documents:  
 Other      Specify documents:

Your statement and supporting documents must be submitted and received by MAXIMUS Federal Services within 35 days of the date designated on the notice if notice was provided by mail or within 32 days of the date designated on the provided notice if the notice was provided electronically. You may submit the information by (1) Facsimile to (916) 605-4280; (2) U.S. Postal Service mail; or (3) Delivery Service.

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**Exhibit 3.2-3: Assignment Notice.** This document illustrates the current content of our assignment notice.

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After assignment, the Coding Specialist will assess the information in the case file for regarding any illegible or incomplete information. Within two business days we will contact the appropriate party, in order to ensure a timely and effective IBR review and determination. We understand that if the Provider or Claims Administrator fails to provide requested information or documentation within the specified time period, we will, after consultation with and approval of DWC, conduct IBR based on available information.

The following shall be treated as one IBR claim or request unless subject to consolidation below:

- A claim involving medical treatment services by a single provider that involves one injured employee, one claims administrator one procedure code, under one fee schedule covering one range of effective dates and one date of service; or
- A claim involving medical legal services by a single provider that involves one injured employee, one claims administrator, an one medical-legal evaluation including supplemental reports based on the same evaluation, if any.
- Two or more requests, with a maximum of twenty (20), for independent bill review by a single provider may be consolidated if the Administrative Director or the IBRO determines that the requests involve common issues of law and fact or the delivery of similar or related services

Requests for independent bill review by a single provider involving multiple dates of medical treatment or medical-legal services may be consolidated and treated as one single independent bill review request if the requests involve one injured employee, one claims administrator, and one billing code under an applicable fee schedule adopted by the Administrative Director, or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, and the total amount in dispute does not exceed \$4,000.00.

Requests for independent bill review by a single provider involving multiple billing codes under applicable fee schedules adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, may be consolidated with no limit on the total dollar amount in dispute and treated as one request if the request involves one injured employee, one claims administrator, and one date of medical treatment service.

After consultation with the Administrative Director, the IBRO may allow the consolidation of requests or independent bill review by a single provider showing a possible pattern and practice of underpayment by a claims administrator for specific billing codes. Requests to be consolidated under the subdivision shall involve multiple injured employees, one claim administrator, one billing code, one or multiple dates of service and aggregated amounts in dispute up to \$4,000.00 or individual amounts in dispute less than \$50.00 each.

The IBR is responsible for assigning a Coding Specialist to perform the review. All of our Coding Specialists have or more of the following certifications: Registered Health Information Technician (RHIT), Registered Health Information Administrator (RHIA), Certified Professional Coder (CPC), or Certified Coding Specialist (CCS). Additionally, all of Coding Specialists meet the following minimum qualifications:

- Have a college or higher degree
- Are health care claims professionals with the following

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- Either a minimum of five (5) years health claims processing experience with an insurer, provider, governmental entity, or medical review organization, or at least ten (10) years medical claim auditing experience
- A thorough understanding of health claims payment practices, health insurance contracts, and judicial or alternative dispute resolution practices and procedures.
- Proficient in CPT, ICD9 or 10, HCPCS, and DSM-I-V coding, Medicare Correct Coding Initiatives, and the application of medical protocols in claims processing, including but not limited to multiple surgeries and bundling rules

There are rare instances when we will need physician review to complete the IBR. Generally the need for MPR resources occurs in the follow situations:

- **Substantiation of diagnosis or procedure code:** For physician or outpatient facility claim cases a physician review (usually surgeon) may be required for substantiation of a procedure when it is unclear on the operative report. This review should not take too long as only the operative report will need to be reviewed. For facility inpatient cases this would usually involve diagnosis substantiation (ex. acute renal failure). This review likely would require more time than a physician claim review as more documents (inpatient medical record) will need to be reviewed by the physician to make a determination. There are situations where a coder should be able to make independent decisions on diagnoses, but sometimes a clinician review is required to clarify.
- **Unspecified procedure codes:** Because the CA Worker's Comp fee schedule was based on an old version of CPT we thought that we may need help from physicians to determine what a similar procedure to the new one would be. I do not know if the work over the past year found that to be true. Do you have any idea on when they will be moving to up-to-date code set (or RBRVS methodology)?
- **Miscellaneous training needs:** This is something that I don't think that would be needed routinely but if we are coming up against the same issue on many cases we may want to consult a specialist to advise how we should be handling on a routine basis.
- **Separate and distinct service:** Based on the NCCI edits. Determination if a service was separate and distinct from other(s). This is just review of the operative report and there are many cases that a clinician will not need to be consulted.
- **Physician requesting reimbursement above fee schedule amount (Modifier 22).** Just operative report review to determine if additional reimbursement required and what percent above would make sense.

In these situations, the IBR Supervisor will identify a qualified MPR to assist with the IBR. We will only use California-licensed MPRs that are in active practice and otherwise eligible to IBRs/IMRs on behalf of DWC.

All of Coding Specialists and MPRs (as necessary) selected to review the case are screened by the IBR Supervisor to ensure they are conflict free in accordance Labor Code section 139.5 (c)(2). If the Supervisor discovers an actual or apparent conflict of interest we will immediately reassign the case to a different Coding Specialist or MPR. We will immediately notify DWC, the provider, and claims administrator of the reassignment.

All assignments are captured in the tracking system, and open IBRs for each Coding Specialist appears in his or her task queue.

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### ***MPR/Coding Specialist Review Process***

Upon receipt of the case file, the Coding Specialist and/or MPR will re-review all information for legibility, completeness, and relevance. In the rare instance a medical issue requiring MPR input is part of the case the review process will include additional steps as noted below.

In addition, the MPR will review 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 IBR Supervisor so the reassignment may occur. DWC will be notified immediately if and when reassignment is necessary.

The Coding Specialist and 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.

The Coding Specialist and MPR will certify and attest that they are qualified to review the case, that they have 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 Coding Specialist or MPR will forward the completed review to the Chief Coding Reviewer or IBR Supervisor.

### **Case Closing Process**

Upon return of the review, the Chief Coding Reviewer will audit each decision. At a minimum the Chief Coding Reviewer will meet the following qualifications:

- Be at a Registered Health Information Technician (RHIT) level or higher;
- Have both inpatient/outpatient and office based coding experience;
- Be able to competently use NDC calculators and NCCI edits; and
- Possess familiarity with California workers' compensation guidelines and fee schedules.

The audit is to ensure that each IBR decision specifically references the billing dispute, 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 Billing disputes Furthermore, each determination is reviewed to ensure that the determinations and analyses are performed under the guidelines set forth at 8 C.C.R. Section 9792.5.13, and are conducted professionally, thoroughly and in a timely manner. The audit also goes through a formal editing process to safeguard against typographical errors or the inclusion of erroneous information. The Chief Coding Reviewer will immediately contact the Coding Specialist or MPR (as necessary) for clarification of any issues.

After the Chief Coder completes the audit, the Coding Specialist will complete the IBR, enter its determination, and upload supporting documents into *entellitrak*. Once this is done they will issue a written determination to the Provider, the Claims Administrator, and the Administrative Director. The determination will include a statement that it constitutes the final determination of the DWC's Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f). Each final determination will include the following information:

- The determination and supporting analysis of each reviewer who participated in the IBR

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- The name of each reviewer
- If the determination finds that the Claims Administrator owes the Provider all or any part of the payment in dispute, the determination shall state that the Claims Administrator is required to reimburse the Provider for the IBR application fee, in addition to the amount found owing

**Case File Organization and Storage**

MAXIMUS Federal IBR files are organized in a standard format. All information received from DWC, Claims Administrators, and treating providers is scanned and then uploaded into *entellitrak*. The uploaded documentation is indexed by submitting party (for example, Claims Administrator, provider, and so on). This task is performed to safeguard and ensure that all information submitted is contained in the electronic case file. As IBRs are processed, further information is added to the electronic case file (for example, Eligibility Letter, Assignment letter, final determination, and additional information). Upon completion of the review process, the electronic version of the IBR 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
- Submitted Additional Information
- Request for Additional Information
- Claims Administrator Submission
- DWC and Submission

As set forth below, IBR 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, IBR staff is required to keep files secure during the review process. To help ensure the confidentiality of files during the review process, all IBR staff is required to sign a HIPAA Agreement.

## 4. Work Plan and Work Schedule Requirements

MAXIMUS Federal's IBR methodology is supported by a proven case management tool, *entellitrak*, a team of certified coders and a medical professional reviewer (MPR) panel of 950 California-licensed practitioners, and a staff with direct experience supporting DWC IBR. 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 20; C.2.b, Page 19

*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 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 has ...:

- A proven case management system that will support all of the deliverables for the DWC IBR Project
- A proven staff with direct California IBR experience to ensure deliverables are completed in an accurate and timely manner
- A work plan to provide IBRs 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	Coding Specialist	10 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 IBR requests
2. Additional Information to Determine Eligibility	Coding Specialist	15 days (mail); 12 days (e-mail)	See <i>Section 4.4.2</i> for the specific elements and related response requirements	This method is used to ensure that our Coding Specialists have all the necessary documentation to complete the IBR within the mandated timeframes
3. Assignment of Cases for IBR	IBR Supervisor	1 day	See <i>Section 4.4.3</i> for the specific elements and related response requirements	This method is used to assign IBRs to Coding Specialists for processing; a unique internal case number is assigned for tracking and monitoring purposes
4. Timeframes for Completing Reviews	All IBR Staff	30 days	See <i>Section 4.4.4</i> for the specific elements and related response requirements	This method includes our proposed IBR workflow and is used to ensure all cases are completed within the appropriate timeframes
5. Case Information and Changes in Case Status	All Staff	30 days	See <i>Section 4.4.5</i> for the specific elements and related response requirements	This method involves the use of <i>entellitrak</i> and is used to track case information and case status changes/updates

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Deliverables/Task	Responsible Party	Hours/ Task	Specific Elements/Response Requirements	Method Justification
6. Number and Type of Reviewers	Chief Coding Reviewer 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 certified coders and California-licensed reviewers to ensure we continue to have the appropriate resources to meet all review timeframes
7. Content of Reviews	Chief Coding Reviewer	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 determination to ensure accuracy and completeness
8. Distribution of Completed Reviews	Coding Specialist	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. Payment of Fees	Administrative Staff and IBR Supervisor	30 days	See <i>Section 4.4.9</i> for the specific elements and related response requirements	This method is used to ensure that filing fees and any additional fees are collected, and to ensure that provider reimbursements are issue when required
10. Appeal and Review of Remanded Cases	Coding Specialist and/or IBR Supervisor	60 days	See <i>Section 4.4.10</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
11. Confidentiality of Records and Information	All Staff	Ongoing	See <i>Section 4.4.11</i> for the specific elements and related response requirements	These methods are used to protect the confidentiality of records and related IBR information
12. Quality Assurance (QA)	Director of QA	Ongoing	See <i>Section 4.4.12</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.12
13. Liability	Medical Director and IBR Supervisor	Ongoing	See <i>Section 4.4.13</i> for the specific elements and related response requirements	These methods are to ensure the immunities afforded to MAXIMUS Federal and our MPRs under Labor Code Section 139.5(b) are upheld
14. Customer Service	Coding Specialist or Administrative Staff	Within 1 business day of contact	See <i>Section 4.4.14</i> for the specific elements and related response requirements	These methods are used to ensure that Interested Parties can access customer service via a toll-free telephone number, fax, or email for program complaints and questions
15. Timeliness	All Staff	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 maintain a 95% timeliness rating for all IBRs

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Deliverables/Task	Responsible Party	Hours/Task	Specific Elements/Response Requirements	Method Justification
16. Case Workflow Tracking System Availability Requirements	Director of Information Systems	Ongoing	See <i>Section 4.4.16</i> for the specific elements and related response requirements	These methods are used to ensure that we have a viable case workflow tracking system to process IBRs pursuant to DWC rules and regulations
17. Fraud and Quality of Care Reporting	QA Director	Ongoing	See <i>Section 4.4.17</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 quality of care.
18. Corporate Information	Project Director/ Client Executive	Annually	See <i>Section 4.4.18</i> for the specific elements and related response requirements	These methods are used to ensure all of the corporate information required under RFP Section A.18 is submitted to DWC on an annual basis
19. Required Documents	Project Director/Client Executive	Annually	See <i>Section 4.4.19</i> for the specific elements and related response requirements	The methods are used to ensure the required document listed in RFP Section A.19 are provided to DWC on an annual basis
20. Criminal Background Checks	Corporate and QA Director	Contract Award and every 2 years thereafter	See <i>Section 4.4.20</i> for the specific elements and related response requirements	These methods are used to ensure that criminal background checks are conducted on every current or prospective employee working on this Project and to ensure that these individuals are re-checked every two years as applicable
21. Certificate of Insurance	Corporate and Project Director	10 days post contract award	See <i>Section 4.4.21</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
22. Prohibited Conflicts of Interest	All Teams	Ongoing	See <i>Section 4.4.22</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 IBR review services

**Exhibit 4-1: Work Plan.** 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 IBR 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 6.2.8: 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 IBR operations and our specific strategies for mitigating them.

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Potential Theoretical of Practical Problems	Solutions, Alternatives, or Contingency Plans	Deliverables/Tasks Affected
Ability to handle IBR volumes	<ul style="list-style-type: none"> <li>■ Scalable workflow process supported by <i>entellitrak</i>, a proven case management system that has a long history of supporting large case volumes</li> <li>■ Utilize existing combined panel of certified coders and 950 board certified, California-licensed MPRs in active practice that are eligible to provide DWC IBRs</li> <li>■ Leverage identified key personnel who have direct DWC IBR management experience, including our certified coders and Appeal Officers</li> <li>■ Combining these resources provides us with the capacity of 1,000 IBRs per month</li> </ul>	<ul style="list-style-type: none"> <li>■ Preliminary Review of Cases</li> <li>■ Additional Information to Determine Eligibility</li> <li>■ Assignment of Cases for IBR</li> <li>■ Information to Conduct IBR</li> <li>■ Timeframes for Completing Reviews</li> <li>■ Case Information and Changes in Case Status</li> <li>■ Number and Type of Reviewers</li> <li>■ Content of Reviews</li> <li>■ Distribution of Completed Reviews</li> <li>■ Appeal and Review of Remanded Cases</li> <li>■ Confidentiality of Records and Information</li> <li>■ Quality Assurance (QA)</li> <li>■ Customer Service</li> <li>■ Timeliness</li> <li>■ Case Workflow Tracking System Availability Requirements</li> <li>■ Fraud and Quality of Care Reporting</li> <li>■ Prohibited Conflicts of Interest</li> </ul>
Understanding of DWC's IBR process and related rules and regulations	<ul style="list-style-type: none"> <li>■ Utilize our experience as the DWC incumbent where we have provided DWC IBRs since program exception</li> <li>■ Leverage our more than 12 years of experience providing CA IBRs for DMHC, CDI, and CalPERS</li> <li>■ Existing knowledge of California Labor Code Sections including 139.5, 4603.6, and California Code of Regulations, Title 8 (8 CCR), §9792.5.9, et seq.</li> </ul>	<ul style="list-style-type: none"> <li>■ Preliminary Review of Cases</li> <li>■ Additional Information to Determine Eligibility</li> <li>■ Assignment of Cases for IBR</li> <li>■ Information to Conduct IBR</li> <li>■ Timeframes for Completing Reviews</li> <li>■ Case Information and Changes in Case Status</li> <li>■ Number and Type of Reviewers</li> <li>■ Content of Reviews</li> <li>■ Distribution of Completed Reviews</li> <li>■ Payment of Fees</li> <li>■ Appeal and Review of Remanded Cases</li> <li>■ Confidentiality of Records and Information</li> <li>■ Quality Assurance (QA)</li> <li>■ Customer Service</li> <li>■ Timeliness</li> <li>■ Case Workflow Tracking System Availability Requirements</li> <li>■ Fraud and Quality of Care Reporting</li> <li>■ Prohibited Conflicts of Interest</li> </ul>
Rapid implementation timeframe and system stability	<ul style="list-style-type: none"> <li>■ Employ our proven IBR expertise, workflows, infrastructure, and staff/reviewer resources to be ready to begin project operations on January 1, 2015</li> </ul>	<ul style="list-style-type: none"> <li>■ Case Information and Changes in Case Status</li> <li>■ Number and Type of Reviewers</li> <li>■ Confidentiality of Records and Information</li> <li>■ Quality Assurance (QA)</li> <li>■ Customer Service</li> <li>■ Timeliness</li> <li>■ Case Workflow Tracking System Availability Requirements,</li> </ul>

**Exhibit 4-2: Potential Problems Risks.** *This table describes potential theoretical or practical problems associated*

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Potential Theoretical of Practical Problems	Solutions, Alternatives, or Contingency Plans	Deliverables/Tasks Affected
Sufficiency of Coding Specialists and MPR resources	<ul style="list-style-type: none"> <li>A staff of certified coders representing the following certifications: CCS, CPC, RHIA, and RHIT</li> <li>Combined panel of 950 credentialed MPRs that are in active practice and eligible to perform DWC IBRs</li> <li>Our Recruiting Department has launched a recruiting initiative to ensure we have sufficient certified coders and California-licensed reviewers in all ABMS specialties and subspecialties, as well as reviewers for emerging new technologies</li> </ul>	<ul style="list-style-type: none"> <li>Number and Type of Reviewers</li> <li>Appeal and Review of Remanded Cases</li> <li>Confidentiality of Records and Information</li> <li>Quality Assurance (QA),</li> </ul>

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

## 4.1 Conduct IBR

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

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

IBR Requirements	MAXIMUS Federal Approach
<ul style="list-style-type: none"> <li>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 provide timely, complete, and professional case analyses and determinations as described in Labor Code sections 4603.6 and 8 CCR 9792.5.9 et seq.</li> </ul>	<ul style="list-style-type: none"> <li>Utilize our existing secure Folsom, California office and staff to manage the DWC IBR Project</li> <li>Utilize <i>entellitrak</i> and supporting suite of tools to process, monitor, and report on DWC IBRs</li> <li>Utilize our team of certified coders and our existing panel of 950 California-licensed, board-certified MPRs in active practice</li> <li>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 Section 4.2.22: <i>Prohibited Conflicts of Interest</i> for additional information)</li> </ul>
<ul style="list-style-type: none"> <li>Provide reviews as set forth in the Deliverable section of this RFP</li> </ul>	<ul style="list-style-type: none"> <li>Utilize <i>entellitrak</i> and supporting suite of tools to process, monitor, and report on DWC IBRs</li> <li>Utilize our team of certified coders and our existing panel of 950 California-licensed, board-certified MPRs in active practice</li> </ul>

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

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IBR Requirements	MAXIMUS Federal Approach
<ul style="list-style-type: none"> <li>■ Recruit and verify credentials of bill reviewers</li> </ul>	<ul style="list-style-type: none"> <li>■ Our Recruiting Department has launched an ongoing recruiting initiative to increase our combined panel of certified coders and our more than 950 California-licensed MPRs. We have identified more than 80 new reviewer candidates, including 10 certified coders, in our application and credentialing pipeline. Please see <i>Section 4.4.6: Number and Types of Reviewers</i> for additional information about our recruiting process.</li> <li>■ 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>4.4.12.2: Credentialing and Privileging</i> for an overview of our credentialing program</li> </ul>
<ul style="list-style-type: none"> <li>■ Perform conflicts of interest checks</li> </ul>	<ul style="list-style-type: none"> <li>■ Through a reviewer and staff conflict of interest process we are able to avoid actual and apparent conflicts via a rigorous screening of every IBR case file throughout the IBR 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 6.2.13: Freedom from Conflicts of Interest</i> for additional information</li> </ul>
<ul style="list-style-type: none"> <li>■ Disclose financial interests of its employees</li> </ul>	<ul style="list-style-type: none"> <li>■ MAXIMUS Federal currently does not and will not in the future employ staff with financial interests as defined by DWC and the pertinent regulations.</li> </ul>
<ul style="list-style-type: none"> <li>■ Accept IBR applications via mail, fax, or online submission</li> </ul>	<ul style="list-style-type: none"> <li>■ MAXIMUS Federal currently accepts IBR applications via mail and fax at our Folsom, California Mailroom, and online submissions through entellitrak.</li> </ul>
<ul style="list-style-type: none"> <li>■ Conduct the initial review of IBR applications for eligibility under guidelines determined by the DWC</li> </ul>	<ul style="list-style-type: none"> <li>■ Our certified Coding Specialists perform eligibility review for IBR applications pursuant to DWC guidelines. Please see <i>Section 3: Overview</i> for additional information about our preliminary review process.</li> </ul>
<ul style="list-style-type: none"> <li>■ Conduct a secondary review of the IBR applications for eligibility under guidelines determined by DWC following the submission of documents by the payor/claims administrator.</li> </ul>	<ul style="list-style-type: none"> <li>■ Our certified Coding Specialists perform secondary eligibility review for IBR applications pursuant to DWC guidelines following the submission of documents by the payor/claims administrator. Please see <i>Section 3: Overview</i> for additional information about our preliminary review process</li> </ul>
<ul style="list-style-type: none"> <li>■ Notify the parties of IBR assignments and request mandatory information in a timely manner</li> </ul>	<ul style="list-style-type: none"> <li>■ Our certified Coding Specialists are responsible for notifying the parties of IBR assignments and requesting mandatory information from the Claims Administrator, Provider, and other parties as necessary. Please see <i>Section 3: Overview</i> for additional information about our case assessment process.</li> </ul>

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

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IBR Requirements	MAXIMUS Federal Approach
<ul style="list-style-type: none"> <li>Ensure that at all times it will have sufficient numbers of reviewers in a sufficient range of medical specialties available to satisfy the review timeframes set forth in this RFP</li> </ul>	<ul style="list-style-type: none"> <li>MAXIMUS Federal can offer DWC a team of certified coders and more than 950 California-licensed reviewers in active practice. Our MPR Panel represents every ABMS Specialty/Subspecialty. We also have an additional 10 qualified coding candidates in our application and credentialing pipeline. Please see <i>Section 4.4.6: Number and Types of Reviewers</i> for additional information about our recruiting process.</li> </ul>
<ul style="list-style-type: none"> <li>Have in place written policies and procedures to allow timely and effective referral of cases to qualified reviewers</li> </ul>	<ul style="list-style-type: none"> <li>Please see <i>Appendix B: Case Referral Policies and Procedures</i>, which is designed to ensure that qualified Coding Specialists and MPRs are assigned to IBRs. Please see <i>Section 3: Overview</i> for a detailed discussion of our case referral process.</li> </ul>
<ul style="list-style-type: none"> <li>Manage the processing and drafting of reviews and the revision of written determinations</li> </ul>	<ul style="list-style-type: none"> <li>Our Chief Coding Reviewer is responsible for processing final determination letters and revising written determinations as applicable. Our Coding Specialists are responsible for drafting reviews. Please see <i>Section 3: Overview</i> for additional information about these case-related actions.</li> </ul>
<ul style="list-style-type: none"> <li>Ensure the confidentiality of medical records and other data</li> </ul>	<ul style="list-style-type: none"> <li>As a provider of California IBR services since the program's inception 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 9792.5.9. Please see <i>Section 4.4.11: Confidentiality of Records and Information</i> for additional information about these measures.</li> </ul>
<ul style="list-style-type: none"> <li>Have in place protocols for providing appropriate training to reviewers in the proper methods of preparing IBR 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.</li> </ul>	<ul style="list-style-type: none"> <li>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 IBRs on behalf of this Project. Our training protocols and documentation of MPR training will be provided to DWC annually unless there are changes</li> </ul>
<ul style="list-style-type: none"> <li>Provide documentation of Quality Assurance/Quality Control (QA/QC) procedures to ensure that high-quality medical necessity determinations are made by reviewers.</li> </ul>	<ul style="list-style-type: none"> <li>Please see <i>Section 4.4.12: 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.</li> </ul>

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

## 4.2 Case Workflow Tracking System

RFP Section A.2 (a-o) Pages 4-6

The DWC requires a case workflow tracking system that meets the needs of the IBR 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



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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 an always better experience. Both DWC and MAXIMUS Federal are fully committed to continuous improvement, particularly where it concerns critical project systems. Over the last few months, MAXIMUS Federal has worked closely with DWC management to steadily improve the user satisfaction of our systems without compromising the continued effective workflow.

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 the integration of our Expert Gateway tool, and continuing improvements to our customized version of *entellitrak*. These continuous updates are made possible as *entellitrak* is based on an open architecture platform developed using the common Java programming language.

DWC staff will continue to have access to *entellitrak* at all times with consideration for the planned and unplanned outage allowances described in this RFP and in *Section 4.2.10. System Availability* of our response. The *entellitrak* system is complemented 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 *entellitrak*; our HIPAA-compliant secure file transfer protocol (sFTP) tool MOVE-IT; our database of expert reviewer qualifications and credentials in the event that medical review is necessary; our pending Expert Gateway; a new advanced reporting solution; and other basic office systems.

We also offer DWC our IBR application system currently used by providers to upload their billing review requests and make the required advanced payments. This web-based addition to the *entellitrak* system allows a provider to file and pre-pay their bill review requests electronically from their office computers. The information from these forms is incorporated as an electronic file to the *entellitrak* system to create a pending case. For the provider, this is the only step they need to do to initiate their review request. *Exhibit 4.2-1: Online IBR Application* shows the system currently used by providers to submit billing requests. 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.

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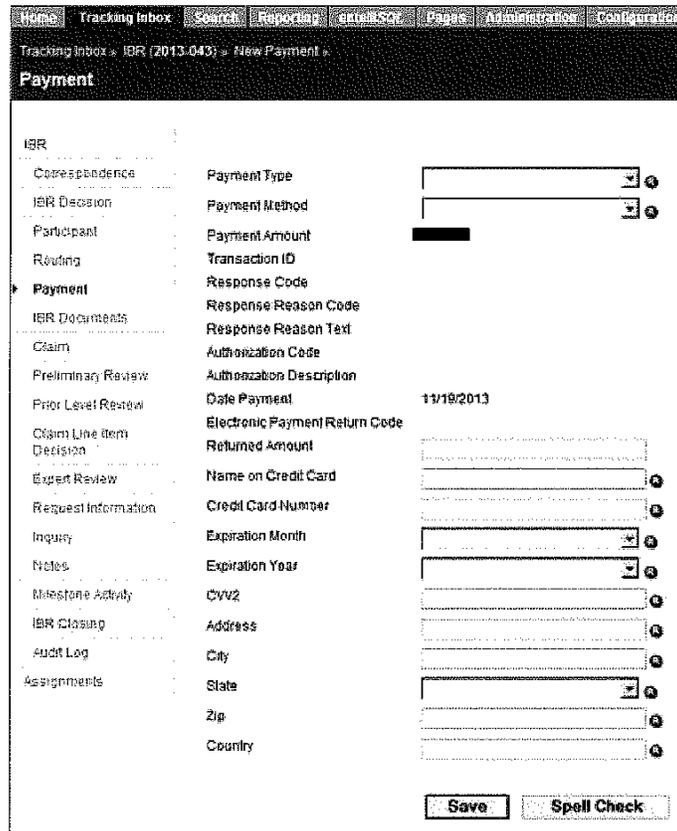
The screenshot shows the 'Request for Independent Bill Review' form. The status is 'Closed'. The form is divided into several sections:

- Provider Information:** Includes fields for Provider Name (DBA), Provider Contact Name (First, Middle, Last, Suffix), Provider Street Address / PO Box, Provider City, Provider State (California), Provider ZIP Code, Provider Phone, Provider Email, License No., and Provider Fax.
- Provider's Agent Representative Information (if applicable):** Includes fields for Claims Administrator City, State (California), ZIP Code, Phone, Email, and Fax.
- Injured Worker:** Includes fields for Federal Employee Identification Number (FEIN) or other ID, Injured Worker First Name, Middle, Last Name, Injured Worker SSN, Injured Worker Date of Birth, Date of Injury, and Injured Worker SIN.
- Independent Bill Review Summary:** Includes a section for 'Physician Services' with a 'Was the treatment in dispute authorized by Employer?' checkbox. It also has fields for 'Reason for denial of full payment', 'Start Date of Service (MM/DD/YYYY)', 'End Date of Service (MM/DD/YYYY)', 'Amount Billed \$', 'Amount Paid \$', and 'Amount in Dispute \$'. There is a checkbox for 'Does the IBR request include consultation of multiple claims?' and a 'Signature' field.

A sidebar on the left contains navigation links: IBR, Correspondence, IBR Discuss, Participant, Rating, Payment, IBR Documents, Claim, Preliminary Review, Prior Level Review, Claim Line Item, Election, Report Review, Request Information, Inquiry, Notes, Incomplete Entries, Document Creation, IBR Closing, and Add Log.

Exhibit 4.2-1: Online IBR Application.

As part of the online provider IBR application, we offer an online payment feature which allows advanced payments to be made at the time the review is requested. *Exhibit 4.2-2: IBR Application Payment Screen* demonstrates this function. This secure payment mechanism provides superior convenience for providers who can choose between credit, debit, or automated clearing house (ACH) electronic bank withdrawal payment methods. The MAXIMUS Federal IBR Project will continue to use this payment portal with the approval of DWC.

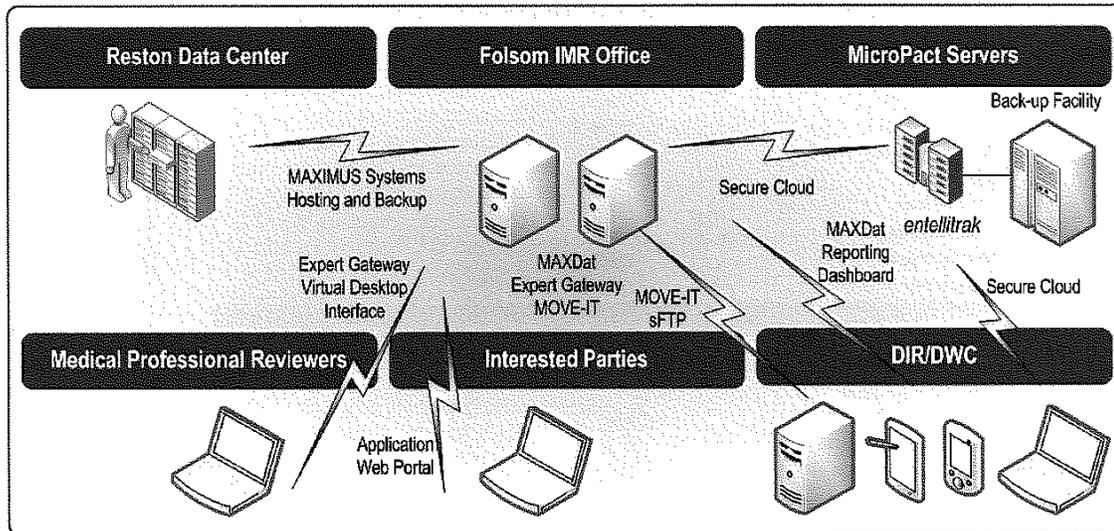


**Exhibit 4.2-2: IBR Application Payment Screen.**

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 IBR Project, although the IBR solution will focus on transparency and the needs of DWC. More information regarding our proposed reporting solution is found subsection 4.2.6: *Case Workflow Tracking Reports*.

In addition to the case workflow tracking system and MAXDat, MAXIMUS Federal also intends to launch our proven Expert Gateway functionality well in advance of the January 1<sup>st</sup>, 2015 launch date for this refreshed contract. Our Expert Gateway system will be used in the event that we need a licensed physician to complete a medical review of the IBR. The Gateway securely delivers claims documentation and related review materials to the assigned reviewers, providing immediate access to all the information required for informed and accurate billing reviews. This proven system currently supports more than 80,000 clinical reviews each month for our national projects.

Together, these system elements provide a solid, sophisticated solution for California’s growing IBR program. *Exhibit 4.2-3: IBR System Connections* demonstrates the parties and connections that compose the IBR system environment.



**Exhibit 4.2-3: IBR System Connections.** MAXIMUS Federal provides the solid infrastructure and connections to support increasing volumes of IBR work as well as 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 IBR 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.

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 billing reviewer, quality review of the received billing 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 billing 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.

*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.

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The screenshot displays the 'entellitrak Data Entry Screen' for the State of California Department of Industrial Relations. The page is divided into two main sections: 'Medical Provider Information' and 'Employer & Claims Administrator Information'. Each section contains various input fields for text, dates, and dropdown menus. At the bottom, there are radio buttons for 'Yes' and 'No' questions, and a 'Save' button.

Medical Provider Information	
Data Provided	Organization Name
Organization Name	Provider of Sacramento
Provider Specialty	Orthopedic Surgery
Provider Address 1	123 Main St.
Provider Address 2	
Provider City	Sacramento
Provider State	California
Provider Zip Code	95660
Provider Phone	555-555-5555
Provider Fax	555-555-5555
Employer & Claims Administrator Information	
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 Address 2	
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 (Use ICD Code where practical)	XXXX
Treatment Requested	MRI lumbar spine
Is the Claims Administrator Disputing Liability for the Requested Medical Treatment Besides the Question of Medical Necessity?	<input type="radio"/> Yes <input checked="" type="radio"/> No
IMR Form Signed?	<input checked="" type="radio"/> Yes <input type="radio"/> No
Status	Received
Appeal Type	
Assign Date	(mm/dd/yyyy)
Date Received	02/04/2014 (mm/dd/yyyy)
Deadline	(mm/dd/yyyy)
<b>Save</b>	

Exhibit 4.2.1-1: entellitrak Data Entry Screen.

In addition to applications entered by the Coding Specialists, providers have access to an online IBR application portal. This portal is demonstrated below in *Exhibit 4.2.1-2: entellitrak IBR Application Portal*.

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 review is sent to a DWC staff member for an eligibility determination. If determined eligible, the system

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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.

		DWC Policy Review			
		DIR Case number	DIR Received Date	DIR Status	DIR Preliminary Review Issue
Assign to	[icon]	[REDACTED]	2013-04-19	Pending Policy Question Response	DIR
Assign to	[icon]	[REDACTED]	2013-04-26	Pending Policy Question Response	Dir, Info
Assign to	[icon]	[REDACTED]	2013-04-24	Pending Policy Question Response	
Assign to	[icon]	[REDACTED]	2013-06-14	Pending Policy Question Response	
Assign to	[icon]	[REDACTED]	2013-06-28	Pending Policy Question Response	Dir, Ltr, Ltr
Assign to	[icon]	[REDACTED]	2013-07-01	Pending Policy Question Response	
Assign to	[icon]	[REDACTED]	2013-07-03	Pending Policy Question Response	Dir, Info, Ltr
Assign to	[icon]	[REDACTED]	2013-07-02	Pending Policy Question Response	Dir, Info
Assign to	[icon]	[REDACTED]	2013-07-05	Pending Policy Question Response	Dir, Info
Assign to	[icon]	[REDACTED]	2013-07-08	Pending Policy Question Response	Dir, Info

**Exhibit 4.2.1-2: entellitrak Work Queue.**

All notices, acknowledgements, and requests to the injured worker 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 Billing Review* and this is tracked 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 Federal 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 accessible 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*.

### 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

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 throughout 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 e-Billing Data

RFP Section A.2 (h,i), Page 4

*entellitrak* has the ability to accept bills submitted electronically through both the IBR application interface and through bulk transfer of files such as 837 files. We will work with DWC to transfer these files appropriately, and DWC will have the ability to view this information in *entellitrak*. We also will provide this data either in raw, coded form or in a human-readable format, including translation of codes where requested.

#### 4.2.6 Case Workflow Tracking Reports

RFP Section A.2 (j) Page 4; A.16 (a-d), Page 14

Reporting is one of the most important elements of the relationship between MAXIMUS Federal and our state clients. DWC needs full transparency into the daily operations of the IBR project and we provide that transparency through multiple avenues, including both self-service and responsive assistance from MAXIMUS Federal project management. In addition to system access, we 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.2.(j)*:

- Application Intake – to include all IBR requests and their operational process status
- In Flight Cases – to include all cases in process
- Workflow Reporting – to include individual and system process queues
- Eligibility Decision – to include all cases in which eligibility has been determined
- Rejection Decision – to include all cases in which eligibility has been rejected
- IBR Decision – to include all cases in which IBR decisions have been made

We understand and agree that these minimum 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 DWC's need for soft-copy, sortable reports with innovative new solutions described below.

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## **Introducing the MAXDat Reporting Platform**

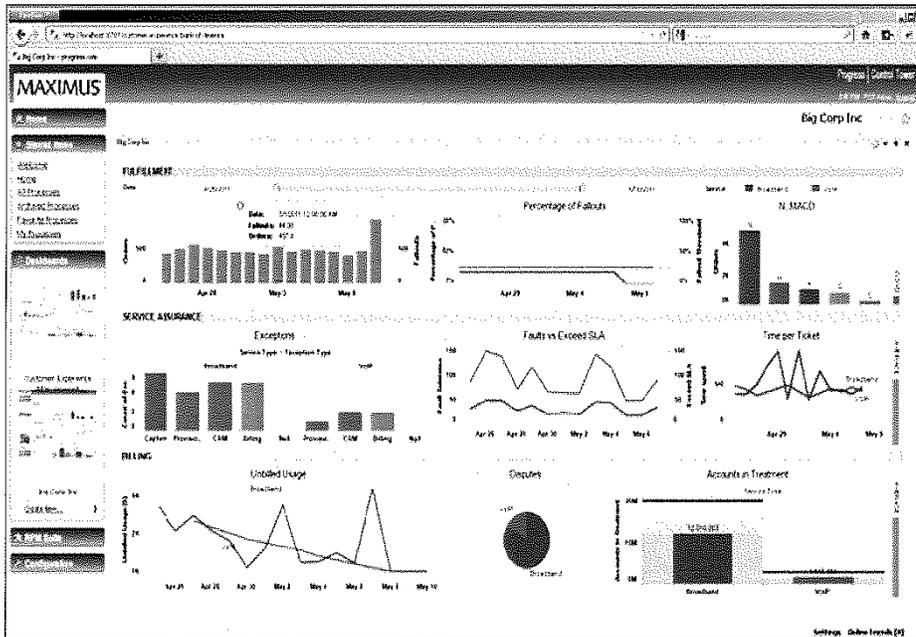
To address DWC needs, our solution includes the latest generation of our MAXDat Reporting platform. This is the same platform used for some of our large health care call center eligibility support projects in Texas, New York, Colorado, and California. Similar to billing reviews, the system routinely 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 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 analyses 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. As requested in the RFP, the information available in MAXDat will include available system information on the status of cases, such as whether the case has been assigned for IBR review, and the dates certain steps in the IMR process have been 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, DWC will be able to re-print weekly, monthly, quarterly, and annually submitted reports through this interface.

*Exhibit 4.2.1-1: Sample MAXDat Dashboard* provides a visual approximation of how case tracking information will be displayed for both MAXIMUS Federal and DWC users.

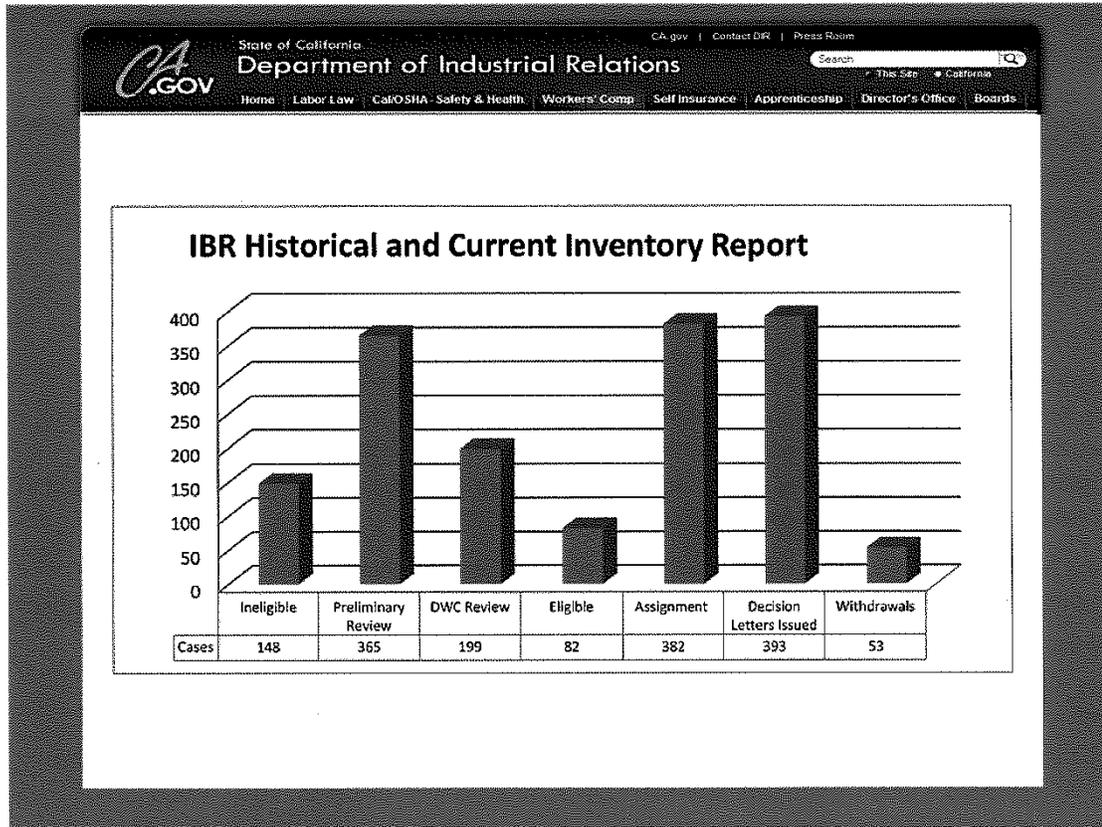


**Exhibit 4.2.1-1: Sample MAXDat Dashboard.** DWC users can display data in graphs and charts including the data elements listed in Appendix A.

As mentioned previously, the MAXDat dashboard is compatible with mobile devices, allowing DWC staff the ability to access IBR 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.

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 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, or a cumulative inventory.

*Exhibit 4.2.1-2: Example of Potential Inventory 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. This example shows data in the current categories requested by DWC.



**Exhibit 4.2.1-2: Example of Potential Inventory Dashboard.** MAXIMUS Federal provides DWC access to the IBR Project inventory in an easy-to-access format.

### 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 process metrics as well as IBR case 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?*

### 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. MAXIMUS Federal reporting specialists 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

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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 IBR Project by working with IBR 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 requested changes will meet the needs of DWC, and analyze 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.

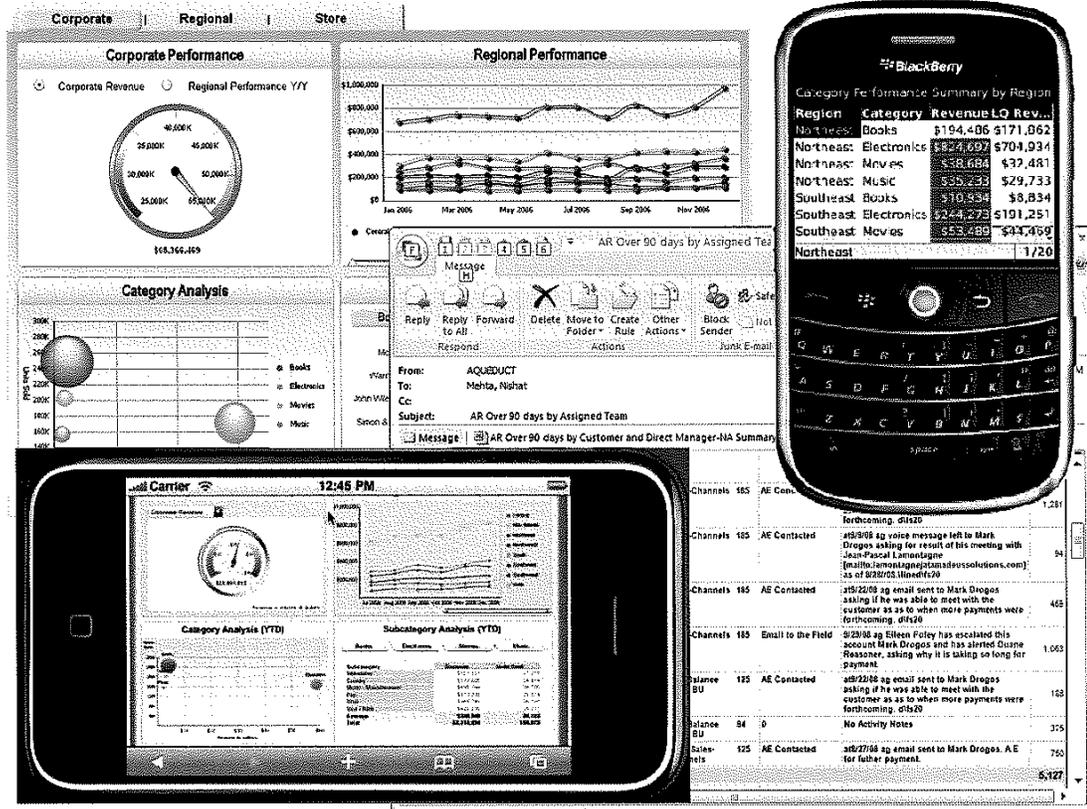
### **4.2.7 Web-Interface Design**

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 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 dates received and case status. 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 IBR Project. *Exhibit 4.2.7-1. MAXDat MicroStrategy Mobile Interface* provides a visual representation of the types of display capabilities inherent with the MAXDat solution.

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**Exhibit 4.2.7-1: MAXDat MicroStrategy Mobile Interface.** The mobile interface provides the DWC managers the right information, in the best form, with minimal user effort.

MAXDat is discussed in more detail in *Section 4.2.6. Case Workflow Tracking Reports*.

### 4.2.8 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, report generation, 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.

### 4.2.9 System Security

The *entellitrak* system is federally accredited and secure with certification and accreditation based on NIST 800-53, 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

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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 also performs routine web vulnerability scans in 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-developed system component, employs a secure Virtual Desktop Interface (VMWare View) that protects the confidentiality of the records and the 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 Coding Specialist 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 allows 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. Our IBR application portal payment functionality uses industry standard encryption for all transactions. For more information on project security and privacy procedures, including physical security, please see *Section 4.4.11: Confidentiality of Records and Information*.

#### **4.2.10 System Availability**

RFP Section A.2 (i-v), Page 5; 16 (a-d), Page 14

We understand that DWC requires access to the case workflow tracking system 7:00 am – 7:00 pm, Monday through Saturday at a minimum, except for planned outages with advance notice as described in *RFP Section A.2.ii*. We also understand that the IBR 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 IBR application will be stored temporarily as a secure data file until fully integrated into the system.

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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 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 our 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.

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 they employ 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 IBR 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 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 it 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.

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## System Readiness Testing and Penalties

The MAXIMUS Federal case workflow tracking system, *entellitrak*, is already in place and performing the required functions for IBR review. We understand that there are additional improvements to the current system that are required to meet all specifications in this RFP. These system improvements are in various stages of development and are planned to be tested and in place prior to January 1, 2015. 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 also 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. We will make any required payments within 30 days of receipt of notice in writing from DWC. MAXIMUS Federal acknowledges the statements provided in RFP Section 16 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 bill reviews from July 1, 2015, to the date the system changes are implemented.
- (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.

## 4.3 Technical Support and Administration

RFP Section A.5 (a-d), 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 administrative processes. Our focus is on efficiently providing our clients the support they require, as conveniently as possible. As the incumbent contractor on the IBR 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 IBR management team. Our goal is to continue to improve our support of the IBR program. We consider our technical support infrastructure an important aspect of our service delivery approach and will work closely with 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.5.a, Page 6

The IBR program is currently supported by our toll-free support line. The support line is operated from our Folsom, California office and is available during regular business hours (Monday-Friday, 8 am – 5 pm PST, excluding California State holidays). Callers are routed to the appropriate MAXIMUS Federal representative who 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 option to leave a message, with the option to flag the message as urgent. Urgent messages will be followed up on by an authorized MAXIMUS representative within the require timeframe.

MAXIMUS Federal will notify the IBR team of any Severity 1 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 that DWC consider testing the Severity 1 outage protocols on an annual basis to ensure that 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 reinforce that the 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.5.b Page 6

Since the IBR 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. 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 along 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 we 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 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.

### 4.3.3 Case Workflow Tracking System Updates and Changes

RFP Section A.5.c, 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 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:

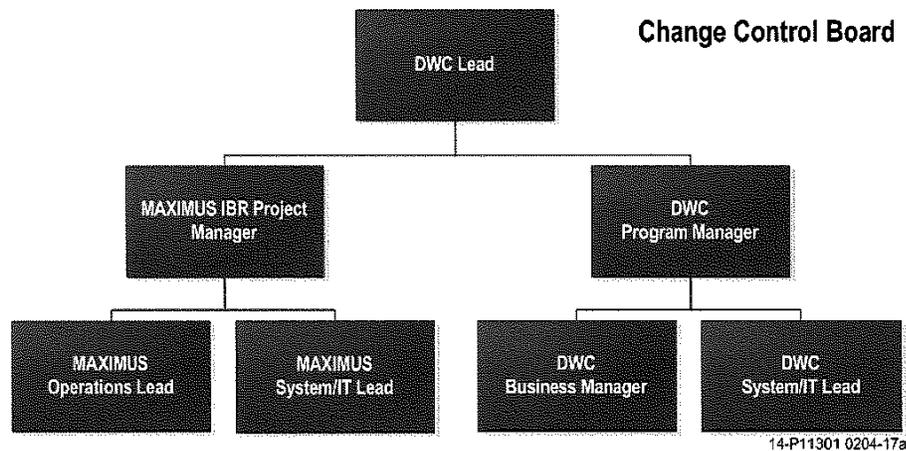
- URLs
- IP Addresses
- Supported Browsers

The system documentation that is provided to DWC will include both detailed system documentation and a non-technical summary of the upgrade. Future case workflow tracking system updates determined to be reasonable have been incorporated into our per unit pricing structure and will not lead to additional costs. Additional information regarding the costs to accommodate reasonable future modifications is included in our Cost Proposal. 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.

### 4.3.4 Additional Functionality Requested

RFP Section A.5.d, Page 6

We recommend that an official change control process be established to review and approve all system enhancements. The change control process will 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, the DWC technology team, the 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 IBR program.



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

MAXIMUS will prepare a system enhancement analysis document that evaluates the estimated implementation level of effort and the effect the implementation would have on IBR workflow processes. DWC will 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 of the system enhancement by DWC the change control board will initiate the system enhancement process with MAXIMUS Federal and we will then prepare a system enhancement project plan that includes the estimated implementation date and deliver the documentation to DWC.

## 4.4 Deliverables

RFP Section A (1-25), Pages 7-17

In this section we discuss our approach for meeting the Deliverables required under the IBR RFP.

### 4.4.1 Preliminary Review of Cases

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

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

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#### **4.4.1.1 Receive Applications with the Filing Fee Through an Online Submission or Via Mail**

RFP Section A.1.a (1-8), Page 7; A.3, Pages 8-9

We will apply those lessons learned and best practices developed in collaboration with DWC in processing IBRs since the inception of the program, including using a dedicated administrative staff to handle incoming applications online or via e-mail.

Upon receipt of an IBR application and filing fee from the Providers, our administrative staff will enter the appropriate IBR case data and create a new IBR case in *entellitrak*. Our administrative staff will automatically reject those IBR requests that are not accompanied by the appropriate filing fee or supporting documents. If we reject the IBR request for either of these reasons our administrative staff will generate a notice via *entellitrak* notifying the Provider that their request was not accepted, including the reasons for the rejection.

Once all IBR review data is captured in *entellitrak*, an IBR Tracking Number is assigned to the case. This is an internal number that includes the DWC IBR number that is used to monitor the progress of the IBR throughout the review process and to ensure that DWC's timeframes are met.

For those IBRs that are deemed complete, a Coding Specialist will be assigned to conduct a preliminary review of the IBR application and supporting documentation. We understand that we have no more than 10 days from receipt of a complete application to complete the preliminary review. Upon completion of our preliminary review we will update *entellitrak* and notify DWC of the following preliminary review findings, as applicable:

- There is a dispute over eligibility for IBR
- The application was not timely filed
- The application is a duplicate submission
- A second bill review was not timely requested or completed
- The medical treatment for which the bill was submitted was not authorized
- The service or good billed is not covered under a fee scheduled adopted by the DIR/DWC or contract for reimbursement under Labor Code section 5307.11
- The dispute involves the selection of an analogous procedure code or formula under a method not authorized by an adopted fee schedule
- There may be another reason why the case currently may be ineligible for IBR

The assigned Coding Specialist will also notify DWC within the 10-day period if the information submitted with the IBR application is insufficient to begin the IBR process and initiate the request for additional information process, as applicable.

If this process identifies potential eligibility issues with the IBR it is routed to DWC for an eligibility determination. If DWC determines the case is ineligible the IBR is terminated. DWC will notify us of the termination and we are responsible for notifying the applicant that the review is ineligible for IBR. If DWC determines the case is eligible, MAXIMUS Federal is notified and the case continues to Requested Additional Information or Case Assessment process.

#### 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 IBR Project Manager and a Coding Specialist familiar with the Project are on the on-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 IBR 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 IBR Project Manager. Our Director of Professional Relations, Medical Director, and IBR 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 IBR 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.

#### 4.4.1.3 Multiple Request are Consolidated Under Section 9792.5.12

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

Unless multiple requests are consolidated as referenced above, we understand that the following situations will be treated as one IBR claim or request unless subject to consolidation below:

- A claim involving medical treatment services by a single provider that involves one injured employee, one claims administrator, one procedure code under one fee schedule covering one range of effective dates, and one date of service; or
- A claim involving medical-legal services by a single provider that involves one injured employee, one claims administrator, and one medical-legal evaluation including supplemental reports based on that same evaluation, if any.

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#### **4.4.1.4 Ineligible IBR**

RFP Section A.1.d, Page 7

If DWC determines the IBR is ineligible, we will reimburse the provider at least 80 percent of the filing fee for a complete IBR review.

#### **4.4.1.5 Withdrawal of an IBR Set Forth in 8C.C.R, Section 9792.5.11**

RFP Section A.1.e, Page 7

Pursuant to 8 CCR Section 9792.5.11, if a provider withdraws their IBR request prior to the assignment to a Coding Specialist or MPR, we will reimburse the provider at least 80 percent of the filing fee.

#### **4.4.2 Additional Information to Determine Eligibility**

RFP Section A.2 (a), Pages 7

After preliminary review of a case, our Coding Specialist will request any additional information from the Provider or Claims Administrator that we determine is necessary to make a determination in the case in accordance with 8 C.C.R. Section 9792.5.10(b). The Coding Specialist will also request additional information from DWC as necessary.

#### **Preliminary Review Notification from DWC Case Eligible for IBR**

RFP Section A.2.b (1-2), Page 8

We understand that the Coding Specialist has one business day to provide written notification to the interested parties, under 8 C.C.R. Section 9792.5.9(b), that the Claims Administrator has the opportunity to dispute both the eligibility of the IBR request and the provider's reason for requesting IBR. The case is deemed eligible when the following has occurred:

- Our preliminary review discloses no reason why the case is ineligible for IBR and the information submitted with the application appears sufficient to begin the IBR review process, or
- We receive notification from DWC that the case appears to be eligible for IBR

Upon receipt of this notice the Claims Administrator has 15 days from the notice date (by mail) or 12 days from the notice date if provided electronically to submit a disputing statement with supporting documentation. This notification also informs the parties of the Claims Administrator's obligation to concurrently send the Provider a copy of any information submitted to us and copies of any supporting documents not previously sent to the Provider.

#### **4.4.2.1 Claims Administrator Submits Statement Disputing Eligibility But Does Not Submit Necessary Supporting Documents**

RFP Section A.2.c, Page 8

If the Claims Administrator submits a statement disputing eligibility but does not submit the necessary supporting documents, the Coding Specialist will send a notification to the Claims Administrator within one business day requesting that the documents be submitted within two business days. Once the documents are available, the Coding Specialist completes the preliminary review and sends notification within 10 days to DWC through *entellitrak* alerting DWC staff as to whether the case appears ineligible for IBR. DWC then reviews the case file and may investigate further and collect any additional information necessary to make an eligibility determination. If DWC deems the case eligible, the DWC staff members enters this in *entellitrak*

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to inform the Coding Specialist to initiate the IBR using all information collected for the case, including the information collected by DWC to determine eligibility..

#### **4.4.3 Assignment of Cases for Independent Bill Review**

RFP Section A.3 (a-g), Pages 8-9

The following sections describe the process for assigning cases of IBR and explain our steps for preventing conflicts of interest in the assignment process.

##### **4.4.3.1 Case Deemed Assigned for IBR**

RFP Section A.3.a, Page 8

MAXIMUS Federal understands that an IBR is deemed ready for assignment when the following conditions have been met:

- When our preliminary review of documents submitted by the Provider and the Claims Administrator do not indicate any reason that the case can be considered ineligible, and
- The information submitted is sufficient to begin the IBR process, or
- DWC can also deem a case to be eligible for IBR.

##### **4.4.3.2 Consolidate Up to Twenty Individual Requests Subject to IBR**

RFP Section A.3.b, Page 8

Pursuant to 8 C.C.R. Section 9792.5.12, we understand that Coding Specialists, under the guidance of the IBR Supervisor, may consolidate up to 20 individual requests subject to IBR for the purpose of having the disputes resolved in a single dispute.

##### **4.4.3.3 Notify the Provider and Claims Administrator of Case Assignment**

RFP Section A.3.c, Page 8

Within one business day after assignment, the Coding Specialist will generate a notice to alert the Provider and Claims Administrator that the case has been assigned for IBR in the manner set forth under 8 C.C.R. section 9792.5.9(f). *Exhibit 4.4.3-1: Assignment Notice* illustrates the current content of the assignment notice.

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<b>MAXIMUS FEDERAL SERVICES, INC.</b> Independent Bill Review P.O. Box 138006 Sacramento, CA 95813-8006 (855) 885-8873 Fax: (916) 605-4280			
<b>Assignment of Independent Bill Review with Request for Additional Documents</b>			
Click here to enter a date.			
<PROVIDER NAME, TITLE> <PROVIDER ADDRESS> <PROVIDER CITY, STATE, ZIP CODE>			
IBR Case Number:	C813 or 14-xxxxxxx	Date of Injury:	<MM/DD/YYYY>
Claim Number:	<CLAIM NUMBER>	Application Received:	<MM/DD/YYYY>
Claims Administrator:	<CLAIMS ADMIN>		
Date(s) of service:	<MM/DD/YYYY> - <MM/DD/YYYY>		
Provider Name:	<PROVIDER/GROUP NAME>		
Employee Name:	<EMPLOYEE NAME>		
Disputed Codes:	<CODES IN DISPUTE>		

Dear <PROVIDER NAME, TITLE>:

A Request for Independent Bill Review (IBR) pursuant to California Labor Code section 4603.6 was received by MAXIMUS Federal Services on <DATE>. The Administrative Director, Division of Workers' Compensation, has assigned MAXIMUS Federal Services to review requests for IBR and, if eligible, to impartially and independently perform the reviews.

Additional information is necessary to make a determination in the Independent Bill Review (IBR). Pursuant to California Labor Code section 4603.6, further documentation is needed in order to provide an accurate analysis and determination. Please provide the following additional documents:

Medical Records Specify documents:

Contracted/Negotiated Rate Specify documents:

Other Specify documents:

Your statement and supporting documents must be submitted and received by MAXIMUS Federal Services within 35 days of the date designated on the notice if notice was provided by mail or within 32 days of the date designated on the provided notice if the notice was provided electronically. You may submit the information by (1) Facsimile to (916) 605-4280; (2) U.S. Postal Service mail; or (3) Delivery Service.

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**Exhibit 4.4.3-1: Assignment Notice.** This document illustrates the current content of our assignment notice.

**4.4.3.4 Request Additional Information from Provider**

RFP Section A.3.d, Page 8

The Coding Specialist shall request any additional information from the Provider, Claims Administrator, or DWC that is necessary to make a determination in the case in the manner set forth under 8 C.C.R. section 9792.5.10(b). Whenever a request is made, the action is tracked in *entellitrak*. All associated notices, requests, and information received are stored in *entellitrak* and presented, as required, in the summary of the case.

**4.4.3.5 Review Information Received From DIR/DWC, the Provider, and the Claims Administrator**

RFP Section A.3.(e,f) Page 8

If after reviewing the information received there is any illegible or incomplete information is found or the Coding Specialist discovers a need for additional information, they will contact the appropriate party

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within two business days by telephone, fax, or secure e-mail, to request the information in order to ensure a timely and effective review and determination. We understand that if the Provider or Claims Administrator fails to provide requested information or documentation within the specified time period, we will, after consultation with and approval of DWC, conduct IBR based on available information.

#### **4.4.3.6 Compliance with Labor Code Section 139.5 and Any Other Conflicts of Interest Requirements**

RFP Section A.3.g, Page 8

MAXIMUS Federal offers DWC the only contractor that is absolutely free of any actual or perceived conflicts of interest. 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 Medical Professional Reviewers (MPRs) or Coding Specialists. These conflicts are avoided through a rigorous screening of every IBR case file before assigning it for medical review, in the event that this type of review is required, and before each billing review. As further explained in this section, our thorough screening process means that any conflicts of interest are prevented before they can occur, but we understand and agree that if any conflict of interest is discovered after assignment to a bill reviewer, the IBR will be immediately reassigned and MAXIMUS Federal will notify DWC, the provider, and the claims administrator of reassignment.

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 C: Conflict of Interest Policy and Procedures* for a detailed description of our conflict of interest measures.

#### **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 workers' compensation insurer or workers' compensation claims administrator, 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, or consulting) or have any relationship with any workers' compensation insurer or workers' compensation claims administrator, health plan or health or disability insurer, nor at any time in the future will we enter into any contractual agreements with any workers' compensation insurer or workers' compensation claims administrator, 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 workers' compensation insurer or workers' compensation claims administrator, health or disability insurer or health plan. Moreover, we have no relationship with any national workers' compensation insurer or workers' compensation claims administrator, health or disability insurer that is doing business in California.

Because MAXIMUS Federal's primary health care business is IMR/IBR, complete avoidance of conflict of interest is not only important to our clients, but is also one of our strategic core competencies. We

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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, provider, drug or device manufacturer, and or any party to an individual case. To ensure lack of conflict in an individual case, we subject 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 Coding Specialist, the file is screened for any potential conflicts with providers or claims administrators involved in the case and/or manufacturers of any device or medication at issue in the IBR.

During the case assignment process, the Chief Coding Reviewer or IBR Supervisor determines if a selected Coding Specialist has any conflicts of interest with the given case. If a medical review is required, the same conflict of interest checks are performed before assignment to an MPR, with consultation with the Medical Director. Finally, the Coding Specialist or 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 IBR. Additionally, prior to the assignment of a case to an expert coder or medical 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 Coding Specialists or 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 Coding Specialist or MPR is contacted and the case file is discussed as an additional means to avoid any conflicts of interest.

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All MAXIMUS Federal Coding Specialists and MPRs are contractually obligated to review each case 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 Medical Director reviews case files to identify potential conflicts of interest prior to assigning the case to a medical reviewer in the event that this type of review is required.

In addition to screening for conflicts, MAXIMUS Federal screens Coding Specialists and MPRs and their reviews to ensure that reviewers are neutral and display no general bias. The importance of neutrality and objectivity is also stressed in orientation and training. The MAXIMUS Federal Chief Coding Specialist, IBR Supervisor, or Medical Director screen all reviews 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 Coding Specialist or MPR is suspended from work with MAXIMUS Federal and subject to additional review by the Medical Director and the Director of Professional Relations' Credentialing Committee.

#### **4.4.4 Timeframes for Completing Reviews**

RFP Section A.4, Page 9

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

##### **4.4.4.1 IBR Completed and Determination Issued to the Provider and Claims Administrator within Sixty (60) Days**

RFP Section A.4.a, Page 9

For IBR reviews we will complete the IBR and submit the determination in writing to the Interested Parties within 60 days after receipt of all documents needed to complete the review.

#### **4.4.5 Case Information and Changes in Case Status**

RFP Section A.5 (a-g), Page 9

In this section we introduce *entellitrak*, 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 *entellitrak's* functionality.

##### **4.4.5.1 Maintain a Case Work-flow Tracking System**

RFP Section A.5.a, Page 9

As discussed in more detail in *Section 4.2: Case Workflow Tracking System* and mentioned throughout this bid we will use *entellitrak* as our case workflow tracking system to track the receipt, acceptance, assignment, and current status of applications and cases accepted for IBR. 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, we currently have in place an online IBR application capability used by providers and claims administrators. The provider or claims administrator is able to access a web interface to request a billing review, submit structured data about the claim or action resulting in the desire to request a review, and securely submit documents in support of the review. The provider or claims administrator is able to see the status of the case using a secure login and password that provides confidentiality of

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medical records and personal information. The identity of the IBR reviewers is kept confidential as required by law and this agreement.

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. DWC staff members receive a system-generated alert when assigned to complete eligibility review of an IBR 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 *entellitrak*, MAXIMUS plans to augment its systems capability by deploying the Expert Gateway to be used by MPRs to support Coding Specialists if clinical input is required. The Expert Gateway enables both medical records and discrete questions for a specific appeal to be directed electronically to an assigned reviewer. More information about the Expert Gateway, including security and confidentiality, can be found in *Section 4.2.9. System Security*.

#### 4.4.5.2 Data and Monitoring

RFP Section A.5.b, Page 9

We understand that all data acquired in the course of performance of the contract is the property of the 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 include the substantive content of fee schedules or billing rules used in the course of reviews. MAXIMUS Federal shall continue to provide all the data acquired while performing to the requirements of the contract to DIR/DWC. *Exhibit 4.4.5.2-1: Data Requirements* demonstrates the MAXIMUS Approach to addressing these data requirements.

Data Requirements	MAXIMUS Federal Approach
<ul style="list-style-type: none"> <li>■ Provide the determination for the parties.</li> </ul>	<ul style="list-style-type: none"> <li>■ Our IBR report form contains the reviewer’s decision and will be uploaded into <i>entellitrak</i> after it has successfully undergone an internal audit by the assigned reviewer for completeness, accuracy, and clarity</li> <li>■ Each determination notice will be pre-populated to increase accuracy and minimize the need for error correction</li> <li>■ We will use <i>entellitrak</i> to generate a determination notice to be sent to the provider and claims administrator</li> <li>■ 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>.</li> </ul>
<ul style="list-style-type: none"> <li>■ Provide a de-identified version of the determination for public disclosure.</li> </ul>	<ul style="list-style-type: none"> <li>■ <i>entellitrak</i> has the functionality to create a redacted case summary suitable for posting on the DWC website</li> <li>■ <i>entellitrak</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</li> <li>■ This report includes the IBR outcome determination and the redacted case reports as described in <i>Section</i></li> </ul>

**Exhibit 4.4.5.2-1: Data Requirements.** *This exhibit demonstrates the MAXIMUS Approach to addressing these data requirements.*

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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Data Requirements	MAXIMUS Federal Approach
<ul style="list-style-type: none"> <li>■ Enable complete workflow monitoring and individual case tracking from the date of receipt of an IBR application through the date of mailing of the final determination and through additional review.</li> </ul>	<p><i>4.2.2: Redacted Final Determination Forms.</i> An example is attached to this proposal as <i>Appendix E. Sample Redacted Case Summary.</i></p> <ul style="list-style-type: none"> <li>■ <i>entellitrak</i> is a proven scalable workflow monitoring and individual case tracking system that tracks the IBR, by date, from receipt to dissemination of the final determination letter, as well as any additional reviews</li> <li>■ <i>entellitrak</i> also monitors all decisions and changes to case status including the date, and the staff member or automated process that made the change</li> <li>■ 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 to be completed.</li> <li>■ The system includes a reason when a process is ended prematurely, such as an incomplete application or required records not submitted</li> <li>■ The information tracked by <i>entellitrak</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.</li> </ul>

**Exhibit 4.4.5.2-1: Data Requirements (continued).** *This exhibit demonstrates the MAXIMUS Approach to addressing these data requirements.*

### 4.4.5.3 Enter All Information Collected on the IBR Application

RFP Section A.5.c, page 9

MAXIMUS Federal Data Entry Specialists and Appeal Officers enter all information collected on the IBR application and submitted documentation into the *entellitrak* system. Information from completed reviews is also incorporated into *entellitrak* automatically. DWC staff members have access to *entellitrak* and may access specific case data in real time. In addition, the MAXDat reporting platform described in *Section 4.2.6. Case Workflow Tracking Reports* provides near real-time access to a wide variety of current and cumulative reports on case tracking data.

### 4.4.5.4 Database Allow Generation of Reports

RFP Section A.5.e, page 9; Appendix A, Pages 57-58

As described in *Section 4.2.6: Case Workflow 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 IBRs as they move through case processing. As such, each step in an IBR review will be tracked and serve as data for reporting purposes.

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#### **4.4.5.5 Enter in the Case Work-flow Management System Any Changes in Case Status and Notify the Provider and Claims Administrator in Writing or in Any Other Manner**

RFP Section A.5.d & f, 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 generate a notice informing the provider or claims administrator in writing, or in any other manner that provides actual and expeditious notice, when any of the following changes occur:

- IBR has been terminated because the Provider has withdrawn the application
- The Claims Administrator has paid the amount in dispute
- A settlement between the parties or other change in circumstances has eliminated need for IBR

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

#### **4.4.5.6 IBR Terminated**

RFP Section A.5.g, page 9

If the IBR is terminated for any of the reasons specified in the RFP or because the provider has withdrawn the application, the claims administrator has paid the amount in dispute, or a settlement between the parties or other change in circumstances has eliminated the need for IBR, 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 IBR that was initiated but not completed.

### **4.4.6 Number and Type of Reviewers**

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

As emphasized throughout this proposal and based on the current IBR volume, we will use six certified coders for this Project. Their coding certifications include Registered Health Information Technician (RHIT), Registered Health Information Administrator (RHIA), Certified Professional Coder (CPC), and Certified Coding Specialist (CCS). Please note that we have another 10 eligible certified coders in our application and credentialing pipeline in anticipation of an increasing IBR workload.

#### **4.4.6.1 Reviewers Experience**

RFP Section A.6.a (1-2.a-b), Page 10

All of our Coding Specialists have or more of the following certifications: Registered Health Information Technician (RHIT), Registered Health Information Administrator (RHIA), Certified Professional Coder (CPC), or Certified Coding Specialist (CCS). Additionally, all of Coding Specialists meet the following minimum qualifications:

- Have a college or higher degree
- Are health care claims professionals with the following
  - Either a minimum of 5 years health claims processing experience with an insurer, provider, governmental entity, or medical review organization, or at least 10 years medical claim auditing experience

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- A thorough understanding of health claims payment practices, health insurance contracts, and judicial or alternative dispute resolution practices and procedures
- Proficient in CPT, ICD9 or 10, HCPCS, and DSM-I-V coding, Medicare Correct Coding Initiatives, and the application of medical protocols in claims processing, including but not limited to multiple surgeries and bundling rules

As needed for IBR cases, we can offer DWC access to more than 950 California-licensed physicians and other health care professionals available to complete IBR cases. Many of our California-licensed reviewers are board certified in multiple specialties and can provide IBR in these clinical areas.

#### **4.4.6.2 Chief Coding Reviewer**

RFP Section A.6.b (1-4), Page 10

Natasha Miller will serve as our Chief Coding reviewer on the IBR Project and will oversee the final determination letter process. She has over 10 years of experience with medical coding and extensive educational success in health care technology and coding. Ms. Miller is not only a Certified Professional Coder (CPC), but also an American Academy of Professional Coders (AAPC) certified Professional Medical Coding Curriculum Instructor (PMCC) and a certified ICD-10-CM Instructor. She is a member of AAPC and AHIMA and currently teaches CPC review classes and ICD-10-CM boot camps including coding skills relating to CPT, HCPCS, ICD-9-CM, and ICD-10-CM. Ms. Miller will provide guidance and quality control reviews for IBR Coding Specialists. Ms. Miller possesses both inpatient/outpatient and office based coding experience; and is able to competently use NDC calculators and NCCI edits. She also has familiarity with California workers' compensation guidelines and fee schedules. As such, Ms. Miller meets requirements for the Chief Coding reviewer outlined in RFP Section A.6.b.

#### **4.4.6.3 List of Reviewers Submitted to DWC Project Manager by January 1, 2015**

RFP Section A.6.c, Page 10

We agree to provide a list of our reviewers to the DWC Project Manager by January 1, 2015. Our list of reviewers will include the name and a resume or summary of qualifications and, if applicable, the professional license number; the state in which the license has been issued; and the board certification of each reviewer. We update our list of reviewers as part of our ongoing monthly report.

#### **4.4.6.4 Determine Medical and Professional Specialties Required to Render Timely, Objective, and Effective Report**

RFP Section A.6.d, Page 10

Our IBR Supervisor is responsible for determining the medical and professional specialties needed to render timely, objective, and accurate IBR determinations. If the Appeal Officer has any questions regarding the selection of the Coding Specialist or MPR, they will discuss the assignment with the Medical Director or the Director of Professional Relations for resolution.

#### **4.4.7 Content of Reviews**

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

In this section we provide an overview of how we ensure that all IBR case-related information is reviewed. Please see *Section 3: Overview* for additional information regarding this process.

#### **4.4.7.1 Review All Pertinent Medical Records and Other Appropriate Information**

RFP Section A.7.a, Page 10

When a case is assigned to a Coding Specialist or MPR, they are instructed to review all pertinent medical records and pertinent case information, including but not limited to the following:

- Copies of the original billing itemization and any supporting documents that were furnished with the original billing
- The explanation of review
- The request for second review and any supporting documentation submitted with the request
- The final explanation of the second review
- The California OMFS, as applicable or a negotiated fee schedule established pursuant to Labor Code section 5307.11

To facilitate this review our administrative staff organizes the case file. For those IBRs requiring MPR input, we will provide 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 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 allotted timeframe.

All Coding Specialists and MPRs must certify and attest that they are qualified to review the case, that they have no conflicts of interest, and that there has not been a change in their credentialing or licensing status since the MPR's submission of information to MAXIMUS Federal for credentialing. Upon completion of the review, the case is forwarded to the Chief Coder for review.

#### **4.4.7.2 Determinations and Analyses are Performed Under Guidelines Set Forth at 8 C.C.R Section 9792.5.13**

RFP Section A.7.b, Page 10

Prior to assignment to the Coding Specialist or MPR, the IBR Supervisor instructs these individuals that their determinations and analyses must be conducted professionally, thoroughly and in a timely manner and be performed under the guidelines set forth at 8 CCR Section 9792.5.13, which includes the following:

- If the request for IBR involves the application of OMFS for the payment of medical treatment, services, or goods, as defined in Labor Code section 4600, the Coding Specialist or MPR will apply the provisions of sections 9789.10 to 9789.111 to determine the additional amounts, if any, that are to be paid to the Provider
- If the IBR request involves the application of a contract for reimbursement rates under Labor Code section 5307.11 for the payment of medical treatment services as defined in Labor Code section 4600, the Coding Specialist or MPR will apply the contract to determine the additional amounts, if any, that are to be paid to the Provider.
- If the request for IBR involves the application of the Medical-Legal Fee Schedule (M/L Fee Schedule) for services defined in Labor Code section 4620, the Coding Specialist will apply the provisions of sections 9793-9795 and 9795.1 to 9795.4 to determine the additional amounts, if any, that are to be paid to the provider.

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- In applying this section, the Coding Specialist or MPR will apply the provisions of the OMFS, the M/L Fee Schedule, and, if applicable, the contract for reimbursement rates under Labor Code section 5307.11, as if the bill is being reviewed for the first time

#### 4.4.8 Distribution of Completed Reviews

RFP Section A.8 (a-b), Pages 10-11

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

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

RFP Section A.8.a, Page 10; A.5 (a-g), Page 9

Upon return of the Coding Specialists' or MPRs' determination, the Chief Coding Specialist will review the determination for quality and completeness and ensure that all issues have been addressed. The Chief Coding Specialist will immediately contact the Coding Specialist or MPR for clarification of any issues. The Chief Coding Specialist will contact the IBR Supervisor, Project Director, and/or Medical Director as necessary for resolution of issues. Once the Coding Specialist has completed their 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 Provider, the Claims Administrator, and the Administrative Director. Each determination will include a statement that it constitutes the final determination of the DWC's Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).

##### 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:

- The determination and supporting analysis of each reviewer who participated in the IBR
- The name of the reviewer
- Where applicable, the determination will state that the Claims Administrator is required to reimburse the Provider for the IBR application fee in addition to the amount found owing

#### 4.4.9 Payment of Fees

RFP Section A.9 (a-b), Page 11

In this section we discuss our processes related to the payment of fees.

##### 4.4.9.1 Required by 8 C.C.R Section 9792.5.7(d) Collect Filing Fee From the Provider Requesting IBR

RFP Section A.9.a, Page 11

Pursuant to 8 CCR section 9792.5.7(d), our Coding Specialists are responsible for collecting the filing fee from the requesting Provider at the time the IBR application is submitted. We understand that additional fees may be collected if a request by a Provider for a consolidated review is separated under 8 CCR

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Section 9792.5.12(e). In this situation the same fee will be charged for each additional IBR request as is charged for one IBR request.

#### **4.4.9.2 Reimburse Provider Requesting IBR for an Ineligible Application**

RFP Section A.9.b, Page 11

Our Coding Specialist will reimburse the requesting Provider for an ineligible IBR application in accordance with 8 CCR Section 9792.5.9(e)(1). We will also reimburse the requesting Provider where their IBR application that is withdrawn (8 CCR Section 9792.5.11). Please see *Section 3: Overview* for additional information regarding these processes.

#### **4.4.10 Appeal and Review of Remanded Cases**

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

In this section we briefly discuss how we will handle the appeal and review of remanded cases. Our Chief Coding Specialist will be responsible for reviewing remanded cases. The Chief Coding Specialist will be responsible for ensuring that expedited reviews and Workers' Compensation Appeals Board (WCAB) Appeals and Remands are handled within the appropriate timeframes and in accordance with pertinent rules and regulations.

##### **4.4.10.1 Notice that an IBR Determination Has Been Appealed**

RFP Section A.9.a, Page 11

The Chief Coding Specialist will make the case record for the IBR available for electronic transmittal by DWC to the WCAB for those cases where we receive notice that an IBR determination has been appealed to the WCAB pursuant to Labor Code section 4603.6(f). We understand that the case record must include the following:

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

##### **4.4.10.2 Notice that an IBR Determination Has Been Reversed and Remanded**

RFP Section A.9.b, Page 11

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

Unless 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: Assignment of Cases for IBR*. We will complete the new review and issue a new final determination in accordance with the requirements within 60 days of receipt of notification from the DWC that the case

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has been remanded or within 3 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 IBR involving a case where our previous IBR determination was reversed and remanded, unless the reversal was based on grounds other than MAXIMUS Federal error or negligence.

#### **4.4.11 Confidentiality of Records and Information**

RFP Section A.11 (a-e), Pages 11-12

In this section, we provide an overview of our procedures to ensure the confidentiality of records and related IBR information associated with the DWC IBR Project. DWC can be assured that MAXIMUS Federal understands and is experienced with confidential record protection of DWC IBR 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 formal and exhaustive procedures. Please see *Appendix H: Confidentiality Policy and Procedures* for an overview of 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 reviewer contracts include terms which require that all information provided by MAXIMUS Federal is kept strictly confidential and will 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. As such, 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 IBR 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 4.4.11-1: 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 4.1.11-1: Information Security Training Course.** This screen shot illustrates a portion of our Information Security Training Course.

## Physical Security

The DWC contract will be managed 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 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. IBR 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 is 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 IBR

case, the hard copy documentation is securely destroyed by certified vendors while an electronic version of the documentation is retained in *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 that all files are available for audit as set forth in the contract.

#### **4.4.11.1 Information Protected Against Unauthorized Disclosure**

RFP Section A.11.a, Page 11

As discussed above we 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 that 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 will 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 that all files are available for audit as set forth in the 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.

#### **4.4.11.2 Records and Information Provided**

RFP Section A.11.b, Page 11

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

#### **4.4.11.3 Unauthorized Persons**

RFP Section A.11.c, Page 11

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

#### **4.4.11.4 Information Designated Confidential by DIR or DWC**

RFP Section A.11.d, Pages 11-12

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, will be used for marketing, solicitation, or other commercial purposes. Any disclosure or use of information

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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 IBR process, requires written consent of DWC.

#### 4.4.11.5 Publicly Available Information

RFP Section A.11.e, Page 12

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.

#### 4.4.12 Quality Assurance

RFP Section A.12 (a-g), 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.12.

##### 4.4.12.1 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 IBRs are reviewed by the Chief Coding Specialist to ensure completeness and adherence to standards.

#### 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

**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
- California Health Care Options

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- 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 results 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 that 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:** Identify and integrate all regulatory requirements

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

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eliminate variations 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 IBR 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 IBRs increases. MAXIMUS Federal has qualified expert statisticians on staff who can provide representative or stratified samples for quality review.

In addition to quality assurance monitoring by the QA Department, we build quality control checks into each process. Staff at any step in the review cycle can flag potential errors for review and correction prior to completion. We use the four-level quality control process for IBR Decisions which allows for Appeal 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 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 Medical Director is responsible for the general oversight of the clinical aspects of reviews, and is

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specifically responsible for implementing Medical Director or peer reviews of Medical Reviewers' work products.

#### **4.4.12.2 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 that it exceeds the standards mandated by DWC and the relevant legislation. Our standards surpass the combined requirements of the National NCQA and URAC. 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 per 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
- 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

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- 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 an 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 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

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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 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

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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.

### **4.4.12.3 Quality Assurance Specifications Set Forth in Labor Code Section 139.5 (d) (3)**

RFP Section A.12.a, Page 12

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 the 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)

#### **4.4.12.4 Confer as Necessary to Review Any Complaints or Discuss Issues Relating to the Overall IBR System**

RFP Section A.12.a (1-2), Page 12

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 IBR program. We will meet the following timelines related to this task:

- Within 5 days after receiving a request from DWC concerning a case reviewed during the preceding 30 days; or
- 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 DWC's general oversight of the IBR system.

#### **4.4.12.5 Within 15 Days of Each Month-end, Prepare a Summary Report of Work Completed the Previous Month**

RFP Section A.12.b, Page 12

Within 15 days of the end of each month, our QA team will prepare a summary report of the work completed the prior month and submit it to DWC. Our report will be available MAXDat and will include the following data elements in a format specified by DWC in Appendix B of the RFP, and additional data elements to be specified by DWC.

#### **4.4.12.6 Within 45 Days of Each Year-end, Prepare a Summary Report of Work Completed the Previous Year**

RFP Section A.12.c, Page 12

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 per Appendix B, in addition to the information contained in Appendix C, in a format specified by DWC and including additional data elements to be specified by DWC.

#### **4.4.12.7 Ongoing Collaboration with DWC**

RFP Section A.12.d, Page 12

We will continue to confer with DWC as necessary to ensure consistent and effective implementation of the IBR 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.

#### **4.4.12.8 Identifying Important Decision That Could Be Used as a Learning Tools**

RFP Section A.12.e, Page 12

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 designated reviewers, DWC staff, providers, and claims administrators.

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#### **4.4.12.9 Conduct an On-site Quality Assurance (QA) Review of Office Procedures and Record Systems**

RFP Section A.12.f, Page 12

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.

#### **4.4.12.10 Conduct Random Audits of Cases**

RFP Section A.12.g, Pages 12-13

We understand that DWC may conduct random audits of cases to ensure that designated reviewers 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 us to revise policies and procedures as needed to correct to any pattern of deficiencies in these areas and may direct MAXIMUS Federal to discontinue use of any reviewer whose decisions are determined to have been medically inappropriate.

#### **4.4.13 Liability**

RFP Section A.13 (A-C), Page 13

We understand and agree that pursuant to Labor Code section 139.5(b), MAXIMUS Federal and our MPRs, including coding reviewers retained to conduct reviews, are considered consultants for purposes of Section A.13 of the RFP. As such, there will be no monetary liability on the part of, and no cause of action will arise against any MAXIMUS Federal consultant on account of any communication by that consultant to the Administrative Director or any other officer, employee, agent, contractor or consultant of the DWC or on account of any communication by that consultant to any person when 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:

- Acts without malice
- Makes a reasonable effort to determine the facts of the matter communicated
- 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.

We further understand that the immunities afforded by Labor Code section 139.5(b) will not affect the availability of any other privilege or immunity afforded under the law. Nothing in RFP Section A.13 will alter the laws regarding the confidentiality of medical records.

#### **4.4.14 Customer Service**

RFP Section A.14, Page 13

To ensure program continuity, we will use the same toll-free telephone number, as well as the same fax number and email address that we currently use to ensure that 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: [ibrhelp@maximus.com](mailto:ibrhelp@maximus.com)

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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 we 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.

#### **4.4.15 Timeliness**

RFP Section A.15, Pages 13-14

We understand that we will be required to maintain a 95 percent timeliness rate in the completion of IBRs. 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 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 IBR separate and apart from any other extensions afforded, we will make a 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 from 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 the Contractor's 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 will 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 will 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 will result in a payment of 20 percent of all fees charged in the subject month
- A monthly timeliness below 70 percent will result in a payment of 30 percent of all fees charged in the subject month

Notwithstanding the foregoing, no payment to WCARF will apply in any subject month wherein MAXIMUS Federal receives an increased volume of IBR 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.

#### **4.4.16 Case Workflow Tracking System**

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

Please refer to our discussion of our case workflow tracking system in *Section 4.2.10: System Availability*.

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#### **4.4.17 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 IBR process. For all of our IBR clients we ensure that our Appeal Officers and MPRs take fraud and quality of care into consideration when reviewing IBRs. If there is any evidence of fraud or the provision of substandard care, our Appeal Officers or MPRs will report this information to the IBR 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 that 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 is being provided. Through our contract with the VA we have also completed large scale quality of care studies. For example, after a rash of suicides at one VA Medical Center we completed a review study of 200 case files to determine if the psychiatry services branch was providing standard of care.

#### **4.4.18 Submit to DWC Annually on or Before the First of Each Year Any Changes**

RFP Section A.18, Pages 14-15

We understand that prior to the start of the new contract the Project Director, in collaboration with the Client Executive, will provide a detailed report that includes the following information:

- The names of all the stockholders and owners of more than 5 percent of any stock or options; the contractor's staff and its reviewers cannot own more than 5 percent of the contractor's stock or options

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- The names of all holders of bonds or notes in excess of \$100,000
- The names of all corporations and organizations that Contractor controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business
- The names and biographical sketches of all directors, officers, and executives of Contractor, 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.
- The percentage of revenue Contractor receives from expert reviews, including but not limited to external medical reviews, quality assurance reviews, utilization reviews, and bill reviews
- The names of any workers' compensation insurer, claims administrator, or provider group for which Contractor provides review services, including but not limited to utilization review, bill review, quality assurance review, and external medical review. Any change in this information will be reported to DIR/DWC within five business days of the change.
- 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
- A description of the system Contractor 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
- A description of how Contractor ensures compliance with the conflict of interest provisions of Labor Code section 139.5.

We will provide an updated report on an annual basis prior to January 1<sup>st</sup> each year that notes any changes from the previous year.

#### **4.4.19 Required Documents**

RFP Section A.19, Page 15

We understand that on an annual basis all of our officers, directors, management employees, and designated reviewers will complete FPPC Form 700, Statement of Economic Interests. Our Medical Director and the IBR Supervisor will be considered Category 1 filers, and all others will be Category 5 filers under the DIR's Conflict of Interest Code. We will provide the reports prior to the start of the new contract and annually no later than April 1<sup>st</sup> for the current year, and upon termination of the contract.

#### **4.4.20 Criminal Background Checks**

RFP Section A.20, Page 15

The QA Director, with support from our Corporate Human Resources Department, will be responsible for conducting criminal background checks on all current and prospective employees prior to assignment to the IBR contract. The QA Director will also re-check all project personnel every two years. We will not assign any personnel to the IBR contract that have a federal or state conviction in the previous seven years for a crime of dishonesty, fraud, theft, or an act of violence, or who has been arrested and is out on bail on his or her own recognizance pending trial for a crime of dishonesty, fraud, theft, or an act of violence. We

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will apply our background check process to all personnel assigned to the IBR contract including management, operations, and coding specialists.

#### **4.4.21 Certificate of Insurance**

RFP Section A.21, Page 15; C.4.a.2, Page 21

Upon contract award, MAXIMUS Federal will 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. We agree to demonstrate proof of automobile liability insurance and public liability insurance as required.

#### **4.4.22 Prohibited Conflicts of Interest**

RFP Section A.22, Pages 15-16

As emphasized throughout this bid, MAXIMUS Federal can offer DWC an industry best conflict 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 workers' compensation insurer or workers' compensation claims administrator, health or disability insurer, or health plan where it would create a conflict with a federal or state government IBR 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.22 and outlined below.

MAXIMUS Federal is not an affiliate or a subsidiary of, nor is 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, and will 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 Coding Specialists and MPRs: They are screened throughout the IBR process to ensure they do not have any material professional, material familial, or material financial affiliation to 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 Coding Specialists and 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 developer or manufacturer of the treatment proposed for the employee whose condition is under review
- The injured employee or the injured employee's immediate family

We understand the definitions of material familial, material financial, and material professional affiliations outlined in labor code 139.5 and in Section A.22 of this RFP and apply them in our conflict of interest policies and procedures.

#### **Ongoing Conflict of Interest Monitoring**

Please see *Appendix B: 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 IBR services. Please see *Section 4.1.3.7: 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 that our reviewers are conflict free when performing an IBR.

#### **4.4.23 Payment**

RFP Section A.23 (a-b), Page 16

We understand that we must submit invoices directly to, and receive payments directly from, the providers who must submit these payments in advance. As stated in the RFP, direct payment is not intended to constitute a material affiliation between MAXIMUS Federal and the providers, and DWC will adopt regulatory penalties to deter late payments.

Invoicing and payment will be based on fees mutually agreed upon by MAXIMUS Federal and DWC. We understand that DWC 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.

#### **4.4.24 Monitoring of Contract Performance**

RFP Section A.24 (1-2), Page 17, 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 IBR 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 will provide monthly written progress reports to the DWC Executive Medical Director or her designee(s) beginning February 15, 2015 for the previous month. The monthly progress report will be provided by the 15<sup>th</sup> of every month until contract completion. The report will address the progress made on completing tasks or making modifications and relevant findings to date and problems encountered, and will include the task and the task number. 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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#### **4.4.25 DWCs Role and Responsibilities**

RFP Section A.25, Page 17

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

- Overseeing the entire IBR process, including implementation and execution of all applicable statutes, regulations, and procedures.
- Reviewing any case in which Contractor notifies DWC that it appears the case may be ineligible for IBR or the information submitted with the application is insufficient to begin the IBR process, and making an independent determination as to whether the case is eligible for IBR.
- 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 IBR process overall.

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## 5. Management and Staffing

MAXIMUS Federal knows the Independent Bill Review (IBR) program and has the infrastructure and committed staff necessary to successfully and efficiently provide superior bill review service to the Division of Workers' Compensation (DWC).

RFP Section C.4.a.2, Page 20

MAXIMUS Federal can provide DWC with a detailed understanding of the IBR 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 IBR 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, give the MAXIMUS Federal Team the flexibility to rapidly respond to changing requirements and IBR 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 received full re-accreditation with no areas for improvement noted five times. Please see *Appendix H: URAC Certificate* for the most recent copy of our URAC certificate. We will continue to adhere to URAC IRO standards for 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 continuously 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 us to confirm that we always have multiple staff and expert reviewers available to address expected and unexpected 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.

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- Our Coding Specialists are experts in CPT, HCPCS, ICD-9-CM, and ICD-10-CM medical coding and possess RHIT, RHIA, CPC, and CCS certifications
- MAXIMUS Federal has access to a Medical Review panel of 350 California-licensed Medical Professional Reviewers and an additional 600 pending the credentialing and training process that may be leveraged for the IBR Project if needed

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*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 an initiative to update the project to new contract requirements such as we will with the IBR Project.

Task Name	Duration
<b>Define New Contract Reporting Requirements</b>	<b>43 days</b>
■ 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 Federal understands the importance of communicating 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 as well as the progress of regularly scheduled work plan tasks. In addition to formally scheduled meetings, the Project Director, Lou Shields, and IBR Supervisor, Tricia Brantley, 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 Federal executive management.

**Work Management**

As mentioned in *Section 4.2.1: Case Tracking Reports*, the IBR Supervisor and Senior Operations Manager monitor the project through near real-time case tracking data contained in the MAXDat dashboards. These managers 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*, new Coding Specialists do not conduct independent work until they have successfully completed a trial period of billing reviews under the close supervision of the IBR Supervisor. After the initial period of intense observation, a sample of all work is subject to quality control review by the IBR Supervisor or the Chief Coding Specialist/Reviewer. The IBR Supervisor or the Chief Coding Specialist/Reviewer handles most problems, concerns, or issues with a review. In addition, the Medical Director provides expert medical guidance when a billing review requires clinical expertise. We also provide the quality assurance review process discussed in *Section 4.4.12: Quality Assurance* to analyze data for trends and continuous improvement initiatives.

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### ***Performance Reviews***

The performance of all employees, and particularly of Coding Specialists, is continually assessed through quality assurance reviews as found in *Section 4.4.12: Quality Assurance*. The IBR Supervisor 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***

MAXIMUS staff members receive 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 IBR 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 IBR 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 Coding Specialists in *Appendix E: Training Materials*.

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

All employees must complete required training provided by our corporate Center for Employee Development (CED) on 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 use MAXIMUS University, our enterprise web-based Learning Management System, 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 periodicals, websites, 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.

### ***Coding Specialist Initial Orientation***

Formal orientation of all IBR Project employees involves the Senior Operations Manager, IBR Supervisor, and Project Director as well as MAXIMUS Federal corporate staff. The Coding Specialist orientation program is exhaustive and is meant to provide them with a broad-based understanding of billing reviews. Coding Specialists are instructed in the following areas:

- Overview of MAXIMUS Federal
- Overview of the California IBR Process

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- Proper methods of preparing IBR determinations
- Billing review standards for analysis and review writing
- Confidentiality and HIPAA requirements
- Conflict of interest monitoring and reporting
- Quality control

### ***On-the-Job Training***

Training doesn't stop in the classroom. All new Coding Specialists receive direct mentoring from the IBR Supervisor or Chief IBR Specialist/Reviewer during their training period. The length of the on-the-job training is dependent on the quality review scores from the Coding Specialist's completed work and the complexity of the specific team responsibilities. While the Coding Specialist is completing his/her initial reviews the IBR Supervisor and Chief IBR Specialist/Reviewer are available to answer any questions or provide clarification on any issues. The IBR is then reviewed for the following:

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

### ***On-going Training***

Coding Specialist training occurs on a continual basis. Ongoing training includes the following:

- Review of quality assurance 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

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 19, C.4.a.2, Page 20

MAXIMUS Federal offers an elite management team that includes experts in all facets of the IBR 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 Federal 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

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perspective, ensuring that the dedicated project management staff members provide the best service for DWC leadership.

Specifically our management team consists of the following members.

**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 50 state and federal clients including the areas of regulatory and contract compliance, client relations, and quality oversight. He is considered a subject matter expert in health care dispute resolution and independent medical review. He served as a subject matter expert in the development and implementation of the independent medical review and provider payment dispute resolution program for the California Workers' Compensation system.

**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 the 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.

**IBR Supervisor - Tricia Brantley**

Tricia Brantley has nearly 15 years of experience with medical claim adjudication and is certified as a Registered Health Information Technician (RHIT®). She has a Bachelor of Science in Healthcare Management and has extensive knowledge of the California Workers Compensation appeals process. She has served as the Chief Coding Reviewer and Supervisor for the IBR Project since 2013. In this role, Ms. Brantley helps Coding Specialists to code and price claims based on the California Workers' Compensation Original Medical Fee Schedule.

**Chief Coding Specialist/Reviewer - Natasha Miller**

Natasha Miller has over 10 years of experience with medical coding and extensive educational success in health care technology and coding. Ms. Miller is not only a Certified Professional Coder (CPC), but also an American Academy of Professional Coders (AAPC) certified Professional Medical Coding Curriculum Instructor (PMCC) and a certified ICD-10-CM Instructor. She is a member of AAPC and AHIMA and currently teaches CPC review classes and ICD-10-CM boot camps including coding skills relating to CPT, HCPCS, ICD-9-CM, and ICD-10-CM. She has a Bachelor of Science in Healthcare Management. Ms. Miller will provide guidance and quality control reviews for IBR Coding Specialists.

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**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.

**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**

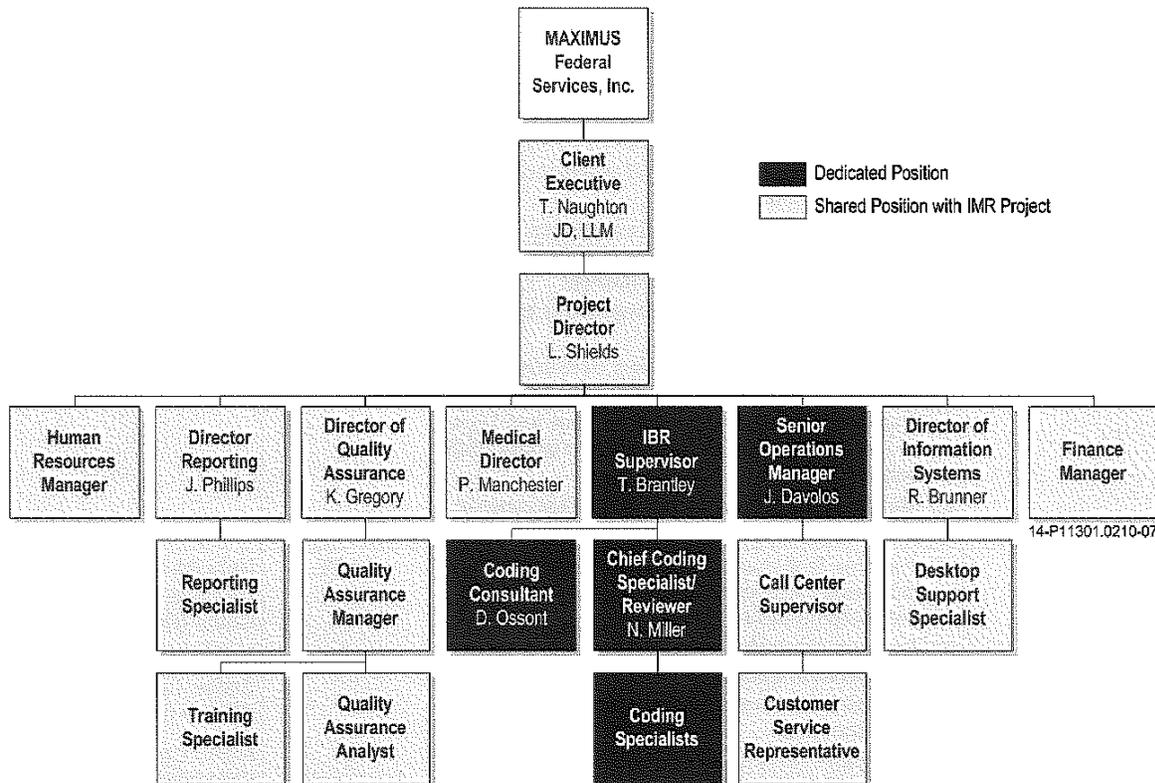
Mr. Phillips brings more than 25 years of experience in the design and management of automated systems and reporting systems. He is currently responsible for statistical reports provided to the Centers for Medicare and Medicaid Services (CMS) and has been instrumental in the design of many data and reporting systems associated with medical appeals programs. He designed and implemented systems for tracking Medicare appeal cases and reconsideration determinations, as well as for the 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 also designed a system for the 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).

**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 define and deliver quality software solutions for our program operations. 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.

*Exhibit 5.1-1: IBR Organization Chart* illustrates the proposed IBR Project organization. The positions highlighted in light blue represent roles that may be shared with the Independent Medical Review (IMR) Project. This sharing of resources allows the IBR Project to have the complete support staff of a larger project while maintaining efficiency and economies of scale. The dedicated positions, highlighted in dark blue, represent all staff members conducting the IBR work and quality control.

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**Exhibit 5.1-1: IBR Organization Chart.**

In *Exhibit 5.1-2: IBR Team Responsibilities* we demonstrate our commitment to providing ample management oversight and identify final responsibility for IBR tasks. Further details are provided in the biographies of our management staff.

Management Position	Job Description (Including Work Plan Tasks)	Full-Time Equivalency	Experienced Staff
<b>Client Executive</b>	<ul style="list-style-type: none"> <li>Provides executive oversight for the project including confirming that resources and infrastructure are in place to successfully meet all contract requirements</li> <li>Available as an escalated contact point for the Department Program Manager for any issues or concerns pertaining to contract requirements or performance</li> </ul>	0.25 FTE*	Thomas C. Naughton, JD, LLM
<b>Project Director</b>	<ul style="list-style-type: none"> <li>Serves as the primary point of contact for the Department Program Manager</li> <li>Oversees all project management staff to ensure timely and appropriate compliance with the contract requirements</li> <li>Monitors all project activities including verifying that accurate and timely reviews are progressing as required</li> <li>Confirms that the Certificate of Insurance is requested and provided from the corporate office</li> </ul>	0.25 FTE*	Lou Shields

**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	Experienced Staff
<b>IBR Supervisor</b>	<ul style="list-style-type: none"> <li>■ Supervises project IBR operations including the work of the Chief Coding Specialist/Reviewer and the Coding Consultant</li> <li>■ Reviews completed IBRs and mentors Coding Specialists in training</li> <li>■ Manages the process of IBRs including monitoring and facilitating timely review completion by all Coding Specialists</li> <li>■ Responsible for enforcing Timeframes for Completing Reviews</li> <li>■ Assignment of cases to Coding Specialists and associated conflict of interest checks screening</li> <li>■ Responsible for ensuring the Number and Type of Reviewers necessary to handle changing IMR volumes</li> <li>■ Maintains the confidentiality of medical records and other data</li> </ul>	1 FTE	Tricia N. Brantley RHIT; Member of AHIMA
<b>Chief Coding Specialist/Reviewer</b>	<ul style="list-style-type: none"> <li>■ Provides final quality control check on case information and letter contents prior to sending final determination letter</li> <li>■ Reviews completed IBRs and mentors Coding Specialists in training</li> <li>■ Maintains the confidentiality of medical records and other data</li> <li>■ Completes IBRs as an additional Coding Specialist, as needed</li> </ul>	1 FTE	Natasha Miller, Certified Professional Coder (CPC)  Certified Professional; Coder – Instructor (CPC – I)  AAPC Certified ICD-10- CM Instructor  Member of AAPC  Member of AHIMA
<b>Coding Consultant</b>	<ul style="list-style-type: none"> <li>■ Provides assistance to the IBR Supervisor and Chief Coding Specialist/Reviewer</li> <li>■ Reviews completed IBRs and mentors Coding Specialists in training</li> <li>■ Maintains the confidentiality of medical records and other data</li> <li>■ Completes IBRs as an additional Coding Specialist, as needed</li> </ul>	1 FTE	Dawn Ossont, RHIT, Certified Coding Specialist (CCS)

**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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Management Position	Job Description (Including Work Plan Tasks)	Full-Time Equivalency	Experienced Staff
<b>Coding Specialist</b>	<ul style="list-style-type: none"> <li>■ Scans incoming review requests and documentation</li> <li>■ Reviews the IBR request for completeness (requests must include denial letter and appropriate documentation)</li> <li>■ Enters data from the review request and associated documentation into <i>entellitrak</i></li> <li>■ Responsible for preliminary review of cases</li> <li>■ Validates data from applications against information in utilization review denial letter</li> <li>■ Identifies potential eligibility issues</li> <li>■ Routes cases with potential eligibility issues to DWC for review</li> <li>■ Assesses completeness of medical records received from parties</li> <li>■ Develops detailed list of medical records received</li> <li>■ Responsible for securing additional information to conduct IBR, as needed</li> <li>■ Enters case information and changes in case status to <i>entellitrak</i></li> <li>■ Responsible for ensuring that the content of reviews meets requirements</li> <li>■ Responsible for the distribution of completed reviews</li> <li>■ Assesses final determination for completeness</li> <li>■ Ensures that authorities cited are consistent with disputed treatments</li> <li>■ Responsible for the appeal and review of remanded cases</li> <li>■ Responsible for the distribution of completed reviews</li> <li>■ Initiates mailing of final determination letter</li> <li>■ Maintains the confidentiality of medical records and other data</li> </ul>	4 FTEs	<ul style="list-style-type: none"> <li>■ Karen Coulter, RHIT</li> <li>■ Denise Sims, Certified Medical Assistant (AAMA)</li> <li>■ Cindy Reynolds, RHIA</li> <li>■ Mary K. Radford RN, CPC</li> </ul>
<b>Senior Operations Manager</b>	<ul style="list-style-type: none"> <li>■ Provides direction and oversight to project processes, training, and improvement initiatives</li> <li>■ Coordinates with other management staff to help ensure timely and appropriate completion of the requirements of the project</li> <li>■ Maintains the confidentiality of medical records and other data</li> </ul>	1 FTE	Jorge Davalos
<b>Medical Director</b>	<ul style="list-style-type: none"> <li>■ Provides medical review consultation and expertise to IBRs requiring medical review and assists in assignment to the MPR panel as necessary</li> <li>■ Provides expert review guidance for the IBR team</li> </ul>	0.25 FTE*	Paul Manchester, MD, MPH <i>California License #52883, Medical Board of California</i>

**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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Management Position	Job Description (Including Work Plan Tasks)	Full-Time Equivalency	Experienced Staff
<b>Director of Quality Assurance</b>	<ul style="list-style-type: none"> <li>■ Oversees, monitors, and improves the quality of services provided by the IMR Project</li> <li>■ Represents the project in MAXIMUS Federal and MAXIMUS Corporate Office of Quality and Risk Management quality programs</li> <li>■ Identifies specific issues that require a corrective action and provides independent verification of performance improvement reports</li> <li>■ Advises of Program Manager and Director of Professional Relations on quality-related issues and monitoring</li> <li>■ Responsible for fraud and quality of care reporting</li> </ul>	0.25 FTE*	Kevin Gregory, ASQ CQIA, PMP
<b>Director of Reporting</b>	<ul style="list-style-type: none"> <li>■ Serves as the primary report developer</li> <li>■ Works with the DWC to improve and customize reports using available case tracking data</li> <li>■ Supervises reporting analysts</li> <li>■ Ensures all reports are completed in a timely and appropriate manner</li> <li>■ Focuses on meeting the reporting needs of the contract and providing responsive answers to DWC reporting inquiries</li> </ul>	0.25 FTE*	Jim Phillips
<b>Director of Information Systems</b>	<ul style="list-style-type: none"> <li>■ Oversees all project systems including <i>entellitrak</i> maintenance and improvements</li> <li>■ Ensures case workflow tracking system availability requirements are met</li> <li>■ Serves as a resource and broker between MAXIMUS corporate system resources and expertise and the project staff</li> </ul>	0.25 FTE*	Richard Brunner
Training Specialist*	<ul style="list-style-type: none"> <li>■ Designs and administers training for both project operations staff and reviewers, including creating system and process instructions</li> </ul>	0.25 FTE*	
Call Center Supervisor*	<ul style="list-style-type: none"> <li>■ Manages the operation of the call center associated with the toll-free service line as well as facsimile (fax) and email</li> <li>■ Supervises the Customer Service Representatives</li> </ul>	0.25 FTE*	
Customer Service Representative*	<ul style="list-style-type: none"> <li>■ Provides customer service to interested parties through the toll-free service line as well as facsimile (fax) and email</li> <li>■ Answers questions regarding the current status of the case and refers parties to DWC as appropriate</li> </ul>	0.25 FTE*	
Desktop Support Specialist*	<ul style="list-style-type: none"> <li>■ Maintains project hardware and updates desktop software as necessary</li> <li>■ Provides on-site technical support for project staff</li> <li>■ Updates system access profiles for project staff, reviewers, and DWC staff members accessing the system</li> </ul>	0.25 FTE*	

**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.

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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Management Position	Job Description (Including Work Plan Tasks)	Full-Time Equivalency	Experienced Staff
Quality Assurance Manager*	<ul style="list-style-type: none"> <li>Coordinates with the Quality Assurance Director to implement project quality initiatives</li> <li>Recommends process improvements and coordinates with the training specialists to initiate refresher training when applicable</li> <li>Manages the work of the quality assurance analysts and training specialists</li> </ul>	0.25 FTE*	
Quality Assurance Analyst	<ul style="list-style-type: none"> <li>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</li> <li>Performs analysis on the results of performance and review statistics to identify areas in need of process changes, system improvements, or refresher training</li> <li>Creates, modifies, and updates project policies and procedures</li> </ul>	0.25 FTE*	
Reporting Specialists	<ul style="list-style-type: none"> <li>Maintains reporting documentation and updates reporting templates when necessary</li> <li>Initiates and distributes reports, as required, and verifies they are available in the MAXDat system</li> </ul>	0.25 FTE*	
Human Resources Manager	<ul style="list-style-type: none"> <li>Manages recruitment, onboarding, termination, and other human resource functions of project employees</li> </ul>	0.25 FTE*	
Finance Manager	<ul style="list-style-type: none"> <li>Prepares financial statements and invoices for Project Director approval and submission to DWC</li> <li>Prepares financial reports for the corporate Finance Department</li> <li>Tracks project revenue and expenditures and maintains the project budget</li> </ul>	0.25 FTE*	

\* Selected staff members also contribute time to the California Independent Medical Review Project, if contract is awarded to MAXIMUS Federal. This cross-functionality is currently in place and benefits DWC with efficient use of increased infrastructure and resources.

**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.

### Recruiting

MAXIMUS Federal continues to recruit certified coding professionals. We have already identified additional candidates for Coding Specialists and are prepared to bring them on to the IBR Project as needed.

### Medical Professional Reviewers

We will use Medical Professional Reviewers (MPRs) to support Coding Specialists where clinical input is required. For example, the MPR will work in conjunction with the Coding Specialist to address coding issues that involve the utilization of an assistant surgeon or where the services in dispute require the highest intensity of care. MAXIMUS Federal has a combined consultant and subcontractor panel of 350 California licensed Medical Professional Reviewers (MPRs) in active practice, representing every American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) specialty. In addition, we have access to another 600 MPRs awaiting the credentialing and training

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**process and 400 MPRs licensed outside of California who are ready to assist if needed. All of our MPRs 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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## 6. Related Experience and References

MAXIMUS Federal is the leading provider of government sponsored independent bill review (IBR) services. We currently operate independent bill review programs in California, Florida, New Jersey and for Center for Medicare & Medicaid Services (CMS). Our team also offers DWC extensive California specific experience gleaned our current IBR contract and DMHC Independent Dispute Resolution Process contract. During 2013 we processed more than 200,000 IBRs across our federal and state clients.

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

In this section we describe our related experience conducting IBR services and our capability to operate the DWC IBR 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, Pages 23-24

SB 863 created as a new method accessible to providers who wish to dispute the amount they were paid for medical treatment or medical-legal billing disputes. The introduction of IBR can be seen as a continuation of an effort in California to standardize and provide clarity to the process by which medical treatments are billed and paid.

Understanding the legislative intent of IBR, MAXIMUS Federal fully realizes how important it is to deliver consistent, accurate, and well-reasoned billing decisions. As such, our IBR coding experts will bring an in-depth understanding of the Official Medical Fee Schedule (OMFS). These coding experts come to us with a background in resolving workers' compensation-related billing disputes, too, so they can immediately apply to their knowledge and experience to the IBR process.

All of MAXIMUS Federal's IBR staff receives targeted training to understand the implications of IBR being a brand-new process in California. Our staff understands that IBR is going to be closely scrutinized by the public, and thus how important it is that they be well-versed in all aspects of workers' compensation billing disputes. We train our IBR staff members to understand not just IBR, but also the first and second bill review processes, and how those processes feed into IBR. Furthermore, we emphasize how their IBR decisions not only resolve specific disputes, but also help educate providers, claims administrators and the general public regarding the rules that apply to workers' compensation billing disputes.

### 6.2 Knowledge of Independent Bill Review Requirements and Workers' Compensation Fee Schedule

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

MAXIMUS Federal is the only IBRO that has experience implementing IBR under SB863. We understand the legislation and the steps required to successfully implement into an IBR operation under

**?** did you **KNOW**

MAXIMUS Federal ...

- To the best of our knowledge we are the only provider of government sponsored independent bill review programs in the United States
- Processed a total of more than 200,000 independent bill reviews during 2013 across our federal and state independent bill review contracts
- Operate government sponsored IBR programs in CA, FL, NJ and for CMS

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SB 863. We are committed to applying our knowledge and experience of the existing DWC IBR 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. We have extensive experience with both DWC and DMHC and understand how to implement California policies, statues, labor codes, and regulations into our program operations. Our team of professionals also has significant hands-on experience providing IBR services following the protocols of DWC. Our objective is to continue to operate the DWC IBR Project in the most cost efficient manner while ensuring the highest quality of IBRs and continually striving to identify areas of innovation and improvement.

For the past 10 years, we have successfully provided IBR services to a number of state and federal clients and processed over 200,000 IBRs during 2013. MAXIMUS Federal is the only IBRO that is completely free from conflicts of interest and offers DWC a detailed and responsive approach to the technical requirements of the DWC IBR Project based on first-hand experience, and best practices and lessons learned developed in close collaboration with DWC. With our past experience implementing IBR programs we also understand how to adopt new or changing legislation into our programs, from process workflows through staff training and system design. 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 DWC IBR Project. We look forward to continuing our collaborative partnership with the DWC on the new contract.

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 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 IBR.

### **6.2.1 License to do Business in the State of California**

RFP Section C.5.d.2, Page 24

Please see *Appendix G: 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 24

As stated in *Section 4.2: Case Workflow 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 IBR contract. This system has been rigorously tested through real volume fluctuations, reducing any risk associated with future changes.

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As of the time of this proposal, use of *entellitrak* 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. *entellitrak* was specifically selected as the best option for tracking and facilitating IBR cases based on extensive knowledge, best practices, and lessons learned as well as providing DWC the best value. The *entellitrak* 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 Workers' Compensation Fee Schedule**

RFP Section C.5.d.2, Page 24

MAXIMUS reviewers are experts in the areas of interpretation and application of the Official Medical Fee Schedule (OMFS). The IBR reviewers maintain current knowledge and updates to the fee schedule as adopted by the DWC.

MAXIMUS reviews disputes involving the various fee schedules as described in the OMFS and Title 8 California Code of Regulations.

The following are types of disputes and the resources utilized in the Independent Bill Review process:

- Physician Services are reviewed using the following: Labor Code sections 4600, 4603.2, 5307.1 and 5307.11; and Regulations Title 8 California Code Regulations 9789.10, 9789.11, 9789.12.1 – 9789.19, 9791, 9791.1, 9792, and 9792.5
- Ambulance services are reviewed using Regulations Title 8 CCR § 9789.70, 9789.110 and 9789.111
- Clinical Laboratory services are reviewed using Regulations Title 8 CCR § 9789.50
- Durable Medical Equipment Prosthetic Orthotics and Supplies (DMEPOS) services are reviewed using the following: Labor Code 5307.1; and Regulations Title 8 CCR § 9789.60
- Inpatient Hospital services are reviewed using Regulations Title 8 CCR § 9789.20-9789.25
- Outpatient Hospital services are reviewed using Regulations Title 8 CCR § 9789.30-9789.39
- Pharmaceutical services are reviewed using the following: Labor Code 5307.1; and Regulations Title 8 CCR § 9789.40
- Medical-Legal services are reviewed using the following resources: Labor Code 5400, 5401, 5402, 4650, 4628 and 139.2; and Regulations Title 8 CCR § 9793 -9795

### **6.2.4 Ability to Handle High-Volume Case Workload**

RFP Section C.5.d.2, Page 24

In addition to our work with DWC and the other California agencies, we have successfully implemented health care IBR programs for more a number of state and Federal agencies including the Centers for Medicare & Medicaid. Our overall experience in state and federal government independent bill review programs sets us far apart from the competition. In 2013 alone we rendered more than 200,000 independent bill review decisions addressing the full spectrum of health care claims including worker's compensation, Medicare, Medicaid, and group health while addressing such issue as appropriate application of fee schedules, correct coding (bundling and unbundling), and reasonable and customary

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reimbursement for non-contracted 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 160,000 IBRs for our Medicare Part A project, more than 15,000 IBRs for our Medicare Part C project, more than 20,000 IBRs for our Medicare Part B project and more than 5,000 IBRs for our state IBR programs. Based upon the two year history of the IBR program having less than 2,000 cases, we believe we are prepared to handle any expected increases in IBR volume in 2015.

### 6.2.5 Experience Managing Electronic Submission of Reviews

RFP Section C.5.d.2, Page 24

We have significant experience receiving electronic IBR cases from all stakeholders for our IBR services for government agencies, individuals, and providers. For example, *entellitrak* features a secure 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 IBR projects we currently receive in excess of 15,000 electronic IBR cases a month.

### 6.2.6 Ability to Provide Data Regarding Case Status and Outcomes

RFP Section C.5.d.2, Page 24

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 IBR 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

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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*.

## 6.2.7 Capability to Provide Reviews in Accordance with RFP

RFP Section C.5.d.2, Page 24

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

## 6.2.8 California Office Space

RFP Section C.5.d.2, Page 24

Our corporate office is located in Reston, Virginia at:

MAXIMUS Federal Services, Inc.  
1891 Metro Center Drive  
Reston, Virginia 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 IBR staff. This office and its staff have been responsible for completing all of DWC's IBRs since 2013. If awarded this contract, we will continue to operate DWC's IBR 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 IBR 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, Coding Specialists and the IBR Medical Director, a California licensed physician board certified in Occupational Medicine who provides expert review guidance and quality assurance for the IBR project. The Folsom facility also houses a cadre of administrative and operations staff who are essential to the DWC IBR project.



## 6.2.9 Medical Director

RFP Section C.5.d.2, Page 24

Paul Manchester, MD, MPH (California License #52883) will continue to serve as the Medical Director for the DWC IBR Project. In this capacity Dr. Manchester will continue to advise the IBR team on clinical issues which arise in IBRs. In addition, Dr. Manchester will provide assistance in assigning necessary medical professional reviewers to IBRs for cases that may require specialty clinical input such

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instances where payment for utilization of assistant surgeons is at issue or the intensity of the required services is at issue. With our panel of 350 California physicians we are in an excellent position to ensure all issues (reimbursement, coding, and clinical) are addressed in all IBRs.

### 6.2.10 Sufficient Number of Reviewers

RFP Section C.5.d.2, Page 24

MAXIMUS Federal understands that at all times we are required to have a sufficient number of reviewers available to satisfy the review time frames set forth in the RFP. We have an established team currently operating the IBR project that includes a group of Coding Specialists. We are actively recruiting additional Coding Specialists to add to the project to address future program volume fluctuations. Our training department has developed DWC IBR specific training materials to assist with the on-boarding of new Coding Specialists. Our customized training materials streamline the training process of new Coding Specialists and also the quality of work products. We also have access to large teams of Coding Specialists on our QIC contracts in the event of a significant month to month increase in IBR requests.

### 6.2.11 Sufficient Number of Staff

RFP Section C.5.d.2, Page 24

MAXIMUS Federal has an experienced team of professional and operations staff who are well versed in all facets of the IBR 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.

### 6.2.12 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 50 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 DWC Independent Billing Review program.

#### Reference #1

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

California Department of Industrial Relations/Division of Workers' Compensation – Independent Bill Review (IBR) Agreement Number 41230041	
<b>Name of Customer</b>	California Department of Industrial Relations, Division of Workers' Compensation
<b>Contact Person and Telephone Number</b>	Rupali Das, Executive Medical Director (510) 286-3700

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California Department of Industrial Relations/Division of Workers' Compensation – Independent Bill Review (IBR) Agreement Number 41230041	
<b>Date of Service</b>	January 1, 2013 to December 31, 2014
<b>Project Abstract</b>	<p>Beginning January 1, 2013, MAXIMUS Federal serves as the independent bill review organization (IBRO) for the California Department of Industrial Relations and Division of Workers' Compensation. As the IBRO, MAXIMUS Federal conducts IBR for medical treatment and medical-legal billing disputes in cases where medical providers disagree with the amount paid by a claims administrator on a properly documented bill.</p> <p>MAXIMUS conducts preliminary reviews of all applications received and collects filing fees in order to determine eligibility for IBR. MAXIMUS conducts the bill review process working with our panel of credentialed medical reviewers to make IBR determinations. Our IBR reviewers are comprised of certified Coding Specialists with extensive experience in the application of California's Official Medical Fee Schedule (OMFS). Our Coding Specialists certifications include the following: Registered Health Information Technician (RHIT), Registered Health Information Administrator (RHIA), Certified Professional Coder (CPC), or Certified Coding Specialist (CCS). MAXIMUS Federal also provides the case workflow tracking system, known as the MAXIMUS Federal IBR Tracking System, and technical and administrative project support. Since project initiation, MAXIMUS Federal has processed approximately 1,600 IBR applications and sent 400 IBR Final Determination Letters.</p>
<b>Relevancy to Scope of Services</b>	<p>As the existing contract for RFP#DIR-DWC-RFP#14-002, 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 IBR 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 IBR program continues to develop.</p>

***Proposed Staff Role and Responsibilities***

Staff listed below is proposed management staff for this proposal.

- Thomas Naughton, **Client Executive** 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.
- Lou Shields, as **Vice President of Operations** responsible for IT solution, IT Infrastructure, PMO, QA, Training, Facilities, Business Process Management (BPM), and Operational Efficiency.
- Tricia Brantley, **IBR Supervisor** responsible for supervising IBR project operations including the work of the Chief Coding Specialist/Reviewer and the Coding Consultant. Reviews completed IBRs and mentors Coding Specialists in training.
- Paul Manchester, **Medical Director** for California Independent Bill Review (IBR). Provides medical review consultation and expertise to IBRs requiring medical review.
- Natasha Miller, **Chief Coding Specialist/Reviewer** provides final quality control check on case information and letter contents prior to sending final determination letter. Maintains confidentiality of medical records and other data.

Independent Bill Review  
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- Dawn Ossont, **Coding Consultant** provides assistance to the IBR Supervisor and Chief Coding Specialist/Reviewer. Reviews completed IBRs and mentors Coding Specialists in training
- Karen Coulter, **Coding Specialist** scans incoming review requests and documentation. Reviews IBR request for completeness. Enters data from the review request and associated documentation into entellitrak.

**Reference #2**

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

Health and Human Services, Office of Inspector General Medicare Parts A & B Review Agreement # 41230038	
<b>Name of Customer</b>	HHS, OIG
<b>Contact Person and Telephone Number</b>	Janet McLeod, CPA, Audit Manager, 410-786-2172
<b>Date of Service</b>	July 1, 2012 – June 30, 2015
<b>Project Abstract</b>	<p>The Office of the Inspector General (OIG): is charged with protecting the integrity of the Health and Human Services (HHS) programs. The Office of Audit Services (OAS) conducts independent audits of HHS programs, including Medicare Parts A and B. MAXIMUS Federal is contracted with OIG/OAS to provide medical review support for their audits. Topics referred for medical review to date include determinations of patient status regarding standard of care for inpatient hospitalization, status post cardiac transplant cardiac biopsies and left ventricular cardiac catheterizations, stem cell transplants, intensity modulated radiation therapy (IMRT), observation services, ambulatory surgeries, chiropractic care, partial hospitalization programs (PHP), physical therapy, durable medical equipment, and home health services.</p> <p>MAXIMUS Federal employs a team of experts that includes legal professionals, medical professionals, and a project management team that is responsible for insuring compliance with HHS regulations. Since onset in 2012, MAXIMUS Federal has delivered nearly 4,000 case determinations to OIG/OAS. Through our efforts, OIG/OAS has identified multiple millions of dollars in Medicare overpayments for care rendered. In the process, all deliverable obligations were met on time or ahead of schedule. Additionally fulfilled were all requirements for non-billable services, such as project status reports and meetings. MAXIMUS Federal has demonstrated overarching success in this project by achieving of 100 percent in performance (all billable and non-billable deliverables) and timeliness; we also received a perfect score of 100 percent on the customer satisfaction on client survey.</p>

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**Health and Human Services, Office of Inspector General  
Medicare Parts A & B Review  
Agreement # 41230038**

**Relevancy to Scope of Services**

The labor services and personnel required under the HHS Office of Inspector General (OIG) project are closely related to those needed by the State of California IBR program. Under the MAXIMUS OIG project, internal clinical nurses and external physician consultants perform medical review of various types of claims involving Medicare Part A institutional providers (both inpatient and outpatient), and Part B physicians and suppliers. These medical reviews help determine whether payments were made in accordance with Medicare reasonableness, medical necessity, reimbursement, and documentation requirements. The MAXIMUS OIG effort follows the admonition contained in Section 1862(a)(1)(A) of the Social Security Act that Medicare will not pay for items or services that are “not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.”

***Proposed Staff Role and Responsibilities***

Staff listed below is 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.
- Dawn Ossont, **Coding Specialist** was responsible for reviewing medical billing codes and assessing the accuracy. She compiled the results of her reviews into the required reporting format under the IDRP program.
- Karen Coulter, **Coding Specialist** was responsible for reviewing medical billing codes and assessing the accuracy. She compiled the results of her reviews into the required reporting format under the IDRP program.

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**Reference #3**

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

California Department of Managed Health Care Independent Dispute Resolution Process (IDRP)	
<b>Name of Firm</b>	California Department of Managed Health Care
<b>Date of Service</b>	Oct. 14, 2008 to June 30, 2015
<b>Project Summary</b>	<p>MAXIMUS Federal provides independent dispute resolution process (IDRP) services to the Department of Managed Health Care (DMHC) to help resolve reimbursement disputes between health plans and non-contracted providers. The MAXIMUS Federal IDRP project provides claim review services to non-contracted providers who deliver EMTALA-required emergency services in order to ensure that providers are paid fairly for services provided to health plan enrollees.</p> <p>Upon receipt of each claim dispute case, MAXIMUS Federal resolves any preliminary issues including the appropriateness of the non-contracted provider's coding and bundling/unbundling of services. The MAXIMUS Federal reviewer then utilizes a "baseball style" arbitration model to determine whether the provider's billed charge or the health plan's paid amount for each of the disputed codes is most representative of the reasonable and customary value of the services. MAXIMUS Federal's determination is communicated in a written report which details the reviewer's rationale with regard to each of the disputed codes.</p>
<b>Relevancy to Scope of Services</b>	Our work on the DMHC IDRP project demonstrates MAXIMUS Federal's proven ability to resolve complex billing disputes in a timely and impartial manner. Our reviewer panel includes knowledgeable and experienced Coding Specialists, registered nurses, and licensed physicians who are well versed in the types of billing disputes encountered by California providers and health plans.

***Proposed Staff Role and Responsibilities***

Staff listed below is 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.
- Dawn Ossont, **Coding Specialist** was responsible for reviewing medical billing codes and assessing the accuracy. She compiled the results of her reviews into the required reporting format under the IDRP program.
- Karen Coulter, **Coding Specialist** was responsible for reviewing medical billing codes and assessing the accuracy. She compiled the results of her reviews into the required reporting format under the IDRP program.

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**Reference #4**

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

State of New Jersey Independent Claims Payment Arbitration Contract Number: A-81112	
Name of Firm	New Jersey Department of Banking and Insurance
Date of Service	March 15, 2012 to March 14, 2015 with two (2) one-year optional renewal periods
Project Summary	<p>The Program for Independent Claims Payment Arbitration (PICPA) is intended to provide health care providers and carriers offering health benefits plans an independent body able to arbitrate claims disputes between a payer and health care provider. MAXIMUS Federal Services is currently the designated arbitration organization for the PICPA. MAXIMUS Federal held the previous five (5) year contract and successfully won the competitive rebid. We continue to provide arbitration and mediation services for certain claims disputes in accordance with the Health Claims Authorization Processing and Payment Act (HCAPPA).</p> <p>Since the inception of our arbitration/mediation work with the DOBI in this area, MAXIMUS Federal has completed more than 13,065 arbitrations, covering both facility and individual provider disputes with payers. The work is performed by a staff of Appeals Officers and Coding Specialists. Monthly volumes have varied dramatically, from fewer than a hundred to more than 900 arbitrations per month. Importantly, during unanticipated spikes in volume, MAXIMUS Federal has been able to seamlessly utilize other staff resources to meet Project demands.</p>
Relevancy to Scope of Services	<p>Expert Coding Specialists evaluate claim payment arbitrations through evaluation of pertinent medical records, consulting physician reports and other documents submitted by the parties, as well as billing, reimbursement, and contract information. The Coding Specialists insure that all reimbursement determinations are consistent with the evidence presented and that each determination is specifically based on the correct coding and reimbursement rules and/or nationally recognized claim payment databases.</p>

***Proposed Staff Role and Responsibilities***

Staff listed below is 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.
- Dawn Ossont, **Coding Specialist** was responsible for reviewing medical billing codes and assessing the accuracy. She compiled the results of her reviews into the required reporting format under the New Jersey program.

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**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	
<b>Name of Customer</b>	Centers for Medicare and Medicaid Services (CMS)
<b>Contact Person and Telephone Number</b>	Mark Smolenski, Contracting Officer (410) 786-0175
<b>Date of Service</b>	Sept 14, 2005 – Present
<b>Project Abstract</b>	<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 and residential facilities, home health services, and hospice services – many of which require coding expertise. MAXIMUS Federal conducts independent reviews involving denials based upon medical necessity, coverage and coding.</p> <p>During 2013 we processed over 300,000 appeals under this contract. Of these 300,000 appeals, more than 160,000 involved billing code issues related to treatments in dispute.</p> <p>Our expert reviewers that perform the review services required under this contract include certified coders, board certified physicians, and licensed allied health professionals, nurses and attorneys. 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%, with the majority involving coding related issues. Our approach to meeting the volume surge involved, hiring and training certified coding resources, 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 efficiently 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>
<b>Relevancy to Scope of Services</b>	<p>Most cases processed on the Medicare QICs require retrospective analysis of medical treatments that were already provided. Such analysis invariably requires – and often hinges on – thorough review of the billing codes submitted for the treatments in dispute. Adjudicators working on the QICs have therefore developed, at minimum, a working knowledge of the relevant billing and coding structures. Moreover, the ability to apply knowledge of ICD-9, DRG, REV, CPT and HCCPS codes is an indispensable component of all QIC appeals adjudication.</p>

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

Independent Bill Review  
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**Proposed Staff Role and Responsibilities**

Staff listed below is proposed management staff for this proposal.

- Bernice Stein, **Medical Director** for CMS QIC Part A East project.
- 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
- 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.
- Lou Shields, **Shared Services Director** for the project and was responsible introducing new operational procedures to streamline and consolidate across the QIC programs.
- Dawn Ossont, **Coding Specialist** was responsible for reviewing medical billing codes and assessing the accuracy. She compiled the results of her reviews into the required reporting format under the New Jersey program.
- Karen Coulter, **Coding Specialist** was responsible for reviewing medical billing codes and assessing the accuracy. She compiled the results of her reviews into the required reporting format under the IDR program

**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-500-2004-0000101, HHS-500-T0004	
Name of Firm	Centers for Medicare and Medicaid Services (CMS)
Date of Service	September 2005 – Present
Project Summary	<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. Our expert reviewers that perform the review services required under this contract include certified coders, board certified physicians, and licensed allied health professionals, nurses and attorneys. During 2013 we processed over 100,000 appeals under this contract. Of these 100,000 more than 20,000 involved medical billing issues.</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>

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

Independent Bill Review  
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Centers for Medicare and Medicaid Services - Part B South Qualified Independent Contractor (QIC) Contract Number and Task Order HHSM-500-2004-000010I, HHSM-500-T0004	
	<b>Note: Work performed by Q2 Administrators (Q<sup>2</sup>A), a subsidiary of MAXIMUS Federal.</b>
<b>Relevancy to Scope of Services</b>	Most cases processed on the Medicare QICs require retrospective analysis of medical treatments that were already provided. Such analysis invariably requires – and often hinges on – thorough review of the billing codes submitted for the treatments in dispute. Adjudicators working on the QICs have therefore developed, at minimum, a working knowledge of the relevant billing and coding structures. Moreover, the ability to apply knowledge of ICD-9, DRG, REV, CPT and HCCPS codes is an indispensable component of all QIC appeals adjudication.

***Proposed Staff Role and Responsibilities***

Staff listed below is proposed management staff for this proposal.

- Lou Shields, **Shared Services Director** for the project and was responsible introducing new operational procedures to streamline and consolidate across the QIC programs.
- 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
- Dawn Ossont, **Coding Specialist** was responsible for reviewing medical billing codes and assessing the accuracy. She compiled the results of her reviews into the required reporting format under the New Jersey program.
- Karen Coulter, **Coding Specialist** was responsible for reviewing medical billing codes and assessing the accuracy. She compiled the results of her reviews into the required reporting format under the IDR program

**6.2.13 Freedom from Conflicts of Interest Plan**

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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 claims administrator; workers compensation, health or disability insurer; network of providers or any other type of payor. We solely provide IBR 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 IBR case file throughout the IBR 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 C: Conflict of Interest Policy and Procedures* for a detailed description of our conflict of interest measures.

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

Independent Bill Review  
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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 4.4.3.6: 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 IBR. 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 DWC absolutely conflict free services.

**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
_____	Attachment 6 Payee Data Record (STD 204) (if currently not on file) <i>(Required upon award of contract)</i>
_____	Attachment 7 Contractor Certification Clauses (CCC) 610. The CCC can be found on the Internet at <a href="http://www.ols.dgs.ca.gov/Standard+Language">www.ols.dgs.ca.gov/Standard+Language</a> . <i>(Required upon award of contract)</i>
<u>X</u>	Attachment 8 Darfur Contracting Act Certification
_____	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) *

\*If applicable

**Note for Attachment 10:** 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).

**ATTACHMENT 2**

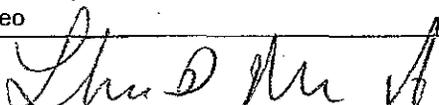
**PROPOSAL/PROPOSER CERTIFICATION SHEET**

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. (FBIN) 20-2998066		8. California Corporation No. C3014438	
9. Indicate applicable license and/or certification information: URAC Certificater California Business License No. C3014438			
10. Proposer's Name (Print) Tom 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><b>NOTE:</b> A copy of your Certification is required to be included if either of the above items is checked "Yes".</p> <p>Date application was submitted to OSBCR, if an application is pending:</p>			

State of California.

Bid DIR DWC RFP 14-002

**ATTACHMENT 3**

See the Cost Proposal for Attachment 3

**SAMPLE COST PROPOSAL WORKSHEET**

DIRECT LABOR	HOURS	RATE	TOTAL
Program Manager	_____ @ _____	_____	
Staff Assistant	_____ @ _____	_____	
Technician	_____ @ _____	_____	
Clerical	_____ @ _____	_____	
			\$ _____
SUBCONTRACTOR(S) (IF ANY) COST ITEMIZED			\$ _____
INDIRECT COSTS (OVERHEAD AND FRINGE BENEFITS)			
Overhead Rate	_____	_____	
Fringe Benefits	_____	_____	
			\$ _____
DIRECT COSTS (EXCEPT LABOR)			
Travel Costs		_____	
Equipment and Supplies (Itemized)		_____	
Other Direct Costs (Itemized)		_____	
			\$ _____
TOTAL COSTS			\$ _____

**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	California Department of Industrial Relations/Division of Workers' Compensation – Independent Bill Review (IBR)		
Street Address	1515 Clay Street, 18th Floor	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 December 31, 2014	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 2**

Name of Firm	Health and Human Services, Office of Inspector General Medicare Parts A & B Review		
Street Address	U.S. Dept. of Health & Human Services 200 Independence Avenue, S.W.	City	Washington State D.C. Zip Code 20201
Contact Person	Janet McLeod, CPA, Audit Manager	Telephone Number	(410) 786-2172
Dates of Service	July 1, 2012 to June 30, 2015	Value or Cost of Service	\$653,086.08

**Brief Description of Service Provided**

MAXIMUS Federal provides medical review support for OIG/OAS audits for Medicaid Parts A and B. Since 2012 we have delivered almost 4,000 case determinations. As a result, OIG/OAS has identified multiple millions of dollars in Medicare overpayments for care rendered. In the process, all deliverable obligations were met on time or ahead of schedule. We achieved 100 percent in performance and timeliness and received a perfect score of 100 percent on customer satisfaction on client surveys.

**REFERENCE 3**

Name of Firm	California Department of Managed Health Care Independent Dispute Resolution Process (IDRP)		
Street Address	980 9th Street, Suite 500	City	Sacramento State California Zip Code 95814
Contact Person	Ellen Bradley	Telephone Number	,916-255-2410
Dates of Service	October 14, 2008 to June 30, 2015	Value or Cost of Service	\$644,000.00

**Brief Description of Service Provided**

MAXIMUS Federal provides independent dispute resolution process services to DMHC to help resolve reimbursement disputes between health plans and non-contracted providers. We resolve any preliminary issues and then use a "baseball style" arbitration model to determine whether amounts billed and paid are customary and reasonable. Our findings are communicated in a written report that details our rationale for our decisions. This project demonstrates our ability to resolve complex billing issues in a knowledgeable and timely manner.

**REFERENCE 4**

Name of Firm	State of New Jersey Independent Claims Payment Arbitration		
Street Address	20 W State Street, Floor 9	City	Trenton
		State	New Jersey
		Zip Code	08608
Contact Person	Veronica Schmitt		Telephone Number : 609-292-5427 ext. 50528
Dates of Service	March 15, 2012 to March 14, 2015 with two (2) one-year optional renewal periods		Value or Cost of Service 4,613,816.00

**Brief Description of Service Provided**

MAXIMUS Federal is currently the designated arbitration organization for the PICPA. We held the previous five year contract and won the competitive rebid. We provide arbitration and mediation services for certain claims disputes in accordance with HCAPPA. We have completed more than 13,000 arbitrations covering both facility and individual provider disputes with payers. We are able to meet the challenge of dramatically varying volumes (from fewer than 100 to more than 900 arbitrations per month) by seamlessly utilizing other staff resources to meet project demands.

**REFERENCE 5**

Name of Firm	Centers for Medicare and Medicaid - Part A East Qualified Independent Contractor (QIC)		
Street Address	Division fo Appeals Operations	City	Baltimore
	7500 Security Blvd, Mailstop: B2-14-21	State	Maryland
		Zip Code	21244
Contact Person	Mark Smolenski, Contracting Officer		Telephone Number (410) 786-0175
Dates of Service	September 14, 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 6**

Name of Firm	Centers for Medicare and Medicaid Services - Part B South Qualified Independent Contractor (QIC)		
Street Address	Division of Appeals Operations	City	Baltimore
	7500 Security Blvd, Mailstop: B2-14-21	State	Maryland
		Zip Code	21244
Contact Person	Mark Smolenski, Contracting Officer		Telephone Number (410) 786-0175
Dates of Service	September 14, 2005 to 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.

**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.

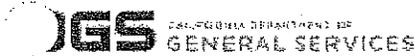
- c. If you are a California certified DVBE: (1) Are you a broker or agent? Yes \_\_\_\_\_ No \_\_\_\_\_  
 (2) If the contract includes equipment rental, does your company own at least 51% of the equipment provided in this contract (quantity and value)? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

**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.

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 2/25/2014

DVBE APP

TO MAXIMUS

Supplier #475  
SWIFT PRINT INC  
P O BOX 6554  
FRESNO CA 93703

THIS DVBE CERTIFICATE MAY ONLY BE USED FOR

BID # RFP 014-002

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](http://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.

### **Maintaining Your Online Certified Firm Profile**

Visit [www.eprocure.dgs.ca.gov/default.htm](http://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](http://www.documents.dgs.ca.gov/pd/smallbus/certchange.pdf)

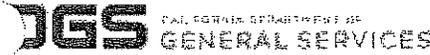
### **Certification Renewal**

Please complete an online application at [www.eprocure.dgs.ca.gov](http://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](mailto:OSDSHelp@dgs.ca.gov) if you have any questions.

Sincerely,

Office of Small Business and DVBE Services

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 4/25/2014  
Oct 5, 2012 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 # RFP 14-002

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](http://www.documents.dgs.ca.gov/pd/smallbus/ppstampreq.pdf). For more information or to verify certification status, visit [www.eprocure.dgs.ca.gov](http://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](http://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](http://www.documents.dgs.ca.gov/pd/smallbus/certchange.pdf).

**Certification Renewal**

Please complete an online application at [www.eprocure.dgs.ca.gov](http://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](mailto:OSDSHelp@dgs.ca.gov) if you have any questions.

Sincerely,

Office of Small Business and DVBE Services



ATTACHMENT 7

CCC-307

CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

<i>Contractor/Bidder Firm Name (Printed)</i>		<i>Federal ID Number</i>
<i>By (Authorized Signature)</i>		
<i>Printed Name and Title of Person Signing</i>		
<i>Date Executed</i>	<i>Executed in the County of</i>	

CONTRACTOR CERTIFICATION CLAUSES

1. **STATEMENT OF COMPLIANCE:** Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 8103) (Not applicable to public entities.)

2. **DRUG-FREE WORKPLACE REQUIREMENTS:** Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

- 1) the dangers of drug abuse in the workplace;
- 2) the person's or organization's policy of maintaining a drug-free workplace;
- 3) any available counseling, rehabilitation and employee assistance programs; and,
- 4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

- 1) receive a copy of the company's drug-free workplace policy statement; and,
- 2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department

**ATTACHMENT 8**

**DARFUR CONTRACTING ACT CERTIFICATION**

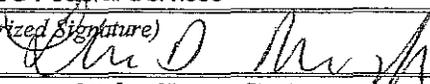
Public Contract Code Sections 10475 -10481 applies to any company that currently or within the previous three years has had business activities or other operations outside of the United States. For such a company to bid on or submit a proposal for a State of California contract, the company must certify 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***

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Certificate Number: XE132 RR - 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 PROCEDURE***

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## IBR Coding Review

FINAL DRAFT

Work Instructions v. 1.0  
11/26/13

**MAXIMUS**

Federal Services

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    Assignment Letter Determination ..... 4  
Case Review ..... 5

**MAXIMUS**

Federal Services

## Revisions

Version	Description
Draft 11/21/13	Developed from an interview with Julie Castner.
Final Draft 11/26/2013	Developed from a second interview with Julie Castner.

## **Case Assignment**

Case assignment takes place when a case has been deemed eligible by MAXIMUS or the DWC.

1. At the beginning of each week, the Admin sends an email to the DES with a list of cases due for assignment for each day of the week.
2. The DES prepares the cases for the Coding Specialist (CS).
3. For each case, the CS reviews all of the documentation provided by the DWC, the Provider, and the Claims Administrator to determine its legibility, completeness, and relevance to the case, and then instructs the DES to issue an assignment letter to the participants to inform them that the case has been assigned.

## **Assignment Letter Determination**

There are two types of assignment letters that may be sent to participants:

- **Assignment of Independent Bill Review**  
Sent to both participants to inform them that the case has been assigned and is ready to be reviewed.
- **Assignment of Independent Bill Review with request for Additional Documents**  
Typically sent to the Provider and copied to the Claims Administrator to inform them that the case has been assigned, but additional information is required before the case can be processed. (This letter may also sent to the Claims Administrator and copied to the Provider.)

If the assignment letter included a request for additional documentation, the participant who received the request has 35 days in which to return the requested documents.

If the participant who received the request fails to provide the requested documentation within the specified time period, MAXIMUS proceeds with the IBR based on the available information. (A notation of any such request and the information provided in our final determination).

**MAXIMUS**

Federal Services

## Case Review

1. Open the tracking spreadsheet and select a case due for review.
2. Get the case folder from the file.
3. In the case folder, review the case communication log to ensure the assignment letter was sent to the participants.
4. If there is an **Assignment of Independent Bill Review with request for Additional Documents** in the case folder, but the case folder does not include any additional documents, continue with the review.
5. Review the Application to determine what type of review this will be:
  - Denied Line of Service
  - Underpayment
  - Incorrect Code Assignment
6. Verify the Date of Service and the amounts billed and disputed.
7. Review the medical records and other pertinent application information submitted including:
  - Copies of the original billing itemization and any supporting documents that were furnished with the original billing
  - The explanation of review
  - The request for second review and any supporting documentation submitted with the request
  - The final explanation of the second review
  - A fee schedule established by the Administrative Director or a negotiated medical fee schedule established pursuant to Labor Code section 5307.11, in effect on the date of service, whichever is applicable.
8. Select a case abstraction form from the shared drive.
9. Enter all necessary information on the form.
10. Enter your determination and rationale in the **Determination Rationale** field.
11. When you have completed the form, save the document as [**case number**] **1st draft**, e.g., **CMS13-0000111 1st draft**.
12. Print the form and place it in the case folder.

**MAXIMUS**

Federal Services

13. Email the document to the Chief Coding Specialist with the subject line **[case number] 1st draft**, e.g., **CMS13-0000111 1st draft**.

## ***APPENDIX C: CONFLICT OF INTEREST POLICY AND PROCEDURE***

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## 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*

California Department of Industrial Relations



*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.

California Department of Industrial Relations



### **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.

#### **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 D: CONFIDENTIALITY POLICY AND PROCEDURE***

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## 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.

## 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.

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.

California Department of Industrial Relations



## 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.

## **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 E: TRAINING MANUALS***

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Independent Bill Review  
State of California, DIR, DWC



## Appendix E. Training Materials

Provided in this section are the Independent Bill Review training materials.

- IBR Request Creation
- IBR Process Flow
- IBR Application Creation
- IBR Preliminary Review
- IBR Coding Review
- IBR Case Audit and FDL Creation
- IBR Case Closing

## **IBR REQUEST CREATION**

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## **IBR Request Creation**

Document type v. 1.0  
10/10/13



**Contents**

Create a New IBR Request ..... 3  
    Submit Supporting Documents ..... 4  
Heading 1 ..... 9  
    Heading 2 ..... 9  
        Heading 3 ..... 9



## Create a New IBR Request

1. On the Home page, click New IBR.

The screenshot shows the MAXIMUS Home page. At the top, there are navigation tabs for 'Home', 'Tracking Inbox', and 'Search'. Below the tabs, the 'Home' section is displayed. A 'Tracking Inbox: IBR' section shows 'No IBR objects found for this filter.' A link for 'New IBR' is highlighted with a mouse cursor. Below this, there is a message: 'Be prepared to have your supporting documents available for submission with the On-Line IBR. If they cannot be submitted with the On-Line IBR, put a check next to 'Supporting Documents will'. At the bottom, there is a 'CA WC Dashboard' with two sections: 'Action Items' (1 - Create New IBR) and 'Review Submitted Forms' (Review Existing IBR).

2. On the IBR request form, enter the appropriate fields.

The screenshot shows the 'New IBR' form. The form is titled 'Request for Independent Bill Review' and 'IBR Status'. It is divided into three main sections: 'Provider Information', 'Provider's Agent / Representative Information (if applicable)', and 'Claims Administrator Information (Organization that Denied Payment)'. Each section contains various input fields for names, addresses, phone numbers, emails, and zip codes. The 'Provider Information' section includes fields for Provider Name, DBA, Provider Contact Name (First, Middle, Last, Suffix), Provider Street Address / PO Box, Provider City, Provider State, Provider ZIP Code, Provider Phone, Provider Email, Provider Fax, Provider NPI, License No., and Provider Type. The 'Provider's Agent / Representative Information' section includes fields for Organization Name (if applicable), Agent Contact Name (First, Middle, Last, Suffix), Street Address / PO Box, City, State, Zip Code, Phone, Email, and Fax. The 'Claims Administrator Information' section includes fields for Organization Name, Claims Administrator Contact Name (First, Middle, Last, Suffix), Claims Administrator Street Address / PO Box, Claims Administrator City, Claims Administrator State, Claims Administrator Zip Code, Claims Administrator Phone, Claims Administrator Email, and Fax.



3. Click Save.

The screenshot shows a web form titled "Injured Worker". It contains several input fields: "Federal Employer Identification Number (FEIN) or other ID:", "Name: Injured Worker First Name:", "Middle:", "Injured Worker Last Name:", "Injured Worker Suffix:", "Injured Worker Date of Birth:", "Date of Injury:", and "Injured Worker SSN:". Below these is a section titled "Independent Bill Review Summary" with checkboxes for "Please select all applicable Fee Schedules:" including "Ambulance Services", "Contract for Reimbursement Rates", "Durable Medical Equipment, Prosthetics, Orthotics and Supplies", and "Hospital Outpatient Departments and Ambulatory Surgical Centers". There are also radio buttons for "Was the treatment in dispute authorized by Employer?" (Yes/No), a text field for "Reason for denial of full payment:", "Start Date of Service (MM/DD/YYYY):", "End Date of Service (MM/DD/YYYY):", "Amount Billed: \$", "Amount Paid: \$", "Amount in Dispute: \$ 0.00", and "Date of Second Bill Review Outcome (MM/DD/YYYY):". At the bottom, there is a "Save" button and a "Spell Check" button.

The IBR request is saved.

4. Follow the workflow messages to complete the application.

### Submit Supporting Documents

5. Click on the **Manage Document(s)** link to upload any supporting documents.

**Note:** If there are no electronic documents to upload for this application, check the check box for **Check this box if the Supporting Document(s) will be mailed.**

The screenshot shows a web page titled "IBR". It has a sidebar with "Payment", "Document Management", and "Management". The main content area includes a "New Payment" button, a "Workflow Messages" section with instructions: "You must provide at least one document or acknowledge which will be mailed in order to submit a case to MAXIMUS to be processed." and "You must provide full payment of case filing fee before case will be sent to MAXIMUS. Please fill out the form on the payment tab to the left.", a "Document(s)" section with "No attachments" and a "Manage Document(s)" link, and a checkbox labeled "Check this box if the Supporting Document(s) will be mailed.". At the bottom, it displays "IBR Case Number: 2013-000", "Request for Independent Bill Review", "IBR Status", and "Intake".

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6. In the Manage Documents dialog box, click **Browse**.
7. Navigate to the directory where your supporting document is located, select the file and click **Open**.
8. In the **Type** section, check one or more boxes to describe the documents you are uploading.
9. In the Description field, include a description of the documents you are uploading. This field is not required.
10. Click **Upload**.  
The Uploaded Files: section will display any documents you uploaded.
11. Repeat steps 5-9 for any additional documents.

Manage Document(s)

Upload a new attachment

Attachment  Browse...

Type

- 275
- 835
- 837
- Claim form 1450
- Claim form 1500

Description

**Upload**

Uploaded Files:

Attachment Type	Date Uploaded	Attachment	Description	Uploaded By
-----------------	---------------	------------	-------------	-------------

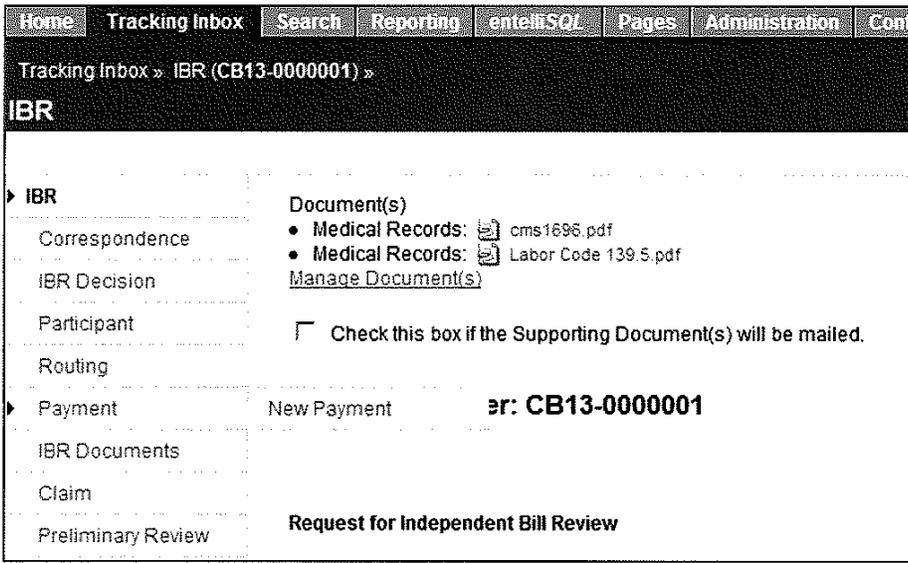
Close Window

12. Click Close Window when all uploads have been completed.

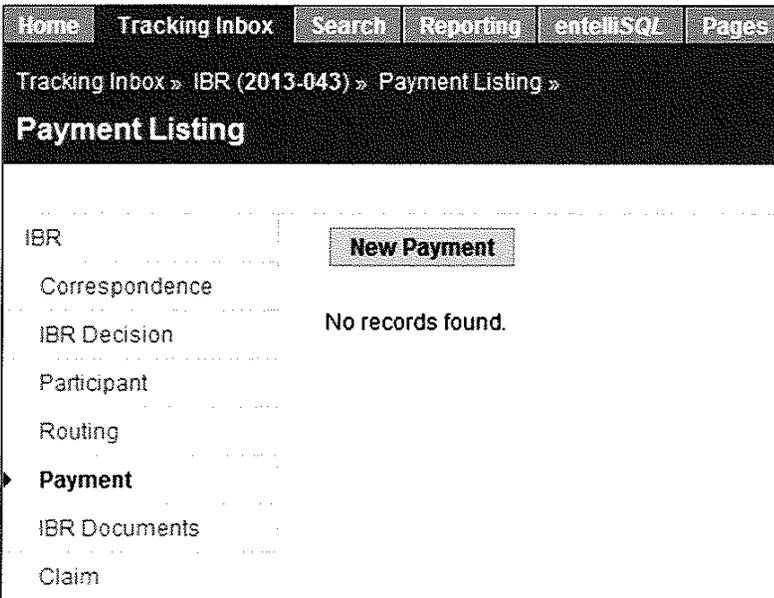


## Submit a Payment

1. In the left navigation, click **Payment**.



2. In the Payment Listing screen, click **New Payment**.



- 3. Enter the appropriate fields and click Save.  
The Message from webpage may appear.

<a href="#">Home</a>	<a href="#">Tracking Inbox</a>	<a href="#">Search</a>	<a href="#">Reporting</a>	<a href="#">entelliSQL</a>	<a href="#">Pages</a>	<a href="#">Administration</a>	<a href="#">Configuration</a>
Tracking Inbox > IBR (2013-043) > New Payment >							
<b>Payment</b>							
IBR	Correspondence	Payment Type	<input type="text"/>				
	IBR Decision	Payment Method	<input type="text"/>				
	Participant	Payment Amount	335.00				
	Routing	Transaction ID	<input type="text"/>				
	<b>Payment</b>	Response Code	<input type="text"/>				
	IBR Documents	Response Reason Code	<input type="text"/>				
	Claim	Response Reason Text	<input type="text"/>				
	Preliminary Review	Authorization Code	<input type="text"/>				
	Prior Level Review	Authorization Description	<input type="text"/>				
	Claim Line Item Decision	Date Payment	11/19/2013				
	Expert Review	Electronic Payment Return Code	<input type="text"/>				
	Request Information	Returned Amount	<input type="text"/>				
	Inquiry	Name on Credit Card	<input type="text"/>				
	Notes	Credit Card Number	<input type="text"/>				
	Milestone Activity	Expiration Month	<input type="text"/>				
	IBR Closing	Expiration Year	<input type="text"/>				
	Audit Log	CW2	<input type="text"/>				
	Assignments	Address	<input type="text"/>				
		City	<input type="text"/>				
		State	<input type="text"/>				
		Zip	<input type="text"/>				
		Country	<input type="text"/>				
<input type="button" value="Save"/> <input type="button" value="Spell Check"/>							

Click on the breadcrumb navigation to return to the Application.

<a href="#">Home</a>	<a href="#">Tracking Inbox</a>	<a href="#">Search</a>	<a href="#">Reporting</a>	<a href="#">entelliSQL</a>	<a href="#">Pages</a>	<a href="#">Administration</a>	<a href="#">Configuration</a>
Tracking Inbox > IBR (2013-043) > New Payment >							
<b>Payment</b>							

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**TOC Heading**

TOC 1

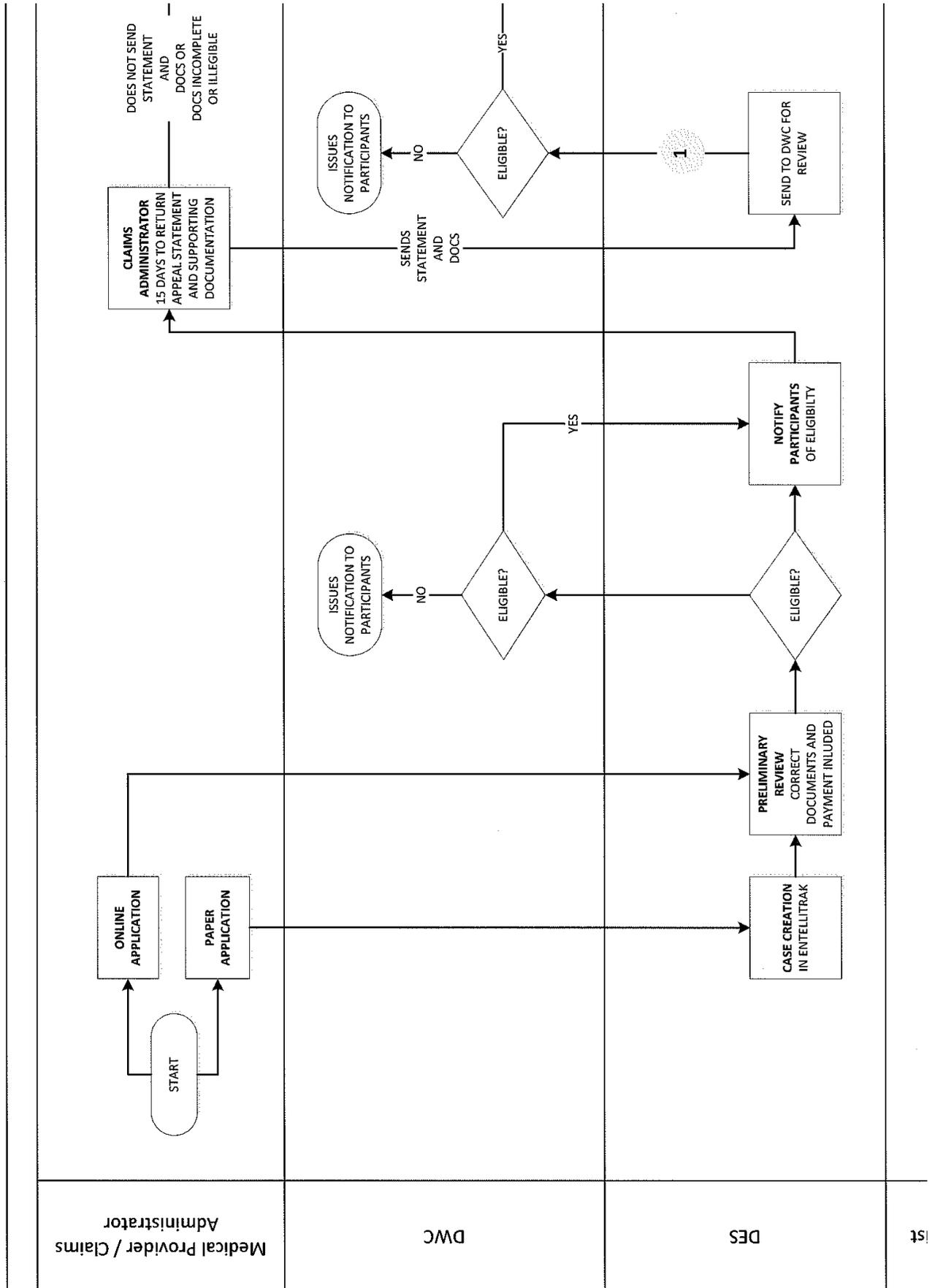
TOC 2

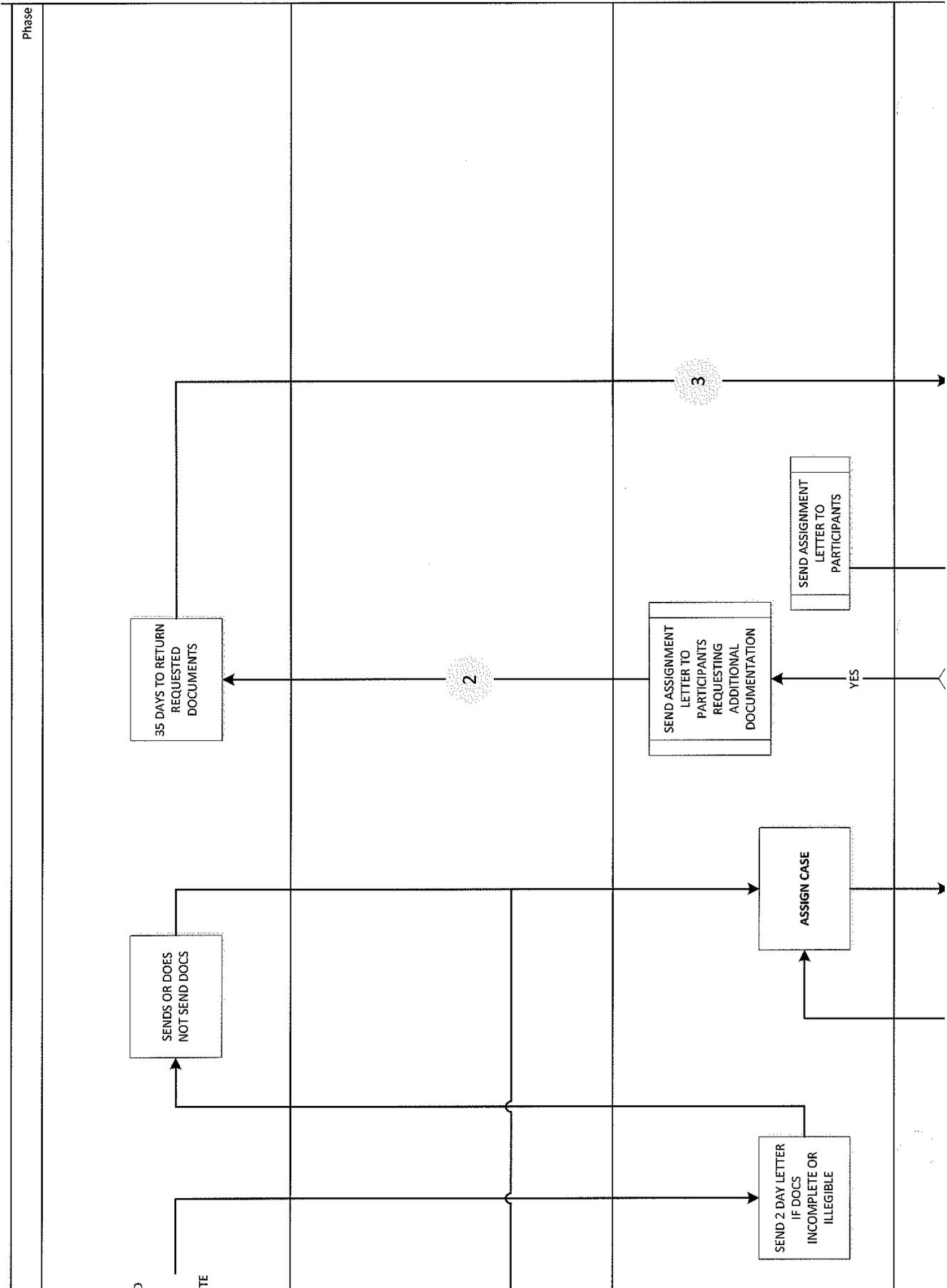
TOC 3

# **IBR PROCESS FLOW**

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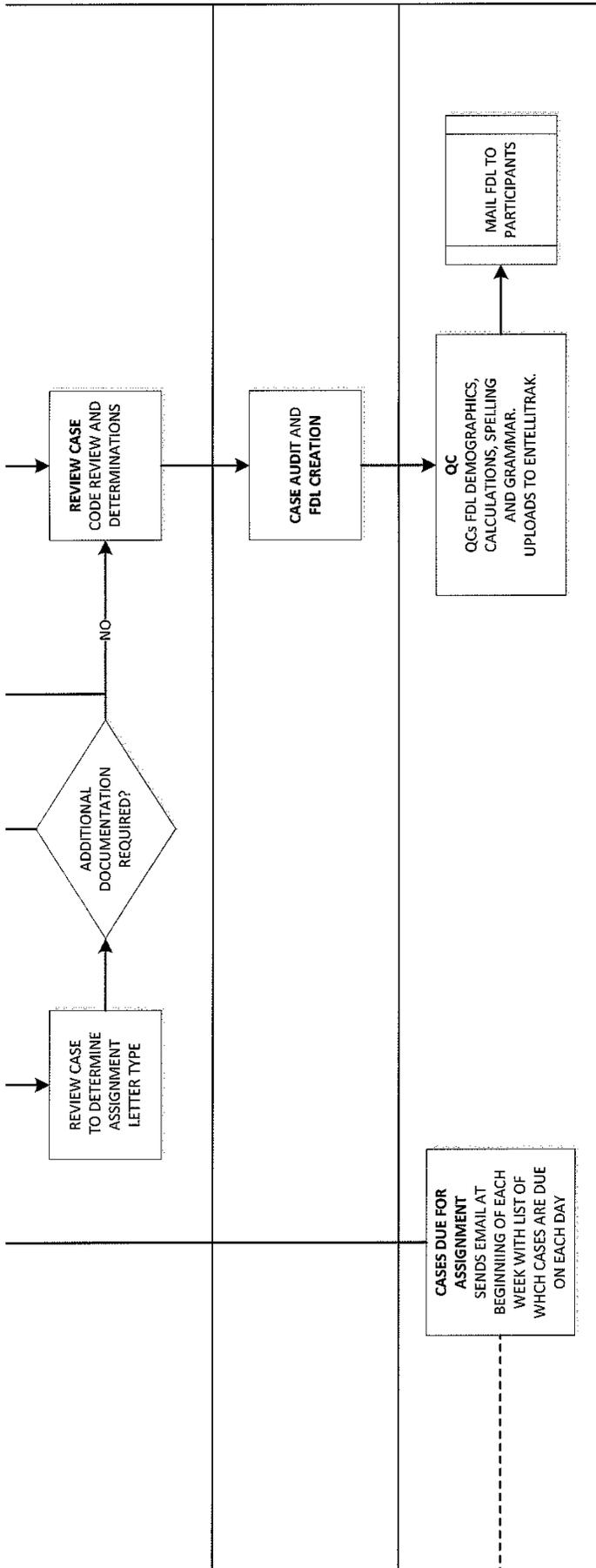
**IBR PROCESS FLOW** 11272013





Coding Specialist	Chief Coding Specialist	Admin
		<div data-bbox="672 1396 800 1566" style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">                 TRACKS CASES AND STATUS             </div>

1. Case is sent to DWC if there is an issue with eligibility. If MAXIMUS determines that there are no eligibility issues, MAXIMUS will likely decide to process the case without first referring to DWC.
2. The request for information is typically sent to the Provider and cc'd to the Case Administrator. It is less typical to request additional documents from the Case Administrator.
3. If additional documents were requested and submitted by the Participant, the Admin prints the documents and places them in the case folder.



# ***IBR APPLICATION CREATION***

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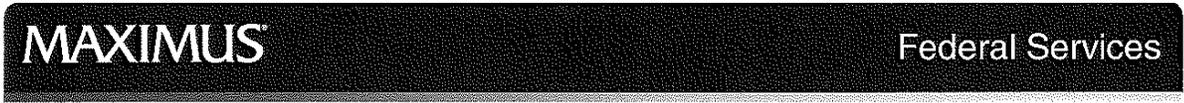
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## **IBR Application Creation**

Work Instructions v. 1.0  
11/21/13



**Contents**

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    Enter Payment Information ..... 8  
    Sign the Application ..... 11  
Route the Case to Preliminary Review ..... 13

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## Revisions

Version	Description
Draft 11/20/13	Based on existing documentation submitted to Eric Lian by Dianne Martino.
Final Draft 11/21/13	Corrections based on Eric Lian Draft presentation to Tami Picard.

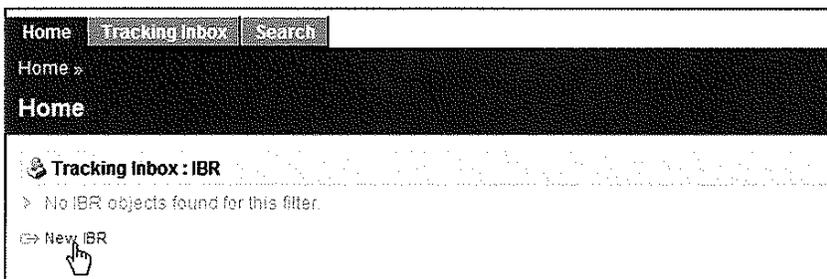
## IBR Creation

MAXIMUS receives IBR (Independent Bill Review) applications in two ways:

- Electronic submissions through the case management system
- Paper

When we receive applications on paper, the documents are scanned into an electronic format and the case is created manually.

1. From the Home tab, click **New IBR**.



2. Enter the information provided by the application into the IBR screen.

**Note:** All fields marked with red R icons are required fields.

The screenshot shows the 'Request for Independent Bill Review' form. The form is titled 'Request for Independent Bill Review' and 'IBR Status'. It is divided into two main sections: 'Provider Information' and 'Provider's Agent / Representative Information (if applicable)'. The 'Provider Information' section includes fields for 'Provider Name', 'DBA', 'Provider Contact Name' (First, Middle, Last, Suffix), 'Provider Street Address / PO Box', 'Provider City', 'Provider State', 'Provider ZIP Code', 'Provider Phone', 'Provider Email', 'Provider Fax', 'Provider NPI', and 'License No.'. The 'Provider's Agent / Representative Information (if applicable)' section includes fields for 'Organization Name (if applicable)', 'Agent Contact Name' (First, Middle, Last, Suffix), 'Street Address / PO Box', 'City', 'State', 'Zip Code', 'Phone', 'Email', and 'Fax'. Red 'R' icons are placed next to several fields to indicate they are required.

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3. Click **Save**.

**Note:** If any of the required fields were not entered, an error message will appear at the top of the screen indicating which fields need to be entered before you can save the screen.

4. Follow the workflow messages to complete the application.

## Submit Supporting Documents

1. Click on the **Manage Document(s)** link to upload any supporting documents.

The screenshot shows the MAXIMUS web application interface. At the top, there is a navigation bar with tabs: Home, Tracking Inbox, Search, Reporting, IntelliSQL, Pages, Administration, and Configuration. Below the navigation bar, the breadcrumb trail reads 'Tracking Inbox > IBR (2013-042) >'. The main content area is titled 'IBR' and contains a sidebar on the left with a tree view of options: IBR, Correspondence, IBR Decision, Participant, Routing, Payment, IBR Documents, Claim, Preliminary Review, and Prior Level Review. The main content area displays 'Workflow Messages' with two messages: 'You must provide at least one document or acknowledge document(s) will be mailed in order to submit a case to MAXIMUS to be processed.' and 'You must provide full payment of case filing fee before case will be sent to MAXIMUS. Please fill out the form on the payment tab to the left.' Below the messages, there is a section for 'Document(s)' with a bullet point 'No attachments' and a link 'Manage Document(s)' which is highlighted with a black arrow. There is also a checkbox labeled 'Check this box if the Supporting Document(s) will be mailed.' and the text 'IBR Case Number: 2013-042'.

2. In the **Manage Documents** dialog box, click **Browse**.
3. Navigate to the directory where your supporting documents are located, select the file and click **Open**.
4. In the **Type** section, check one or more check boxes to describe the documents you are uploading.
5. In the **Description** field, include a description of the documents you are uploading.
6. Click **Upload**.
7. Repeat steps 6-10 for any additional documents.

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Manage Document(s)

Upload a new attachment

Attachment

Type  275  
 835  
 837  
 Claim form 1450  
 Claim form 1500

Description

Uploaded Files:

Attachment Type	Date Uploaded	Attachment	Description	Uploaded By
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8. Click **Close Window** when all uploads have been completed.

### Enter Payment Information

1. In the left navigation, click **Payment**.

Home Tracking Inbox Search Reporting entelliSQL Pages Administration Conf

Tracking Inbox > IBR (CB13-0000001) >

**IBR**

- IBR
- Correspondence
- IBR Decision
- Participant
- Routing
- Payment** ← New Payment ar: CB13-0000001
- IBR Documents
- Claim
- Preliminary Review

Document(s)

- Medical Records: cms1696.pdf
- Medical Records: Labor Code 139.5.pdf

[Manage Document\(s\)](#)

Check this box if the Supporting Document(s) will be mailed.

**Request for Independent Bill Review**

2. On the **Payment Listing** screen, click **New Payment**.

Home Tracking Inbox Search Reporting entelliSQL Pages

Tracking Inbox > IBR (2013-043) > Payment Listing >

**Payment Listing**

- IBR
- Correspondence
- IBR Decision
- Participant
- Routing
- Payment** ← New Payment
- IBR Documents
- Claim

No records found.

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3. If payment has been submitted by check, use the following dummy information to enter the payment into the Payment screen:

Item	Description
Credit Card Type	Visa
Credit Card Number	4111-1111-1111-1111 (Do not enter the dashes)
Name on Credit Card	Providers Name
Expiration Month	January
Expiration Year	2020
CVV2	123

Home Tracking Inbox Search Reporting IntelliSQL Pages Administration Configuration

Tracking Inbox > IBR (2013-043) > New Payment >

**Payment**

IBR	Correspondence	Payment Type	<input type="text"/>
	IBR Decision	Payment Method	<input type="text"/>
	Participant	Payment Amount	335.00
	Routing	Transaction ID	<input type="text"/>
	<b>Payment</b>	Response Code	<input type="text"/>
	IBR Documents	Response Reason Code	<input type="text"/>
	Claim	Response Reason Text	<input type="text"/>
	Preliminary Review	Authorization Code	<input type="text"/>
	Prior Level Review	Authorization Description	<input type="text"/>
	Claim Line Item Decision	Date Payment	11/19/2013
	Expert Review	Electronic Payment Return Code	<input type="text"/>
	Request Information	Returned Amount	<input type="text"/>
	Inquiry	Name on Credit Card	<input type="text"/>
	Notes	Credit Card Number	<input type="text"/>
	Milestone Activity	Expiration Month	<input type="text"/>
	IBR Closing	Expiration Year	<input type="text"/>
	Audit Log	CVV2	<input type="text"/>
	Assignments	Address	<input type="text"/>
		City	<input type="text"/>
		State	<input type="text"/>
		Zip	<input type="text"/>
		Country	<input type="text"/>

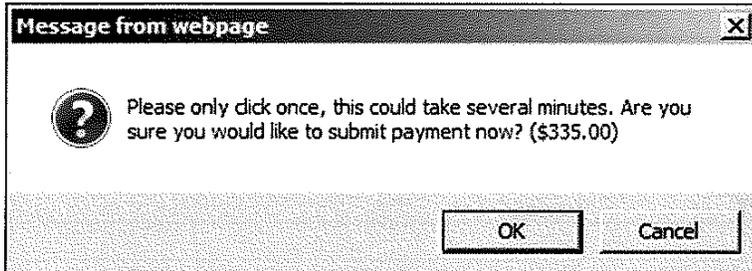
Save Spell Check

Click **Save**.

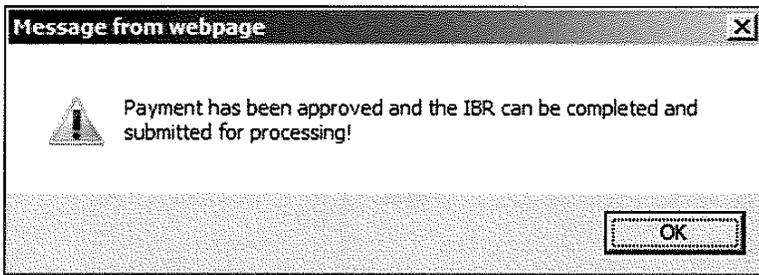
**MAXIMUS**

Federal Services

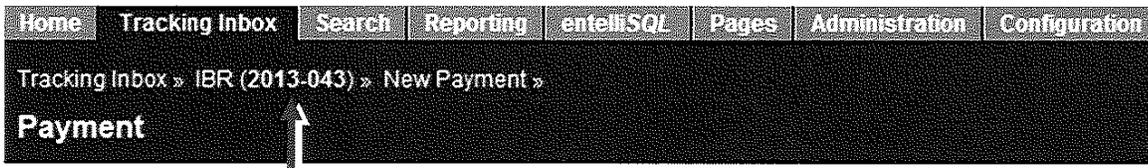
4. An entellitrak message appears. Click **OK**.



5. The payment has been approved message appears. Click **OK**.



6. Click on the breadcrumb navigation to return to the **IBR** screen.



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### Sign the Application

1. Scroll to the bottom of the **IBR** screen.
2. Click the **Signature** icon.

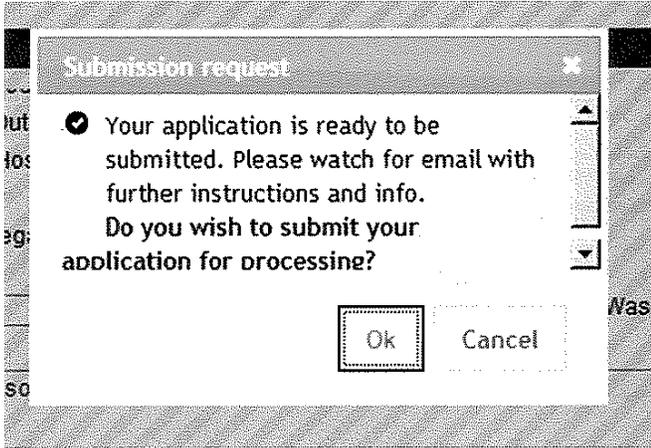
Amount Billed: \$ 15000.00 Amount Paid: \$ 1000.00 Amount in Dispute: \$ 14,000.00  
Date of Second Bill Review Outcome (MM/DD/YYYY): 11/12/2013 Does the IBR request include consolidation of multiple claims:  Yes  No  
Signature: [ ] ←  
[ Save ] [ Spell Check ] [ Delete ]

3. Enter your system password and click **OK**.

Password Confirmation  
Enter password: [ ]  
[ Ok ] [ Close ]

The signature field is populated with your system name.

4. Click **Save**.
5. In the **Submission request** dialog, click **OK**.



You have completed the IBR.

## Route the Case to Preliminary Review

1. From within the case you want to send to preliminary review, in the left navigation, hover your cursor over **Routing** and select **New Routing**.
2. In the **Next Assignment** drop-down list, select **Assign to Preliminary Review**.

**Routing**

IBR

Correspondence

IBR Decision

Participant

**Routing**

Payment

IBR Documents

Claim

Preliminary Review

Next Assignment: Assign to Preliminary Review

Previous Status: Submitted

Remarks:

Timestamp: 11/20/2013 02:36 PM

Save Spell Check

3. Click **Save**

If the routing was successful, a message appears indicating that the case has been moved to the Pending Preliminary Review status.

**Routing Listing**

IBR

Correspondence

IBR Decision

Participant

**Routing**

New Routing

Workflow Messages

- The IBR Record has moved to the Pending Preliminary Review status.

## ***IBR PRELIMINARY REVIEW***

---

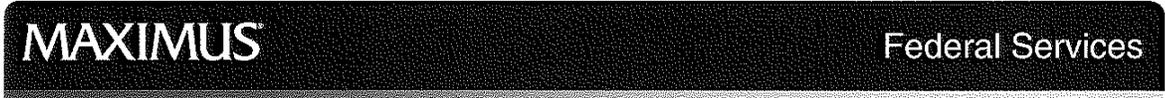
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## **IBR Preliminary Review**

Work Instructions v. 1.  
11/19/1



**Contents**

Preliminary Review Overview ..... 3  
Self-Assign a Case and Review the Application ..... 4  
    Review the IBR Application ..... 4  
Record the Preliminary Review ..... 7

**MAXIMUS**

Federal Services

## Revisions

Version	Description
Draft 11/20/13	Based on existing documentation submitted to Eric Lian by Dianne Martino.
Final Draft 11/21/13	Corrections based on Eric Lian Draft presentation to Tami Picard.

## Preliminary Review Overview

During preliminary review, MAXIMUS notifies the Division of Workers' Compensation (DWC) through the case management system if it appears from the application that:

- There is a dispute over eligibility for Independent Bill Review (IBR)
  - The application was not filed within the allotted time
  - The application is a duplicate submission
  - The dispute involves proper selection of an analogous procedure code or formula where no fee schedule exists for the category of service
  - The case is ineligible for IBR for some other reason

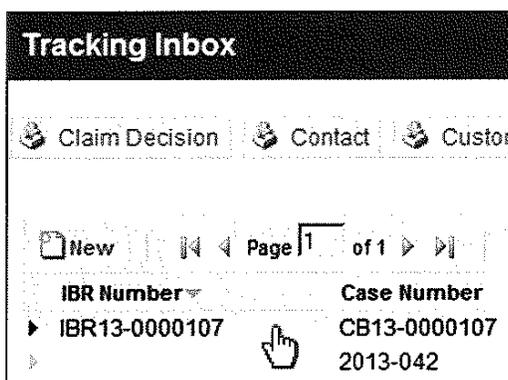
MAXIMUS also notifies the DWC if the information submitted with an application is insufficient to begin the bill review process.

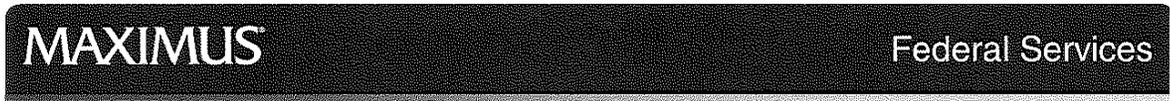
If the preliminary review performed by MAXIMUS and/or the DWC determines the case is eligible for IBR, MAXIMUS can initiate the process of requesting documentation from the Claims Administrator to support their side of the dispute.

## Self-Assign a Case and Review the Application

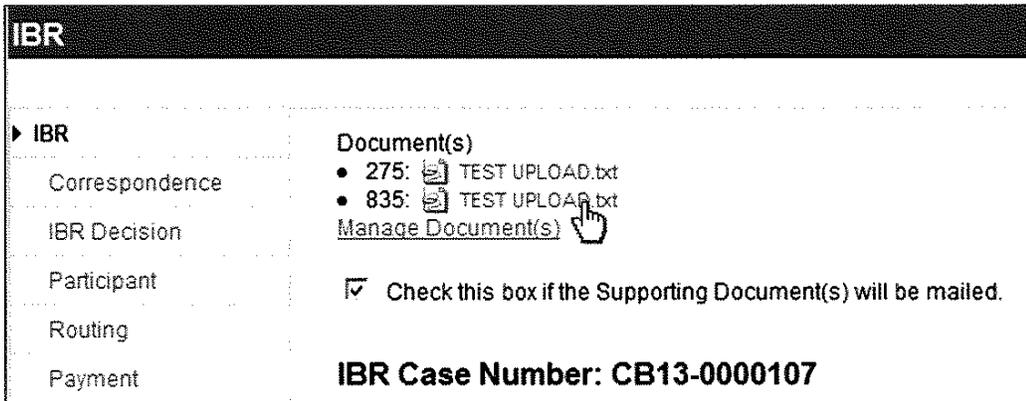
### Review the IBR Application

1. From the entellitrack **Home** tab, check the **IBR Tracking Inbox** to see if you have any cases to review. If there is a case, click on it to access it.





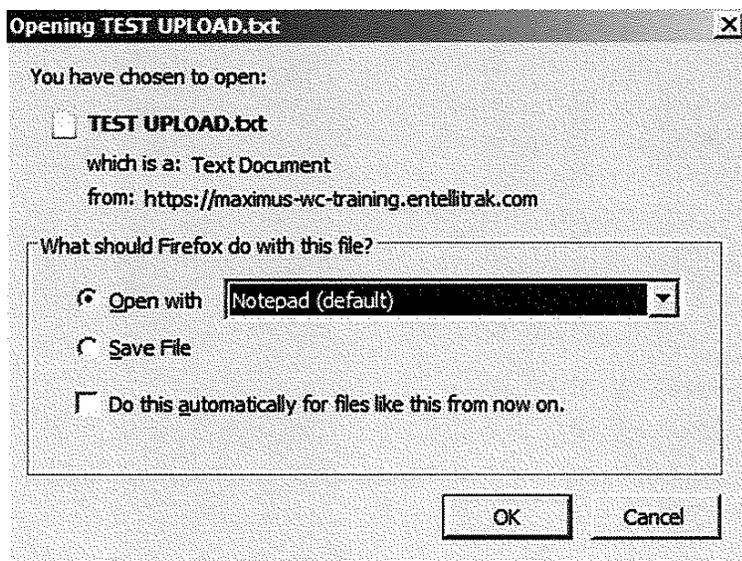
2. Click on the document name to review the documents sent with the application.  
You can find the list of files above the application form.



You are prompted with choices to open or save the file using the default application for the file type you are opening.

If you are using the Firefox browser:

- To view the document, ensure Open with is selected and click OK.
- To save the document, ensure Save File and click OK.



3. Repeat step 2 for each document you want to view.

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4. Complete your preliminary review of the application. [WHAT CRITERIA ARE WE USING TO COMPLETE PRELIMINARY REVIEW?]

**Note:** Make a note to yourself about any eligibility issues that might require MAXIMUS to send the case to the DWC for further review. This will be helpful during the next step when you record the preliminary review.

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## Record the Preliminary Review

If you determined the application is ineligible, you are ready to record the preliminary findings, which will automatically route the case to DWC.

1. Access the case in the IBR Tracking Inbox.
2. In the left navigation, hover your mouse cursor over the **Preliminary Review** tab and select **New Preliminary Review**.
3. Complete the fields in the top portion of the **Preliminary Review** screen that are included in the following table.

Field	Description
Preliminary Start Date	Date that the preliminary review started.
Preliminary Determination Date	Date that MAXIMUS determined if the appeal is eligible or needs to be sent to DWC for further review.
Eligibility Issue?	<b>Yes:</b> There is a question of eligibility that requires the case to be forwarded to DWC.
Preliminary Review Issue	Only displays if Yes is selected in Eligibility Issue? Select the category of eligibility.
Notes	Enter a brief description of the specific issue that caused MAXIMUS to forward the case to the DWC.

4. Click **Save**.

If you answered Yes in the Eligibility Issue? field, the case is automatically removed from your tracking inbox and will appear on a list of cases for the DWC to evaluate.

## ***IBR CODING REVIEW***

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**MAXIMUS**

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## **IBR Coding Review**

CONFIDENTIAL

Work Instructions v. 1.0  
11/26/13



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    Assignment Letter Determination ..... 4  
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**MAXIMUS**

Federal Services

## Revisions

Version	Description
Draft 11/21/13	Developed from an interview with Julie Castner.
Final Draft 11/26/2013	Developed from a second interview with Julie Castner.

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## Case Assignment

Case assignment takes place when a case has been deemed eligible by MAXIMUS or the DWC.

1. At the beginning of each week, the Admin sends an email to the DES with a list of cases due for assignment for each day of the week.
2. The DES prepares the cases for the Coding Specialist (CS).
3. For each case, the CS reviews all of the documentation provided by the DWC, the Provider, and the Claims Administrator to determine its legibility, completeness, and relevance to the case, and then instructs the DES to issue an assignment letter to the participants to inform them that the case has been assigned.

## Assignment Letter Determination

There are two types of assignment letters that may be sent to participants:

- **Assignment of Independent Bill Review**  
Sent to both participants to inform them that the case has been assigned and is ready to be reviewed.
- **Assignment of Independent Bill Review with request for Additional Document:**  
Typically sent to the Provider and copied to the Claims Administrator to inform them that the case has been assigned, but additional information is required before the case can be processed. (This letter may also sent to the Claims Administrator and copied to the Provider.)

If the assignment letter included a request for additional documentation, the participant who received the request has 35 days in which to return the requested documents.

If the participant who received the request fails to provide the requested documentation within the specified time period, MAXIMUS proceeds with the IBR based on the available information. (A notation of any such request and the information provided in our final determination).

## Case Review

1. Open the tracking spreadsheet and select a case due for review.
2. Get the case folder from the file.
3. In the case folder, review the case communication log to ensure the assignment letter was sent to the participants.
4. If there is an **Assignment of Independent Bill Review with request for Additional Documents** in the case folder, but the case folder does not include any additional documents, continue with the review.
5. Review the Application to determine what type of review this will be:
  - Denied Line of Service
  - Underpayment
  - Incorrect Code Assignment
6. Verify the Date of Service and the amounts billed and disputed.
7. Review the medical records and other pertinent application information submitted including:
  - Copies of the original billing itemization and any supporting documents that were furnished with the original billing
  - The explanation of review
  - The request for second review and any supporting documentation submitted with the request
  - The final explanation of the second review
  - A fee schedule established by the Administrative Director or a negotiated medical fee schedule established pursuant to Labor Code section 5307.11, in effect on the date of service, whichever is applicable.
8. Select a case abstraction form from the shared drive.
9. Enter all necessary information on the form.
10. Enter your determination and rationale in the **Determination Rationale** field.
11. When you have completed the form, save the document as **[case number] 1st draft**, e.g., **CMS13-0000111 1st draft**.
12. Print the form and place it in the case folder.
13. Email the document to the Chief Coding Specialist with the subject line **[case number] 1st draft**, e.g., **CMS13-0000111 1st draft**.

# ***IBR CASE AUDIT AND FDL CREATION***

---

**MAXIMUS**

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# **IBR Case Audit and FDL Creation**

FINAL DRAFT

Work Instructions v. 1.0  
11/26/13



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**MAXIMUS**

Federal Services

## Revisions

Version	Description
Draft 11/21/13	Developed from an interview with Tricia Brantley .
Final Draft 11/26/2013	Developed from a second interview with Tricia Brantley.

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## Case Audit and Review

1. Open the case file and review the Application and case documents.
2. Determine the fee schedule and codes in dispute.
3. Compare this information to the information in the case abstraction form prepared by the Coding Specialist.
4. In the **Determination Rationale** field, review the determination prepared by the Coding Specialist.

**Note:** You may decide to use any, all, or none of the determination rationale when preparing your final determination.

5. Open the **Chief Coding Specialist Final Determination** worksheet and enter any necessary information.

**Note:** The information you enter on the worksheet to audit the case may be used to prepare the FDL.

## FDL Creation

1. Select an FDL template.
2. Select the date from the **Date** field.
3. Copy the information you entered in the **Chief Coding Specialist Final Determination** worksheet and paste to the FDL template.
  - Enter any address or case related information into the gray entry fields.
  - Enter any necessary information into the **Determination** section.
  - Enter any necessary information into the **Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed** section.
  - Enter any necessary information into the **Supporting Analysis** section.
  - Enter any necessary information into the **Chief Coding Specialist Decision Rationale** section (if this section is available).
4. When you have completed the FDL, save as document to the case folder and name the document [case number] [last name, first initial] **IBR Final Determination [Upheld/Reversed]**,  
e.g., **CB13-0000108 Smith, A IBR Final Determination Upheld**
5. Print the FDL and place it in the case folder.
6. Give the completed case folder to the Admin for QC.

## **IBR CASE CLOSING**

---

**MAXIMUS**

Federal Services



## **IBR Case Closing**

Work Instructions v. 1.0  
11/21/13



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Print the Envelopes.....	4
Upload Documents to entellitrak.....	4
Close the Case .....	6
Log the Case in the Tracking Spreadsheet .....	6



## Revisions

Version	Description
Draft 11/22/13	Based on an interview with Denise Sims.

**MAXIMUS**

Federal Services

## Case Closing

The Case Closer receives the case to be closed from Chief Coding Specialist.  
The case is the physical case folder.

## QC the FDL

- Addresses
- Claim Numbers
- Grammar

## Print the FDL

- 1 copy for the case folder
- 1 copy for the Claims Administrator
- 1 copy for the Medical Provider

## Print the Envelopes

- 1 envelope with the Claims Administrator address
- 1 envelope with the Medical Provider address

## Upload Documents to entellitrak

1. Open the IBR Case Tracking spreadsheet and entellitrak.

**Note:** The current case closer uses the IBR Intake User profile.

2. Search for the case number and open the case.
3. Click **Manage Document(s)**.

IBR	
<b>IBR</b>	
Correspondence	<b>Workflow Messages</b> You must provide full payment of case filing fee before case will be sent to MAXIMUS. Please fill out the form on the payment tab to the left.
IBR Decision	
Participant	<b>Document(s)</b> <ul style="list-style-type: none"><li>• Claim form 1500, EOR, Medical Records:  CB13-0000001 APPLICATION.pdf</li><li>• Other:  HOWARD SIIU IBR.pdf</li><li>• Other:  CB13-0000013 Withdrawal 3.6.13fax.pdf</li><li>• Other:  CII13-0000001.pdf</li></ul> <a href="#">Manage Document(s)</a>
Routing	
Payment	
IBR Documents	Supporting Document(s) will NOT be mailed.
Claim	
Preliminary Review	<b>IBR Case Number: CB13-0000001</b>
Prior Level Review	

**MAXIMUS**

Federal Services

4. Click **Browse** and navigate to the FDL.
5. For document **Type**, select **Other**.
6. In the **Description** field, enter "FDL".

Manage Document(s)

Upload a new attachment

Attachment

Type

- Claim form UB-4
- EOB
- EOR
- Medical Records
- Other

Description

Uploaded Files:

Attachment Type	Date Uploaded	Attachment	Description	Uploaded By
Claim form 1500, Medical Records, EOR	21-FEB-13	CB13-0000001 APPLICATION.pdf	null	Khushboo Naidu
Other	25-FEB-13	HOWARD SILL	IBR WITHDRAWAL	Khushboo Naidu

7. Click **Browse** and navigate to the NOARFI.
8. For document **Type**, select **Other**.
9. In the **Description** field enter "NOARFI".
10. Click **Close Window**.

### Close the Case

1. In the left navigation, hover your cursor over IBR Closing and click New IBR Closing.
2. In the IBR Case Close Notes field, enter "Final Determination Issued".

The screenshot shows the 'IBR Closing' form interface. On the left is a navigation menu with options: IBR, Correspondence, IBR Decision, Participant, Routing, Payment, and IBR Documents. The main form area contains the following fields:

- IBR Case Close Notes:** A text input field containing 'Final Determination Issued' with a help icon.
- IBR Case Close By:** A text input field containing 'efian'.
- IBR Case Close Date:** A date and time picker showing '11/22/2013 06:59 PM' with a help icon and a format '(mm/dd/yyyy hh:mm AM/PM)'.

At the bottom of the form are two buttons: 'Save' and 'Spell Check'.

3. Click **Save**.  
The case is closed.

### Log the Case in the Tracking Spreadsheet

1. On the IBR Cases tab of the IBR Case Tracking spreadsheet, identify the row for the case and enter the following information:
  - **Column E** – Internal status until assigned, enter "**Closed - Final Determination Issued**".
  - **Column R** – Final Case status, enter "**Closed**".
2. Click on the Monthly Report Info tab and enter the following information:
  - **Column T** – Final Determination Completed, enter the current date.
  - **Column AA** – Refunds Due, enter any refunds due.
  - **Column AH** – Final Case Status, enter "**Closed**".

## ***APPENDIX F: SAMPLE REDACTED CASE SUMMARY***

---

Independent Bill Review  
State of California, DIR, DWC



## Sample Redacted Case Summary

The following is a sample redacted case summary final determination letter for illustration purposes. The actual data elements and redacted fields will be confirmed with DWC prior to creating these summaries for posting to the DIR website. We agree to provide all elements listed in Appendix A, as subject to redaction of identifying information as determined by DWC.

### MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280

---

#### Independent Bill Review Final Determination <Outcome>

<DATE>

IBR Unique ID Number: 12345

<PROVIDER NAME> Redacted<  
<PROVIDER ADDRESS> Redacted<  
<PROVIDER CITY, STATE, ZIP CODE> Redacted<  
<PROVIDER PHONE> Redacted<  
<PROVIDER FAX> Redacted<

IBR Case Number: EAMS Number:	CB13 or 14- xxxxxxx<Redacted> <EAMS Number>	Date of Injury:	<MM/DD/YYYY>
Claim Number: JCN (if applicable)	<CLAIM NUMBER><Redacted> <JCN>	Application Received:	<MM/DD/YYYY>
Claims Administrator:	<CLAIMS ADMIN><Redacted>		
Date(s) of service:	<MM/DD/YYYY> - <MM/DD/YYYY>		
Provider Name:	<PROVIDER/GROUP NAME><Redacted>		
Provider FEIN:	<Redacted>		
Employee Name:	<EMPLOYEE NAME><Redacted>		
Disputed Codes:	99358		

Independent Bill Review  
State of California, DIR, DWC



Dear <PROVIDER NAME><Redacted>

### **Determination**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on <DATE IBR ASSIGNED>, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. The IBR was referred to DWC for preliminary review on <Date Referred> and determined eligible on <Date IBR Determined Eligible>.

MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$XX.00 and the amount found owing of \$XX, for a total of \$xx.**

### **Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed**

The following evidence was used to support the decision:

- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- Official Medical Fee Schedule or negotiated contract: PPO Contract
- Other: OMFS General Information and Instructions

### **Supporting Analysis**

The dispute regards the denial of a Prolonged Evaluation and Management service (99358). The Claims Administrator denied the Prolonged Evaluation and Management service code 99358 indicating "No separate payment was made because the value of the service is included within the value of another service performed on the same day."

CPT 99358 - Prolonged Evaluation and Management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records, job analysis, evaluation of ergonomic status, work limitations, work capacity, or communication with other professionals and/or the patient/family); each fifteen minutes.

Per review of the OMFS Evaluation and Management section, code 99358 is used when a physician provides prolonged service not involving direct care that is beyond the usual service in either the inpatient or outpatient setting. The CPT code 99358 may be used when the physician is required to spend 15 or more minutes before and/or after direct (face-to-face) patient contact in reviewing extensive records, tests or in communication with other professionals. The Provider submitted an "Initial Comprehensive Orthopedic Consultation Report and Request for Authorization of Surgery." The report documented a total of 1 hour 15 minutes of time spent in review of diagnostic studies and medical record which included: Primary Treating Physician's medical records and MRI. The documentation supports the reimbursement of CPT 99358 (5 units).

Independent Bill Review  
State of California, DIR, DWC



The reimbursement amount of \$XX is warranted per the Official Medical Fee Schedule code 99358.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99358	5	\$XX.XX	\$XXX.XX	\$X.XX	\$XXX.XX	PPO Contract

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (\$XX.00) and the OMFS amount for CPT code 99358 (\$XX) for a total of \$XX.

*The Claims Administrator is required to reimburse the provider \$XX within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).*

Sincerely,

<Chief Coder Name>, <RHIT, CCS>

Copy to:  
CLAIMS ADMINISTRATOR **Redacted**>  
CLAIMS ADMINISTRATOR ADDRESS **Redacted**>  
CLAIMS ADMINISTRATOR CITY, STATE, ZIP CODE **Redacted**>

Copy to:  
Division of Workers' Compensation Medical Unit  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

## ***APPENDIX G: CALIFORNIA 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 H: SAMPLE CURRENT REPORTS***

---

Independent Bill 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 4.2.6: Case Workflow Tracking Reports* and includes all the data elements required in Appendix A, B, and C.

### Monthly Report Summary Example

Information or Data Element IBR	Status
Number of IBR requests received	217
Number designated as potentially ineligible for IBR based on review of provider's documents	58
Number determined to be ineligible for IBR based on review of provider's documents	36
Number designated as potentially ineligible for IBR based on review of claims administrator's documents	11
Number determined to be ineligible for IBR based on review of claims administrator's documents	1
Number deemed eligible for IBR	124
Number of IBR claims aggregated and treated as one IBR request (as defined in Exhibit A, Section 10, of IBR contract)	18
Number of IBR requests disaggregated into separate requests	6
Number of IBR Withdrawals	10
Number of IBR determinations completed	56
Number of IBR determinations completed within required timeframe	13
Number of IBR determinations completed outside required timeframe	43
Average number of days to complete IBR determination	94
Number of payment decisions overturned, total	33
Fees received for IBR, total	\$X
Average fee received per IBR 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**

Providers will be required to pay a fee to Contractor when filing a request for IBR. Contractor shall charge Providers additional fees for any IBR request that must be disaggregated into separate IBR requests and shall partially reimburse the fee paid for an IBR request if the case is dismissed as ineligible. 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) CONTRACTS 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:

Contractor 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

Contractor is a firm 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, Contractor 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) FIRCE 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<sup>[1]</sup>, confidential<sup>[2]</sup>, and/or sensitive<sup>[3]</sup> information assets (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 4603.2

(a) (1) Upon selecting a physician pursuant to Section 4600, the employee or physician shall notify the employer of the name and address, including the name of the medical group, if applicable, of the physician. The physician shall submit a report to the employer within five working days from the date of the initial examination, as required by Section 6409, and shall submit periodic reports at intervals that may be prescribed by rules and regulations adopted by the administrative director.

(2) If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was entitled to select the physician pursuant to Section 4600, the employee shall be entitled to continue treatment with that physician at the employer's expense in accordance with this division, notwithstanding Section 4616.2. The employer shall be required to pay from the date of the initial examination if the physician's report was submitted within five working days of the initial examination. If the physician's report was submitted more than five working days after the initial examination, the employer and the employee shall not be required to pay for any services prior to the date the physician's report was submitted.

(3) If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was not entitled to select a physician outside of the medical provider network, the employer shall have no liability for treatment provided by or at the direction of that physician or for any consequences of the treatment obtained outside the network.

(b) (1) Any provider of services provided pursuant to Section 4600, including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall submit its request for payment with an itemization of services provided and the charge for each service, a copy of all reports showing the services performed, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received. Nothing in this section shall prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an alternative manual or electronic request for payment with providers for services provided pursuant to Section 4600.

(2) Except as provided in subdivision (d) of Section 4603.4, or under contracts authorized under Section 5307.11, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1, in effect on the date of service. Payments shall be made by the employer with an explanation of review pursuant to Section 4603.3 within 45 days after receipt of each separate, itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician. If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in the explanation of review, that the itemization is contested, denied, or considered incomplete, within 30 days after receipt of the itemization by the employer. An explanation of review that states an itemization is incomplete shall also state all additional information required to make a decision. Any properly documented list of services provided and not paid at the rates then in effect under Section 5307.1 within

the 45-day period shall be paid at the rates then in effect and increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the itemization, unless the employer does both of the following:

(A) Pays the provider at the rates in effect within the 45-day period.

(B) Advises, in an explanation of review pursuant to Section 4603.3, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees. In the case of an itemization that includes services provided by a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the itemization shall satisfy the requirements of this paragraph.

An employer's liability to a physician or another provider under this section for delayed payments shall not affect its liability to an employee under Section 5814 or any other provision of this division.

(3) Notwithstanding paragraph (1), if the employer is a governmental entity, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made within 60 days after receipt of each separate itemization, together with any required reports and any written authorization for services that may have been received by the physician.

(4) Duplicate submissions of medical services itemizations, for which an explanation of review was previously provided, shall require no further or additional notification or objection by the employer to the medical provider and shall not subject the employer to any additional penalties or interest pursuant to this section for failing to respond to the duplicate submission. This paragraph shall apply only to duplicate submissions and does not apply to any other penalties or interest that may be applicable to the original submission.

(c) Any interest or increase in compensation paid by an insurer pursuant to this section shall be treated in the same manner as an increase in compensation under subdivision (d) of Section 4650 for the purposes of any classification of risks and premium rates, and any system of merit rating approved or issued pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Part 3 of Division 2 of the Insurance Code.

(d) (1) Whenever an employer or insurer employs an individual or contracts with an entity to conduct a review of an itemization submitted by a physician or medical provider, the employer or insurer shall make available to that individual or entity all documentation submitted together with that itemization by the physician or medical provider. When an individual or entity conducting a itemization review determines that additional information or documentation is necessary to review the itemization, the individual or entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the physician or medical provider pursuant to subdivision (b).

(2) An individual or entity reviewing an itemization of service submitted by a physician or medical provider shall not alter the procedure codes listed or recommend reduction of the amount of the payment unless the documentation submitted by the physician or medical provider with the itemization of service has been reviewed by that individual or entity. If the reviewer does not recommend payment for services as itemized by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or changed other parts of the itemization and the specific deficiency in the itemization or documentation that caused the reviewer to conclude that the altered procedure code or amount recommended for payment more accurately represents the service performed.

(e) (1) If the provider disputes the amount paid, the provider may request a second review within 90 days of service of the explanation of review or an order of the appeals board resolving the threshold issue as stated in the explanation of review pursuant to paragraph (5) of subdivision (a) of Section 4603.3. The request for a second review shall be submitted to the employer on a form prescribed by the administrative director and shall include all of the following:

(A) The date of the explanation of review and the claim number or other unique identifying number provided on the explanation of review.

(B) The item and amount in dispute.

(C) The additional payment requested and the reason therefor.

(D) The additional information provided in response to a request in the first explanation of review or any other additional information provided in support of the additional payment requested.

(2) If the only dispute is the amount of payment and the provider does not request a second review within 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

(3) Within 14 days of a request for second review, the employer shall respond with a final written determination on each of the items or amounts in dispute. Payment of any balance not in dispute shall be made within 21 days of receipt of the request for second review. This time limit may be extended by mutual written agreement.

(4) If the provider contests the amount paid, after receipt of the second review, the provider shall request an independent bill review as provided for in Section 4603.6.

(f) Except as provided in paragraph (4) of subdivision (e), the appeals board shall have jurisdiction over disputes arising out of this subdivision pursuant to Section 5304.

### **Section 4603.3**

(a) Upon payment, adjustment, or denial of a complete or incomplete itemization of medical services, an employer shall provide an explanation of review in the manner prescribed by the administrative director that shall include all of the following:

(1) A statement of the items or procedures billed and the amounts requested by the provider to be paid.

(2) The amount paid.

(3) The basis for any adjustment, change, or denial of the item or procedure billed.

(4) The additional information required to make a decision for an incomplete itemization.

(5) If a denial of payment is for some reason other than a fee dispute, the reason for the denial.

(6) Information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing. The explanation of review shall inform the medical provider of the time limit to raise any objection regarding the items or procedures paid or disputed and how to obtain an independent review of the medical bill pursuant to Section 4603.6.

(b) The administrative director may adopt regulations requiring the use of electronic explanations of review.

### **Section 4603.4**

(a) The administrative director shall adopt rules and regulations to do all of the following:

(1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms.

(2) Require acceptance by employers of electronic claims for payment of medical services.

(3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.

(b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996.

(c) The rules and regulations requiring employers to accept electronic claims for payment of medical services shall be adopted on or before January 1, 2005, and shall require all employers to accept electronic claims for payment of medical services on or before July 1, 2006.

(d) Payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made with an explanation of review by the employer within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Section 5307.1. If the billing is contested, denied, or incomplete, payment shall be made with an explanation of review of any uncontested amounts within 15 working days after electronic receipt of the billing, and payment of the balance shall be made in accordance with Section 4603.2.

**Section 4603.6**

(a) If the only dispute is the amount of payment and the provider has received a second review that did not resolve the dispute, the provider may request an independent bill review within 30 calendar days of service of the second review pursuant to Section 4603.2 or 4622. If the provider fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent bill review shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622.

(b) A request for independent review shall be made on a form prescribed by the administrative director, and shall include copies of the original billing itemization, any supporting documents that were furnished with the original billing, the explanation of review, the request for second review together with any supporting documentation submitted with that request, and the final explanation of the second review. The administrative director may require that requests for independent bill review be submitted electronically. A copy of the request, together with all required documents, shall be served on the employer. Only the request form and the proof of payment of the fee required by subdivision (c) shall be filed with the administrative director. Upon notice of assignment of the independent bill reviewer, the requesting party shall submit the documents listed in this subdivision to the independent bill reviewer within 10 days.

(c) The provider shall pay to the administrative director a fee determined by the administrative director to cover no more than the reasonable estimated cost of independent bill review and administration of the independent bill review program. The administrative director may prescribe different fees depending on the number of items in the bill or other criteria determined by regulation adopted by the administrative director. If any additional payment is found owing from the employer to the medical provider, the employer shall reimburse the provider for the fee in addition to the amount found owing.

(d) Upon receipt of a request for independent bill review and the required fee, the administrative director or the administrative director's designee shall assign the request to an independent bill reviewer within 30 days and notify the medical provider and employer of the independent reviewer assigned.

(e) The independent bill reviewer shall review the materials submitted by the parties and make a written determination of any additional amounts to be paid to the medical provider and state the reasons for the determination. If the independent bill reviewer deems necessary, the independent bill reviewer may request additional documents from the medical provider or employer. The employer shall have no obligation to serve medical reports on the provider unless the reports are requested by the independent bill reviewer. If additional documents are requested, the parties shall respond with the documents requested within 30 days and shall provide the other party with copies of any documents submitted to the independent reviewer, and the independent reviewer shall make a written determination of any additional amounts to be paid to the medical provider and state the reasons for the determination within 60 days of the receipt of the administrative director's assignment. The written determination of the independent bill reviewer shall be sent to the administrative director and provided to both the medical provider and the employer.

(f) The determination of the independent bill reviewer shall be deemed a determination and order of the administrative director. The determination is final and binding on all parties unless an aggrieved party files with the appeals board a verified appeal from the medical bill review determination of the administrative director within 20 days of the service of the determination. The medical bill review determination of the administrative director shall be presumed to be correct and shall be set aside only upon clear and convincing evidence of one or more of the following grounds for appeal:

- (1) The administrative director acted without or in excess of his or her powers.
- (2) The determination of the administrative director was procured by fraud.
- (3) The independent bill 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 and not a matter that is subject to expert opinion.

(g) If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent bill review by a different independent review organization. In the event that a different independent bill review organization is not available after remand, the administrative director shall submit the dispute to the original bill review organization for review by a different reviewer within the organization. In no event shall the appeals board or any higher court make a determination of ultimate fact contrary to the determination of the bill review organization.

(h) Once the independent bill reviewer has made a determination regarding additional amounts to be paid to the medical provider, the employer shall pay the additional amounts per the timely payment requirements set forth in Sections 4603.2 and 4603.4.

### **Section 4620**

(a) For purposes of this article, a medical-legal expense means any costs and expenses incurred by or on behalf of any party, the administrative director, or the board, which expenses may include X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and, as needed, interpreter's fees by a certified interpreter pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code, for the purpose of proving or disproving a contested claim.

(b) A contested claim exists when the employer knows or reasonably should know that the employee is claiming entitlement to any benefit arising out of a claimed industrial injury and one of the following conditions exists:

(1) The employer rejects liability for a claimed benefit.

(2) The employer fails to accept liability for benefits after the expiration of a reasonable period of time within which to decide if it will contest the claim.

(3) The employer fails to respond to a demand for payment of benefits after the expiration of any time period fixed by statute for the payment of indemnity.

(c) Costs of medical evaluations, diagnostic tests, and interpreters incidental to the production of a medical report do not constitute medical-legal expenses unless the medical report is capable of proving or disproving a disputed medical fact, the determination of which is essential to an adjudication of the employee's claim for benefits. In determining whether a report meets the requirements of this subdivision, a judge shall give full consideration to the substance as well as the form of the report, as required by applicable statutes and regulations.

(d) If the injured employee cannot effectively communicate with an examining physician because he or she cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during the medical examination. Upon request of the injured employee, the employer or insurance carrier shall pay the costs of the interpreter services, as set forth in the fee schedule adopted by the administrative director pursuant to Section 5811. An employer shall not be required to pay for the services of an interpreter who is provisionally certified unless either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code.

### **Section 4621**

(a) In accordance with the rules of practice and procedure of the appeals board, the employee, or the dependents of a deceased employee, shall be reimbursed for his or her medical-legal expenses and reasonably, actually, and necessarily incurred, except as provided in Section 4064. The reasonableness of, and necessity for, incurring these expenses shall be determined with respect to the time when the expenses were actually incurred. Costs for medical evaluations, diagnostic tests, and interpreters' services incidental to the production of a medical report shall not be incurred earlier than the date of

receipt by the employer, the employer's insurance carrier, or, if represented, the attorney of record, of all reports and documents required by the administrative director incidental to the services. This subdivision is not applicable unless there has been compliance with Section 4620.

(b) Except as provided in subdivision (c) and Sections 4061 and 4062, no comprehensive medical-legal evaluations, except those at the request of an employer, shall be performed during the first 60 days after the notice of claim has been filed pursuant to Section 5401, and neither the employer nor the employee shall be liable for any expenses incurred for comprehensive medical-legal evaluations performed within the first 60 days after the notice of claim has been filed pursuant to Section 5401.

(c) Comprehensive medical-legal evaluations may be performed at any time after the claim form has been filed pursuant to Section 5401 if the employer has rejected the claim.

(d) Where, at the request of the employer, the employer's insurance carrier, the administrative director, the appeals board, or a referee, the employee submits to examination by a physician, he or she shall be entitled to receive, in addition to all other benefits herein provided, all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination to the same extent and manner as provided for in Section 4600.

### Section 4622

All medical-legal expenses for which the employer is liable shall, upon receipt by the employer of all reports and documents required by the administrative director incidental to the services, be paid to whom the funds and expenses are due, as follows:

(a) (1) Except as provided in subdivision (b), within 60 days after receipt by the employer of each separate, written billing and report, and if payment is not made within this period, that portion of the billed sum then unreasonably unpaid shall be increased by 10 percent, together with interest thereon at the rate of 7 percent per annum retroactive to the date of receipt of the bill and report by the employer. If the employer, within the 60-day period, contests the reasonableness and necessity for incurring the fees, services, and expenses using the explanation of review required by Section 4603.3, payment shall be made within 20 days of the service of an order of the appeals board or the administrative director pursuant to Section 4603.6 directing payment.

(2) The penalty provided for in paragraph (1) shall not apply if both of the following occur:

(A) The employer pays the provider that portion of his or her charges that do not exceed the amount deemed reasonable pursuant to subdivision (e) within 60 days of receipt of the report and itemized billing.

(B) The employer prevails.

(b) (1) If the provider contests the amount paid, the provider may request a second review within 90 days of the service of the explanation of review. The request for a second review shall be submitted to the employer on a form prescribed by the administrative director and shall include all of the following:

(A) The date of the explanation of review and the claim number or other unique identifying number provided on the explanation of review.

(B) The party or parties requesting the service.

(C) Any item and amount in dispute.

(D) The additional payment requested and the reason therefor.

(E) Any additional information requested in the original explanation of review and any other information provided in support of the additional payment requested.

(2) If the provider does not request a second review within 90 days, the bill will be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

(3) Within 14 days of the request for second review, the employer shall respond with a final written determination on each of the items or amounts in dispute, including whether additional payment will be made.

(4) If the provider contests the amount paid, after receipt of the second review, the provider shall request an independent bill review as provided for in Section 4603.6.

(c) If the employer denies all or a portion of the amount billed for any reason other than the amount to be paid pursuant to the fee schedules in effect on the date of service, the provider may object to the denial within 90 days of the service of the explanation of review. If the provider does not object to the denial within 90 days, neither the employer nor the employee shall be liable for the amount that was denied. If the provider objects to the denial within 90 days of the service of the explanation of review, the employer shall file a petition and a declaration of readiness to proceed with the appeals board within 60 days of service of the objection. If the employer prevails before the appeals board, the appeals board shall order the physician to reimburse the employer for the amount of the paid charges found to be unreasonable.

(d) If requested by the employee, or the dependents of a deceased employee, within 20 days from the filing of an order of the appeals board directing payment, and where payment is not made within that period, that portion of the billed sum then unpaid shall be increased by 10 percent, together with interest thereon at the rate of 7 percent per annum retroactive to the date of the filing of the order of the board directing payment.

(e) (1) Using the explanation of review as described in Section 4603.3, the employer shall notify the provider of the services, the employee, or if represented, his or her attorney, if the employer contests the reasonableness or necessity of incurring these expenses, and shall indicate the reasons therefor.

(2) The appeals board shall promulgate all necessary and reasonable rules and regulations to insure compliance with this section, and shall take such further steps as may be necessary to guarantee that the rules and regulations are enforced.

(3) The provisions of Sections 5800 and 5814 shall not apply to this section.

(f) Nothing contained in this section shall be construed to create a rebuttable presumption of entitlement to payment of an expense upon receipt by the employer of the required reports and documents. This section is not applicable unless there has been compliance with Sections 4620 and 4621.

STATE OF CALIFORNIA  
**AGREEMENT SUMMARY**  
 STD. 215 (REV. 1-2014)

AGREEMENT NUMBER <b>41430054</b>	AMENDMENT NUMBER
-------------------------------------	------------------

CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED

1. CONTRACTOR'S NAME <b>MAXIMUS FEDERAL SERVICES, INC.</b>		2. FEDERAL ID. NUMBER <b>20-2998066</b>
3. AGENCY TRANSMITTING AGREEMENT <b>DEPARTMENT OF INDUSTRIAL RELATIONS</b>	4. DIVISION, BUREAU OR OTHER UNIT <b>DIV. OF WORKERS' COMPENSATION</b>	5. AGENCY BILLING CODE <b>37390</b>
6. NAME AND TELEPHONE NUMBER OF CONTRACT ANALYST FOR QUESTIONS REGARDING THIS AGREEMENT <b>Matthew Shiroma (510) 286-6844</b>		
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> <b>Maximus Federal Services, Inc.</b> <b>Contract #41230041</b>		

8. BRIEF DESCRIPTION OF SERVICES - LIMIT 72 CHARACTERS INCLUDING PUNCTUATION AND SPACES  
 Contractor will provide Independent Bill Review (IBR) services to the Department of Industrial Relations (DIR) and the Division of Workers' Compensation (DWC).

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 makes wide-ranging changes to the California Workers' Compensation system. This agreement will place the job of resolving payment disputes with an independent review organization and its expert medical claims examiners, thus freeing Workers' Compensation judges to adjudicate and resolve the main issues in a case, which are between the primary parties namely, the injured employee and the employer.

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: <b>PCA/Index: 36300/3851</b>	AMOUNT ENCUMBERED BY THIS DOCUMENT <b>\$0.00</b>
<i>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.</i>	PRIOR AMOUNT ENCUMBERED FOR THIS AGREEMENT
ACCOUNTING OFFICER'S SIGNATURE <i>Susan De Carlo</i>	DATE SIGNED <b>12/12/2014</b>
	TOTAL AMOUNT ENCUMBERED TO DATE

12. AGREEMENT	From	Through	TOTAL COST OF THIS TRANSACTION	BID, SOLE SOURCE, EXEMPT
Original	01/01/2015	12/31/2017	\$0.00	DIR DWC RFP 14-002
Amendment No. 1				
Amendment No. 2				
Amendment No. 3				
Amendment No. 4				
Amendment No. 5				
<b>TOTAL</b>			<b>\$0.00</b>	

(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)*

DIR DWC RFP 14-002

NOTE: Proof of advertisement in the State Contracts Register or an approved form STD. 821, Contract Advertising Exemption Request, must be attached

14. SUMMARY OF BIDS (List of bidders, bid amount and small business status) (If an amendment, sole source, or exempt, leave blank)

The Maximus Federal Services, Inc. is the only responsive responsible bidder for this DIR DWC RFP 14-002.

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?

There were 34 bidders who viewed and 15 downloaded the RFP but only one bidder submitted a bid.

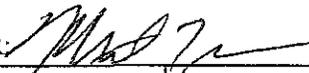
17 (a) JUSTIFICATION FOR CONTRACTING OUT (Check one)

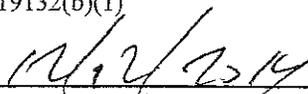
- Contracting out is based on cost savings per Government Code 19130(a). The State Personnel Board has been so notified.
- Contracting out is justified based on Government Code 19130(b). Justification for the Agreement is described below.

Justification: see attached

17 (b) EMPLOYEE BARGAINING UNIT NOTIFICATION

By checking this box, I hereby certify compliance with Government Code section 19132(b)(1)

AUTHORIZED SIGNER: 

DATE: 

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      B. STD.204, VENDOR DATA RECORD
- NO       YES       N/A       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)* \_\_\_\_\_

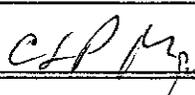
SMALL BUSINESS REFERENCE NUMBER

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 (f) [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/TITLE

DATE SIGNED

