

MEDLITIX UTILIZATION REVIEW PLAN

For California Workers' Compensation

Submitted Pursuant to Revised Regulations Effective April 1, 2026

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DWC Form UR-01 (signed by Medical Director) is attached as Appendix A.

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1. Purpose and Scope

1.1 Purpose of This Plan

This Utilization Review Plan (the "Plan") establishes the policies, procedures, and standards for conducting utilization review of medical treatment requests for injured workers covered under California workers' compensation insurance. This Plan is designed to ensure that all utilization review activities conducted by medlitix comply with the requirements set forth in California Labor Code sections 4610 and 4610.5, and Title 8, California Code of Regulations, as revised and effective April 1, 2026.

1.2 Regulatory Framework

This Plan is governed by and complies with:

- California Labor Code sections 4610 and 4610.5
- Title 8, California Code of Regulations (revised, effective April 1, 2026)
- Medical Treatment Utilization Schedule (MTUS) as set forth in Title 8, California Code of Regulations, including the MTUS Drug Formulary
- All applicable California Division of Workers' Compensation (DWC) administrative regulations and guidance

1.3 Scope of Utilization Review

medlitix conducts utilization review for:

- Prospective review of medical treatment requests submitted before treatment is rendered
- Concurrent review of ongoing medical treatment
- Retrospective review of medical treatment after it has been rendered

2. Definitions (§ 9792.6.1)

The following definitions apply to this Plan and are aligned with the updated § 9792.6.1 and other relevant sections of the California Code of Regulations:

Authorization

Assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury.

Claims Administrator

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

Concurrent Review

Review of additional treatment requests or ongoing treatment during an inpatient stay.

Denial

A determination by a Physician Reviewer that the requested treatment is not medically necessary or otherwise not authorized, based on clinical documentation submitted and/or applicable treatment guidelines.

Dispute of Liability / Liability Dispute

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

Emergency Health Care Services

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

Exempt Drug

A drug on the MTUS Drug List, which is designated as being a drug that does not require authorization through prospective review prior to dispensing the drug, provided that the drug is prescribed in accordance with the MTUS Treatment Guidelines.

Expedited Review

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

Expert Reviewer

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

Material Modification

Any change to the UR plan or UR organization that requires submission to the DWC within 30 calendar days, including ownership changes, Medical Director changes, corporate structure changes, address, company names, and process changes affecting compliance.

Medical Director

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

Medical Treatment Utilization Schedule

The standards of care adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2, beginning with section 9792.20.

Modification

A determination by a Physician Reviewer that part of the requested treatment or service is not medically necessary.

MTUS Drug Formulary

The drug formulary adopted as part of the Medical Treatment Utilization Schedule (MTUS) pursuant to Title 8, California Code of Regulations, listing drugs by exempt, non-exempt, special fill, and perioperative fill status.

Non-Physician Reviewer

A licensed healthcare professional who supports the utilization review process, but who may not independently modify or deny medical treatment requests on the basis of medical necessity.

Normal Business Day / Working Day

A day other than a Saturday, Sunday, or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources website.

Prospective Review

A utilization review conducted prior to the rendering of medical treatment.

Request for Authorization (RFA)

A written request for proposed medical treatment submitted on the DWC Form RFA by the treating physician. The RFA is complete when it identifies the employee and requesting provider, specifies all recommended treatments, and includes supporting documentation no more than 30 days old. It must be signed by the treating physician and submitted by mail, fax, encrypted email, or electronic data interchange (EDI) to the address designated by the claims administrator.

Retrospective Review

Utilization review conducted after medical services have been provided for which prior authorization was not obtained.

Reviewer (Physician Reviewer)

A medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in medical treatment services, where these services are within the scope of the reviewer's or physician reviewer's practice.

Utilization Review Plan

The written plan filed by a claims administrator or utilization review organization with the DWC describing the policies, procedures, and standards for conducting utilization review activities.

Utilization Review Process

Utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians prior to, retrospectively, or concurrently with the provision of medical treatment services.

3. Utilization Review Process

General Procedures & Intake Process (§9792.9.1)

3.1 Submission of Requests for Authorization (§ 9792.9.1)

Medical treatment requests may be submitted to medlitix through the following designated channels:

- Secure facsimile transmission to 724-359-4173
- Electronic submission via secure portal (QuickBase advisUR)
- Encrypted email to reviews@mlxiro.com
- Electronic health record (EHR) integration / electronic data interchange (EDI) via approved clearinghouse
- Mail delivery to 7500 Brooktree Road, STE 300, Wexford, PA 15090

medlitix maintains telephone access (855-323-3654) and has a representative available from 9:00 AM to 5:30 PM Pacific Time on business days. medlitix maintains the ability to receive communications from requesting physicians after business hours by maintaining a voicemail system, facsimile system, and email address for after-hours requests.

3.2 Acknowledgment of Receipt/Tracking and Logging

medlitix acknowledges receipt of all RFAs. All requests are time-stamped upon receipt and logged into medlitix's utilization review tracking system (QuickBase advisUR) on the date of receipt. An RFA received after 5:30 PM Pacific Time shall be deemed to have been received on the following business day, except in the case of a concurrent or expedited review. The tracking system records:

- Date and time of receipt
 - Where the RFA is sent by mail, the form shall be deemed to have been received by five (5) business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service
 - Where the RFA is delivered via certified mail, the form shall be deemed to have been received on the receipt date entered on the return receipt
 - In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the RFA shall be deemed to have been received five (5) days after the latest date the sender wrote on the document
- Injured worker's name and claim number
- Requesting physician's name and contact information
- Type of treatment requested
- Review timeline classification

3.3 Completeness Review

Upon receipt of an RFA, medlitix staff conducts an initial completeness review to determine whether the request contains all information reasonably necessary to make a determination. A complete RFA includes:

- Completed DWC Form RFA with all required fields
- Medical records supporting the request
- Physician's rationale for treatment
- Diagnosis and body part(s) affected
- Any other relevant clinical documentation

If the request is incomplete, medlitix sends a written Request for Information to the requesting physician and the injured worker (or their representative) within five (5) business days, specifying what information is needed and the extended review timeframe. The extended timeframe shall not exceed 14 days from the initial 5-day period for non-urgent prospective or concurrent requests.

3.4 Dispute of Liability; Deferral (§ 9792.9.2)

A utilization review decision may be deferred when a dispute of liability exists. A deferral may be triggered in instances including, but not limited to:

- The claims administrator disputes the compensability of the claim or the specific body party for which treatment is requested
- There is a pending dispute as to whether the requested treatment arises out of and in the course of employment
- The request relates to a body party not yet accepted as part of the claim

When a deferral is issued, medlitix provides written notice to the requesting physician, injured worker, and the injured worker's attorney/representative, within five (5) business days, explaining the basis for the deferral and the next steps for resolution.

3.5 Timeframes for Decision Making (§ 9792.9.3)

medlitix complies with the statutory timeframes for issuing utilization review decisions. The first day in counting any timeframe requirement is the first normal business or working day after receipt of the complete or accepted as complete request for authorization, except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the request for authorization.

- Expedited Prospective/Concurrent – 72 hours from receipt of written information reasonably necessary to make the decision
 - Expedited UR — Flagging & Processing

- Intake screening: All incoming expedited UR requests are immediately flagged and reviewed for the physician's written certification of expedited need upon receipt
- Eligibility validation: Clinical staff confirm the request is supported by documentation of imminent/serious health threat or that standard UR timeframes would be detrimental; requests failing this threshold are reclassified to standard review under §9792.9.3(b) and the requesting physician is notified
- Prospective/Concurrent – Within 5 business days from the receipt of completed DWC Form RFA (unless extended per §9792.9.6)
- Retrospective – Within 30 calendar days of receipt of RFA and information regarding rendered medical treatment

3.6 Clinical Review Process

Once a complete request is received, a clinical reviewer evaluates the medical necessity and appropriateness of the requested treatment. The review process includes:

1. Initial Screening: A licensed, qualified health professional conducts an initial review to determine if the request meets established screening criteria.
2. MTUS Application: The reviewer applies the Medical Treatment Utilization Schedule (MTUS), including the MTUS Drug Formulary, and other evidence-based treatment guidelines to evaluate the request. Specific drug formulary rules are applied as described in Section 5 of this Plan.
 - a. When the condition or injury is not addressed by the MTUS or the MTUS' presumption of correctness is being challenged, the following hierarchy is applied:
 - i. The most current version of the American College of Occupational and Environmental Medicine (ACOEM) or the Official Disability Guidelines (ODG)
 - ii. The most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based
 - iii. Current studies that are scientifically based, peer-reviewed, and published in journals that are nationally recognized by the medical community
 - b. Reviewing/updating guidelines
 - i. The VP, Clinical Quality, monitors the DWC website and the Office of Administrative Law no less than quarterly for any amendments, updates, or newly adopted regulations affecting the MTUS.
 - ii. Upon adoption of any MTUS amendment, the VP, Clinical Quality, will review the changes, notify all reviewers and staff, and update any internal criteria or decision-support tools to reflect the revised standard.
 - iii. Where the MTUS does not address a specific condition or treatment, supplemental evidence-based guidelines from nationally recognized specialty

societies may be applied and shall be reviewed and updated on an as-needed basis as new or revised guidelines become available.

3. Physician Review: If the request cannot be approved based on the MTUS or screening criteria, or if the request is complex, a physician reviewer evaluates the request. The physician reviewer must be competent to evaluate the specific clinical issues involved. Only a physician reviewer may issue a modification or denial based on medical necessity.
4. Expert Reviewer: For requests requiring specialized expertise, medlitix consults with an expert reviewer who is board-certified in the relevant specialty and has the clinical competency to address the specific medical condition.

4. Notices for Initial Decisions

4.1 Written Decision Notices (§ 9792.9.4; § 9792.9.5)

All utilization review decisions are communicated in writing. Decision letters are sent to:

- The requesting physician
- The injured worker
- The injured worker's attorney/representative, if applicable
- The claims administrator

Decision letters, regardless of outcome, are transmitted via facsimile (with confirmation of receipt), encrypted electronic transmission (where the recipient has agreed to receive electronic communications), or first-class mail (with proof of mailing).

For prospective, concurrent, or expedited review, any decision to approve, modify, or deny a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. Written communication of the decision shall be issued as follows:

For a decision to approve, written communication shall be issued to the requesting physician within 24 hours for concurrent review and within two (2) business days for prospective review, but only where the initial communication was made by telephone.

For a decision to modify or deny, initial communication of a modification or denial to the requesting physician will be made by telephone within 24 hours of the decision. Written communication shall be issued to the injured worker, if applicable, to the injured worker's representative, and the requesting physician within 24 hours for concurrent review, within two (2) business days for prospective review, and within 72 hours of receipt of the request for expedited review.

Please refer to Appendix B: Sample Decision Letters for a sample of all decision notices.

All modification or denial UR decision letters identify the URAC-accredited entity that is liable for the UR decision, in compliance with § 9792.9.5.

4.2 Approval Determinations (§ 9792.9.4)

Medical treatment requests are approved when the requested treatment is consistent with the current MTUS or other evidence-based guidelines, is medically necessary for the work-related injury or illness, and is likely to cure or relieve the effects of the injury.

Approval letters include the following, as applicable under the revised regulations:

- The date the completed, or accepted as complete, RFA was first received

- The medical treatment service requested
- The specific medical treatment service approved
- The date of the decision
- If a request for additional information (or test/consult/exam) preceded the approval, the date of the request for such information, and the date such information was received
- If the approval is for a name-brand drug where the RFA did not specify “do not substitute” or “dispense as written,” the approval of the generic form shall indicate, “Generic substitute authorized,” or words to that effect
- If the approval is for a drug that is exempt on the MTUS Drug Formulary, the approval decision shall indicate “Exempt per MTUS Drug Formulary” or words to that effect
- If the approval is for a non-drug treatment that qualifies under the 30-day exemption (§9792.9.7), the written decision shall identify the approved treatment as “30-day exemption” or words to that effect

4.3 Modification Determinations (§ 9792.9.5)

medlitix may modify a medical treatment request to approve an alternative treatment that is consistent with the MTUS or other evidence-based guidelines, medically appropriate for the injured worker’s condition, and likely to provide similar or superior clinical outcomes. All modifications and denials must be made by a physician who is competent to evaluate specific clinical issues and the requested treatment. Non-physician reviewers may not deny or modify medical treatment requests. Modifications and denials are communicated within the applicable decision timeframe. The injured worker and requesting physician have the right to dispute the modification through the internal appeals and/or Independent Medical Review (IMR) process.

Modification letters include the following, as applicable under the revised regulations:

- The date on which the completed or accepted request for authorization was first received
- If the timeframe for decision was extended under section 9792.9.6, a description of the information needed, the dates, times, and manner in which requests were made, and the date the information/exam/test/consults were received
- The date of the decision
- A description of the specific course of medical treatment set forth on the RFA
- List of medical records reviewed
- A specific description of the medical treatment service approved, if any
- Clear, concise, and appropriate explanation in plain language, where possible, of the reasons for the reviewing physician’s decision
- Where the requesting physician has expressly opined that prerequisite treatment or criteria per the applicable guidelines should be overlooked, an explanation for why the requesting physician’s explanation is insufficient
- Citation and description of the relevant medical criteria or guidelines used to reach the decision

- Details about the internal utilization appeals process
- Name, specialty, hours of availability, and a United States telephone number of the reviewer and/or expert reviewer. The reviewer, expert reviewer, or medical director shall be available a minimum of four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM Pacific Time, for the treating physician to discuss the decision. In the event the assigned reviewer is unavailable, the requesting physician may discuss the decision with another qualified physician reviewer who is competent to evaluate the specific clinical issues involved in the treatment request.
- The Application for Independent Medical Review, DWC Form IMR
- A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application
- Mandatory language outlined in §9792.9.5 (e)

Emergency Health Care Services

Authorization is not required prior to the provision of emergency health care services. The claims administrator shall not deny coverage solely on the basis that prior authorization was not obtained for emergency treatment rendered to stabilize an injured worker. Emergency health care services are subject to retrospective utilization review. Medical documentation related to emergency services shall be provided to the claims administrator upon request.

Concurrent Review

Medical treatment that is currently underway shall not be discontinued based on a concurrent review modification or denial until the requesting physician has been notified of the decision and an appropriate care plan has been mutually agreed upon between the utilization review organization and the requesting physician that adequately addresses the medical needs of the injured worker.

4.4 Denial Determinations (§ 9792.9.5)

Medical treatment requests are denied when the requested treatment is not consistent with the MTUS or evidence-based guidelines, is not medically necessary, is experimental or investigational, or there is insufficient medical evidence to support the request. All denials must be made by a physician who is competent to evaluate the specific clinical issues. Non-physician reviewers may not deny medical treatment requests.

Denial letters include the following, as applicable under the revised regulations:

- The date on which the completed or accepted request for authorization was first received
- If the timeframe for decision was extended under section 9792.9.6, a description of the information needed, the dates, times, and manner in which requests were made, and the date the information/exam/test/consults were received
- The date of the decision
- A description of the specific course of medical treatment set forth on the RFA
- List of medical records reviewed
- Clear, concise, and appropriate explanation in plain language, where possible, of the reasons for the reviewing physician's decision
- Where the requesting physician has expressly opined that prerequisite treatment or criteria per the applicable guidelines should be overlooked, an explanation for why the requesting physician's explanation is insufficient
- Citation and description of the relevant medical criteria or guidelines used to reach the decision
- Details about the internal utilization appeals process
- Name, specialty, hours of availability, and a United States telephone number of the reviewer and/or expert reviewer. The reviewer, expert reviewer, or medical director shall be available a minimum of four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM Pacific Time, for the treating physician to discuss the decision. In the event the assigned reviewer is unavailable, the requesting physician may discuss the decision with another qualified physician reviewer who is competent to evaluate the specific clinical issues involved in the treatment request.
- The Application for Independent Medical Review, DWC Form IMR
- Clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within the timeframe indicated on the last page of the application
- Mandatory language outlined in §9792.9.5 (e)

For a denial based on untimely receipt of requested information, the denial letter must include (consistent with Labor Code §4610(i)(5)):

- The reason for the decision (i.e., did not timely receive requested information)
- Specific description of the needed information
- Date and time of attempts made to contact the physician to obtain missing information
- Manner in which the attempts were made (e.g., fax, email, telephone)

Emergency Health Care Services

Authorization is not required prior to the provision of emergency health care services. The claims administrator shall not deny coverage solely on the basis that prior authorization was not obtained for emergency treatment rendered to stabilize an injured worker. Emergency health care services are subject to retrospective utilization review. Medical documentation related to emergency services shall be provided to the claims administrator upon request.

Concurrent Review

Medical treatment that is currently underway shall not be discontinued based on a concurrent review modification or denial until the requesting physician has been notified of the decision and an appropriate care plan has been mutually agreed upon between the utilization review organization and the requesting physician that adequately addresses the medical needs of the injured worker.

4.5 Duplicate Requests – 12-Month Rule (§ 9792.9.5(g))

Pursuant to Labor Code §4610(k) and § 9792.9.5(g), a utilization review decision to modify or deny a treatment recommendation shall remain effective for twelve (12) months from the date of the decision without further action by the employer or claims administrator, with regard to any further recommendation by the same physician or another physician within the requesting physician's practice group, for the same treatment, unless the further recommendation is supported by a documented change in the material facts to the basis of the utilization review decision.

4.6 Extension of Timeframe for Decision (§ 9792.9.6)

A decision timeframe may be extended only when one or more of the following circumstances exist:

- All information reasonably necessary to make a determination has not been received
- The physician reviewer has requested an additional examination or test upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice; or
- The physician reviewer requires a specialized consultation and review of medical information by an expert reviewer

If medlitix cannot make a determination within the required timeframe due to the need for additional information, a request for information letter is issued. The letter notification must:

- Be sent within 5 business days of receipt of the request
- Specify what additional information is needed
- Inform the requesting physician, the injured worker, and the injured worker's attorney,

if applicable, of the extended timeframe (not to exceed 14 days from the initial 5-day period for non-urgent prospective or concurrent requests, or 30 calendar days for retrospective reviews)

If the requested information is not received within the designated timeframes, the physician reviewer shall deny the request.

If medlitix cannot make a determination within the required timeframe due to the request for an additional examination, test, or consultation by an expert reviewer, the physician reviewer shall, within 5 business days from receipt of the RFA, provide written notification to:

- The requesting physician
- The injured worker
- The injured worker's attorney (if applicable)

The written notification shall state that a decision cannot be made within the standard timeframe and shall, as applicable:

- Identify and request the additional examination(s) or test(s) required; or
- Indicate that an expert consultation is needed and specify the required specialty of the expert reviewer to be consulted

If the results of the additional examination, test, or expert consultation are not received within 30 calendar days from the date of the RFA, the physician reviewer shall deny the request, stating that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam, test, or specialized consultation.

4.7 IMR Rights and Mandatory Language (§ 9792.9.5(e))

All denial and modification letters include the following mandatory language, consistent with the revised regulations effective April 1, 2026.

MANDATORY PARAGRAPH (Title 8 California Code of Regulations, §9792.9.5(e))

"You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me ((insert claims adjuster's or appropriate contact's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me."

AND

"For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

IMR application deadlines are identified on the enclosed DWC Form IMR as follows:

- 10 calendar days from the mailing date of the UR determination letter – if the disputed medical treatment involves only a drug listed on the MTUS Drug Formulary
- 30 calendar days from the mailing date of the UR determination letter – for all other disputes (including drugs not on the MTUS Drug Formulary)

5. Utilization Review Criteria (§ 9792.8)

5.1 Medical Necessity

All utilization review decisions are based on a determination of medical necessity in accordance with the Medical Treatment Utilization Schedule (MTUS) and other evidence-based guidelines.

5.2 Authorized Treatment

Treatment is approved, modified, or denied in accordance with evidence-based guidelines, including the MTUS. When the MTUS does not address a specific condition or treatment, medlitix applies other recognized evidence-based medical treatment guidelines as specified by regulation.

When the condition or injury is not addressed by the MTUS or the MTUS' presumption of correctness is being challenged, the following hierarchy is applied:

- a. The most current version of the American College of Occupational and Environmental Medicine (ACOEM) or the Official Disability Guidelines (ODG)
- b. The most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based
- c. Current studies that are scientifically based, peer-reviewed, and published in journals that are nationally recognized by the medical community

5.3 First 30-Day Exemption (§ 9792.9.7)

Medically necessary care consistent with the MTUS may be provided without prospective UR authorization for the first 30 days post-injury under the conditions set forth in § 9792.9.7. This exemption applies to non-drug treatments meeting the applicable criteria. Written decisions approving treatment under this exemption shall identify the treatment as "30-day exemption" or words to that effect.

5.4 Drug Authorization and MTUS Drug Formulary (§ 9792.9.8)

Drug authorization is governed by the MTUS Drug Formulary rules. Specific rules include:

- Exempt drugs: Limited to a one (1) seven (7)-day supply at the initial visit within seven (7) days of the date of injury without prospective review. Approval decisions for exempt drugs must indicate "Exempt per MTUS Drug Formulary."
- Brand-name exempt drugs where a generic is available: Require authorization through prospective review. If approved in generic form without a "do not substitute" instruction, the approval must indicate "Generic substitute authorized."

- Non-exempt and Unlisted Drugs: Require authorization through prospective review prior to prescribing or dispensing. (§9792.27.1–9792.27.23)
- Special Fill Drugs: May be prescribed/dispensed without prospective review if: (1) prescribed at the initial visit within 7 days of the injury; (2) supply does not exceed the day limit in the MTUS Drug List; (3) drug is a generic or single-source brand, or brand where physician substantiates medical necessity; and (4) prescribed in accord with MTUS. (§9792.27.12)
- Perioperative Fill Drugs: May be prescribed/dispensed without prospective review if: (1) issued during the perioperative period (4 days before through 4 days after surgery); (2) supply does not exceed the day limit; 3) drug is a generic or single-source brand, or brand where physician substantiates medical necessity; and (4) prescribed in accord with MTUS. (§9792.27.13)

The MTUS Drug List must be used in conjunction with the MTUS Guidelines, which contain specific treatment recommendations based on condition and phase of treatment (Recommended (R), Not Recommended (X), or No Recommendation (NR)). Users must consult the guidelines to determine the applicable recommendation and phase of care.

When the condition, injury, or request is not addressed, the following hierarchy is applied:

- a. The most current version of the American College of Occupational and Environmental Medicine (ACOEM) or the Official Disability Guidelines (ODG)
- b. The most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based
- c. Current studies that are scientifically based, peer-reviewed, and published in journals that are nationally recognized by the medical community

6. Appeal and Independent Medical Review

6.1 IMR Rights and Process (§4610.5; § 9792.10.1)

Injured workers have the right to request an Independent Medical Review (IMR) for any utilization review decision that denies or modifies treatment. medlitix informs injured workers of their IMR rights in all modification and denial decision letters.

The injured worker or their attorney, if applicable, may request IMR by submitting a completed DWC Form IMR Application to the Division of Workers' Compensation. Applicable deadlines include:

- Within 10 calendar days of the UR determination letter for disputes involving only a drug listed on the MTUS Drug Formulary
- Within 30 calendar days of the written UR determination letter for all other disputes

6.2 Cooperation with IMR (§ 9792.10.5)

medlitix cooperates fully with the IMR process by providing complete medical records and utilization review files to the IMR organization within the required timeframe, including:

- Physician reports — copies and a list of all reports from the treating physician relevant to the employee's current condition, produced within the 6 months prior to the authorization request. If the treating physician has been involved for less than 6 months, reports from any prior treating or referring physician within that period are also required.
- The IMR Application (DWC Form IMR) — the copy that was included with the written denial/modification determination. The written determination itself and application instructions are excluded.
- Correspondence to the employee — all information and correspondence provided to the employee about the utilization review decision, other than the written determination itself.
- Employee-submitted materials — any documents the employee or their provider submitted to support the treatment request.
- Other relevant documents — any materials used in making the denial/modification decision, plus any written explanation of why the treatment was denied or modified on medical necessity grounds.
- Response to additional issues — any response to additional issues the employee raised in their IMR application.

Timing of submission:

- 10 days for disputes regarding a drug(s) listed on the MTUS Drug Formulary
- 15 days (or 12 days if notified electronically) for all other disputes
- 24 hours for expedited review

6.3 Internal Reconsideration Process

While California workers' compensation utilization review disputes are primarily resolved through the IMR process, medlitix maintains an internal reconsideration process for administrative errors or when new clinical information becomes available. Internal reconsideration may be requested when:

- New clinical information becomes available that was not available at the time of the original decision
- There is evidence of an administrative or procedural error in the review process
- The requesting physician provides additional clinical rationale not included in the original request

Requests for reconsideration must be submitted in writing. Any request by the injured worker or the treating physician to initiate an internal UR appeal must be submitted in writing to the claims administrator within ten (10) calendar days of receipt of the utilization review decision.

Timeframes for Completion:

- Standard requests: The internal UR appeal shall be completed and a determination issued within thirty (30) days of receipt of the request.
- MTUS Drug List requests: If the underlying UR decision solely denies or modifies a medical treatment request for a drug appearing on the MTUS Drug List, the internal UR appeal shall be completed and a determination issued within ten (10) days of receipt of the request.

Communication of Modified Determinations

If the internal UR appeal results in a modification of the originally requested medical treatment, the claims administrator shall communicate the determination in accordance with the requirements of 9792.9.5(e), including written notice to:

- The requesting physician;
- The injured worker; and
- The injured worker's representative or attorney, if applicable.

The Application for Independent Medical Review, DWC Form IMR, accompanying the written decision letter, must indicate that the decision constitutes a modification after appeal.

7. Personnel and Qualifications (§ 9792.7)

7.1 Medical Director

medlitix has designated a physician licensed in the State of California to serve as the Utilization Review Medical Director. The Medical Director is responsible for overseeing the utilization review program, ensuring clinical quality, and compliance with all applicable regulations. The medical director is responsible for all decisions made in the utilization review process.

Medical Director: Cassondra Majestic, MD

License No. A 136050

Board-certified in Emergency Medicine

Address: 7500 Brooktree Road, STE 300, Wexford, PA 15090

Phone: 855-323-3654

The Medical Director's qualifications include:

- Board certification in Emergency Medicine, Occupational Medicine, Internal Medicine, or a relevant specialty
- Active California medical license in good standing
- Minimum five (5) years of clinical experience
- Comprehensive knowledge of California workers' compensation medical treatment guidelines and utilization review regulations

7.2 Physician Reviewers

All physician reviewers possess a current, unrestricted license to practice medicine in the United States, board certification in the relevant specialty, have at least five (5) years of full-time equivalent experience providing direct clinical care to patients, and the clinical expertise to evaluate the specific issues under review. Only physician reviewers may issue modification or denial determinations based on medical necessity.

7.3 Non-Physician Reviewers

Non-physician reviewers (including registered nurses, licensed clinical social workers, and other licensed healthcare professionals) support the utilization review process in screening and administrative roles. Non-physician reviewers may not independently modify or deny medical treatment requests. All modifications and denials based on medical necessity must be made by a licensed physician reviewer who is competent to evaluate the specific clinical issues involved.

7.4 Expert Review Consultants

Expert review consultants are engaged for cases requiring specialized clinical expertise beyond the scope of available physician reviewers. Expert reviewers are board-certified in the relevant specialty or subspecialty, possess an unrestricted license in the United States, and have at least five (5) years of full-time equivalent experience providing direct clinical care to patients, and have the clinical competency to address the specific medical condition under review.

7.5 Training and Competency

All clinical reviewers complete comprehensive initial training before conducting utilization review, including California workers' compensation laws and regulations, MTUS and evidence-based guidelines, UR regulations (Title 8), decision documentation requirements, confidentiality and privacy requirements (HIPAA and California privacy laws), and conflict of interest identification and disclosure. Ongoing training includes annual updates on regulatory changes and quarterly case review sessions.

8. Plan Submission and Modification

8.1 Initial Submission

This UR Plan is submitted to the DWC in a searchable electronic format with required attachments, including signed DWC Form UR-01, sample decision letters, and client/UR vendor list.

8.2 Material Modifications (§ 9792.7(c)(4))

Material changes to this Plan are submitted to the DWC within 30 calendar days and include:

- Ownership changes
- Medical Director changes
- Corporate structure changes
- Process changes affecting compliance
- Changes to the list of claims administrator clients for whom medlitix performs UR functions

Each material modification submission includes a statement certifying that the utilization review plan, as modified, continues to be in compliance with the rules governing utilization review at sections 9792.6.1 through 9792.12.

8.3 Plan Review and Updates

This Utilization Review Plan is reviewed and updated annually by the Utilization Review Medical Director and the VP, Clinical Quality, to ensure ongoing compliance with California workers' compensation regulations and to incorporate process improvements identified through quality assurance activities. Significant changes to the Plan are communicated to all utilization review staff and to contracted clients.

Upon request by the public, medlitix shall make available the complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process. This may be done through electronic means. If a member of the public requests a hard copy of the utilization review plan, medlitix may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed \$0.25 per page plus actual postage costs.

9. Quality Assurance and Compliance Monitoring

9.1 Quality Assurance Program

medlitix maintains a comprehensive quality assurance program to ensure the accuracy, consistency, and regulatory compliance of all utilization review activities, including:

- Regular audits of utilization review files and decisions
- Implementing inter-rater reliability assessments among clinical reviewers
- Monitoring of decision timeframes and compliance with regulatory deadlines
- Review of IMR overturn rates and analysis of overturn reasons
- Tracking of complaints and appeals

9.2 Performance Metrics

medlitix monitors the following performance metrics on a quarterly basis:

- Percentage of decisions issued within regulatory timeframes
- Approval, modification, and denial rates by treatment type and body part
- IMR overturn rates by reviewer and treatment type
- Average time to decision for emergency/expedited and non-urgent requests
- Completeness of documentation and decision letters

9.3 URAC Accreditation

medlitix is URAC-accredited. Please see the attached URAC certificate in Appendix D.

9.4 Delegated UR Functions

medlitix does not currently delegate any UR functions.

9.5 Financial Incentive Policy

medlitix prohibits any financial incentives or compensation arrangements that would create conflicts of interest in the utilization review process. Clinical reviewers and the Medical Director are not paid based on the outcome of utilization review decisions. medlitix does not provide reimbursement, bonuses, or incentives to its reviewers or staff based on consumer utilization of health care services. All utilization review personnel are required to disclose any potential conflicts of interest, including financial interests in healthcare providers or facilities, personal or professional relationships with treating physicians, or any other circumstances that could compromise objectivity. Reviewers attest to no conflict of interest upon case completion. Cases determined to possess a conflict of interest are reassigned to another reviewer.

10. Penalties and Enforcement

medlitix acknowledges its compliance obligations under California workers' compensation regulations and the consequences of violations. Compliance obligations include, but are not limited to:

- Timely issuance of utilization review decisions within applicable regulatory timeframes
- Proper documentation and communication of all UR decisions, including required mandatory language
- The utilization review plan meets or exceeds the standards established by URAC
- Accurate and timely submission of plan modifications to the DWC
- Prohibition on financial incentives that influence UR decision-making

Failure to comply with applicable UR regulations may subject medlitix and/or its clients to administrative penalties, sanctions, and other enforcement actions by the DWC as provided by law. medlitix maintains internal compliance monitoring procedures to identify and promptly correct any areas of non-compliance.

11. Documentation and Recordkeeping

11.1 Record Retention

medlitix retains all utilization review records for a minimum of five (5) years as required by Title 8, California Code of Regulations. Records maintained include:

- Requests for authorization (DWC Form RFA)
- Medical records and supporting documentation
- Utilization review decision letters
- Reviewer notes and clinical rationale
- Communications with physicians, injured workers, and claims administrators
- IMR applications and determinations
- Audit and quality assurance documentation

Records are maintained in a secure electronic format with appropriate backup and disaster recovery procedures.

11.2 Confidentiality

medlitix maintains strict confidentiality of all protected health information (PHI) in accordance with HIPAA and California's Confidentiality of Medical Information Act (CMIA). All utilization review staff members sign confidentiality agreements and receive annual HIPAA training. Access to medical records and UR files is restricted to authorized personnel based on role-based access controls.

11.3 Data Security

medlitix employs industry-standard data security measures, including:

- Encryption of data in transit and at rest
- Secure facsimile and electronic transmission protocols
- Regular security audits and vulnerability assessments
- Business associate agreements with all vendors and contractors
- Incident response and breach notification procedures

11.4 Provider and Patient Communications

All communications with providers and injured workers are conducted in a professional, timely, and compliant manner. Decision letters are transmitted by fax, encrypted electronic transmission, or first-class mail, as described in section 4. medlitix maintains documentation of all communications for the required retention period.

12. Complaint and Grievance Process

12.1 Filing a Complaint

Injured workers, physicians, and other parties may file complaints regarding medlitix's utilization review process. Complaints may be submitted in writing to medlitix's Compliance Department or via email.

12.2 Complaint Resolution

medlitix investigates all complaints promptly and thoroughly. The Compliance Department acknowledges receipt within 5 business days, investigates the complaint, provides a written response within 10 business days, and takes corrective action if the complaint is substantiated.

12.3 Escalation to Regulatory Agencies

If a complaint cannot be resolved internally, injured workers and other parties may file a complaint with the California Division of Workers' Compensation. Contact information for the DWC is provided in all utilization review decision letters.

13. Contact Information

medlitix Utilization Review Department

Phone: 855-323-3654

Fax: 724-359-4173

Email: reviews@mlxiro.com

Address: 7500 Brooktree Road, STE 300, Wexford, PA 15090

Website: www.medlitix.org

California Division of Workers' Compensation

Phone: 1-800-736-7401

Website: www.dir.ca.gov/dwc/

UR Questions/Modifications Email: dwcure@dir.ca.gov

Plan Approval and Certification

This Utilization Review Plan has been reviewed and approved by the undersigned Medical Director and is hereby certified as compliant with California Labor Code sections 4610 and 4610.5, and Title 8, California Code of Regulations, sections 9792.6.1 through 9792.12, as revised effective April 1, 2026.

Cassandra Majestic, MD

Medical Director Signature

Cassandra Majestic, MD

Printed Name

Medical License Number

A 136050

Date: 5/29/2026

Appendix A: DWC Form UR-01 (Signed)



**Division of Workers' Compensation
Department of Industrial Relations
State of California**

Form UR-01

Submit two copies of the completed, signed application and the complete Utilization Review (UR) Plan in compact discs or flash drives in word-searchable PDF format to: Division of Workers' Compensation, Attn: Medical Unit: Utilization Review Plan Approval, PO Box 71010, Oakland, CA 94612.

Select: ☒ New Plan ☐ Material Modification

1. UR Plan Information

Name of UR Plan Applicant: Physio Solutions LLC dba medlitix

Address: 7500 Brooktree Road, STE 300 Wexford

Number/Unit:

State: PA Zip Code: 15090 Telephone Number: 855-323-3654

Fax Number: 724-359-4173 E-mail address: reviews@mlxiro.com

Type of Entity Filing: Utilization Review Organization

2. UR Plan Contact Person Information

First Name: Nicole Middle Initial: M. Last Name: Ambrisco

Title: VP, Clinical Quality

Address: 7500 Brooktree Road, STE 300 Wexford

Number/Unit:

State: PA Zip Code: 15090

Telephone Number: 855-323-3654

Fax Number: 724-359-4173

E-mail address: nambrisco@mlxiro.com

3. Medical Director Information

First Name: Cassandra Middle Initial: Last Name: Majestic

Address: 7500 Brooktree Road, STE 300 Wexford

Number/Unit:

State: PA Zip Code: 15090 Telephone Number: 855-323-3654

Fax Number: 724-359-4173 E-Mail Address: reviews@mlxiro.com

CA License No.: A 136050

NPI: 1538501705

Board Certified Specialty (if any): Emergency Medicine

4. URAC Accreditation

Accreditation Status: Full URAC accreditation

Original accreditation date: 02/01/2022 Click or tap to enter a date.

Most recent accreditation date: 03/01/2025 Click or tap to enter a date. Expiration Date: 03/01/2028
Click or tap to enter a date.

Comments: Please see the attached URAC certificate.

5. UR Plan Client and Vendor Information

List all entities that utilize or contract for UR Plan services. Use additional pages if necessary.

medlitix does not currently perform utilization review functions on behalf of contracted claims administrators.

Does the UR Plan delegate any UR functions? No

If yes, indicate to whom and which function for each delegation. Use additional pages if necessary.

N/A

6. Material Modification to UR Plan

If applicable, describe the changes that were made.

The UR plan was revised pursuant to revised regulations effective April 1, 2026.

Signature of authorized individual: I, the undersigned Medical Director of the UR Plan named herein, have signed this document with knowledge of its contents, and verify that they are true and correct to the best of my knowledge and belief. I further understand that the DWC's approval of the UR plan identified herein does not equate to approval of policies and procedures that are contrary to law, and any such approval is unintended.

Name of Medical Director:

Cassandra Majestic, MD

Date: Click or tap to enter a date.

5/29/2026

Signature:

Cassandra Majestic, MD

Appendix B: Sample Decision Letters

The following sample decision letter templates are maintained by medlitix for California UR decisions:

- CA Certified (Approval) Letter Template
- Initial Modified Letter Template
- Initial Non-Certification Letter Template
- Appeal Modified Letter Template
- Appeal Non-Certification Letter Template
- Request for Information Letter Template
- Proof of Service by Mail
- DWC Form IMR Application



[Date]

CA CERTIFIED LETTER TEMPLATE

[Requesting Provider Name]

[Requesting Provider Address]

[Requesting Provider City, State, Zip]

[Requesting Provider Fax #]

[Claimant Name:]

[Claim #:]

[DOI:]

[Carrier / TPA:]

[RFA Received Date:]

[Request for Additional Information Date, if applicable:]

[Date Additional Information Received, if applicable:]

[Case #:]

[Determination Date:]

[Determination]: CERTIFIED

Dear [Requesting Provider]:

We are in receipt of a treatment request form [client] for the above claimant to perform Utilization Review for [treatment requested] and determine whether the medical treatment requested is medically necessary. Upon review of the clinical documentation submitted, and by applying the [CA MTUS or other evidence-based] guidelines, it has been determined that the treatment is medically necessary and we are recommending Certification of the treatment [treatment approved].

Respectfully,

Utilization Review Department



PROOF OF SERVICE BY MAIL

[Claimant Name:]

[Claim #:]

[Case #:]

[Determination Date]:

The determination letter for the above-referenced Utilization Review Request and associated documents were deposited in a sealed, postage-paid envelope with the US Postal Service and mailed to:

[Claimant Name, Complete Address]

The following parties received the determination letter and associated documents via Fax or email:

[Claimant's Attorney, Complete Address – if applicable] [method of delivery]

[Claim's Adjuster name] [claims adjuster's email]

I am at least 18 years of age and not party to this action.

[medlitix staff member name]



[Date]

INITIAL MODIFIED LETTER TEMPLATE

[Requesting Provider Name]

[Requesting Provider Address]

[Requesting Provider City, State, Zip]

[Requesting Provider Fax #]

[Claimant Name:]

[Claim #:]

[DOI:]

[Carrier / TPA:]

[RFA Received Date:]

[Request for Additional Information Date/Time, and manner in which request was made, if applicable:]

[Date Additional Information Received, if applicable]:

[Case #:]

[Determination Date:]

[Determination:] MODIFIED

Dear [Requesting Provider],

We are in receipt of a treatment request from [client name] for the above claimant to perform Utilization Review and determine whether the medical treatment requested is medically necessary for this claim.

Treatment requested:

[treatment requested] [CPT] [Requested units] [Body Part] [Determination] [Guideline]

[treatment requested] [CPT] [Requested units] [Body Part] [Determination] [Guideline]

[treatment requested] [CPT] [Requested units] [Body Part] [Determination] [Guideline]

Medical records received for review:

[type of document] [Provider] [Pages rec'd] [Document Start Date] [Document End Date]

[type of document] [Provider] [Pages rec'd] [Document Start Date] [Document End Date]

[type of document] [Provider] [Pages rec'd] [Document Start Date] [Document End Date]

Peer to Peer Contact: (if requested)

[Date] [Time] [Type] [Spoke with]

Rationale:

[Includes a summary of the records received/reviewed and rationale for the decision being made]

Criteria:

[References the guidelines utilized to form the above determination]

If the requesting provider would like to discuss this determination with the reviewer, they may contact medlitix at: 855-323-3654 to arrange a time to speak with the reviewer. All reviewers are available for at least four (4) hours per week during normal business hours from 8:30 AM PT to 5:30 PM PT.

[Reviewing Dr.'s Credentials, including: Name, License #, Specialty]

[Dr.'s Signature]



For Clients who elect the Voluntary appeal process, the following language is included:

You have the right to request a voluntary internal utilization review appeal of this decision by submitting a written request to medlitix within 10 days of your receipt of this utilization review decision. The internal appeals process is voluntary and does not trigger, waive, or bar your right to pursue independent dispute resolution under California Labor Code sections 4610.5 and 4610.6, but may be pursued on an optional basis.

CA Labor Code and Regulations, as required:

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application) If you have questions about the information in this notice, please call me [insert claims adjuster's or appropriate contact's name in parentheses] at [insert telephone number]. However, if you are represented by an attorney, please contact your attorney instead of me.

For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within the timeframe indicated on the last page of the application.

Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.



**Division of Workers' Compensation
Department of Industrial Relations
State of California**

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- **Sign and date this application and consent to obtain medical records.**
- **Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:**
Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 606-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE Type of Utilization Review:**

Regular ☐

Expedited ☐

Modification after Appeal ☐

Medication Only – MTUS
Formulary Drug List ☐

Retrospective for Exempt
Treatment (Non-Drug) ☐

Retrospective for Exempt
Treatment (Drug) ☐

Employee Information:

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____ Date of Injury: _____
Insurance Claim Number: _____ EAMS Case Number: _____
WCIS Jurisdictional Claim Number (if assigned): _____
Employee Attorney (if known): _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____

Requesting Physician Information:

Physician First Name: _____ Middle Initial: _____ Last Name: _____
Practice Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____ Specialty: _____

Claims Administrator Information:

Employer Name: _____
Name of Administrator: _____ Contact Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter: _____

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity?

☐ Yes ☐ No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

1.

2.

3.

4.

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature _____

Date _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☐ 30 days from the mailing date of the written determination letter.

☐ 10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" determination letter) that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review ("IMR") of the medical treatment request by a physician who is not connected to your Claims Administrator. If the IMR is decided in your favor, your Claims Administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your Claims Administrator.

- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.
- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

**DWC-IMR, c/o Maximus Federal Services, Inc.
PO Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270**

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.



PROOF OF SERVICE BY MAIL

[Claimant Name:] [Claim #:]

[Case #:] [Determination Date]:

The determination letter for the above-referenced Utilization Review Request and associated documents were deposited in a sealed, postage-paid envelope with the US Postal Service and mailed to: [Claimant Name, Complete Address]

The following parties received the determination letter and associated documents via Fax or email:

[Claimant's Attorney, Complete Address – if applicable] [method of delivery] [Claim's Adjuster name] [claims adjuster's email]

I am at least 18 years of age and not party to this action.

[medlitix staff member name]



[Date]

INITIAL NON-CERT LETTER TEMPLATE

[Requesting Provider Name]

[Requesting Provider Address]

[Requesting Provider City, State, Zip]

[Requesting Provider Fax #]

[Claimant Name:]

[Claim #:]

[DOI:]

[Carrier / TPA:]

[RFA Received Date:]

[Request for Additional Information Date/Time, and manner in which request was made, if applicable:]

[Date Additional Information Received, if applicable]:

[Case #:]

[Determination Date:]

[Determination:] NON-CERTIFICATION

Dear [Requesting Provider],

We are in receipt of a treatment request from [client name] for the above claimant to

perform Utilization Review and determine whether the medical treatment requested is medically necessary for this claim

Treatment requested:

[treatment requested] [CPT] [Requested units] [Body Part] [Determination] [Guideline]
[treatment requested] [CPT] [Requested units] [Body Part] [Determination] [Guideline]
[treatment requested] [CPT] [Requested units] [Body Part] [Determination] [Guideline]

Medical records received for review:

[type of document] [Provider] [Pages rec'd] [Document Start Date] [Document End Date]
[type of document] [Provider] [Pages rec'd] [Document Start Date] [Document End Date]
[type of document] [Provider] [Pages rec'd] [Document Start Date] [Document End Date]

Peer to Peer Contact: (if requested)

[Date] [Time] [Type] [Spoke with]

Rationale:

[Includes a summary of the records received/reviewed and rationale for the decision being made]

Criteria:

[References the guidelines utilized to form the above determination]

If the requesting provider would like to discuss this determination with the reviewer, they may contact medlitix at: 855-323-3654 to arrange a time to speak with the reviewer. All reviewers are available for at least four (4) hours per week during normal business hours from 8:30 AM PT to 5:30 PM PT.

[Reviewing Dr.'s Credentials, including: Name, License #, Specialty]

[Dr.'s Signature]



For Clients who elect the Voluntary appeal process, the following language is included:

You have the right to request a voluntary internal utilization review appeal of this decision by submitting a written request to medlitix within 10 days of your receipt of this utilization review decision. The internal appeals process is voluntary and does not trigger, waive, or bar your right to pursue independent dispute resolution under California Labor Code sections 4610.5 and 4610.6, but may be pursued on an optional basis.

CA Labor Code and Regulations, as required:

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application) If you have questions about the information in this notice, please call me [insert claims adjuster's or appropriate contact's name in parentheses] at [insert telephone number]. However, if you are represented by an attorney, please contact your attorney instead of me.

For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within the timeframe indicated on the last page of the application.

Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.



**Division of Workers' Compensation
Department of Industrial Relations
State of California**

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- **Sign and date this application and consent to obtain medical records.**
- **Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:**
Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 606-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE Type of Utilization Review:**

Regular ☐

Expedited ☐

Modification after Appeal ☐

Medication Only – MTUS
Formulary Drug List ☐

Retrospective for Exempt
Treatment (Non-Drug) ☐

Retrospective for Exempt
Treatment (Drug) ☐

Employee Information:

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____ Date of Injury: _____
Insurance Claim Number: _____ EAMS Case Number: _____
WCIS Jurisdictional Claim Number (if assigned): _____
Employee Attorney (if known): _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____

Requesting Physician Information:

Physician First Name: _____ Middle Initial: _____ Last Name: _____
Practice Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____ Specialty: _____

Claims Administrator Information:

Employer Name: _____
Name of Administrator: _____ Contact Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter: _____

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity?

☐ Yes ☐ No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

1.

2.

3.

4.

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature _____

Date _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☐ 30 days from the mailing date of the written determination letter.

☐ 10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" determination letter) that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review ("IMR") of the medical treatment request by a physician who is not connected to your Claims Administrator. If the IMR is decided in your favor, your Claims Administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your Claims Administrator.

- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.
- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

**DWC-IMR, c/o Maximus Federal Services, Inc.
PO Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270**

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.
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Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.



PROOF OF SERVICE BY MAIL

[Claimant Name:]

[Claim #:]

[Case #:]

[Determination Date]:

The determination letter for the above-referenced Utilization Review Request and associated documents were deposited in a sealed, postage-paid envelope with the US Postal Service and mailed to: [Claimant Name, Complete Address]

The following parties received the determination letter and associated documents via Fax or email:

[Claimant's Attorney, Complete Address – if applicable] [method of delivery]

[Claim's Adjuster name] [claims adjuster's email]

I am at least 18 years of age and not party to this action.

[medlitix staff member name]



[Date]

APPEAL MODIFIED LETTER TEMPLATE

[Requesting Provider Name]

[Requesting Provider Address]

[Requesting Provider City, State, Zip]

[Requesting Provider Fax #]

[Claimant Name:]

[Claim #:]

[DOI:]

[Carrier / TPA:]

[RFA Received Date:]

[Request for Additional Information Date/Time, and manner in which request was made, if applicable:]

[Date Additional Information Received, if applicable:]

[Case #:]

[Determination Date:]

[Determination:] MODIFIED

Dear [Requesting Provider],

We are in receipt of a treatment request from [client name] for the above claimant to perform Utilization Review and determine whether the medical treatment requested is medically necessary for this claim.



Treatment requested:

[treatment requested] [CPT] [Requested units] [Body Part] [Determination] [Guideline]

[treatment requested] [CPT] [Requested units] [Body Part] [Determination] [Guideline]

[treatment requested] [CPT] [Requested units] [Body Part] [Determination] [Guideline]

Medical records received for review:

[type of document] [Provider] [Pages rec'd] [Document Start Date] [Document End Date]

[type of document] [Provider] [Pages rec'd] [Document Start Date] [Document End Date]

[type of document] [Provider] [Pages rec'd] [Document Start Date] [Document End Date]

Peer to Peer Contact: (if requested)

[Date] [Time] [Type] [Spoke with]

Rationale:

[Includes a summary of the records received/reviewed and rationale for the decision being made]

Criteria:

[References the guidelines utilized to form the above determination]

If the requesting provider would like to discuss this determination with the reviewer, they may contact medlitix at: 855-323-3654 to arrange a time to speak with the reviewer. All reviewers are available for at least four (4) hours per week during normal business hours from 8:30 AM PT to 5:30 PM PT.

[Reviewing Dr.'s Credentials, including: Name, License #, Specialty]

[Dr.'s Signature]



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Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.



**Division of Workers' Compensation
Department of Industrial Relations
State of California**

Form IMR

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Modification after Appeal ☐

Medication Only – MTUS
Formulary Drug List ☐

Retrospective for Exempt
Treatment (Non-Drug) ☐

Retrospective for Exempt
Treatment (Drug) ☐

Employee Information:

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____ Date of Injury: _____
Insurance Claim Number: _____ EAMS Case Number: _____
WCIS Jurisdictional Claim Number (if assigned): _____
Employee Attorney (if known): _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____

Requesting Physician Information:

Physician First Name: _____ Middle Initial: _____ Last Name: _____
Practice Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____ Specialty: _____

Claims Administrator Information:

Employer Name: _____
Name of Administrator: _____ Contact Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter: _____

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity?

☐ Yes ☐ No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

1.

2.

3.

4.

Request for Review and Consent to Obtain Medical Records

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Employee Signature _____

Date _____

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☐ 10 days from mailing date of written determination letter
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- The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.
- Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

**DWC-IMR, c/o Maximus Federal Services, Inc.
PO Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270**

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- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.



PROOF OF SERVICE BY MAIL

[Claimant Name:]

[Claim #:]

[Case #:]

[Determination Date]:

The determination letter for the above-referenced Utilization Review Request and associated documents were deposited in a sealed, postage-paid envelope with the US Postal Service and mailed to:

[Claimant Name, Complete Address]

The following parties received the determination letter and associated documents via Fax or email:

[Claimant's Attorney, Complete Address – if applicable] [method of delivery]

[Claim's Adjuster name] [claims adjuster's email]

I am at least 18 years of age and not party to this action.

[medlitix staff member name]



[Date]

APPEAL NON-CERT LETTER TEMPLATE

[Requesting Provider Name]

[Requesting Provider Address]

[Requesting Provider City, State, Zip]

[Requesting Provider Fax #]

[Claimant Name:]

[Claim #:]

[DOI:]

[Carrier / TPA:]

[RFA Received Date:]

[Request for Additional Information Date/Time, and manner in which request was made, if applicable:]

[Date Additional Information Received, if applicable]:

[Case #:]

[Determination Date:]

[Determination:] NON-CERTIFICATION

Dear [Requesting Provider],

We are in receipt of a treatment request from [client name] for the above claimant to perform Utilization Review and determine whether the medical treatment requested is medically necessary for this claim.

Treatment requested:

[treatment requested] [CPT] [Requested units] [Body Part] [Determination] [Guideline]

[treatment requested] [CPT] [Requested units] [Body Part] [Determination] [Guideline]



[treatment requested] [CPT] [Requested units] [Body Part] [Determination] [Guideline]

Medical records received for review:

[type of document] [Provider] [Pages rec'd] [Document Start Date] [Document End Date]

[type of document] [Provider] [Pages rec'd] [Document Start Date] [Document End Date]

[type of document] [Provider] [Pages rec'd] [Document Start Date] [Document End Date]

Peer to Peer Contact: (if requested)

[Date] [Time] [Type] [Spoke with]

Rationale:

[Includes a summary of the records received/reviewed and rationale for the decision being made]

Criteria:

[References the guidelines utilized to form the above determination]

If the requesting provider would like to discuss this determination with the reviewer, they may contact medlitix at: 724-359-4173 to arrange a time to speak with the reviewer. All reviewers are available for at least four (4) hours per week during normal business hours from 8:30 AM PT to 5:30 PM PT.

[Reviewing Dr.'s Credentials, including: Name, License #, Specialty]

[Dr.'s Signature]



CA Labor Code and Regulations, as required:

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Department of Industrial Relations
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Form IMR

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Regular ☐

Expedited ☐

Modification after Appeal ☐

Medication Only – MTUS
Formulary Drug List ☐

Retrospective for Exempt
Treatment (Non-Drug) ☐

Retrospective for Exempt
Treatment (Drug) ☐

Employee Information:

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____ Date of Injury: _____
Insurance Claim Number: _____ EAMS Case Number: _____
WCIS Jurisdictional Claim Number (if assigned): _____
Employee Attorney (if known): _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____

Requesting Physician Information:

Physician First Name: _____ Middle Initial: _____ Last Name: _____
Practice Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____ Specialty: _____

Claims Administrator Information:

Employer Name: _____
Name of Administrator: _____ Contact Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Telephone Number: _____
Fax Number: _____

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter: _____

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity?

☐ Yes ☐ No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

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Employee Signature _____

Date _____

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FAX Number: (916) 605-4270**

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.



PROOF OF SERVICE BY MAIL

[Claimant Name:]

[Claim #:]

[Case #:]

[Determination Date]:

The determination letter for the above-referenced Utilization Review Request and associated documents were deposited in a sealed, postage-paid envelope with the US Postal Service and mailed to:

[Claimant Name, Complete Address]

The following parties received the determination letter and associated documents via Fax or email:

[Claimant's Attorney, Complete Address – if applicable] [method of delivery]

[Claim's Adjuster name] [claims adjuster's email]

I am at least 18 years of age and not party to this action.

[medlitix staff member name]



[Date]

REQUEST FOR INFORMATION LETTER TEMPLATE

[Requesting Provider Name]

[Requesting Provider Address]

[Requesting Provider City, State, Zip]

[Requesting Provider Fax #]

REQUEST FOR INFORMATION LETTER

[Claimant Name:]

[Claim #:]

[DOI:]

[Carrier / TPA:]

[RFA Received Date:]

[Case #:]

We are in receipt of a treatment request from [client name] to perform Utilization Review and determine whether the medical treatment requested is medically necessary for this claim. Upon receipt and review of the submitted documentation, it has been determined that additional information is needed to complete this review. Please submit the following information to our office by [date] via email to reviews@mlxiro.com or via fax to 724-359-4173 and include the Case # [case #]. Please be advised that for non-urgent prospective or concurrent requests, the review period may be extended beyond the initial 5-day period by up to 14 additional calendar days and 30 calendar days for retrospective reviews.

- [requested clinical documentation]
- [requested clinical documentation]
- [requested clinical documentation]

Upon receipt of the information, our Physician Reviewer will conduct a complete review and return a determination.

Thank you in advance,

Utilization Review Department



PROOF OF SERVICE BY MAIL

[Claimant Name:]

[Claim #:]

[Case #:]

[Determination Date]:

The determination letter for the above referenced Utilization Review Request and associated documents were deposited in a sealed, postage-paid envelope with the US Postal Service and mailed to:

[Claimant Name, Complete Address]

The following parties received the determination letter and associated documents via Fax or email:

[Claimant's Attorney, Complete Address – if applicable] [method of delivery]

[Claim's Adjuster name] [claims adjuster's email]

I am at least 18 years of age and not party to this action.

[medlitix staff member name]

Appendix C: Client / UR Vendor List

medlitix does not currently perform utilization review functions on behalf of a contracted claims administrator client. A list of clients for whom medlitix performs UR functions is to be maintained and updated as required under § 9792.7(c)(1). This list is available to the DWC upon request and is updated within 30 calendar days of any material change.

Appendix D: URAC Certificate



CERTIFICATE OF AWARD

in recognition of

Physio Solutions LLC d/b/a medlitix

7500 Brooktree Road, Suite 300

Wexford, Pennsylvania 15090

for compliance with

Independent Review Organization Accreditation 6.0:

Comprehensive Review Accreditation Program

is awarded

Full Accreditation

Effective from 03/01/2025 through 03/01/2028

A handwritten signature in black ink that reads "Shawn Griffin MD".

Shawn Griffin, MD
President & Chief Executive Officer

Certificate Number: IRC010014



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 granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.

Appendix E: Policies and Procedures



CQP 1-1	Reviewer Selection and Credentials Documentation for IRO Review
Origination Date	07/10/2021
Effective Date	12/6/2022
Last Reviewed Date	07/30/2022, 12/18/23, 9/10/24, 1/31/25, 07/08/25
Last Revision Date	06/05/2023, 12/18/23, 2/11/25, 07/08/25, 7/27/25

Policy:

The purpose of this policy is to establish the procedures for reviewer selection and documentation of their qualifications in credentials files.

Definitions:

Case: A specific request for medical or clinical services referred to an independent review organization for a determination regarding the medical necessity and medical appropriateness of a health care service or whether a medical service is experimental/investigational or not.

Clinical Peer: A physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the ordering provider, or may be an MD or DO.

Conflict of Interest: Any relationship or affiliation on the part of medlitix or a reviewer with an affected party that could compromise the independence or objectivity of the independent review process. Conflict of interest includes, but is not limited to:

1. An ownership interest of greater than 5% between any affected parties;
2. A material professional or business relationship, which may include:
 - a) staff privileges at the facility rendering treatment or the referring entity;
 - b) a relationship with:
 - i) the injured worker, covered person or – when applicable – their authorized representative;



- ii) any officer, director or management employee of the insurance issuer, plan fiduciary, or plan employee;
 - iii) attending provider *the health care provider's medical group or IPA*;
 - iv) the developer or manufacturer of the principal drug, device, procedure or therapy.
3. A direct or indirect financial incentive for a particular determination;
 4. Incentives to promote the use of a certain product or service;
 5. A known familial relationship;
 6. Any prior involvement in the specific case under review.

Reviewer(s): The individual (or individuals) selected to consider a case. Most often, one individual will be assigned based on his/her qualifications and lack of conflict of interest. A referring entity may request a panel review.

Policy Provisions

1) Reviewer Selection and Credentials File Documentation CQP 1-1 c

- a) For each case, the medlitix Medical Director or equally qualified designee will:
 - i) select the reviewer(s) with responsibility for considering the case and rendering a determination;
 - ii) assure that the credentials of newly hired selected reviewers are verified according to this policy and are on file with medlitix and are not expired; and
 - iii) provide each reviewer a file that includes all information necessary to consider the case.
 - b) In determining whether a reviewer is appropriate for assignment to a case, the medlitix Medical Director or equally qualified designee shall consider whether the reviewer:
 - i) is either a Doctor of Medicine or a Doctor of Osteopathic Medicine or is the same licensure or certification as the ordering practitioner.
- (1) If the reviewer is a Doctor of Medicine, a Doctor of Osteopathic Medicine or a Doctor of Podiatric Medicine, the reviewer must possess a medical board certification.
 - (a) Medlitix recognizes accepted by a state or federal government entity of the U.S. or one of its territories, which include, but are not limited to: a state medical board, and a state or federal legislature, regulatory agency, department, division, or program which are determined by the Medical Director.



- (b) Medlitix does not recognize "Board Eligible" designations or international board certifications
 - ii) has a type or scope of *licensure* or *certification*, clinical expertise, and professional experience that typically manages the procedure, treatment, or issue under review that permits them to apply their clinical judgement in consideration of an individual member's clinical needs to render a review determination.
 - (1) Licensure is reviewed and verified via the issuing State's verification website prior to the date of expiration. Licensure is recorded by saving the timestamped file to ensure compliance as part of the reviewer's file.
 - iii) has a current, unrestricted *licensure* or *certification* as required for clinical practice in a state of the United States that is recognized in the relevant jurisdiction(s);
 - (1) if restricted and allowed by a relevant jurisdiction, the Medical Director will determine if it is of the type that does not affect the health professional's ability to fulfill the roles and responsibilities of a reviewer.
 - iv) Possess knowledge of the issue under review, or of the current, evidence-based clinical guidelines and novel treatments for the medical or behavioral health condition, disease, treatment or procedure under review and have the the clinical expertise to manage the medical or behavioral health condition or disease under review.
 - v) Has at least five years of full-time equivalent experience providing clinical healthcare to patients.
 - vi) Is located within the borders of the U.S. or one of its territories when conducting the review.
- c) In instances where State or Federal regulations require minimum expertise or qualifications for a particular review, medlitix will apply these standards in addition to those found in 1.b.
- d) In cases for external review, in addition to the qualifications outlined in 1.a. to 1.c., reviewers will have experience providing direct clinical care to patients within the last 3 years. Reviewers must also:
- i) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person, which is addressed in the reviewer's attestation



- ii) Meet any specific jurisdictional requirement, such as state-specific credentialing or active practice threshold requirements
- e) In selecting a reviewer, the medlitix does not allow the covered person, the covered person's authorized representative, if applicable, or the insurance issue or group health plan to choose or control the choice of the physician(s) or other health care professional(s) to be selected to conduct the review.

2) Credentialing Plan

- a) The Medical Director has the authority to sign and approve all clean reviewer credentials files. Files with variations will be referred to the Executive Committee for discussion and decision with the Medical Director. Only the Executive Director can sign reviewer contracts.
- b) Requires reviewer verification for credentials specified in the credentialing program (CQP 1-1 ai) Prior to assigning a review to a newly hired reviewer **CQP 1-1 aii** and prior to expiration. **CQP 1-1 aiii**
- c) Reviewer selection criteria: Peer reviewers are selected to participate in medlitix using the following criteria: **CQP 1-1 c**
 - i) Current unrestricted licensure as an MD, DO or DPM in the state of residence, or other state requiring licensure in that state to conduct peer review;
 - ii) Board certification in a desired specialty related to the types of cases and the population served by medlitix;
 - iii) Professional experience, length of time providing direct patient care, dates indicating when the direct patient care occurred and current active practice status with more than five years of post-residency experience in direct patient care;
 - iv) Has no history of sanctions or disciplinary actions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character;
 - v) Verification the reviewer is not included on the List of Excluded Individuals/Entities (LEIE) maintained by the Office of Inspector General (OIG), if applicable
- (1) medlitix will, upon initial credentialing and no later than semi-annually (every 6 months), verify these exclusions on the OIG website and upload a copy of the timestamped webpage to the reviewer's profile in QuickBase.

Acceptable malpractice history from, at a minimum, the previous 5 years; Adequate availability to meet turn-around time requirements; and

- vi) Previous experience in peer review for medical necessity/ appropriateness preferred.



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- d) medlitix requires a signed statement that practitioner will notify the organization immediately (within 3 business days of their notification) of changes in licensure or certification status, including board certification status, or sanctions levied; the medlitix Medical Director will determine the continuing participation status of the practitioner based on information obtained from the practitioner and the primary source.
- e) No reviews will be assigned to a *reviewer* whose credentials are verified as inactive or have not been re-verified prior to scheduled expiration. **CQP 1-1 b**
- f) Once a reviewer has passed credentialing, the following dates will be logged in the medlitix database for continued monitoring
 - i) License and Board Certification expiration dates
 - (1) This information is pulled into a report which displays upcoming expirations within 90 days in which the Medical Director will follow up with the reviewer if renewal is planned or credential will expire.
 - ii) Active Practice Dates
 - (1) If a reviewer ceases active practice, the end date is logged into the system which will add 3 years to the external eligibility date. Once this date has passed, the system will change eligibility to inactive for external Current Hours of Active Practice
 - (2) medlitix performs reviews which are subject to jurisdictional minimums for active practice which range from 8-20 hours per week. Reviewer hours are logged in the system which will mark them ineligible for a review should their current hours of active practice fall below the jurisdictional threshold.

3) Credentials File Documentation CQP 1-1 c

- a) For peer review cases, the medlitix Administrator or designee will assure that each reviewer also has on file current information:
 - i) A current active unrestricted license, issued in a state of the United States, as an MD, DO or DPM (verified from the primary source) updated on expiration;
 - ii) A resume of education and clinical experience, which should include professional experience covering length of time providing direct patient care and dates indicating when the direct patient care occurred, including a minimum of 5 years direct patient care experience;
 - iii) A verified history of sanctions or disciplinary actions;



b) Peer reviewers also have on file:

- i) A signed conflict of interest disclosure attestation;
- ii) A signed confidentiality statement; and
- iii) A signed medlitix contract currently in effect.

c) Re-credentialing will be done every two years (24 months).

- i) Reviewers are required to submit an updated resume at the time of re-credentialing.



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COI 1-2	Organizational and Reviewer Conflict of Interest Policy & Procedure
Origination Date	03/28/2021
Effective Date	03/28/2021
Last Reviewed Date	06/09/2023, 12/18/23, 9/10/24
Last Revision Date	06/09/2023, 12/18/23

Policy:

1. medlitix understands the necessity of objectivity in its role as an Independent Review Organization.
2. medlitix enlists review and attestation mechanisms to ensure there is no affiliation or relationship on the part of the organization or the reviewer that would compromise the independence of the review process.

Procedure:

- 1) Organizational Conflict of Interest
 - a) Prior to initiating review services, medlitix executes a contract with each entity enlisting its services. As part of the medlitix contracting process, medlitix screens each contracting entity for any existing organizational conflicts of interests, according to:
 - i) Applicable state and federal law or regulation;
 - ii) According to the contracting entity;
 - iii) Including clarification whether a relationship between medlitix and an insurance issuer's or group health plan's parent company, sister companies or subsidiaries constitutes an organizational conflict of interest for the contracting entity.
 - b) For each review contract, medlitix attests to its known organizational conflict of interest prior to or as part of executing the contract. This attestation includes the identification of the following if present:
 - i) Is owned or controlled or is a subsidiary of or in any way owned or controlled by or exercises control with an insurance issuer or group health plan, a national, state or



local trade association of issuers or plans or a national, state or local trade association of health care providers;

ii) Conducts internal review and if so, discloses the names of those entities for which it conducts internal review, so the referring entity has the opportunity to forward these cases to a different organization for external review

iii) Has a material professional, familial, or financial conflict of interest regarding any of the following:

(1) An insurance issuer;

(2) Any officer, director, or management employee of an insurance issuer;

(3) Any group health plan administrator, plan fiduciary, or plan employee;

(4) A medical group or independent practice association;

(5) A facility providing health care service and treatments; and

(6) The developer or manufacturer of a drug, device, procedure or other therapy.

iv) Any other organizational conflict of interest as specified by the contracting entity.

c) If an organizational conflict of interest is identified, medlitix fully discloses the conflict of interest to the contracting entity prior to executing the final contract. medlitix will submit an attestation regarding current organizational conflict of interest.

d) Upon this disclosure, if the contacting entity requests to proceed with the medlitix contract for IRO services, medlitix will only proceed with the contracting entity upon receiving written acknowledgement and consent that the contacting entity is aware of potential conflict of interest and request to continuing contracting with medlitix.

e) The organization conflict of interest attestation will be reviewed annually and/or often as necessary if any organizational conflict of interest is identified prior to the annual review and/or any new contract is signed by medlitix to conduct internal or external review. The organizational conflict of interest attestation will be reviewed by the Quality Management Committee. New organizational conflicts of interest identified are shared with the contracting entity and evaluated accordingly.

2) Reviewer Conflict of Interest



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- a) medlitix defines a reviewer's conflict of interest according to applicable federal and state laws and regulations as well as contracting entity specifications, including clarification of the following situations with regards to conflict of interest: A reviewer has a contract to provide health care services to enrollees of a health benefit plan of an insurance issuer or group health plan that is the subject of a review; and **COI 1-1 a**
- i) A reviewer has staff privileges at a facility where the recommended health care service or treatment would be provided if the insurance issuer's or group health plan previous non certification is reversed. **COI 1-1 b**
- b) medlitix will assure clear understanding of reviewer conflict of interest with each of its clients. It will be addressed in the contract or an addendum to the contract or a memorandum of understanding between medlitix and the contracting entity.
- c) All reviewers when initiating a contract or employment with medlitix will attest that they will ensure that there is no conflict of interest before accepting a case for review.
- d) All reviewers will be required to sign an attestation form for each case referred for review and prior to review. This attestation will contain a Conflict-of-Interest attestation. It will also contain an attestation regarding the reviewer's scope of licensure or certification that typically manages the medical condition, procedure, treatment or issue under review, relevant and current experience (how recent is the reviewer's relevant direct patient care experience), length of experience (length of time providing direct patient care), knowledge and education regarding the reviewer's qualification to review the case. This signed attestation form for each case reviewed will be part of the case file for the individual case.
 - i) If a conflict of interest is identified by the reviewer, he/she will not review the case and will notify medlitix management immediately. medlitix will proceed to recuse the reviewer, and the case will be reassigned to another peer reviewer.
 - ii) If the assigned reviewer cannot attest to having the licensure, experience, knowledge and education required to conduct an internal or external review the case, the case will be returned to the staff member making the assignment for reassignment to another reviewer.
- e) Reviewer Conflicts of Interest to which they attest they do not have are defined as:



- i) The reviewer does not accept compensation for review activities that is dependent in any way on the specific outcome of the case. **COI 2-1 a**
- ii) To the best of the reviewer's knowledge, the reviewer was not involved with the specific episode of care prior to referral of the case for review. **COI 2-1 b**
- iii) The reviewer does not have a material professional, familial, or financial conflict of interest regarding any of the following:
 - (1) The referring entity; **COI 2-1 ci**
 - (2) The insurance issuer or group health plan that is the subject of the subject of the review, e.g. A reviewer has a contract to provide health care services to enrollees of a health plan that is the subject of the review); **COI 2-1 cii**
 - (3) The covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; **COI 2-1 ciii**
 - (4) Any officer, director, or management employee of the insurance issuer that is the subject of the review; **COI 2-1 civ**
 - (5) Any group health plan administrator, plan fiduciary, or plan employee; **COI 2-1 cv**
 - (6) The health care provider, the health care provider's medical group or independent practice association recommending the health care services or treatment that is the subject of the review; **COI 2-1 cvi**
 - (7) The facility at which the recommended health care service or treatment would be provided, e.g. a reviewer has staff privileges at a facility where the recommended health care service or treatment would be provided if the insurance or group health's previous non-certification is reversed; or **COI 2-1 cvii**
 - (8) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the review. **COI 2-1 cviii**

3) Financial Incentives



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- a) To further ensure that decisions of medlitix are independent and appropriate, medlitix does not accept compensation for independent review activities that are dependent in any way on the specific outcome of a case and would compromise medical decision making.
- b) medlitix does not provide reimbursement, bonuses or incentives to its reviewers or staff based on consumer utilization of health care services.

4) Staff Training: Conflict of Interest

- i) To ensure reviewers and staff are aware of what constitutes a conflict of interest, and the medlitix process for identifying and disclosing such conflicts, training is provided upon hire and annually thereafter to all individuals involved in the medlitix independent review process.

5) Staff Training: Licensure, Experience, Knowledge Requirements for External Reviews

- i) Review staff will receive education regarding the qualifications necessary to conduct external review and the process to refuse to conduct an external review. This training will be provided during the orientation process and annually thereafter to all professionals involved in the medlitix independent review process.

6) Attachments

- i) 4.1 Organizational Attestation Conflict of Interest
- ii) 4.2 Reviewer Attestations





Attachment 4.1: Organizational Conflict of Interest Attestation

(medlitix) attests to its known organizational conflict of interest prior to or as part of executing a contract for external review service.

1. medlitix is owned or controlled or is a subsidiary of or in any way owned or controlled by , or exercises control with an insurance issuer or group health plan, a national state or local trade association or issuers or plans, or a national, state or local trade association of health care providers: NO_____YES_____

If yes, give detail:

2. medlitix conducts Internal Reviews: NO_____YES_____

If yes, provide the names for Internal Review:

3. medlitix has a material professional, familial, or financial conflict of interest regarding any of the following:

- a. An insurance issuer: NO_____YES_____

If yes, give detail:

- b. Any officer, director, or management employee of an insurance issuer: NO_____YES_____

If yes, give detail:

- c. Any group health plan administrator, plan fiduciary, or plan employee: NO_____YES_____



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If yes, give detail:

d. A medical group or independent practice association: NO_____YES_____

If yes, give detail:

e. A facility providing health care service and treatments: NO_____YES_____

If yes, give detail:

f. The developer or manufacturer of a drug, device, procedure or other therapy: NO_____YES_____

If yes, give detail:

medlitix attests that all the responses are correct to the best of its current knowledge and operations.

medlitix will make the contracting entity aware of any other potential conflict of interest that may arise during the course of conducting business.

medlitix:

Chief Executive Officer (Name)

Chief Executive Officer (Signature)

Date



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Attachment 4.2: Reviewer Attestation

Case Identifier: _____ Date Referred: _____

For each case reviewed, the reviewer will attest to the following:

Reviewer's Attestations: Please check appropriate box

1. **I do** ☐ / **do not** ☐ have a contract to provide health care services to enrollees of the Health Benefit Plan of an insurance issuer or the group health plan in question.
2. **I do** ☐ / **do not** ☐ have staff privileges at the Facility in question where the recommended health care service or treatment would be provided. COI 2-1 cvii
3. **I do** ☐ / **do not** ☐ accept compensation for review activities that is dependent in any way on the specific outcome of the case in question. COI 2-1 a
4. To the best of my knowledge, **I was** ☐ / **was not** ☐ involved with the specific episode of care in question prior to referral of the case for review. COI 2-1 b
5. **I do** ☐ / **do not** ☐ have current relevant experience and/or familiarity with current body of knowledge and health insurance practice to render a determination for the Case under review. COI 3-1 aii
6. **I do** ☐ / **do not** ☐ have a scope of licensure or certification that typically manages the medical condition, procedure, treatment or issue under review. COI 3-1 ai

Physicians:

6. **I am** / **am not** ☐ in active practice in my specialty profession.
7. **I am** / **am not** ☐ Board certified in my specialty of _____.
8. **I do/ do not** have at least five (5) years full time equivalent experience providing direct clinical care to patients COI 3-1 aiii
_____years in direct patient care.
9. **I do/do not** have experience providing direct clinical care to patients within the past three (3) years.

No delegation of the review rendered COI 3-1 a iv

Do you have a material professional, familial, or financial conflict of interest regarding the following:

- a. Referring entity: COI 2-1 ci Yes ☐ No ☐
- b. Insurance Issuer or Group Health Plan that is the subject of the review: COI 2-1 cii
Yes ☐ No ☐



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- c. Covered person and/or the covered person's authorized representative whose treatment is the subject of the review: COI 2-1 ciii Yes ☐ No
- d. Officer, director, or management employee of the Insurance issuer that is the subject of the review: COI 2-1 civ Yes ☐ No
- e. Group health plan administrator, plan fiduciary, or plan employee: COI 2-1 cv Yes ☐ No
- f. Health care Provider, the provider's medical group, or independent practice association, which is recommending the health care service or treatment that is the subject of the review: COI 2-1 cvi Yes ☐ No
- g. Facility at which the recommended health care service or treatment would be provided: Yes ☐ No COI 2-1 cvii
- h. Developer/manufacture of the principal Drug, Device, Procedure, or other therapy being recommended and is the subject of the review: COI 2-1 cviii Yes ☐ No

REVIEWER NAME:

**REVIEWER SIGNATURE
AND CREDENTIALS:**

DATE:



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URAC RM 1-1	Regulatory Compliance Management
Origination Date	06/25/2021
Effective Date	06/25/2021
Last Reviewed Date	04/06/2023, 9/10/24
Last Revision Date	04/06/2023

Policy:

It is the purpose of these policies and procedures to:

1. Assure that medlitix remains cognizant of and compliant with all applicable laws and regulations;
2. Audit compliance and assure that all staff and contractors to which medlitix delegates functions remain cognizant of and compliant with all applicable jurisdictional laws and regulations; RM 1-1 b
3. Tracks applicable laws and regulations in the jurisdictions where the organization conducts business; RM 1-1 a
4. Assigns a Compliance Committee to oversee the Regulatory Compliance Program RM 1-1 d
5. Responds promptly to detected risks, problems and incidents related to regulatory compliance and takes corrective action to prevent future occurrences RM 1-1 c; and
6. Assure that responsible state agencies are notified when events occur or are suspected that affect patient safety, such as malpractice or misconduct and abuse.

Definitions:

Delegation (includes the verb delegate/delegated): A formal arrangement whereby medlitix authorizes a contractor to perform functions under the scope of the Standards on its behalf.

Delegate (n): A business that performs some specified functions related to key processes covered under these Standard on behalf of medlitix.

License: A license or permit (or equivalent) to practice medicine or a health profession that is 1) issued by any state or jurisdiction in the United States; 2) required for the performance of job functions; or 3) a state required business permit or license.



Policy Provisions

1. Regulatory Compliance Program Outline

- i. The Director of Operations shall serve as a member of the medlitix Compliance Committee, in addition to the VP of Clinical Quality. To fulfill the compliance program responsibilities, the Director of Operations will: Ensure review, no less frequently than monthly, the then-current laws and regulations of all legal jurisdictions with relevant legal authority over the activities of medlitix. Such a review may additionally be conducted by an attorney or other qualified contractor selected by medlitix. RM 1-1 ai
- ii. Maintain current file of access to all applicable laws, regulations and accreditation standards. RM 1-1.aii
- iii. Ensure review, no less frequently than when a policy is update or at the time of its scheduled review, medlitix's policies and procedures to assess whether they comply with the relevant laws and regulations. Such a review may be delegated to an attorney or other qualified contractor. Review, no less frequently than annually, medlitix's licenses to assure that medlitix has current licenses in all jurisdictions that require licenses. Oversee the implementation of the action plan and approve the completion of that implementation.
- iv. If medlitix delegates any review functions, the Medical Director will conduct such oversight as is necessary, pursuant to the medlitix Policies and Procedures on Delegation, to assure that delegates are in compliance with all applicable laws and regulations.

2. Regulatory Tracking

- a. medlitix is a member of NAIRO and utilizes the Monthly Legislative Tracking Report compiled to cross reference any proposed, pending or passed changes in regulation which would affect the policies and procedures of medlitix in the jurisdiction it operates.
- b. Any potential changes to policies and procedure are discussed by the Compliance Committee at the Monthly Meeting where the Executive Committee will decide if:
 - i. A currently policy or procedure needs to be amended
 - ii. A new policy or procedure needs to be added
- c. In addition to NAIRO tracking, medlitix attends various quarterly meetings hosted by the various governmental agencies it holds accreditations in. Should any



updates to specific processes be discussed at these meetings, steps 2.b.i and 2.b.ii would be repeated

- d. medlitix additionally monitors for regulatory body-specific feedback on a case by case basis and implements steps 2.b.i and 2.b.ii accordingly.
- e. Timeliness of compliance will be determined by the effective dates of the law or regulations. medlitix will comply on time as required or within 60 days of knowledge of the legal requirement.

3. Auditing Compliance RM 1-1

- a. On a quarterly basis, the VP, Clinical Quality will randomly audit 3 charts per jurisdiction in which medlitix operates.
 - i. Jurisdictional-specific information is housed within the QuickBase system where the VP, Clinical Quality will complete a chart audit based on pre-determined criteria. A score is generated based on accuracy percentage. Any score below 90% will trigger an additional review of 2 charts and formulation of a Corrective Action Plan as outlined in section 4.a.

4. Risk Analysis and Corrective Action

- a. On a quarterly basis, the Compliance Committee will provide a report to the Executive Committee:
 - i. Noting any areas of non-compliance with applicable laws and regulations and
 - ii. Outlining an action plan describing the steps medlitix will take in order to come into compliance in a timely manner with the applicable laws and regulations.
 - iii. Provide guidance on areas / metrics to be added and monitored in the QuickBase system specific to that jurisdiction to allow for auditing and ensure ongoing compliance.
- b. If on a peer review determination there is brought to light evidence of gross negligence, obvious malpractice, or wrongful conduct of an ethical or criminal nature on the part of the treating physician, medlitix will report the matter to the appropriate local, state or federal authority, including, but not limited to, agencies of law enforcement, state medical licensing, or fraud divisions of payer organizations.

5. Maintenance of Compliance



- a. The VP of Clinical Quality completes and submits all required annual reporting to regulatory bodies specific to that jurisdictions' requirements on an annual basis, or sooner if required.
- b. The Compliance Committee and Executive Director complete all other state specific reporting including
 - i. Filing of Taxes
 - ii. Maintenance of Business licenses / annual reporting
 - iii. Providing updating as needed to Secretary of State, Department of Revenue, etc.



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RM 3-1	Information Systems Management Policy
Origination Date	6/25/21
Effective Date	6/25/21
Last Reviewed Date	5/1/23, 9/10/24, 11/5/24
Last Revision Date	5/1/23

Policy:

The purpose of this policy is to establish guidelines for the implementation of an information system (electronic and paper) that collects, maintains, and analyzes information necessary for organizational management. This policy also established procedures for security of these processes and destruction of information.

Definitions:

Data Integrity: The quality or condition of being accurate, complete and valid, traceable, and not altered or destroyed in an unauthorized manner.

Electronic Equipment: Includes, but is not limited to, computers, monitors, printers, copiers / fax machines, and servers (if onsite non-cloud servers).

Protected Health Information: is individually identifiable health information in any medium (electronic, hard copy, etc.) that is transmitted or maintained in any medium, by any means. "Health information" includes any information in the medical record or designated record set that can be used to identify an individual and that was created, used, or disclosed in the course of providing of a health care service, such as diagnosis or treatment. PHI is health information data that is person-identifiable because it includes personal identifiers such as name and address. However, it is not considered PHI if personal identifiers are not associated with or derived from a healthcare service event (treatment, payment, operations, medical records).

Referring Entity: The organization or individual that refers a case to an organization. Referring entities may include organizations such as insurance regulators, health benefits plans or their agents, consumers, and attending providers. Some states may limit by law which individuals or organizations may be a referring entity.

1. Policy Provisions



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- a. medlitix maintains a single information system (QuickBase) used by all personnel to collect, maintain, and analyze information necessary for organizational management that:
 - i. Is electronically based to the greatest extent possible with the systems in place;
 - ii. Is appropriately accessed by all personnel performing similar functions on a need-to-know basis for the purpose of essential sharing of data (e.g. UR Specialist staff and reviewers for review files, and review coordinator staff and administrative personnel for credentials only, executive team for sensitive credentialing information) - See Appendix A
 - iii. Provides for data integrity;
 - iv. Supplements data confidentiality and security provisions found in other policies.
 - v. Includes a plan for storage, maintenance, and destruction of both electronic and paper information as applicable.
 - vi. Encrypts and password protects all electronically stored individually identifiable health information whether on the Cloud or email.

2. Procedure

- a. Data Integrity: To encourage data integrity, medlitix shall, at a minimum:
 - i. Encourage referring entities to submit/make available as much information as possible at the time of referral and in a secure electronic format or via a secure portal accessible by medlitix, QuickBase or encrypted email; Use unique identifiers for consumer data;
 - ii. Create an electronic information management system using appropriate structured data fields to minimize error potential (Cascading drop downs are frequently utilized to aid in error prevention);
 - iii. Provide secure access for:
 - 1. preparation of case files prior to reviewer assignment;
 - 2. creation and maintenance of case review reports in a secure electronic format; and
 - 3. storage of all case related information.
 - iv. Encourage reviewer applicants to submit as much credentialing information as possible via a secure electronic format, perform web-based primary source verifications and maintain electronic credentials files; and
 - v. As a part of its ongoing efforts to oversee the quality of work of its clinical specialist staff, review coordinators and reviewers on a systematic basis, the Executive Team and Medical Director will review the accuracy of information regarding cases as it is recorded in the case file database, correcting errors found immediately upon discovery.



3. Data Confidentiality and Security:

- a. medlitix requires all employees and owners to execute Confidentiality Agreements. Reviewers, vendors and all other contractors that will or potentially will come in contact with PHI or IIHI (ex. Building maintenance / cleaning staff, bookkeeping services, etc.), will execute a HIPAA Business Associate Agreement committing such persons to comply with HIPAA / HITECH and medlitix's confidentiality and security policies.
 - i. All staff and reviewers will be trained on confidentiality of protected health information whether oral, written or electronic, identification and reporting of breaches;
 - ii. medlitix promptly reports breaches of confidentiality as required by law should they occur. (medlitix uses the HHS website at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html> and the HITECH Survival Guide found at <http://www.hipaasurvivalguide.com/hitech-act-text.php> for access to federal requirements.)
- b. medlitix encrypts and password-protects all electronically stored individually identifiable health information. While paper records are seldom handled, any printed protected health information is kept in a secure location during active use (see paragraph 3b-i below).
- c. Only those persons with a legal right and need to know under federal and state laws and regulations have access to any protected health information.
- d. All inbound FAX transmissions are received electronically. medlitix includes a confidentiality warning on all outbound FAX transmissions.
- e. medlitix uses 256-bit encrypted email for the transmission of protected health information outside of its portal via the Microsoft 365 E3 Outlook Client. For assignment notifications externally to its reviewer / client panel and internally to staff email, all automated notifications do not contain any PHI or IHII and require the end user to login to the QuickBase Portal via two-factor authentication to view case specifics.
- f. medlitix utilizes Microsoft 365 E3 for its internal email / drive / remote device applications and manages all staff laptops under Windows Enterprise. This enables endpoint monitoring and device control for all remote staff and the ability to govern the policies on each computer centrally.

4. Data Management / Interpretation

- a. medlitix prevents duplication of data by the following:



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- i. Each case is assigned a unique Review ID to ensure downstream processes (physician review, QA, billing, etc.) are all reflective of the original case processed.
- ii. Subsequent reviews on the same patient/member/claimant are given an attribute (such as adding .01) to the end of the Review ID to note if the case is an appeal.
- iii. When a case is completed, an entry is automatically added into the Conflict-of-Interest table which is searched prior to acceptance of cases to ensure, dependent on the line of business, that medlitix can proceed with the review if allowed per regulatory requirements.
- iv. Throughout the review continuum, medlitix retains audit logs to determine who acted on the data, at which time and what occurred to determine the cause of any staff or contractor issue throughout the review.

5. Storage, Maintenance, and Destruction of Software / Data

- a. medlitix utilizes a cloud server hosted on the Quick Base Platform. Servers are hosted at the Flexential Data Centers. Backups are taken daily; in a server-to-enterprise architecture all stored and archived at multiple locations inside the Flexential Data Centers.
- b. medlitix retains all its electronic files for seven (7) years except as otherwise provided in these policies and procedures or otherwise stipulated by client.
 - i. Paper files are maintained in secure storage and converted to electronic formats for storage after the time of active use. RM 3-1.bi
 - ii. Only Executive Staff have administrator-level privileges to the QuickBase system which allows for deletion of records / information. All other staff are required to submit a request to Executive staff in order to delete any information from the system.
- c. When medlitix destroys files, it shall do so in a way that protects the confidentiality and security of the information therein.
 - i. Disks are wiped clean and then destroyed;
 - ii. Paper documents are discouraged by medlitix. On the rare occasion paper documents are received they are promptly converted to electronic format and then the paper documents are shredded; paper occasionally created via printing when needed is promptly shredded after use by the medlitix' staff.
 - iii. Electronic devices will be wiped clean and then destroyed when replaced.

6. Storage, Maintenance, and Destruction of Hardware / Equipment



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- a. Medlitix maintains a log of all fixed assets (Electronic Equipment) through the Microsoft 365 E3 Administrator portal.
- b. In the instance that equipment is damaged, a report is made to the Executive Director who will evaluate if a replacement is necessary after consulting with appropriate IT resources.
- c. If a device is to be destroyed or removed, the Executive Director will complete the following steps:
 - i. The obsolete device will be removed from the user's office and replaced with an appropriate device.
 - ii. If a PC / Laptop, the hard drive will then be removed from the computer, securely erased, and then destroyed. These procedures include sanitizing the Hard Drive by using a secure hardware device that will delete the partition and all readable data per NIST800-88 Clear. This will destroy all applications and data that are currently installed on the drive.
 - iii. The Personal Computer (PC) is now ready to be removed from the organization. This procedure removes any risk of confidential information being removed from the organization on PCs.
 - iv. Laptops and External/Removable drives will be treated in the manner described above.
 - v. Copier Hard Drives will be treated in the manner described above. The Executive Director will be responsible for the data wipe of copier hard drives, documenting and recording the process for privacy purposes. All system hardware (PC's, Servers, hard drives, etc.) decommissioned will be logged and recorded in the IT Hardware Removal Log.
 - 1. If the copier is not the property of medlitix, the Administrator will be responsible for ensuring all proprietary information and confidential data is removed from the machine and all settings have been restored to factory defaults prior to the device leaving the site. OR
 - 2. The Copier will have as part of its service contract a security data wipe clause which the service company will use to sanitize the information contained on the copier hard drives.
- d. Receipt of new equipment
 - i. All new equipment with hard drives will be inspected to determine acceptance or returned to vendor. Upon acceptance, the device will be added to the Fixed Assets Inventory List. The list will contain the item description, date accepted, serial number or part number (if available), name of vendor, physical location of the item and name of employee in which it was assigned, if applicable.



Appendix A. Role-Based Access Controls

External Users	Contract Reviewer	Client	medlitix Staff	medlitix Leadership
QuickBase advisUR	Assigned Cases Only – View / Edit	Assigned Cases Only – View Only	X	X
QuickBase Physician Panel	X	X	X	X
Gusto	Assigned Payables Only – View Only	X	X	X
Internal Users				
QuickBase advisUR	X	X	All Departmental Cases – View / Edit	View / Edit All Cases
QuickBase Physician Panel	X	X	View – Policies, Accreditation Information, Physician Contact Information, COI Table Edit – Complaints, Staff Calendar	View / Edit- Policies, Accreditation Information, Full Physician Profiles with Credentialing Information, Complaints, Staff Calendar, COI Table, Breach Log, Risk Assessments, Staff Personnel Files
Gusto	X	X	X	All Payables – View / Edit
ADP WFN	X	X	View / Edit Personal Profile	View / Edit All Profiles
Keeper	X	X	View Departmental Passwords Only	View / Edit All Passwords
Microsoft 365	X	X	View / Edit Personal Information Only	View / Edit All Users

