FIRST AMENDMENT TO AGREEMENT NO. 35378

35378

THIS FIRST AMENDMENT TO AGREEMENT NO. 35378 is made and entered, in duplicate, as of April 15, 2020 for reference purposes only, pursuant to a minute order adopted by the City Council of the City of Long Beach at its meeting on September 17, 2019, by and between MEDEX MANAGED CARE, INC. a California corporation ("Medex"), with principal offices at 1201 Dove Street, Suite 300, Newport Beach, California 92660, and the CITY OF LONG BEACH, a municipal corporation ("City").

WHEREAS, City and Medex (the "Parties") entered into Agreement No. 35378 whereby Medex agreed to provide managed care services, specifically utilization review; and

WHEREAS, the Parties desire to update the Scope of Services;

NOW, THEREFORE, in consideration of the mutual terms, covenants, and conditions herein contained, the Parties agree as follows:

1. The Scope of Services in Exhibit "A" to the Agreement is hereby amended to include the Addendum attached hereto and incorporated herein by this reference as Exhibit "A-1".

2. Except as expressly modified herein, all of the terms and conditions contained in Agreement No. 33578 are ratified and confirmed and shall remain in full force and effect.

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IN WITNESS WHEREOF, the Parties have caused this document to be duly executed with all formalities required by law as of the date first stated above.

MEDEX MANAGED CARE, INC., a California corporation

_____, 2020 By _____
Name David Kim
Title COO

_____, 2020 By _____
Name _____
Title _____

"MEDEX"

CITY OF LONG BEACH, a municipal corporation

April 17, 2020 By Rebecca A Garner
City Manager

EXECUTED PURSUANT TO SECTION 301 OF THE CITY CHARTER

This First Amendment to Agreement No. 35378 is approved as to form on April 17, 2020.

CHARLES PARKIN, City Attorney

By Anne Hathme
Deputy

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EXHIBIT "A-1"

ADDENDUM TO AGREEMENT

The purpose of the Addendum is to add language delineating performance standards as required by the URAC Workers' Compensation Utilization Management accreditation of MEDEX with regards to the Utilization Review services currently being performed for Payor, the terms of which have been previously agreed upon by both parties. All other terms and provisions of the Agreement shall remain in full force and effect.

MEDEX shall comply with all laws and regulations within the state in which jurisdiction has been ascertained. For illustrative purposes, this Addendum references laws, regulations, timeframes, and definitions that govern Utilization Management within the jurisdiction of the State of California.

A) SCOPE AND EXTENT

Utilization review evaluates the necessity, appropriateness, and efficiency of the use of medical services. Utilization management is an organized process of managing medical services provided by others; it is a method of quality assurance and cost containment.

The purpose of this service is for MEDEX to review Requests for Authorizations (RFA) submitted to Client and/or Client's Claims Administrator by treating physicians. As defined by California Labor Code Section 4610(a), Utilization Review means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny RFAs based in whole or in part on medical necessity to cure and relieve treatment recommendations by physicians, as defined in Section 3209.3 prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician, may modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve (LC 4610-e).

B) DEFINITIONS

Authorization means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on either a completed "Request for Authorization, " DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2), that has been transmitted by the treating

physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 9, section 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Authorization," DWC Form RFA if that form was initially submitted by the treating physician.

Availability of Services

i. Telephone access shall be available from 8:00 a.m. to 5:30 p.m. Pacific Time on normal business days for health care providers to request authorization for medical services.

ii. The facsimile number (949) 612-9207 is available at all times to receive requests for authorization for medical services.

iii. After business hours, physicians requesting authorization for medical services have access to the MEDEX voice mail system and the facsimile as noted above.

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

Concurrent Review means utilization review conducted during an inpatient stay.

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

Evidence Based means based, at a minimum, on a systematic review of literature published in medical journals included in MEDLINE

Expedited Review means utilization review or independent medical review conducted when the injured workers' 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.

Medically Necessary means the evaluation of the severity of injury and degree of impairment so as to determine issues of the frequency, duration, intensity, and appropriateness of treatment.

Medical Treatment means care which is reasonably required to cure or relieve the employee form the effects of the industrial injury consistent with the requirements of section 9792.20 – 9792.23.

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Medical Treatment Guidelines refers to the most current version of written recommendations revised within the last five years which are systematically developed by a multidisciplinary process through a comprehensive literature search to assist in decision-making regarding the appropriate medical treatment for specific clinical circumstances.

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

Medically Necessary or Medical Necessity means medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury.

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

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

Request for Authorization means a written request for a specific course of proposed medical treatment.

i. Unless accepted by a claims administrator under section 9792.9.1(c)(2), a request for authorization must be set forth on a "Request for Authorization (DWC Form RFA)," completed by a treating physician, as contained in California Code of Regulations, title 9, section 9785.5. Prior to March 1, 2014 any version of the DWC Form RFA adopted by the Administrative Director under section 9785.5 may be used by the treating physician to request medical treatment.

ii. "Completed," for the purpose of this section and for the purposes of investigations and penalties, means that the request for authorization must, identify both the employee and the provider, identify with specificity a recommended treatment or treatments, and be accompanied by documentation substantiating the need for the requested treatment.

iii. The request for authorization must be signed by the treating physician and may be mailed, faxed or emailed to, if designated, the address, fax number or e-mail designated by the claims administrator for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

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

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

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Utilization Management means monitoring care provided by others.

Utilization Review Decision means a decision pursuant to Labor Code section 4610 to approve, modify, or deny a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code sections 4600 or 5402 (c).

Utilization Review Process means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment or services pursuant to Labor Code section 4600. The utilization review process begins with the completed DWC Form RFA, or a request for authorization accepted as complete under section 9792.9 1 (c)(2), is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

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

C) SERVICE MANAGEMENT

a. Administration. MEDEX shall complete the UR, enter its determination, and upload supporting documents into our system and issue a written determination, along with the required information to the interested parties.

b. Accepting Referrals. MEDEX shall accept RFAs from the Client and/or the Client's TPA via electronic mail, facsimile, or Internet portal. RFA's sent directly to MEDEX from a provider will be forwarded to the administrator or returned to the provider. RFA submissions should be accompanied by a medical report explaining the necessity for the request. If additional information is needed, MEDEX will contact the medical provider to solicit the information.
    i. Expedited Utilization Reviews.
        1. Rush Reviews – Determination rendered within 1 business day.
        2. STAT Reviews – Determination rendered same business day.

c. Qualifications of Reviewers
    i. Peer Review. MEDEX's reviewer shall be capable of conducting a peer review and interface with a requesting physician to discuss an RFA or UR determination or resolve treatment or diagnosis questions.
    ii. Specialty Reviewers. MEDEX shall determine the medical and professional specialties required to render a timely, objective, and effective determination from appropriately qualified reviewers. The

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specialty of a reviewer selected to render individual medical determinations shall be based on the specialty of the requesting physician.

iii. Location of Reviewers. No reviews or determinations will be performed by either a physician or non-physician outside the United States of America.

d. Review Criteria

i. Review Standards. In performing its function, MEDEX shall use the Medical Treatment Utilization Schedule (MTUS) promulgated by the DWC administrative director under Labor Code sections 5307.27 and 4604.5, and found in sections 9792.20 *et seq.* of Title 8, California Code of Regulations. However, treatment shall not be denied on the sole basis that the condition or injury is not addressed by the MTUS. The requested treatment may be evaluated in accordance with other scientifically and evidence-based, peer-reviewed medical treatment guidelines that are nationally recognized by the medical community, in accordance with subdivisions (b) and (c) of section 9792.25, and pursuant to the Utilization Review Standards found in section 9792.6 through section 9792.10.

ii. Analysis and Determination Standards. Each reviewer shall provide an individual assessment of the RFA that sets forth the reviewer's professional analysis and determination on whether the medical treatment requested is medically necessary. Each analysis shall cite the injured employee's medical condition, relevant documents reviewed in the process of making the determination, including a detailed listing of records reviewed, detailed relevant findings associated with the standards set forth in Labor Code section 4610(c)(2) to support the determination, and rationale supporting the analysis.

e. Types of Review

i. Types of UR Determinations. MEDEX's UR reviewer shall review the RFA submitted and shall make a determination as to whether the RFA is approved (certified), modified, or denied (non-certified).

ii. Prospective and Concurrent Review. MEDEX's utilization review shall conform to Labor Code Section 4610 (g)(1). Specifically, all prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonable to make the determination, but in no event more than fourteen days from the date of the medical treatment recommendation by the physician.

iii. Retrospective Review. In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated by MEDEX to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make a

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determination.

f. Timeliness and Notice
   i. Determination Timeliness. Decisions to approve, or modify requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision.
   ii. Denial and Modification Timeliness. Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated to requesting physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review.
   iii. Notice. The notice to modify or deny an RFA shall contain all the information as described in section 9792.9.1(3)(1), Title 8 of the California Code of Regulations.

g. Appeals. MEDEX maintains and makes available a written description of the procedures for appealing an adverse determination.

h. Independent Medical Review
   i. Medical treatment disputes for injuries occurring on or after January 1, 2013 will be resolved by a physician through a process known as Independent Medical Review. A request for medical treatment must go through utilization review to confirm that it is medically necessary before it is approved. If utilization review denies or modifies the treating physicians request for medical treatment because the treatment is not medically necessary, the injured employee may request a review of that decision thru the IMR process by completing an Application for Independent Medical Review, DWC Form IMR. Beginning July 1, 2013, IMR became effective for all dates of injury.
   ii. When a utilization review decision denies or modifies a treatment recommendation, MEDEX will provide the requesting physician, the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney with an Application for Independent Medical Review, DWC Form IMR. A pre-addressed envelope will be provided to the injured worker so they can return the DWC Form IMR to the Administrative Director or the Administrative Directors' designee to initiate the IMR process. MEDEX will complete the DWC IMR form on behalf of the claims administrator and include on the form any information required by the Administrative Director to facilitate the completion of the IMR process.

i. Records Retention. MEDEX shall retain the medical records and the determination in our secure web-based system that shall be accessible for Client to review.

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