UTIIZATION REVIEW FORUM COMMENTS

Denise Niber, Claims and Medical Director
California Workers' Compensation Institute (CWCI)

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The Institute recognizes that the Division's task in amending these regulations is far from simple and supports the Division's decision to start via Forum. At this juncture, the Institute would like to offer the following bulleted comments for consideration.

Where specific text revisions are recommended, they are identified by underscore and ~~strikeout~~. Comments and discussion by the Institute are identified by *italicized text.*

Priority Considerations

- A primary objective of SB 1160 was to reduce the number of UR events by providing more expeditious treatment with a corresponding reduction in the administrative burden. The Institute urges the Division to focus on these goals as the rulemaking process continues.

- As regulation sections 9792.6.1(u) and 9785 (g) are currently drafted, a request for authorization is allowed via narrative report. Without a required form, claims administrators are going to have a much more difficult time triaging what is and what isn't a request for authorization in an expeditious manner which could cause delays in treatment. If the narrative request for authorization option is to remain, the Institute recommends that language be mandated at the top of the narrative report stating, "Request for Authorization" in bold font.

- Our interpretation of the proposed regulation section 9792.9.7(a) is that a written request for authorization is required for all services, even if it is not subject to prospective review. This would be in conflict with the goal of reducing the administrative burden associated with pass-through and other services. Clarification is needed concerning when a request for authorization is required

- Labor Code section 4610(i)(1) requires that prospective or concurrent UR decisions be made within "five working days," and the Institute applauds the Division's inclusion of definitions for "working days" and "business days" in the new UR regulations. To maintain statutory consistency with section 4610(i)(1), however, all UR timeframe regulations should reference "working days" as opposed to "business days," with two exceptions:

    1. Availability of UR services under section 4600.4 (specifically referencing "each normal business day"); and

    2. Deadline for communicating a prospective UR decision under section 4610(i)(4)(B) (specifically referencing "two business days").

- In light of the evolving role of non-primary treatment providers, the interests of the injured worker are best supported by application of appropriate rules to all providers of medical treatment. Application of rules to all treatment providers comports with current practices, and is consistent with Labor Code sections 4610(f)(2) and 4610.5(c)(3). Accordingly, the Institute recommends revision of Article 5 (TITLE) and Labor Code section 9785 to clearly differentiate the responsibilities of the Primary Treating Physician, while also confirming the requirements of any treating physician, *vis-à-vis* requests for authorization, prescribing drug treatment and/or providing pass-through treatment.

- Labor Code 4610(f) gives employers and insurers the exclusive right to determine members of their MPNs. Proposed sections 9792.9.7(c) and (d) would contradict the statute, at least in part, by creating specific requirements for removal of a provider from an MPN and by vesting jurisdiction with the WCAB for any resulting dispute. Each of these provisions represents an invalid infringement on the employer's and insurer's rights under Labor Code section 4610(f).

Summary of General Recommendations

- Use of email for submitting requests for authorization and other sensitive communications (with respect to content or time) should only be permitted with prior agreement of the parties.

- References to "physical address" should be changed to "mailing address."

- Despite the statutory mandate of Labor Code section 6409(a), CCR section 9785(e) makes no reference to electronic submission of the Doctor's First Report (Form 5021).

- CCR section 9786 is internally inconsistent, because subdivision (b)(6) defines "good cause" to grant a petition for a change in physician as including non-compliance with the MTUS, while (c)(2) prohibits that same non-compliance with appropriate medical treatment from serving as "good cause." The Institute recommends deletion of conflicting language in (c)(2), in order to avoid confusion.

- Adoption of the proposed PR-1 report will require revisions to the Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services (sections 9789.12.14 and 9789.14(b)(1)).

- The Division's website URL reference to its home page listed in CCR section 9781(d)(7) is outdated. The Institute recommends that the provided URL be an address that is unlikely to change in the future, such as: http://www.dir.ca.gov/dwc/.

- The definition in CCR section 9792.6.1(n) "Material Modification" is too vague to be appropriately enforced. Since penalties are tied to failure to comply, this definition needs to be expressly stated.

- In section 9792.9.5(f), following a UR denial based on lack of information, there is no provision for the provider or the injured worker to submit the missing information, and there is no limitation on the time within which the additional information may be submitted.

- Sections 9792.9.7(a)(4) and 9792.6.1(u) incorrectly reference the requirements for an RFA "in accordance with" and "in the manner authorized by" section 9785(h); the references should be updated to section 9785(g), in order to reflect the renumbering of that section.

- The definition of "pattern and practice" as set forth in section 9792.9.7(c)(2) is too lenient, and should be re-defined to encourage provider compliance with the MTUS.

Comments Related to PR-1 Form:

- Under "Expedited Request for Authorization," recommend adding "Imminent and serious threat to life or health" in order to conform with Labor Code section 4610(i)(3).

- Strongly recommend that the PR-1 be modified to make a "request for authorization" more obvious. Suggest adding a requirement that the number of services being requested be included along with the "request for authorization" label/check box. Suggest that all box choices related to a request for authorization be in bold font, sectioned off at the very top, with added wording to remind the requesting physician to complete the necessary sections to substantiate the request.

- Add a section requiring the requesting physician to provide specific reference to the MTUS, in order to encourage consideration of the MTUS.
- The present formatting does not provide enough space for each specific treatment request.

- RFAs often contain multiple treatment requests for the same date of service (especially related to surgery requests); the present formatting requires the provider to attach additional pages rather than providing separate rows for each request.

- The Division's concept of a multi-part form for treatment requests involving a call-and-response format across several entities is not practical from an operational standpoint. Inclusion of the physician's treatment request, claims administrator authorization, and URO response in a single document is not desirable; indeed, the UR determination contains much more information than is contemplated on page 4 of the PR-1 form. The Institute recommends that space be provided to identify what is being approved, and that the "response" section on page 4 be eliminated.

Comments Related to UR-01 Form:

- Add option to allow qualified public entities to indicate exemption from URAC accreditation if the requirements of section 9792.27(a)(6)(B) have been met.

Regulations: Medical Provider Network, Physician Reporting, Utilization Review and Independent Medical Review

Title 8, California Code of Regulations

Division 1, Chapter 4.5 Division of Workers' Compensation

Subchapter 1 Administrative Director – Administrative Rules

Recommendation:

Modify § 9767.6 (f) as follows:

(f) The insurer or employer shall deliver to the initial primary treating MPN physician selected by the employee all relevant medical records relating to the claim, including the results of diagnostic and laboratory testing done in relation to the injured employee's treatment. The insurer or employer shall advise any subsequently selected MPN physician that any medical record or diagnostic and laboratory test result deemed relevant to that provider will be ~~delivered~~ upon request. The insurer or employer shall also advise all selected MPN physicians of the name, telephone number, fax number, email address, if agreed by the parties in writing, and ~~physical~~ mailing address of the individual to whom a request for authorization should be sent.

Discussion:

The Institute recommends further consideration be given to the use of email as an accepted method of communication, particularly as it relates to HIPAA and other privacy concerns. In any circumstance, the Institute recommends that email submissions be permitted only upon written prior agreement by the parties, and only if submitted via secure email.

Replace "physical address" with "mailing address" because the physical address may differ from the address where the correspondence should be directed.

Recommendation:

Modify Article 5 TITLE, as follows:

Article 5. Predesignation of Personal Physician; Request for Change of Physician; Reporting Duties of ~~the Primary~~ Treating Physicians; Petition for Change of Primary Treating Physician

Discussion:

In light of the evolving role of non-primary treatment providers, the interests of the injured worker are best supported by application of appropriate rules to all providers of medical treatment.

Recommendation:

Modify § 9781(d)(5) as follows:

(5) Provide the physician or facility with the name, telephone number, fax number, email address, and ~~physical~~ mailing address of the individual to whom a request for authorization should be sent.

Discussion:

Replace "physical address" with "mailing address" for reasons previously delineated, and to maintain consistency.

Recommendation:

Modify § 9781(d)(7) as follows:

(7) Provide the physician or facility with (1) the complete requirements of section 9785; and (2) the required reporting forms under that section. In addition, the claims administrator shall refer the physician or facility to the Division of Workers' Compensation's website where the applicable information and forms can be found at ~~http://www.dir.ca.gov/DWC/dwc_home_page.htm~~ https://www.dir.ca.gov/dwc/ or https://www.dir.ca.gov/dwc/MedicalProvider.htm.

Discussion:

The URL currently referenced is no longer active and needs to be updated to a URL that is unlikely to change. The URL https://www.dir.ca.gov/dwc/MedicalProvider.htm currently takes the provider to pertinent information, as well as a link to applicable forms. If, however, there is a possibility that this URL will change, the Division's home page URL is recommended: https://www.dir.ca.gov/dwc/ .

Recommendation:

Modify § 9785 to delete references to "primary" as follows:

§9785. Reporting Duties of ~~the Primary~~ Treating Physicians.

Discussion:

To maintain statutory and regulatory consistency, the Institute recommends deletion of "primary" as a qualifier in the title, and revision of the text of section 9785 to more fully address the respective obligations of each treating physician. Since section 9785 addresses both primary and secondary treating physicians (with subdivision (h) specifically stating that either may submit an RFA), it is inconsistent to limit reporting requirements to only the primary treating physician.

In light of the evolving role of non-Primary treating physicians, the interests of the injured worker are best supported by application of appropriate rules to all providers of medical treatment.

Recommendation:

Modify § 9785 (a) as follows:

(1) The "primary treating physician" is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer, the employee pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, or under the contract or procedures applicable to a Health Care Organization certified under section 4600.5 of the Labor Code, or in accordance with the physician selection procedures contained in the medical provider network pursuant to Labor Code section 4616. For injuries on or after January 1, 2004, a chiropractor shall not be a primary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized additional visits in writing. For purposes of this subdivision, the term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation ~~or are limited to evaluation and management~~. This prohibition shall not apply to post-operative rehabilitation treatment pursuant to section 9792.24.3 ~~the provision of postsurgical physical medicine~~ that is prescribed by the employee's surgeon, or physician designated by the surgeon, and is ~~pursuant to~~ in accordance with the ~~postsurgical component of the~~ medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. ~~For purposes of this subdivision, the term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.~~

(2) A "secondary physician" is any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee. For injuries on or after January 1, 2004, a chiropractor shall not be a secondary treating physician after the employee has received 24 chiropractic visits, unless the employer has authorized, in writing, additional visits. For purposes of this subdivision, the term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation. This prohibition shall not apply to post-operative rehabilitation treatment pursuant to section 9792.24.3 ~~the provision of postsurgical physical medicine~~ that is prescribed by the employee's surgeon, or physician designated by the surgeon, and is ~~pursuant to~~ in accordance with the ~~postsurgical component of the~~ medical treatment utilization schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. ~~For purposes of this subdivision, the term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.~~

Discussion:

To avoid confusion, CCR sections 9785(a)(1) and (2) should be rewritten to reflect the changes made to CCR section 9792.24.3 of the Medical Treatment Utilization Schedule regulations regarding post-surgical treatment.

Recommendation:

Modify § 9785 (d) as follows:

(d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation in the manner prescribed in subdivisions (e), (f), (g), ~~and~~ (i), and (j) of this section. The primary treating physician may transmit reports to the claims administrator by mail or FAX or by any other means satisfactory to the claims administrator, including electronic transmission.

Discussion:

Each of the identified subdivisions reference compensation; omission of subdivision (j) appears to have been an oversight.

Recommendation:

Modify § 9785 (f)(2) as follows:

(2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a ~~new~~ need for referral to a secondary physician for treatment or consultation ~~by another physician~~, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices;

Discussion:

Deletion of language in subdivision (2)(C) will improve syntax while maintaining substance.

Recommendation:

(g) (5) Any treating physician who renders drug treatment pursuant to CCR section 9792.27.3 shall provide the report mandated by subdivision (b)(2) of that section.

Discussion:

In order to ensure that prescribing physicians either conform to, or justify treatment outside of, the MTUS Drug Formulary, the Institute recommends that the 9785 requirement letter specifically reference the reporting mandate of section 9792.27.3(b)(2), and that the mandate apply to any prescribing physician. While some injured workers will be maintained on long-term opioid and/or psychotropic therapy, it is nevertheless incumbent upon the prescribing physician to attempt to taper these medications in accordance with the guidelines, or to justify continuing drug treatment outside the MTUS Drug Formulary. Since the claims administrator is mandated to not abruptly discontinue continuing drug treatment on legacy claims, the regulations need to address this type of problem so that no prescribing physician is allowed to ignore the MTUS Drug Formulary to the detriment of the injured worker.

Recommendation:

Modify § 9785(j) as follows:

(j) The primary treating physician, upon finding that the employee is permanent and stationary as to all conditions and that the injury has resulted in permanent partial disability, shall complete the "Physician's Return-to-Work & Voucher Report" (DWC-AD 10133.36) and attach the form to the report required under subdivision (~~h~~i).

Discussion:

Because the subdivisions have been renumbered, the reference to (h) in section 9785(j) needs to be corrected.

Recommendation & Discussion: § 9785.6 Treating Physician's Report (DWC Form PR-1):

Because both primary and secondary physicians will be using the PR-1 form, the Institute recommends that the form include restrictions based on the role of the submitting physician. The options to comment on Release from Care and Change in Work Status should be limited to the designated Primary Treating Physician. Otherwise, the potential for conflicting determinations as between treatment providers will increase disputes and litigation.

Adoption of the proposed PR-1 report will require revisions to the Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services (sections 9789.12.14 and 9789.14(b)(1)).

Recommendation:

Modify § 9786(c)(2) as follows:

(2) Good cause shall not include a showing that ~~current treatment is inappropriate or that~~ there is no present need for medical treatment to cure or relieve from the effects of the injury or illness.

Discussion:

The language recommended for deletion in § 9786 (c)(2) is in direct conflict with the provisions of (b)(6), and should be deleted.

Recommendation:

Modify **§** 9786(c)(3) as follows:

(3) Where an allegation of good cause is based upon failure to timely issue the "Doctor's First Report of Occupational Injury or Illness," Form ~~DLSR~~ 5021, within 5 working days of the initial examination pursuant to Section 9785, subdivision (e)(1)~~ or (e)(2)~~, the petition setting forth such allegation shall be filed within 90 days of the claims administrator's knowledge of the initial examination.

Discussion:

Clarifying language is recommended in order to avoid a loophole where the claims administrator is unaware of the examination itself.

*Most references to "primary" treating physician in section 9786 should be deleted. Given that Labor Code sections 4603 and 4610(f)(2) do not qualify the physician as **primary**, the Division should consider revising 9786, as well as 9786.1 (and the form), in a way that maintains*

statutory consistency and recognizes the potential need for change of treating physician who is not primary.

Recommendation:

Delete § 9792.5(f)(1)(I):

~~(I) A statement that if the claims administrator's internal utilization review appeals process fails to resolve the dispute regarding the necessity of the requested information, or whether the requested information was previously available to the claims administrator, the injured worker may seek resolution of the dispute by filing a petition for determination of medical treatment dispute with the Workers' Compensation Appeals Board under California Code of Regulations, title 8, section 10451.2, subdivision (c).~~

Discussion:

Inclusion of this subdivision represents an improper expansion of WCAB jurisdiction. The Courts of Appeal have, in numerous published decisions, confirmed the principles stated in Dubon II that a dispute related to the timeliness of a UR determination falls under the jurisdiction of the WCAB, but all other disputes related to medical necessity fall within the IMR process.

Recommendation:

Modify § 9792.6.1 (m) as follows:

(m) "Immediately" means within one ~~business~~working day.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.6.1 (n) as follows:

(n) "Material modification" ~~includes but is not limited to a change in the plan's operations or contracts impacting utilization review~~ is ~~such as~~ when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

Discussion:

The definition of "Material modification" is overly broad and vague; since penalties are tied to non-compliance, this definition needs to be stated in express terms. The Institute recommends reverting to the original language of the regulation.

Recommendation:

Modify § 9792.6.1(u)(1) as follows:

(1) Unless accepted by a claims administrator under section 9792.9.1(b), a request for authorization must be completed by the treating physician in the manner authorized by section 9785(~~h~~g).

Discussion:

The correct reference here is to § 9785(g), not (h), due to new renumbering of that section.

Recommendation:

Modify § 9792.6.1(u)(2) as follows:

(2) "Complete~~d~~ or completed," for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization:

(A) identifies both the employee and the requesting provider;

(B) identifies with specificity all ~~the recommended~~ requested treatments in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used; ~~and~~

(C) is accompanied by documentation~~, issued or created no later than 30 days before the date of the request for authorization,~~ that includes a progress report for an evaluation date no earlier than 30 days prior to the date of a request for authorization ~~which substantiates~~substantiating the need for the requested treatment. A request for authorization may be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.1(f); and

(D) is signed by the treating physician. By agreement of the parties, the treating physician may submit the request for authorization with an electronic or digital signature.

Discussion:

This section has been subdivided for purposes of clarity.

The recommended revision in new subdivision 2(C) restricts the time frame to ensure that requests for treatment are intended for the injured workers' most current needs. The 30-day time frame should not apply to all documentation since there may be relevant supporting documentation (e.g., an MRI report) that is older than 30 days.

Recommendation:

Modify § 9792.6.1(u)(3) as follows:

(3) The request for authorization ~~must be signed by the treating physician and~~ may be mailed, faxed, or sent electronically through the use of a secure, encrypted email system to the address, fax number, or e-mail address designated by the claims administrator under section 9781(d)(5) for this purpose. ~~By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.~~

Discussion:

The deletion of language in the first sentence corrects syntax. The final sentence has been moved to the definition of "completed" in subdivision (u)(2)(D), above.

Recommendation:

Modify § 9792.6.1(cc) as follows:

(cc) "Business day" is any day other than a Sunday, a day declared by the Governor to be an official State holiday, or a day listed at Calhr.ca.gov. "Working day" means any business day other than a Saturday. ~~"Working day" means any day other than a Saturday, Sunday, or a day declared by the Governor to be an official State holiday. "Business day" shall not include January 1, the third Monday in January, the third Monday in February, March 31, the last Monday in May, July 4, the first Monday in September, November 11, Thanksgiving Day, the day after Thanksgiving, and December 25.~~

Discussion:

The Institute wholeheartedly supports the Division's intent to remove Saturdays from the definition of "working days." The suggested language is a simplified version that allows for future flexibility (i.e., holidays that may change over time). Because the website includes all of the Division's listed holidays and further because it is stated in the alternative to a Governor declaration, the proposed language will exclude Saturdays as well as all present and future State holidays from the definition of "working days."

Recommendation:

Modify § 9792.7 (a) as follows:

(a) Every claims administrator shall establish and maintain a utilization review process for the determination of medical necessity of requested ~~medically necessary~~ treatment in compliance with Labor Code section 4610. Each utilization review process shall be set forth in a utilization review plan which shall contain:

Discussion:

Additional language is added to §9792.7(a) to correct syntax.

Recommendation:

Modify § 9792.7 (b) as follows:

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

Discussion:

The recommended deletion maintains statutory consistency with Labor Code section 4610 (c)

Recommendation:

Modify 9792.7 (c) as follows:

(c) (1) The complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process, shall be filed by the claims administrator, or by the external utilization review organization contracted by the claims administrator to perform the utilization review, with the Administrative Director. In lieu of filing the utilization review plan, the claims administrator may submit a letter identifying the external utilization review organization which has been contracted to perform the utilization review functions, provided that the utilization review organization has filed a complete utilization review plan with the Administrative Director. A change in the information contained or which would be contained in the DWC Form UR-01, Application for Approval as a UR Plan, shall be filed with the Administrative Director within 30 calendar days after the modification is made. Notice ~~of a~~ to the Division of Workers' Compensation of a material modification, as defined at section 9792.6.1(n), shall be made in writing twenty (20) calendar days prior to the implementation of the material modification. The notice of material modification shall include 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 et seq.

Discussion:

Language is deleted from subdivision (c)(1) to correct syntax.

Recommendation:

Modify 9792.7(g)(3) as follows:

(3) The Administrative Director shall post on the Division's website a list of all entities who have filed a complete utilization review plan under this section, indicating ~~the~~ which plans have been approved under subdivision (e).

Discussion:

Additional language is added to §9792.7(g)(3) to correct syntax.

Recommendation:

Modify § 9792.9.1(a)(1), as follows:

For purposes of this section, a request for authorization ~~the DWC Form RFA~~ shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to

be the date the form was received by the claims administrator or the claims administrator's utilization review organization. A request for authorization ~~the DWC Form RFA~~ transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following ~~business day~~ working day, except in the case of an expedited or concurrent review. The copy of the request for authorization or the cover sheet accompanying the form transmitted by a facsimile transmission or by electronic mail shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall display the facsimile telephone number to which the form was transmitted. The requesting physician must indicate if there is the need for an expedited review on the request for authorization.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.1(a)(2)(A):

Where the request for authorization ~~DWC Form RFA~~ is sent by mail and the place of address and the place of mailing is within the State of California, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator five (5) ~~business~~calendar days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.

Discussion:

A change of "business days" to "working days" in this instance is ***not*** *recommended, as the computation of time for presumed receipt of a mailed document is wholly different from computation of whether a utilization review determination is timely. The "mailbox rule" is borrowed from Code of Civil Procedure section 1013, and the Institute accordingly recommends the use of "calendar days" instead of "business days" in order to maintain consistency with well-established rules for mailed documents. However, as with CCP § 1013, the five-day presumption should apply only to intra-state mail; the Institute urges the Division to consider adoption of language similar to CCP § 1013 as it relates to out-of-state mailings.*

Recommendation:

Do not change "business days" in 9792.9.1(a)(3):

(3) Every claims administrator shall maintain telephone access and have a representative personally available by telephone from 9:00 AM to 5:30 PM Pacific Time, on business days for health care providers to request authorization for medical services. Every claims administrator shall have a facsimile number available for physicians to request authorization for medical services. Every claims administrator shall maintain a process to receive communications from

health care providers requesting authorization for medical services after business hours. For purposes of this section the requirement that the claims administrator maintain a process to receive communications from requesting physicians after business hours shall be satisfied by maintaining a voice mail system or a facsimile number or a designated email address for after business hours requests.

Discussion:

To promote consistency with Labor Code section 4600.4, "business days" in this instance is ***not*** *recommended to be replaced with "working days." The issue of maintaining access (for providers to request authorization for medical services) is wholly different from how to count days in determining whether a utilization review determination is timely. Indeed, in the case of an expedited review where there is an imminent and serious threat to the health of an employee, this availability of access is crucial.*

Recommendation:

Modify § 9792.9.1(b) as follows:

(b) Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it "not complete" and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) ~~business days~~working days from receipt. A request for authorization accepted as complete shall be subject to investigation under section 9792.11 and the assessment of administrative penalties under section 9792.12.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.2(b) as follows:

(b) If the claims administrator disputes liability under this subdivision, it may, no later than five (5) ~~business days~~working days from receipt of the request for authorization, issue a written decision deferring utilization review of the requested treatment unless the requesting physician has been previously notified under this subdivision of a dispute over liability and an explanation for the deferral of utilization review for a specific course of treatment. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall contain the following information specific to the request:

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.3(a) as follows:

(a) The first day in counting any timeframe requirement is the day after the receipt of the 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 information reasonably necessary to make a determination, which shall include but not be limited to a request for authorization.

Discussion:

The addition of "information reasonably necessary" comports with the statutory language of Labor Code section 4610(i)(3).

Recommendation:

Modify § 9792.9.3(b) as follows:

(b) Prospective or concurrent decisions to approve, modify, ~~delay,~~ or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) ~~business days~~ working days from the date of receipt of the completed request for authorization.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.4(b) as follows:

(b) For prospective, concurrent, or expedited review, approvals shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or, if agreed to by the parties, secure electronic mail. If the communication is by telephone, it shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within two (2) ~~business days~~working days for prospective review.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.5 (c) as follows:

(c) For prospective, concurrent, or expedited review, a decision to modify or deny a request for treatment on the basis of medical necessity shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or, if agreed to by the parties, secure electronic mail. The facsimile or electronic mail shall contain the information set forth in subdivision (e) or (f). If the communication is by telephone, it shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) ~~business days~~ working days for prospective review and for expedited review within 72 hours of receipt of the request.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.5 (e) as follows:

(e) The written decision modifying or denying treatment authorization~~,~~ based on medical necessity shall be provided to 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. The written decision shall be signed by ~~either the claims administrator or~~ the reviewer, and shall contain the following information specific to the request:

Discussion:

Deletion of punctuation is necessary to improve syntax.

In light of the new restriction of this subdivision to instances of medical necessity, the provision allowing a claims administrator to sign the decision should be eliminated. Claims administrators may not modify or deny treatment based on medical necessity.

Recommendation:

Modify § 9792.9.5 (f)(1)(H) as follows:

(3) Either the requesting physician or the injured worker may, within 45 days of the denial, submit the missing information as identified under (f)(1)(E). Upon receipt of the additional information, the process of reconsideration under (f)(1)(G) shall commence.

Discussion:

Following a UR denial based on lack of information, provision should be made for the provider or the injured worker to submit the missing information, and a limitation of 45 days should be imposed for the submission of the additional information.

Recommendation:

re: §9792.9.6 (a) - Extension of Timeframes for Decision

Discussion:

The Institute suggests that consideration be given to the potential for abuse of Expedited RFA. With only 72 hours to issue a determination, the claims administrator faces an insurmountable hurdle when presented with such a request at, say, 5:00 p.m. on a Friday prior to a three-day weekend. Strictly counting 72 hours renders the deadline to expire on a holiday (i.e., neither a working day nor a business day). While the Institute recognizes the "imminent and serious threat" faced by an injured worker in need of treatment, a solution is required for situations where the use of an Expedited RFA is unwarranted.

Recommendation:

Modify § 9792.9.6 (b)(1) as follows:

(b)(1) If the circumstance under subdivision (a)(1)(A) applies, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) ~~businessdays~~working days from the date of receipt of the request for authorization.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.6 (c)(2) as follows:

(2) If any of the circumstances set forth in subdivisions (a)(1)(B) or (C) are deemed to apply following the receipt of a complete or accepted request for authorization, the physician reviewer shall within five (5) ~~business days~~working days from the date of receipt of the request for authorization notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes

Recommendation:

Modify § 9792.9.6 (d)(1) as follows:

(d)(1) Upon receipt of the information requested pursuant to subdivisions (a)(1) (A), (B), or (C), the claims administrator or reviewer, for prospective or concurrent review, shall make the decision to approve, modify, or deny the request for authorization within five (5) ~~business days~~working days of receipt of the information in accordance with the applicable provisions of sections 9792.9.4 and 9792.9.5.

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.9.7(a)(4) as follows:

(4) All treatment or services anticipated to be provided to the injured worker in the first 30 days after the date of injury, including the exempt drugs prescribed to the injured worker under the MTUS Drug Formulary, are set forth in a request for authorization provided to the claims administrator in accordance with section 9785(~~h~~g). The form shall be submitted to the claims administrator concurrent with the Doctor's First Report of Occupational Injury or Illness. Subsequent treating physicians during the 30-day period shall submit a request for authorization following their first visit with the injured worker indicating all treatment being rendered.

Discussion:

The correct reference here is to § 9785(g), not (h), due to new renumbering of that section.

This subdivision requires an RFA to be submitted for every treatment request, including fast-track treatment during the first 30 days. If that is the intention of the Division, this language is appropriate. However, if the intention of the fast-track provisions is to provide treatment without encumbrance, then the requirement for submission of an RFA in every instance is inappropriate. An alternative would be to permit provision of fast-track treatment without an RFA unless specifically requested/required by the claims administrator.

Recommendation:

Modify § 9792.9.7(c)(1)(C)(2) as follows:

(2) For the purpose of this section, "pattern and practice" means failing, over a period of ~~six~~ three months, to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, with at least ~~five~~three injured workers.

Discussion:

A non-complying treating physician may well be providing inappropriate treatment to injured workers across multiple claims administrators. Requiring each claims administrator to meet a threshold of five patients in six months is an inappropriate burden, when injured workers are at risk from harmful treatment.

Recommendation:

Modify § 9792.9.8(b)(1) as follows:

(1) Prospective decisions to approve, modify, or deny a request for authorization for a drug not covered under subdivision (a) of this section shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) ~~business days~~working days from the date of receipt of a completed or accepted request for authorization. The decision shall be communicated in the manner set forth in sections 9792.9.4 and 9792.9.5.

Modify § 9792.9.8(b)(2)(B) as follows:

(B) If the information is not received within five (5) ~~business days~~working days from the date of the request for information, the reviewer shall deny the request in accordance with section 9792.9.5(f).

Discussion:

Other than regulatory language involving Labor Code section 4600.4 or 4610(n) (maintaining access for requests for authorization), or section 4610(i)(4)(B) (time allowed for issuing/communicating the UR decision, in writing), all references to "business days" in the regulations should be changed to "working days" in order to maintain statutory consistency with Labor Code section 4610 UR timeframes.

Recommendation:

Modify § 9792.12 (b)(1) as follows:

For failure to comply with the requirement that only a licensed physician may modify or deny, regardless of the reason for denial, requests for authorization of medical treatment to cure or relieve as required under section 4610(g)(3) of the Labor Code~~.~~, except as provided for in Labor Code section 4604.5(c): $25,000;

Discussion:

It appears that the Division is attempting to remove the claims administrator's ability to enforce the statutory cap of Labor Code section 4604.5(c) by removing this exception language, thereby subjecting a claims administrator to a $25,000 fine for following a statutory provision. The Institute does not believe the Administrative Director has the authority to negate statute and, therefore, recommends the exception language be kept.

Steve Cattolica January 15, 2019

Thank you for the opportunity to provide brief comments regarding this package of proposed regulations.

Notwithstanding the vital details that will ultimately render the final version of the regulations workable or not, two fundamental principals must be adhered to:

(1) Choice of physician within an MPN must not be restricted as a result

AND

(2) The language of these regulations cannot be ambiguous with respect to the accreditation required by SB 1160. All UR programs must be held to the same standard, not one or another.

Specifically:

(1) The authority granted within Section 9785 (e)(2) and (g)(3) to primary treating physicians and the claims administrator respectively, can be easily co-opted to narrow the choice of physicians able to comply by requiring use of proprietary reports or reporting systems. Use of such reports or systems cannot be allowed to become criteria to narrow physician choice. Inherently, the language of these two sections puts ultimate authority on one side of the agreement and will be misused.

(2) URAC Utilization Management accreditation includes a thorough and clearly delineated internal second review process be undertaken at the request of the treating physician. Compliance with this process by the URO assures that URAC accreditation standards will not be sidestepped in favor of California's IMR process.

Unless both URAC accreditation programs (Utilization Management and Independent Review) include the same requirements for internal second review, an injured worker will not be assured of equal treatment within California's workers' compensation system. Further, if one or the other is more lenient than the other with respect to this requirement, the outcome of utilization review may or may not become arbitrarily variable.

Only if both accreditations are equal in this regard, can the Division allow both to stand as equal in its regulations.

Unless these two accreditations are identical in their requirements for gaining and maintaining accreditation, it is obvious that the more rigorous of the two should be the only standard.

California's injured workers deserve nothing less.

Carlos Luna, Vice President — January 15, 2019
Risico Total Managed Care, Inc.

Risico Total Managed Care commends the DWC for its work to:

- Expedite appropriate EBM treatment for injured workers;
- Increase effective communication between treating physicians and utilization review physicians; and
- Improve the overall quality of utilization review services in workers' compensation.

Risico Total Managed Care is a (URAC Accredited in WCUM) division of Risico, a multi-faceted, innovative, customer driven company that provides claims management, managed care and insurance products to thousands of customers throughout California. Risico delivers complete, start-to-finish Workers' Compensation solutions that are flexible and interchangeable to meet the specific and changing needs of the California market. Through its family of companies, Risico Insurance Services, Inc., Risico Claims Management, Inc., and Risico Total Managed Care, Inc., Risico enables people, businesses and communities to manage health care in more affordable and effective ways.

Risico's products and services are focused on supporting injured workers return to productivity following a workplace injury. This is accomplished through the use of California's Medical Treatment Utilization Schedule (MTUS) Evidence-Based Medicine (EBM) Treatment Guidelines and Drug Formulary, which are based on the American College of Occupational and Environmental Medicine (ACOEM) EBM Practice Guidelines and the ACOEM-based Drug Formulary.[1] Since 1993, Risico has been a leading provider serving Employers in both the public and private sectors, Third-Party Administrators (TPAs), and Insurers throughout the state of California.

It is through Risico's distinct perspective at the intersection of employers, employees, providers, prescribers, and insurers that we provide the following recommendations to support the ongoing improvement of California's workers' compensation Medical Provider Network, Physician Reporting, Utilization Review and Independent Medical Review regulations.

§9767.6. Treatment and Change of Physicians Within MPN
DWC PROPOSED 11/2018

(f) The insurer or employer shall deliver to the initial primary treating MPN physician selected by the employee all relevant medical records relating to the claim, including the results of diagnostic and laboratory testing done in relation to the injured employee's treatment. The insurer or employer shall advise any subsequently selected MPN physician that any medical record or diagnostic and laboratory test result deemed relevant to that provider will be delivered upon request. The insurer or employer shall also advise all selected MPN physicians of the name, telephone number, fax number, email address, and physical address of the individual to whom a request for authorization should be sent.

RISICO RECOMMENDATION

[1] ACOEM represents more than 4,500 physicians and other health care professionals that specialize in occupational and environmental medicine and is the nation's largest medical society that has dedicated itself to promoting the health of individuals through preventive medicine, clinical care, research and education.

Risico recommends replacing "individual to who a request for authorization should be sent" with "person or entity to who a request for authorization should be sent."

RATIONALE

Most companies scan mail and then enter it into a claims system. Therefore, it's more reasonable for the insurer or employer to provide the physician with contact information of the person or entity to whom a request for authorization should be sent. This is also consistent with the information being provided for bills under §9781(d)(2).

§9781. Employee's Request for Change of Physician
DWC PROPOSED 11/2018

(d)~~(4)~~ (5) P~~p~~rovide the physician or facility with ~~(1)~~ the name, telephone number, fax number, email address, and physical address of the individual to whom a request for authorization should be sent.~~;~~

RISICO RECOMMENDATION

Risico recommends replacing "individual to who a request for authorization should be sent" with "person or entity to who a request for authorization should be sent."

RATIONALE

Most companies scan mail and then enter it into a claims system. Therefore, it's more reasonable for the insurer or employer to provide the physician with contact information of the person or entity to whom a request for authorization should be sent. This is also consistent with the information being provided for bills under §9781(d)(2).

§9785. Reporting Duties of the Primary Treating Physician
DWC PROPOSED 11/2018

(g) (1) Prior to (SIX MONTHS AFTER EFFECTIVE DATE OF REGULATION), except ~~Except~~ for a response to a request for information made pursuant to subdivision (f)(7), reports required under ~~this~~ subdivision (f) shall be submitted on the "Primary Treating Physician's Progress Report" form (Form PR-2) contained in ~~S~~section 9785.2.1; the "Treating Physician's Report" form (DWC Form PR-1) contained in section 9785.6; or in the form of a narrative report. If a narrative report is used in lieu of a Form PR-2, it must be entitled, "Primary Treating Physician's Progress Report," or, if a narrative report is used in lieu of a Form PR-1, It must be entitled, "Treating Physician's Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same-subject headings in the same order as Form PR-2 or Form PR-1. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3."

~~For dates of service prior to October 1, 2015, use Form PR-2 (Rev. 06-05). For dates of service on or after October 1, 2015, use Form PR-2 (Rev. 2015). Although ICD-10 coding is required on or after October 1, 2015, for a twelve-month period ending October 1, 2016, no medical treatment or medical-legal bill shall be denied based solely on an error in the level of specificity of the ICD-10 diagnosis code(s) used. Providers may use either version of the form until December 31, 2015. As of January 1, 2016, providers must use the 2015 version of the form~~.

(g)(2) On or after (SIX MONTHS AFTER EFFECTIVE DATE OF REGULATION), except for a response to a request for information made pursuant to subdivision (f)(7), reports required under subdivision (f) shall be submitted on the "Treating Physician's Report" form (DWC Form PR-1) contained in Section 9785.6, or in the form of a narrative report. If a narrative report is used, it must be entitled "Treating Physician's Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as the DWC Form PR-1. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-1: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code §139.3."

RISICO RECOMMENDATION

Risico recommends adding the sentence, "A DWC RFA form must continue to accompany any Primary Treating Physician's Progress Report Forms (Form PR-2) or narrative reports, which include a request for authorization" after the phrase "and must contain the same information using the same subject headings in the same order as Form PR-2 or Form PR-1."

Risico strongly recommends the following verbiage, "If a narrative report includes a request for authorization, the words "Request For Authorization" must be included at the top of page 1 of the narrative report." be added after the phrase "and must contain the same information using the same subject headings in the same order as the DWC Form PR-1."

RATIONALE

The DWC Form RFA should remain mandatory during the transition period. This will greatly support a smooth transition and avoid making requests for treatment hard to find.

In the event a narrative report is used in place of a PR-1, it is important to require the clear identification that the report contains a "Request For Authorization".

§ 9785.6. DWC Form PR-1: "Treating Physician's Report" – Mandatory for Services On or After January 1, 2019
DWC PROPOSED 11/2018

Treating Physician's Report (DWC Form PR-1).

Note: Authority cited: Sections 133, 4603.5 and 5307.3, Labor Code.

Reference: Sections 4061.5, 4600, 4603.2, 4610, 4660, 4662, 4663 and 4664, Labor Code.

Risico would like to acknowledge that while the intent of consolidating all pertinent information into one form is convenient, it may present unintended consequences due to present Protected Health Information (PHI) and the need to potentially disseminate the form to non-covered entities throughout the authorization process. This will likely present the need to separate sections of the form for communication with said parties due to PHI. The separation of the various sections of the DWC Form PR-1 could introduce issues when determining / proving what information was received and when it was received when challenged by applicant attorneys. Nonetheless, we offer the following input pertinent to DWC Form PR-1:

Section "Check all applicable boxes:" (Top of the page)

- Add verbiage "Check the box if employee faces an imminent and serious threat to his or her health" next to box labeled "Expedited request for authorization".
- Add a box labeled "Resubmission: Change in Material Facts". This is available on DWC Form RFA; it is pertinent to point out to physicians that denials / modifications will stand for one year unless overturned, or if there is a change in material facts.
- A clearly labeled section must be added to the form to correspond with the box labeled "Response to Request for Information" where a provider can include requested information.

General Input

- DWC Form PR-1 should be accompanied by instruction page(s) following page 2. Instructions should identify all mandatory sections/boxes.
- Due to the large amounts of Protected Health Information (PHI) contained in the form, Risico advises that the RFA section be separated from the rest of the form. This protects PHI in the event that a vendor requests a copy of RFA information, which is common (e.g., MRI request).
- Regulations must reflect that "SECTION A. Request for Authorization" is mandatory for all treatment requests.

Section A (Request for Authorization)

- Section A should be able to accommodate multiple line item requests.
- Add box labeled "Generic OK" in "Request for Drug" section to identify if a generic medication is acceptable.
- Add box labeled "Consulted CURES 2.0" in "Request for Drug" section in the event a narcotic agent is being requested.

- Risico recommends adding the following statement under the header "Claims Administrator/Utilization Review Organization Responses" (Page 4): "This section is optional when communicating approvals of treatment; a claims administrator may utilize other means of written notification."
- All pages of DWC Form PR-1 should have the claim number listed on them due to the likelihood of the form being separated for communicating with the various parties throughout the claims continuum.

Section B (Evaluation and Management Worksheet)

- Add a selection / text box where a provider can clearly identify if a non-industrial diagnosis is included and how it will impact the claim.
- Add verbiage "(Medical Rational Required)" following "Dispense Rx as written" on item "8. Treatment Plan".

Section C (Work Status)

- Correct typo in headers on pages 7 and 8. It should read "Employers may only receive Section C (Work Status) as other sections contain private healthcare information."

§ 9792.6.1. Utilization Review Standards—Definitions – On or After January 1, 2013
DWC PROPOSED 11/2018

(n) "Material modification" includes but is not limited to a change in the plan's operations or contracts impacting utilization review ~~is~~ such as when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

(u)(3) The request for authorization ~~must be signed by the~~ treating physician and may be mailed, faxed, or ~~e-mailed~~ sent electronically through the use of a secure, encrypted email system

to~~, if designated,~~ the address, fax number, or e-mail address designated by the claims administrator under section 9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

RISICO RECOMMENDATION

Risico recommends the following verbiage, "change in plan's operations or contracts" be edited to specify what operational changes constitute a "material modification".

In addition, Risico recommends the following verbiage, "such as when the claims administrator changes utilization review vendor" be removed from the definition of "Material modification". Risico offers that regulations be added to instruct UROs to notify the DWC within 30 days of any new contract / client, and if URO services are terminated related to any client.

Risico recommends the verbiage "must be signed" remain as part of the regulation standard.

Risico also recommends the addition of definitions for the following terms, “Reconsideration”, “Internal Utilization Review Appeal”, “Resubmission”. Workers’ Compensation stakeholders do not agree on what these terms mean.

RATIONALE

In its current form, the verbiage defining “Material modification” is too vague and implies that the addition of new client constitutes a material modification. Specific operational changes that warrant a material modification should be clearly defined, while instructions on notifying the DWC of new contracts / clients be provided separately. Notification of a new contract / client can be provided by simple form, or email notification to the DWC; this should not require changing the actual UR Plan, only the active client listing.

Additionally, requests for authorization should always be signed to document the request originated from the physician, therefore “must be signed” should remain.

§9792.7. Utilization Review Standards--Applicability
DWC PROPOSED 11/2018
(c) (1) The complete utilization review plan, consisting of the policies and procedures, and a description of the utilization review process, shall be filed by the claims administrator, or by the external utilization review organization contracted by the claims administrator to perform the utilization review, with the Administrative Director. In lieu of filing the utilization review plan, the claims administrator may submit a letter identifying the external utilization review organization which has been contracted to perform the utilization review functions, provided that the utilization review organization has filed a complete utilization review plan with the Administrative Director. A change in the information contained or which would be contained in the DWC Form UR-01, Application for Approval as a UR Plan, shall be filed with the Administrative Director within 30 calendar days after the modification is made. Notice of a to the Division of Workers’ Compensation of a material modification, as defined at section 9792.6.1(n), shall be made in writing twenty (20) calendar days prior to the implementation of the material modification. The notice of material modification shall include 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 et seq.

RISICO RECOMMENDATION

Risico recommends verbiage “shall be made in writing twenty (20) calendar days prior to the implementation of the material modification.” be amended to “shall be made in writing thirty (30) calendar days after the material modification.”

RATIONALE

The change from twenty (20) days to thirty (30) days allows the URO time to make changes in the UR plan and aligns with other related proposed regulatory changes.

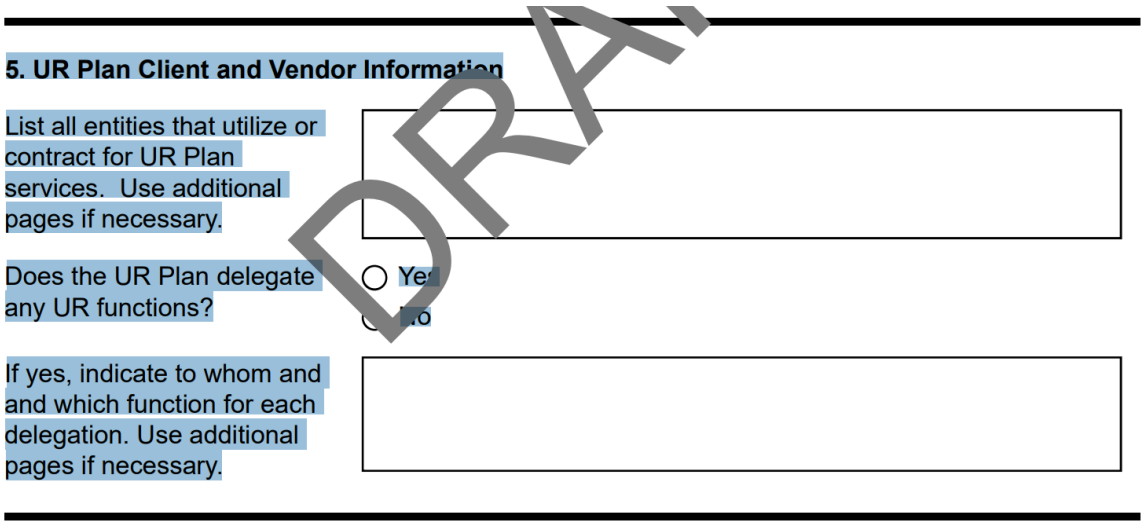
§ 9792.7.1. DWC Form UR-01: "Application for Approval as Utilization Review Plan."
DWC PROPOSED 11/2018

Application for Approval as Utilization Review Plan (DWC Form UR-01).

Authority cited: Sections 133, 4603.5, 4610, and 5307.3, Labor Code.

Reference: Sections 4600 and 4610, Labor Code.

Section "5. UR Plan Client and Vendor Information"



RISICO RECOMMENDATION

Risico recommends removing "5. UR Plan Client and Vendor Information" section from DWC From UR-01.

RATIONALE

This information is only necessary on the "Application for Approval" if a change / addition in clients warrants a material modification.

§9792.9.1. Utilization Review ~~Standards –~~ Receipt of Request for Authorization; Acceptance of Incomplete Request ~~Timeframe, Procedures and Notice – On or After January 1, 2013~~.
DWC PROPOSED 11/2018
(a) (1) For purposes of this section, a request for authorization ~~the DWC Form RFA~~ shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to

be the date the form was received by the claims administrator or the claims administrator's utilization review organization. A request for authorization ~~the DWC Form RFA~~ transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review. The copy of the request for authorization ~~DWC Form RFA~~ or the cover sheet accompanying the form transmitted by a facsimile transmission or by electronic mail shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall display the facsimile telephone number to which the form was transmitted. The requesting physician must indicate if there is the need for an expedited review on the request for authorization ~~DWC Form RFA~~.

RISICO RECOMMENDATION

Risico recommends the following verbiage, "except in the case of an expedited or concurrent review." be revised as follows, "except in the case of an expedited prospective or expedited concurrent review."

RATIONALE

The use of "concurrent review" does not make sense in this statement unless it's relates to expedited concurrent review due to timeframes: Prospective concurrent has a five (5) day timeframe while expedited concurrent has a time defined in hours (72 hours). Modifying the verbiage to expedited prospective / expedited concurrent aligns with defined timeframes

§9792.9.1. Utilization Review ~~Standards —~~ Receipt of Request for Authorization; Acceptance of Incomplete Request ~~Timeframe, Procedures and Notice – On or After January 1, 2013~~.

DWC PROPOSED 11/2018

(b) Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it "not complete" and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt. A request for authorization accepted as complete shall be subject to investigation under section 9792.11 and the assessment of administrative penalties under section 9792.12.

RISICO RECOMMENDATION

Risico recommends changing the following verbiage, "(b) Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a non-physician reviewer as allowed by section 9792.7 or physician

reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it "not complete" and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt." be revised to state as follows, "(b) Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or send a notification to the requesting physician (with the returned request) specifying the reason(s) the request was deemed not complete, no later than five (5) business days from receipt."

RATIONALE

The phrase "or mark it "not complete" is being taken literally and prompting unnecessary legal challenges to determinations of non-complete requests.

§9792.9.5. Utilization Review — Decisions to Modify or Deny a Request for Authorization Based on Medical Necessity
DWC PROPOSED 11/2018

(e)(11) ~~(J)~~ Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

(f)(1)(H) Details about the claims administrator's internal utilization review appeals process if there is a dispute regarding the necessity of the requested information or a dispute as to whether the requested information was previously available to the claims administrator.

(I) A statement that if the claims administrator's internal utilization review appeals process fails to resolve the dispute regarding the necessity of the requested information, or whether the requested information was previously available to the claims administrator, the injured worker may seek resolution of the dispute by filing a petition for determination of medical treatment dispute with the Workers' Compensation Appeals Board under California Code of Regulations, title 8, section 10451.2, subdivision (c).

RISICO RECOMMENDATION

Risico recommends that the DWC clearly articulate in the regulations if an internal utilization review appeals process is a required function for claims administrators, or not.

Risico recommends the proposed language be reverted back to underscore the role of IMR as the dispute resolution process in California keeping the decision-making authority on medical disputes, and the necessity of additional requested information (e.g., tests, specialized consult, etc.) in the hands of trained, qualified medical professionals.

RATIONALE

Section (e)(11) indicates that the claims administer is required to provide the injured worker details of its internal utilization review appeals process "if any", while numerous other sections (f)(1)(H),

(f)(1)(I), and more describe what appears to be a new process related to a dispute specific to the necessity of requested information.

It is important to understand that the newly proposed language de-emphasizes the role of IMR in California as the eminent dispute resolution process for the medical treatment of injured workers. In doing so, the dispute resolution of medical issues will be placed in the hands of non-medical professionals.

§9792.9.7. Utilization Review – Medical Treatment – Within/Beyond the First 30 Days of the Date of Injury
DWC PROPOSED 11/2018

(c) (1) If the claims administrator determines, after retrospective review, that a physician providing treatment under subdivision (a) of this section has a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, the claims administrator may:

(A) Remove the ability of the physician to render treatment exempt from prospective review to any injured worker whose claim is adjusted or administered by the claims administrator. The claims administrator must provide written notice to the physician that: (1) documents, based on retrospective review, the physician's pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary; (2) advises that based on the documented failure the physician can no longer render exempt treatment to any injured worker whose claims are adjusted or administered by the claims administrator; and (3) advises of the requirement of prospective utilization review for all subsequent medical treatment.

(B) Remove the physician as the injured worker's primary treating physician by filing a petition for change of primary treating physician under section 9786.

(C) Terminate the physician from the claims administrator's or employer's medical provider network or health care organization.

(2) For the purpose of this section, "pattern and practice" means failing, over a period of six months, to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, with at least five injured workers.

RISICO RECOMMENDATION

Risico recommends replacing verbiage (c)(2) "pattern and practice" means failing, over a period of six months, to render treatment that is consistent with the Medical Treatment Utilization

Schedule, including the MTUS Drug Formulary, with at least five injured workers." with the following verbiage, "pattern and practice" means failing, over a period of sixty days, to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, with at least 3 injured workers."

RATIONALE

Medically inappropriate treatment and prescriptions that do not align of the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, present significant safety issues for injured workers and a significant cost to employers. In the case of medications, dependency issues can develop extremely fast. Establishing "pattern and practice" must happen quickly and efficiently in order to protect the well-being of injured workers.

§9792.9.7. Utilization Review – Medical Treatment – Within/Beyond the First 30 Days of the Date of Injury
DWC PROPOSED 11/2018

(d) Any dispute between the treating physician and the claims administrator regarding the removal of the physician under subdivisions (c) shall be resolved by the Workers' Compensation Appeals Board.

RISICO RECOMMENDATION

Risico recommends amending verbiage in section (d) to state, "Any dispute between the treating physician and the claims administrator regarding the removal of the physician under subdivisions (c) shall be resolved in accordance with §9767.3 (c)(5)."

RATIONALE

The MPN Applicant should maintain the exclusive right to determine the members of its Medical Provider Network (MPN). Delegating this authority to any other party will create confusion and friction among employers, providers, and other involved stakeholders.

§ 9792.10.1. Utilization Review Standards--Dispute Resolution – On or After January 1, 2013
DWC PROPOSED 11/2018

(a)(1) A request for independent medical review of a utilization review decision that denies or modifies a medical treatment request must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days of service of the written utilization review determination issued by the claims administrator under section 9792.9.5(e).

(2) If the utilization review decision only denies or modifies a medical treatment request for a drug listed on the MTUS Drug List, the request for independent medical review must be filed by the eligible party within 10 days of service of the written utilization review decision.

(b)~~(1)~~ A request for independent medical review must be ~~filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days of service of the written utilization review determination issued by the claims administrator under section 9792.9.1(e)(5). The request must be~~ made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision ~~delaying,~~ denying~~,~~ or modifying the request for authorization of medical treatment. At the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision ~~delaying,~~ denying~~,~~ or modifying the request for authorization of medical treatment, to the claims administrator.

RISICO RECOMENDATION

Risico recommends placing the same parameters / timeframes on requesting an independent medical review of utilization review decisions denying or modifying a medical treatment, drugs listed on the MTUS Drug List, and drugs not listed on the MTUS Drug List.

RATIONALE

Most requests for authorization will include a mix of requests for drugs and other items. Establishing varying parameters / timeframes for IMR requests for drugs and other treatment will create confusion in and potentially delay needed medical care to the injured worker.

§ 9792.10.2. Application for Independent Medical Review, DWC Form IMR
DWC PROPOSED 11/2018

[DWC Form IMR (Rev. 07/2018)]

Authority: Sections 133, 4603.5, 4610.5, and 5307.3, Labor Code.

Reference: Sections 4600, 4610, and 4610.5, Labor Code.

Section "Deadline for Filing IMR Application" (Page 2)

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 is 15 days from the mailing date of the determination letter. (See date above.) For all other disputes, the deadline is 35 days from the mailing date of the written determination letter. Both deadlines include additional days for mailing. However, under either deadline, add five (5) days if you live outside of California. Your deadline for filing this IMR Application is indicated in the checked box.

RISICO RECOMMENDATION

Risico recommends replacing verbiage "For all other disputes, the deadline is 35 days from the mailing date of the written determination letter." with the following, "For all other disputes, including disputes that involve drugs listed in MTUS Formulary Drug List as well as drugs not listed in the MTUS Formulary Drug List, the deadline is 35 days from the mailing date of the written determination letter."

RATIONALE

Disputes involving both drugs listed in the MTUS Formulary Drug List and drugs not listed in the MTUS Formulary List occur frequently. Modifying the verbiage to the recommended text adds clarity and provides guidance on this frequently occurring issue.

Section "INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM"

DWC PROPOSED 11/2018

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

RISICO RECOMMENDATION

Risico recommends removing "DELAY," from this section.

RATIONALE

The removal of "delay" will align with the word's removal from throughout the proposed 11/2018 regulations.

§ 9792.10.8. Independent Medical Review – Payment for Review
DWC PROPOSED 11/2018

(k)(1) A description of the system used to identify each request for authorization (if applicable). To the extent the system identifies any of the following information in an electronic format, the claims administrator or utilization review organization shall provide in an electronic format a list of each and every request for authorization received by~~at~~ the investigation subject~~site~~ during a three month calendar period specified by the Administrative Director, or his or her designee, and the following data elements: i) a unique identifying number for each request for authorization if one has been assigned; ii) the name of the injured worker; iii) the claim number used by the claims adjuster; iv) the initial date of receipt of the request for authorization; v) the type of review (expedited prospective, prospective, expedited concurrent, concurrent, retrospective, appeal); vi) the disposition (approve;~~,~~ deny;~~,~~ and if denial, whether the denial was based on medical necessity or was a result of delay; ~~delay,~~ modify;~~,~~ withdrawal); and, vii) if applicable, the type of person who withdrew the request (requesting physician, claims adjuster, injured employee or his or her attorney, or other person). In the event the claims administrator or

utilization review organization is not able to provide the list in an electronic format, the list shall be provided in such a form that the listed requests for authorization are sorted in the following order: by type of utilization review, type of disposition, and date of receipt of the initial request;

RISICO RECOMMENDATION

Risico recommends replacing the verbiage, "whether the denial was based on medical necessity or was a result of delay;" with the following verbiage, "whether the denial was due to insufficient information or if an exam, or recommended test was not completed;".

RATIONALE

The proposed regulations have eliminated the "delay" process. As a result, the proposed text in (k)(1) should be more specific and should align with the remainder of the proposed regulations (11/2018).

CONCLUSION

Risico recently celebrated 25-years of industry-leading services to private and public sector employers, Third-Party Administrators (TPAs), and Insurers throughout the state of California. Our distinct perspective at the intersection of employers, employees, providers, prescribers, and insurers offers valuable insight to support the ongoing improvement the effectiveness of California's workers' compensation system.

Risico's goal is to help support the ongoing development of an equitable workers' compensation system that will produce optimal health outcomes for injured workers and avoid excessive spending for employers in the State of California.

Jason Schmelzer, Legislative Advocate January 15, 2019
California Coalition on Workers' Compensation (CCWC)

The California Coalition on Workers' Compensation (CCWC) is an association of California's public and private sector employers that advocates for a balanced workers' compensation system that provides injured workers with fair benefits, while keeping costs low for employers. Our members include not only businesses of every size, but also cities, counties, schools and other public entities. Thank you for the opportunity to comment on the draft regulations through the DWC Forums.

Introduction

Sections 9871(d)(5) and 9792.6.1(u)(3).

Comment: As the state's workers' compensation system continues to move into electronic

reporting and communications, our organizations recognize many of the proposed regulations reflect existing traditional communications of hard copies. We urge the Department of Industrial Relations (DIR) and the Division of Workers' Compensation (DWC) to move as quickly as prudently possible to update these regulations to reflect electronic format communications such as email.

To accomplish this, our organizations recommend that when referencing email communications such as those contained in Sections 9781(d)(5) and 9792.6.1(u)(3) that the regulations specify "***email address if agreed to by the parties."***

Our suggested language to correct this problem is as follows:

Amend 9792.6.1(u)(3) to read: The request for authorization must be signed by the treating physician and may be mailed, faxed, or sent electronically through the use of a secure, encrypted ~~email~~ system to the address, fax number, ~~or~~ e-mail address, or other secure electronic interchange designated by the claims administrator ~~under section 9781(d)(5)~~ for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic or digital signature.

Comment: Section9785(e): There is no reference in Section 9785(e)regarding the mandatory electronic submission of form 5021, the Doctor's First Report., ~~there is no reference to how electronic transmission will occur~~.

Reason for Correction: The authorizing statute ***requires*** electronic transmission ~~is expected~~ to the DWC and payor under Labor Code (LC) 6409. This omission should be corrected to meet the statutory requirement on delivery of this mandated report.

There are several sections in the proposed regulation that require a uniform correction. The needed correction is to correct the term "*business day"* to "*working day."*

Comment: Over the last year, controversy has arisen in several unpublished/non-binding decisions, regarding the definition and application of "business day" versus "working day." These decisions have resulted in practical definition of working day to now include the day after Thanksgiving and more importantly each and every Saturday throughout the year. From a practical standpoint this misapplication of the law will shorten the timeframe of responding to a request for medical care by one day in almost all instances and noting that the time frame for a response is only five days this has caused significant work flow problems to all claims administrators and their URO's.

Labor Code 410(i)(1), as amended in 2012, clearly states that the time frame for the response to a request for authorization is five working days. The regulations that were enacted to implement this change to the statute incorrectly defined the time frame as being five business days in direct contradiction to the clear wording of the Labor Code.

Accordingly, we recommend the proposed regulations clearly define what is a "working day" versus an "business day" Additionally, it is needed to amend both the existing regulations and

proposed changes to reference the time frame to respond to a Request for Authorization as being "five working days."

For example, Section 9792.6.1(cc) currently reads as follows:
(cc) "Working day" means any day other than a Saturday, Sunday, January 1, the third Monday in January, the third Monday in February, March 31, the last Monday in May, July 4, the first Monday in September, November 11, Thanksgiving Day, the day after Thanksgiving, and December 25. ~~or a day declared by the Governor to be an official State holiday~~.
"Business day" shall not include January 1, the third Monday in January, the third Monday in February, March 31, the last Monday in May, July 4, the first Monday in September, November 11, Thanksgiving Day, the day after Thanksgiving, and December 25.

A careful review of the proposed and existing regulations illustrated the need to change all references of "five business days" to "five working days." This would include but not be limited to Sections:

- 9792.9.1 (3) (b) ... for the return of the request, no later than five (5) business days from receipt.
- 9792.9.2 (b) no later than five (5) business days from receipt of the request for authorization
- 9792.9.4 (b) (2) ... within two (2) business days for prospective review.
- 9792.9.5. (c) (2) ... within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request
- 9792.9.6
  (b)(1) ~~(2) (A)~~ If the circumstance under subdivision (a) ~~(f)~~(1)(A) applies, a reviewer or non- physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization.
  (2) ~~(B)~~ If any of the circumstances set forth in subdivisions (a) ~~(f)~~(1)(B) or (C) are deemed to apply following the receipt of a complete or accepted request for authorization ~~DWC Form RFA or accepted request for authorization~~, the physician reviewer shall within five (5) business days
  (d) (1) ... authorization within five (5) business days of receipt of the information in accordance
- 9792.27.13 (1) ... not to exceed five (5) business days from the
- 9792.9.8 (A) (2) (2) business days from the date of receipt of the request for authorization.

(B) If the information is not received within five (5) business days from the date of the request

● 9792.10.2 (5) (c) to subdivision (b) within five (5) business days following receipt of the request.

● 9792.10.5 (3) (c) to subdivision (b) within five (5) business days following receipt of the request.

Penalty Regulations

Comment: There is considerable inconsistency within the proposed regulations pertaining to penalties for Utilization Review (UR) plan changes regarding whether they are 'material' changes or non 'material'. We suggest that there should only be penalties applied to 'material' changes and 'material' needs to be defined within this regulation. If a change is 'immaterial' there should be no basis for a penalty. Please see attached highlighted references to the regulations.

Technical cleanup comment to amend proposed sections of the Utilization Review Standards:

● Section 9767.6(f). To be consistent with all sections, change *physical* address to *mailing* address.

Suggested language:

9767.6(f) The insurer or employer shall deliver to the initial primary treating MPN physician selected by the employee all relevant medical records relating to the claim, including the results of diagnostic and laboratory testing done in relation to the injured employee's treatment. The insurer or employer shall advise any subsequently selected MPN physician that any medical record or diagnostic and laboratory test result deemed relevant to that provider will be delivered upon request. The insurer or employer shall also advise all selected MPN physicians of the ~~name, telephone number, fax number, email address, and physical address of the individual to whom a request for authorization should be sent~~ fax number, mailing address, email address, and other secure electronic interchange designated by the claims administrator under section 9792.6.1(u)(3) to send a request for authorization.

● 9781(d)(5) Provide the physician or facility with the ~~name, telephone number, fax number, email address, and physical address of the individual to whom a request for authorization should be sent~~ fax number, mailing address, email address, and other

secure electronic interchange designated by the claims administrator under section 9792.6.1(u)(3) to send a request for authorization.

Additionally, regarding subsection (7) of this section: There is no need to require service. We recommend removing this requirement with streamlining process where possible by provide a reference to the link. We propose language to state that any physician agreeing to treat an individual under workers compensation is presumed to know the duties ascribed under CCR § 9785.

- 9785 (a)(5) "Released from care" definition; recommend change to "Discharged from care"

Reason: Throughout these proposed regulations, the words, "released" and "discharged" have been used interchangeably. This inconsistency is a longstanding flaw in the utilization review regulations and needs to be addressed. We recommend the phrase "discharged from care" be used to define the determination by the primary treating physician that the employee's condition has reached a permanent and stationary status with no need for continuing or future medical treatment.

- 9785.6 We suggest revised wording such as "Use of the PR-4 is mandatory 6 months after the effective date of the regulations."

- 9786 (b)(6) is the lone exception applicable for removal of the MPN physician.

- 9792.6.1 We support (a) and (d) revisions. (cc) working day includes business days as referenced herein. (n) and (0) We suggest simplifying the language.

- 9792.6.1 (s) – do referenced subsections of 9792.27.1(m) and 9792.27.15 exist?

Comment: Section §9792.6.1. This regulation is broadly written and would be helpful to provide a clear definition. We offer the following:

"Material modification" includes but is not limited to a change in the plan's operations or contracts impacting utilization review ~~is~~ such as when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7. Additionally, the definition of a "change in a plan's operations or contracts" is overly broad and is too vague for effective compliance and should be clarified in the proposed regulation. The definition must be specific on what operational change warrants a

material modification. Additions or deletions to UR plans occur frequently within a year and does not warrant a "Material Modification."

One illustration of the need for this change, consider the following: When an URO adds or subtracts a client from its UR Plan, we believe that should be excluded from a material modification process as long as it is within 30 days of the addition or deletion of a client from the UR Plan. All that should be required is a letter filed (electronically) with the DWC detailing the name, address of the changed client and the effective date of said change. This should eliminate the conflict between the 20 and 30 days of proposed §9792.7(c)(1). We be offer the following language to address

- 9792.6.1(u)(3) – It appears that the first line of the section has incorrectly removed "must be signed by the" from that sentence. This leaves that sentence to read "The request for authorization treating physician and may be mailed, faxed or sent electronically…" The phrase should be reinserted for clarity. We suggest the following language:

> The request for authorization must be signed by the treating physician and may be mailed, faxed, or sent electronically through the use of a secure, encrypted ~~email~~ system to the address, fax number, ~~or~~ e-mail address, or other secure electronic interchange designated by the claims administrator under section 9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic or digital signature.

- 9792.1 (a)(2)(A): instead of 5 business days it should read 5 working days to be consistent with statute and 9792.6.0(cc), above.(cc) "Working day" means any day other than a Saturday, Sunday, January 1, the third Monday in January, the third Monday in February, March 31, the last Monday in May, July 4, the first Monday in September, November 11, Thanksgiving Day, the day after Thanksgiving, and December 25. or a day declared by the Governor to be an official State holiday. "Business day" shall not include January 1, the third Monday in January, the third Monday in February, March 31, the last Monday in May, July 4, the first Monday in September, November 11, Thanksgiving Day, the day after Thanksgiving, and December 25.

- 9792.1 (b) – did not address whether a nurse can deny – however see 9792.9.5(a) – must be done by a physician reviewer.

- 9792.7(c)(1), line 10 – text is "notice of a to the DWC". We recommend the text be changed "notice to the DWC" which is grammatically correct.

- §9792.9.5. (f)(1)(G) does not set out any time limitation for the requesting provider to provide the information from a Request for more information (RFI) so that a

Reconsideration can be initiated. Instead we offer the following be considered for insertion:

- (G) A statement that the request for authorization of the treatment will be reconsidered upon receipt of the additional information, exam or test, or specialized consultation if the additional information, exam, or test is provided to utilization review within forty- five (45) days from the date of the denial pursuant to section 9792.9.5. Any information, exam, or test results submitted to utilization review after that date shall be in accord with section 9792.9.1.

- PR-1. We also recommend that the PR-1 have a clear place for the requesting physician to provide detail to why his/her request should be considered an expedited review (9792.6.1 (j))

- 9792.9.7 (b)(8) – the word "medical" in this sentence appears to be a misspelling. We suggest
the correct spelling in this context is "medial".

- 9792.9.8. (f) (1)
This section expands the text to include drugs that are anticipated. The text reads, "…all drugs that are being prescribed, dispensed or anticipated to be used to treat…" We do not see the need that administrators be authorizing medication that is "anticipated to be used? Therefore, we recommend the words, "or be anticipated to be used" be deleted from this section. This phrase is used twice in this section. Please note that the text of section (f) does not include "anticipated.

- 9792.10.1. We support the proposed regulatory language.

- 9792.10.1 (a)This section has been deleted in its entirety. We recommend this section remain. This section specified that the employer and injured worker (IW) would not be liable for payment for any treatment that was denied or modified, unless the UR decision was overturned by IMR or the WCAB.

9792.10.5 (a)(1) The text states the IMR must receive records "electronically" from the claims administrator. What is the definition of "electronically"? Does electronically include faxing, emailing? Or does this mean records from the administrator must be submitted via the Maximus portal? Should this state "electronically with agreement from both parties"?

- 9792.10.8 – subsections (a)(1)(B) and (a)(2)(B) reference subsections of 9792.27.1(m) and 9792.27.15. Do these exist in this regulatory package?

- **§ 9792.11. Investigation Procedures: Labor Code § 4610 Utilization Review Violations.** section (B) – two additional words should be deleted for the sentence to be grammatically correct. Recommend deletion of "and the" because there is only one subject in the sentence.

- 9792.12 This regulation needs language added to specify what is subject to audit

§ 9792.12. Administrative Penalty Schedule for Utilization Review and Independent Medical Review Violations. , section (e)(1)

The current text appears to allow for penalties for "any other act or failure" that might possibly be done wrong that isn't specifically identified in the penalty sections. We believe that this section and undefined. It is unreasonable for administrators be penalized $50,000 for a violation that is not clearly defined in the proposed regulations. This should be removed.

Proposed Forms

Expedited RFA

Our organizations recommend the addition of an abbreviated definition for the sake of clarity. We suggested adding language in small font *"**Imminent** & **serious** threat to life or health."*

DWC Form PR-1

General comment: The regulations and the PR1 form need to clearly state that the treatment modalities and medications that are to be considered by the claims administrator are limited to what is listed in the form itself. While a narrative report that might be appended to the form might expand on what is requested, any additional treatment modalities/ medications that are discussed in a narrative but not listed in the form are not subject to review by the claims administrator.

This language would both be part of the regulations and place in the form itself.

Change use of the phrase "Released from care" to "Discharged from care" on page one of the proposed PR-1. This change is needed in the first section of checkboxes at the top of the form, in the second column. The recommended change is already in place on pages 6 and 8 of the proposed PR-1 form.

Section A: Multiple problems:

- First, there is a l need to go back and address regulations requiring mandatory use of this section, even if report is in a Narrative format.
- Diagnosis, Diagnosis Code and Service are limited to one.

- Diagnosis: Current proposed language does not provide for the listing of all diagnosis related to the claim.

General Recommendations:

- This form needs to be expanded to allow for all requests for a single DOS to be covered in a single submission. We note that the average is 2.5-3 per RFA and up to 8-10 for a surgery. Form as written is limited and inadequate to meet the current average treatment requests.

- Need to allow for additional pages as needed

.

- Disability area should be 'check the box' Permanent Disability and Maximum Medical Improvement

Section A of the PR1: **Request for Authorization**

Comment: Our organization believes the format proposed will create difficulty for all. The average RFA currently contains 2-3 items. When a surgery is requested, the RFA may contain 8-10 items for review. The design of this form will cause the report to increase from the proposed eight pages to as many as 18, just to cover the recommended treatment. We also believe that while the existing format may not have covered all issues identified in the current format, that it was far more productive and conservative in paper production.

Proposed alternative:
We would recommend that the RFA format utilize the following, which will allow for multiple requests stemming from a single date of service:

Medical Treatments: ***Inclusion of the MTUS Citation is optional but encouraged.***

Diagnosis	**ICD-10 Code**	**Service Requested**	**CPT/HCPCS Code**	**Frequency Duration**	**MTUS Citation**

If not supported by MTUS, provide citation supporting treatment

Medications: ***Inclusion of the MTUS Citation is optional but encouraged.***

Diagnosis	ICD 10 Code	Drug	Dose	Strength & Form	Frequency	Quantity	Duration	MTUS Citation

If not MTUS supported substantiate need for below.

Page 4: Claims Administrator/Utilization Review Organization (URO) Response:
We do not believe that page 4 is needed or appropriate. In responding to the RFA the URO must meet certain criteria, including documentation of medical records and MTUS or other guidelines reviewed. This page does not help and would be duplicative of efforts already required. We recommend that it be removed.

Section B: Evaluation and Management Worksheet
We believe that the treatment plan section needs further revision. The focus should be on vocational functional improvement as in addition to ADLs. It is important that the treatment is focused on returning the employee to the pre-injury function and the return to work. It is important for the physician to identify those aspects of the employment that the employee is having difficulty performing in order to identify further treatment options to overcome those barriers. Studies clearly recognize that a return to work, reduces impairment, loss of income and provides for greater longevity.

Further, the treatment and outcome sections 3 and 4 should be reformatted to align the intervention with the outcome. We would like the providers to consider the expected outcome from the intervention and monitor the recovery. We believe that combining the treatment and outcome sections to tie the intervention with the outcome would save space and force an analysis of the treatment and the response. We again would prefer that the focus be on vocational function in addition to ADLs, since that should be the goal of recovery.

Our proposed recommended changes to the form are below:

Treatment Requested	**Functional Outcome Expected**	**Corresponding Vocational Function**	**Achieved**	**Not Achieved**	**Barrier to Achievement**	**Plan to Address Barrier**
PT x 6 sessions	Lift 25 pounds	Lift 25 pounds		X	Illness prevented participation in PT	Proceed with recommended PT given illness resolved

Section C: Work Status

Need to change initial language to read Employers may only receive *Section C*. Same for the next page.

We would prefer to see the claim number referenced on each page. This will work even if the RFA section is used in conjunction with the narrative report.

We recommend that this section include, within the heading, the following statement to clarify application of industrial work restrictions.

"Complete this section as it applies to the industrially related body part(s) Diagnoses: DWC Form UR-01 Application for Approval as Utilization Review Plan

- In section 1, the form is missing a response box for "Type of Entity Filing"
.
- In section 4, we recommend the addition of an option to identify "public sector internal utilization review organization" pursuant to Regulation 9792.7(a)(6)(B).

- Above the signatory area, we recommend the addition of the mandatory statement under penalty of perjury which certifies "the utilization review plan, as modified, continues to be in compliance with the rules governing utilization review at sections 9792.6.1 et seq" which is required pursuant to regulation 9792.7(c)(1). Presently, this requirement is met by attaching a separate written statement signed by the plan's medical director under penalty of perjury. It would be more efficient to provide a section in the UR-01 form for this purpose.

- In order to reduce unnecessary submissions for modifications, we suggest this form have an area for "initial" or "modification" at the top. It appears this form must be submitted for each new plan filed or when a material modification to the UR plan is made.

IMR Form

- On the IMR form: At the top of the form, there are two checkboxes for 1) Modification after Appeal and 2) Medication Only-MTUS Formulary Drug List. We would like to recommend adding a third checkbox for "Denial – Lack of Medical Information"

  This form is filled out and provided to the IW on every UR denial. It would be very clear to all parties that the denial was due to lack of medical information and not based on medical necessity. The IW can take the form to their doctor and ask why? Ones that the AAs submit to IMR could be clearly identified as ones needlessly submitted. It would also be more efficient for the DWC Medical Unit which has the responsibility to review and forward eligible IMR submissions to Maximus.

In conclusion, our organizations are pleased with many revisions to the proposed regulations and await the expected release of the formal rulemaking package on Utilization Review as announced for this past February 2018. We are available if there is any need for clarification on these comments.

Center for Legal Affairs
California Medical Association

On behalf of our more than 44,000 physician and medical student members, the California Medical Association (CMA) would like to thank you for the opportunity to provide comments on the Department of Industrial Relations, Division of Workers' Compensation (hereinafter, "the Division") proposed regulations concerning Medical Provider Network, Physician Reporting, Utilization Review, and Independent Medical Review, found in Title 8 of the California Code of Regulations. We appreciate the Division using these proposed regulations to address a number of important issues, particularly regarding the implementation of SB 1160 (chaptered in 2016). CMA supported SB 1160 to increase transparency and accountability within the workers' compensation utilization review (UR) process and better ensure timely access to care for injured workers in certain circumstances.

While we support the intent of these regulations, many of which will help accomplish the goals noted above, we write to articulate our concerns with provisions that we believe will create additional burdens on physicians and detract from the time they are able to spend focused on patient care.

§9785. Reporting Duties of the Primary Treating Physician

CMA is concerned with the proposed regulations requiring the use of the new "Treating Physician's Report" form (hereafter PR-1) or an equivalent narrative report, replacing the "Primary Treating Physician's Progress Report" form (hereafter PR-2). At eight pages in length, the PR-1 would be significantly more time-consuming for physicians to complete than the PR-2 is, and the proposed requirements for a narrative report would be equally labor-intensive. This will have the effect of increasing time spent reviewing records during patient visits as well as updating and completing paperwork after visits. The increased time spent to accommodate the requirements of the PR-1 form, which is not reimbursable, would unfortunately decrease the time clinicians are able to spend with their patients and reduce the overall quality and availability of care for injured workers.

CMA is further concerned with the level of detail required in the PR-1 form, some of which may create confusion depending on the circumstances of the patient. For instance, a question on medication appearing on Page 8 asks if the injured worker is prescribed medication that may affect their "ability to respond to an emergency." There are multiple issues to consider here – many medications "may affect alertness" and different providers may naturally interpret this clause differently. Additionally, most employees are not emergency first responders, and physicians currently using the PR-2 are cognizant of the unique circumstances of those who do have such job responsibilities.

Given the extent of the changes proposed in the draft regulations we would consider it advisable for the Division to convene a working group to discuss the proposed changes. Many of our physician members are engaged in the treatment of injured workers and navigating the workers'

compensation system in their practice, and we believe that considering their concerns in a working group setting would lead to the strengthening of these regulations.

§9785.6. DWC Form PR-1: "Treating Physician's Report" – Mandatory for Services On or After January 1, 2019

The heading of this section suggests that the use of the amended PR-1 Form will be mandatory for services on or after January 1, 2019. Given that the Division has not yet amended the form through the statutorily mandated rulemaking process, CMA urges the Division to clarify that the use of any amended PR-1 Form (or any other amended forms) will not be required until a minimum of 6 months after the effective date of any amended regulations. Allowing use of the existing PR-1 and PR-2 Forms for a period of at least 6 months following the final adoption of an amended form will provide an opportunity for the Division to inform and educate physicians and other providers of the change without causing delays in care to injured workers or unnecessary administrative burdens on those treating them.

Andrea Guzman, Claims Regulatory Director January 15, 2019
State Compensation Insurance Fund

State Compensation Insurance Fund appreciates the opportunity to provide input regarding the Division of Workers' Compensation's (DWC) proposed revisions to the Medical Provider Network, Physician Reporting, Utilization Review and Independent Medical Review. State Fund respectfully submits the following comments for your consideration.

State Fund highly recommends removing from the proposed regulations the use of a "narrative report" and request the DWC "Request for Authorization" be added back in until the PR-1 can be solely used as a "Request for Authorization". In addition, we request the diagnosis and ICD10 codes be required when submitting a PR-1, IMR, and DWC "Request for Authorization". Clarity of the treatment being requested would assist Utilization Review in completing a thorough review and provide a timely decision.

Recommended text changes are indicated by underscore for additional language and ~~strikeout~~ for deleted language.

§9767.6 Treatment and Change of Physicians Within MPN:

Recommendation

Text Changes

(d)(5) Provide the physician or facility with the company name, telephone number, fax number, email address (if agreed by all parties), and ~~physical~~ mailing address of where ~~the individual to whom~~ a request for authorization should be sent.

(f) The insurer or employer shall deliver to the initial primary treating MPN physician selected by the employee all relevant medical records relating to the claim, including the results of diagnostic and laboratory testing done in relation to the injured employee's treatment. The insurer or employer shall advise any subsequently selected MPN physician that any medical record or diagnostic and laboratory test result deemed relevant to that provider will be delivered upon request. The insurer or employer shall also advise all selected MPN physicians of the company name, telephone number, fax number, ~~email address, and physical address of the individual to whom a request for authorization should be sent~~ mailing address, email address(if agreed by all parties), and other secure electronic interchange designated by the claims administrator under section 9792.6.1(u)(3) to send a request for authorization.

(g) A Petition for Change of ~~Primary~~ Treating Physician, as set forth at section 9786, cannot be utilized to seek a change of physician for a covered employee who is treating with a physician within the MPN, except as allowed under subdivision (b)(6) of section 9786. If the employer petitions to change the ~~Primary~~ Treating Physician pursuant to Labor Code section 4603, the panel of physicians, including the chiropractor if requested by the employee, shall be from the current MPN provider listing and shall meet the applicable MPN Access Standards.

Discussion

State Fund requests clarity on the meaning of "individual" to ensure that the company designated to perform UR is disclosed and not the individual adjuster. Telephone number or email address not be required for submission of request for treatment, but continue to provide a company name, address and fax number. Identifying a specific person to receive treatment requests from a medical provider could be problematic. In addition, the deletions are recommended to maintain statutory consistency with LC4603, which does not limit the request to change physicians to "primary".

§9781 Employee's Request for Change of Physician:

Recommendation

Text Changes

(d)(5) Provide the physician or facility with the company name, telephone number, fax number, email address (if agreed by all parties), ~~physical~~ mailing address and other secure electronic interchange designated by the claims administrator under section 9792.6.1(u)(3) to send a request for authorization.

Discussion

State Fund recommends fax number, email address (if agreed by all parties), and physical address of the organization to provide an orderly process to insure Utilization Review timeframes are adhered to.

Recommendation

Text Changes

~~(d)(7) Provide the physician or facility with (1)~~ if available, to be used to request authorization of ~~treatment plans; (2) the complete requirements of section 9785; and (2)~~ (3) the required reporting ~~forms~~ under that section ~~set forth in sections 9785.2 and 9785.4. In lieu of providing the materials required in (1) and (2) and (3) immediately above,~~ In addition, ~~the claims administrator shall~~ may refer the physician or facility to the Division of Workers' ~~Compensation's website where the applicable information and forms can be found at http://www.dir.ca.gov/DWC/dwc_home_page.htm.~~

Discussion

State Fund believes there is no need to require service. We recommend removing this requirement with streamlining process where possible by providing a reference to the link. We propose language to state that any physician agreeing to treat an individual under workers compensation is presumed to know the duties ascribed under CCR § 9785.

§9785 Reporting Duties of the Primary Treating Physician:

Recommendation

(a)(5) "Released from care" means a determination by the primary treating physician that the employee's condition has reached a permanent and stationary status with no need for continuing or future medical treatment.

Discussion

Throughout these proposed regulations the words, "released" and "discharged" have been used interchangeably. This inconsistency has been a longstanding issue in the utilization review regulations and State Fund requests that it be addressed. We recommend the phrase "discharged from care" be used to define the determination by the primary treating physician that the employee's condition has reached a permanent and stationary status with no need for continuing or future medical treatment.

Recommendation

Text Changes

(e)(1) Within 5 working days following initial examination, the initial ~~a~~ primary treating physician, including physicians rendering first aid treatment as defined in Labor Code section 5401(a), shall submit a written report to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury or Illness," Form 5021, set forth in section 14006.1. Emergency and urgent care physicians shall also submit a Form 5021 to the claims administrator following the initial visit to the treatment facility.

Discussion

State Fund requests the deleted text in the regulations pertaining to the form 5021 entitled "Doctor's First Report of Occupational Injury or Illness," be added back in. The deleted text includes report content including treatment plan, duration, and frequency, service date specific use of ICD diagnostic codes (9 vs. 10) and the requirements for each new primary treating physician submission of the "Doctor's First Report of Occupational Injury or Illness" form 5021. All of these items will assist Utilization Review in providing a thorough review and timely

decision. In addition, the statute requiring electronic transmission to the DWC and payor under LC6409 is not address, so clarification is needed.

Recommendation

Text Changes

(g) (1) Prior to (SIX MONTHS AFTER EFFECTIVE DATE OF REGULATION), except for a response to a request for information made pursuant to subdivision (f)(7), reports required under subdivision (f) shall be submitted on the "Primary Treating Physician's Progress Report" form (Form PR-2) contained in section 9785.2.1; the "Treating Physician's Report" form (DWC Form PR-1) contained in section 9785.6; or on the current DWC Request for Authorization Form with ICD10 and diagnosis required ~~in the form of a narrative report. If a narrative report is used in lieu of a Form PR-2, it must be entitled, "Primary Treating Physician's Progress Report," or, if a narrative report is used in lieu of a Form PR-1, It must be entitled, "Treating Physician's Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2 or Form PR-1.~~ A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A Request for Information ~~A narrative report~~ and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3."

(g)(2) On or after (SIX MONTHS AFTER EFFECTIVE DATE OF REGULATION), except for a response to a request for information made pursuant to subdivision (f)(7), reports required under subdivision (f) shall be submitted on the "Treating Physician's Report" form (DWC Form PR-1) contained in Section 9785.6~~, or in the form of a narrative report. If a narrative report is used, it~~

~~must be entitled "Treating Physician's Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as the DWC Form PR-1.~~ A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A ~~narrative report and a~~ letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-1: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code §139.3."

Discussion

State Fund recommends the PR-1 and/or the current DWC Request for Authorization Form, with required ICD10 codes and diagnosis, to be used in lieu of the narrative report. This recommendation is based on the fact that request for authorization can be potentially missed due to the generalization of the proposed regulations. In addition, a response to a request for information must be submitted with the PR-1 where there is a check box that allows for identification of the information. The time frame of six months is not enough

time for large medical providers to update the form in their system. This short time frame will cause hardship for these providers.

§ 9785.6 DWC Form PR-1: "Treating Physician's Report" – Mandatory for Services On or After January 1, 2019:

Recommendation

State Fund recommends the ICD10 codes and diagnosis be required from physicians when completing the "Treating Physician's Report (DWC Form PR-1)".

Discussion

State Fund recommends that the PR-1 form be required to include ICD10 codes and diagnosis. The lack of ICD10 codes and diagnosis not provided by the requesting physician puts non-medical licensed Utilization Review in the position of determining diagnosis and ICD10 codes. In addition, State Fund recommends the PR-1 form allow for listing of all diagnosis related to a claim and expand space to allow for all requests for a single date of service to be covered in a single submission. The options to comment on Release from Care and Change in Work Status should be limited to the designated Primary Treating Physician. Otherwise, the potential for conflicting determinations as between treatment providers with increase disputes and litigation.

State Fund recommends adding an abbreviated definition to the "Expedited Request for Authorization" in order to eliminate inappropriate use of this form. Suggested language would be "Imminent threat to life or health".

§9786 Petition for Change of Primary Treating Physician:

Recommendation

(b)(6): State Fund recommends a provision of definitions and/or clarification for the following:

- Clearly shown by verified statement of facts, and, where appropriate, supportive documentary evidence.
- Pattern and practice of failing to render treatment consistent with the MTUS.
- Whether supportive documentary evidence is limited to specific claim petition being filed or can it be utilized from across all claims inventory.
- If claims administrator liability to pay revoked, and PTP may continue to treat until AD grants petition – may the PTP lien for treatment provided during the petition review time frame?

Discussion

State Fund recommends provision of definitions and/or clarifications on the above mentioned items to insure our full understanding of the intent of the new regulation, so it can be properly implemented.

§9792.6.1 Utilization Review Standards—Definitions – On or After January 1, 2013:
Recommendation

(n) "Material modification" includes but is not limited to a change in the plan's operations or contracts impacting utilization review such as when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7.

Discussion

State Fund recommends "change in plan's operations or contracts" should be specific on what operational change warrants a material modification. State Fund recommends that when an URO adds or subtracts a client from its UR Plan, should be excluded from a material modification process as long as it is within 30 days of the addition or deletion of a client from the UR Plan. All that should be required is a letter filed with the DWC detailing the name, address of the changed client and the effective date of said change. This should eliminate the conflict between the 20 and 30 days of proposed 9792.7(c)(1). Additions or deletions to UR plans occur frequently within a year and does not warrant a "Material Modification."

Recommendation

Text Changes

(cc) "Working day" means any day other than a Saturday, Sunday, January 1, the third Monday in January, the third Monday in February, March 31, the last Monday in May, July 4, the first Monday in September, November 11, Thanksgiving Day, the day after Thanksgiving, and December 25 or a day declared by the Governor to be an official State holiday. "Business day" shall not include January 1, the third Monday in January, the third Monday in February, March 31, the last Monday in May, July 4, the first Monday in September, November 11, Thanksgiving Day, the day after Thanksgiving, and December 25 or a day declared by the Governor to be an official State holiday.

Discussion

State Fund recommends adding the same clarification dates under "Working Day" as under "Business Day" to ensure there is a full understanding of the intent of the new regulation, so it can be properly implemented.

Recommendation

Text Changes

(u)(2) "Completed," for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization identifies both the employee and the requesting provider; identifies with specificity all the recommended treatments in the designated section for requests for authorization if a form is used~~, or, on the first page if a narrative report is used~~; and is accompanied by documentation, issued or created no later than 30 days before the date of the request for authorization, which substantiates the need for the requested treatment.

Discussion

State Fund recommends removing the purely narrative report. This would potentially flood Utilization Review queues with unnecessary documents and will require programming of optical software as well as relying on adjusters to catch "missed" requests for authorization.

Recommendation

Text Changes

(u)(3) The request for authorization must be signed by the treating physician and may be mailed, faxed, or sent electronically through the use of a secure, encrypted email system (if agreed by all parties) to the address, fax number, or e-mail address designated by the claims administrator under section 9781(d)(5) for this purpose.

Discussion

State Fund recommends indicating "signed by the treating physician" if it is mailed or faxed and if sent electronically by agreement of parties may be submitted with an electronic signature.

Recommendation

Text Changes

(aa) The utilization review process begins when a PR-1 or DWC Request for Authorization form accepted as complete under section 9792.9.1(b), is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

Discussion

State Fund recommends the PR-1 and/or the current DWC Request for Authorization form with required ICD10 codes and diagnosis to be used and the utilization review process to begin when the PR-1 has been received. This will assist in timely Utilization Review decisions.

§9792.7. Utilization Review Standards—Applicability:

Recommendation

Text Changes

(c)(1) Notice ~~of a~~ to the Division of Workers' Compensation of a material modification, as defined at section 9792.6.1(n), shall be made in writing twenty (20) calendar days prior to the implementation of the material modification.

Discussion

State Fund recommends the text be changed "notice to the DWC" which is grammatically correct.

§9792.9.1 Utilization Review Receipt of Request for Authorization; Acceptance of Incomplete Request:

Recommendation

Text Changes

(a) For purposes of this section, ~~a request for authorization~~ the DWC Form RFA shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail, if available, on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or the claims administrator's utilization review organization. ~~A request for authorization~~ T~~t~~he DWC Form RFA transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review. The copy of the ~~request for authorization~~ DWC Form RFA or the cover sheet accompanying the form transmitted by a facsimile transmission or electronic mail, shall bear a notation of the date, time and place of transmission and the facsimile telephone number or the electronic mail address to which the form was transmitted or the form shall be accompanied by an unsigned copy of the affidavit or certificate of transmission, or by a fax or electronic mail transmission report, which shall display the facsimile telephone number to which the form was transmitted. The requesting physician must indicate if there is the need for an expedited review on the ~~request for authorization~~ DWC Form RFA

Discussion

State Fund recommends the definition "Request for Authorization" be better defined on what is allowed/identified as a Request for Authorization, so it can be clear on the requirement and be uniform with the industry.

§9792.9.3 Utilization Review — Timeframes:

Recommendation

Text Changes

(a)The first business day in counting any timeframe requirement is the day after the receipt of the request for authorization, except when the timeline is measured in hours.

Discussion

State Fund recommends inserting the word "business" to better define the beginning of the timeframe to ensure timely Utilization Review decisions.

Recommendation

Text Changes

(b) Prospective or concurrent decisions to approve, modify, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed request for authorization and receipt of the written information reasonably necessary to make the determination.

Discussion

State Fund recommends adding "the need to receive written information reasonably necessary to make the determination" language back in the regulations in order to clearly define medical necessity for treatment and assist Utilization Review in providing timely decisions.

Recommendation

Text Changes

(d) Retrospective decisions to approve, modify, or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination.

Discussion

State Fund recommends that this section include the section that was stricken. If retro requests are not required to submit a request of authorization of any kind, Utilization Review could potentially miss the request and provide a way around for providers that are currently submitting "old" retro requests [UDS from July…] that will be required to submit them within 30 days if regulations are promulgated.

§9792.9.5 Utilization Review — Decisions to Modify or Deny a Request for Authorization Based on Medical Necessity:

Recommendation

Text Changes

(d) For retrospective review, a written decision to deny part or all of the requested medical treatment based on medical necessity shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of a PR-1 and medical information that is reasonably necessary to make a determination.

Discussion

State Fund recommends a PR-1 and medical information that is reasonably necessary to assist in a thorough review and timely Utilization Review decisions.

Recommendation

(f)(1)(G) A statement that the request for authorization of the treatment will be reconsidered upon receipt of the additional information, exam or test, or specialized consultation as long as the additional information, exam, or test is provided to utilization review within forty-five (45) days from the date of the denial pursuant to section 9792.9.5. Any information, exam, or test results submitted to utilization review after that date shall be in accord with section 9792.9.1.

Discussion

State Fund recommends the PR-1 have a clear place for the requesting physician to provide detail to why his/her request should be considered an expedited review (9792.6.1 (j))

§9792.9.6 Utilization Review — Extension of Timeframe for Decision:

Recommendation

Text Changes

(a)(2) If any of the circumstances set forth in subdivisions (a)(1)(B) or (C) are deemed to apply following the receipt of a complete PR-1 or ~~accepted request for authorization~~ DWC Form RFA ~~or accepted request for authorization~~,

Discussion

State Fund recommends a PR-1 or DWC Form RFA that is reasonably necessary to assist in a thorough review and timely Utilization Review decisions.

§9792.9.7 Utilization Review – Medical Treatment – Within/Beyond the First 30 Days of the Date of Injury:

Recommendation

Text Changes

(a)(4) The ~~form~~ PR-1 in accordance with section 9785.6 shall be submitted to the claims administrator concurrent with the Doctor's First Report of Occupational Injury or Illness. Subsequent treating physicians during the 30-day period shall submit a request for authorization following their first visit with the injured worker indicating all treatment being rendered.

Discussion

State Fund recommends the PR-1, with required ICD10 codes and diagnosis, be submitted with the Doctor's First Report of Occupational Injury or Illness to ensure all treatment is thoroughly addressed and a timely Utilization Review decision can be made.

Recommendation

Text Changes

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

Discussion

State Fund recommends removing medical and inserting medial as it seems this was a typographical error.

On behalf of the California Applicants' Attorneys Association ("CAAA") please find the following comments regarding the proposal for revisions to the Medical Provider Network, Physician Reporting, Utilization Review and Independent Medical Review regulations currently posted on the DWC Forum for public comments.

At page one of the proposed changes, Section 9767.6 (f) states that the defendant is to deliver to the initial primary treating physician selected by the employee all relevant medical records relating to the claim. But who decides what is relevant? The claims examiner? Furthermore, there is no required timeframe within which to deliver the medical file to the initial primary treating physician.

Section 9767.6 (f) goes on to say that if there is a subsequently selected MPN physician, that they are to be advised that if they request any medical records deemed relevant to the provider they will be sent. However, again there is no timeframe.

A basic tenet of contracts law is that a contract that does not specify the time of performance is essentially useless. Therefore, the proposed language in Section 9767.6 (f) is essentially useless because there is no timeframe within which the records are to be provided.

Section 9767.6 (f) should be modified to indicate that the defendants have 10 days to deliver the complete medical file (the claims examiner should not be deciding what is relevant and what is not) to the primary treating physician or any subsequent treating physician. This 10 day service requirement would be consistent with regulation Section 10608. Service of medical records should be done automatically without the need for any requests: What doctor is going to treat a patient without the records?

Proposed new language for Section 9767.6 (f) to address the above is as follows:

"The insurer or employer shall deliver to the initial primary treating MPN physician selected by the employee, or any subsequently selected primary treating MPN physician, all medical records relating to the claim…within 10 days of receiving notice of the selected treating physician. The insurer or employer shall serve a itemized list of documents and medical records provided to the MPN physician on the injured worker, or on the injured workers' attorney if represented. "

Furthermore, Section 9767.6 (f) does not address the situation where the MPN physician selected by the worker indicates they will not decide whether to take the case until they receive a copy of the medical file. This section also needs to be amended to state that if applicant requests it, the complete medical file will be sent within 10 days to the proposed primary treating physician so that he or she can determine whether he or she will treat the patient.

A similar problem arises at page 4 of the proposed regulatory changes. This relates to Section 9781 (d). The rule states that where a treating physician is designated, the claims administrator shall authorize treatment, furnish the name and contact information regarding where bills are to be sent and deliver relevant medical records. Pay careful attention to subsection (d) (3). It only

applies to the initially selected physician and only requires production of relevant medical records. Again, how is the adjuster to know what is relevant, and what if there is a second selected physician? The proposal tries to cover this in subsection (d) (4) by saying the subsequently selected physician will be advised that the records deemed relevant to the provider can be delivered upon request. That is just not adequate. The authorization under Section 9781 (d) (1) should be required to be in writing and the service of all medical records be automatic on both the primary treating physician and any subsequently selected treating physician.

Proposed new language for Section 9781(d)(3) to address the above is as follows:

"Deliver to the initially selected physician, facility, or personal chiropractor or acupuncturist, or physician, facility, personal chiropractor or acupuncturist subsequently selected by the employee, all medical records relating to the claim…within 10 days of receipt of notice of the selected physician, facility, personal chiropractor or acupuncturist."

The changes on page 6 to Section 9785 (b) (3) are also of concern. These changes address the situation where the employee disputes a UR determination to "delay" care. The word "delay" has been struck from the section meaning that if a determination is made to delay treatment, the section does not apply. In other words, such a dispute may not be resolved by IMR nor under Labor Code Section 4062. It is not clear how a delay in authorizing medical treatment would be resolved, if at all. Perhaps the delay in this situation is where the UR reviewer asks for more information extending the time line to 14 days to authorize or deny the treatment, and if that is the case that should be clarified.

On page 16, Section 9792.6.1(u)(2) contains proposed changes to the definition of "Completed" for purposes of an RFA submission. The proposed language states that the RFA must be "accompanied by documentation, issued or created no later than 30 days before the date of the request for authorization, which substantiates the need for the requested treatment." Does this mean that in addition to the current (within 30 days of the RFA) report, the doctor cannot attach older reports which may document the medical necessity of the requested treatment? If yes then "issued or created no later than 30 days before the date of the request for authorization" must be stricken.

There appears to be a grammatical error at page 16 in the proposed change to Section 9792.6.1 (u) (3) in the first sentence. The stricken language "~~must be signed by the"~~ does seem necessary to bring meaning to this sentence so it should stay in.

The proposed changes to Section 9792.6.1 (y) again strike the word "delay". As set forth in our comments to Section 9785 (b) (3) does this mean that a UR decision to delay treatment is not subject to IMR, or to any review? This needs to be clarified wherever the word "delay" is stricken in the proposed revisions to the regulations (also in Section 9792.7 (b) (1) and (2) and Section 9792.9.5 (a) and (c)).

On page 17, subsection (cc) defines working day to exclude Saturdays. However, UR determinations are frequently served on Saturdays. Pursuant to the Labor Code, Saturday constitutes a business day and in the recent panel decision of California Dept. of Corrections and

Rehabilitation Parole and Community Services v. WCAB (GOMEZ), Saturday is construed as a business day consistent with the Labor Code. Therefore this language should be stricken "~~Working day" means any day other than a Saturday, Sunday, or a day declared by the Governor to be an official State holiday.~~

At page 18, the proposed amendment to Section 9792.7 (a) adds the term "medically necessary". In other words, the revision tries to define that the UR process is for "medically necessary" treatment. But this is not the legal standard. The legal standard is "to cure or relieve" so "medically necessary" should be stricken.

The proposed changes to Section 9792.7 (e) at page 20 also appear very problematic. The proposal allows a deficient UR program to continue with "conditional approval" for six months, and then to continue for another six months after that. This would essentially allow an invalid UR program to operate without any penalty and decide what treatment injured workers get for a year (and possibly more as there are no enforcement provisions). This seems awfully indulgent of the insurance industry and prejudicial to injured workers.

The proposed changes to Section 9792.9.7 (a) (1) on page 34 address treatment within the first 30 days without prospective UR. The changes provide that where treatment or services are for a body part or a condition that has been accepted as compensable, treatment should be provided within the first 30 days after the date of injury without prospective UR under certain circumstances. This section then contains a list of conditions limiting the requirement to pay for treatment in the first 30 days without UR. However, in most cases nothing is "accepted" in the first 30 days after a claim is filed. Thus subsection (a) (1) should be amended to refer to any body part alleged that has not yet been denied, rather than referring only to "accepted" body parts., as follows: <u>" The treatment or service is for a body part or condition that has been accepted as compensable by the claims administrator, or for any alleged body part or condition that has not yet been denied."</u>

Finally, as a general suggestion if the administration wants to improve the system and make it work, they should require that the RFA and any attached documentation or narrative report must be served on the injured worker, and if represented upon his/her attorney no later than the time the UR denial is served. If the claims administrator or the UR organization fails to serve the RFA and attached documentation the UR denial should then be considered invalid. We all have many cases where we have a UR denial, but we have not received any medical treatment records for the last three months and we do not even have the RFA. *The UR companies should already have the treatment report and RFA and could easily program their systems to send the PR-2, RFA, and UR denial together to the injured worker, attorney, and claims administrator.*

Catherine Montgomery, Founder January 15, 2019
Daisy Bill

Since 1/1/2014 DaisyBill clients have sent over 4 million California workers' comp bills and over

200,000 RFAs using DaisyBill software. Currently, over 4,000 workers' comp professionals actively use DaisyBill to manage their bills and RFAs for over 2,500 providers.

From our extensive experience, we know providers struggle to gather the appropriate information required to manage an injury. The provider makes multiple phone calls to collect the appropriate information which is usually verbally provided by the claims administrator. Often the provider learns the information is "incorrect" or invalid. For example, currently there is no document which officially identifies the name of the PTP. Our providers often mistakenly believe they are the PTP only to subsequently learn that is not the belief of the claims administrator.

Given the amount of information required in the proposed PR-1, claims administrator should be required to send all PTPs a standardized form with the standardized information noted below.

Additionally, the PTP could share this form with secondary physicians, as there is a significant problem with secondary physicians not knowing the correct PTP information, claims administrator, RFA or billing information.

While the claims administrators may balk at the additional paperwork, this standardized information would eliminate the tremendous churn DaisyBill witnesses every single day due to providers not having easy access to this information. All of the information noted below should be standard; the only specific information required is the Injury and PTP information.

1. Injury
    - Injured worker name
    - Injured worker social security number (Bill required information)
    - Start date of injury
    - Claim number
2. Primary Treating Physician
    - Name:
    - Address
    - Telephone
    - Fax number
    - Email
    - Specialty
    - PTP effective date
3. Claims Administrator (PR-1 Form required information)
    - Address
    - Contact Name
    - E-mail
    - Telephone
    - Fax number
4. Employer MPN
    - MPN Name

- Weblink to MPN

5. Request for Authorization
   - Telephone number to request verbal authorization
   - Fax number to fax RFA form (PR-1 Form Section B)
   - If applicable, provide the physician or facility with a list of medical treatment services that can be rendered without the submission of a request for authorization.
6. Reports
   - PR-1 Form
     - Send with bill?
       - Yes
       - No
         - Mail Address
         - Fax
         - Other means
   - Secondary reports
     - Send to PTP
       - Mail Address
       - Fax
7. Billing Information
   - Non-electronic bills
     - Address to send non-electronic bills
   - Electronic bills
     - Clearinghouse and Payer ID

Article 5. Predesignation of Personal Physician; Request for Change of Physician; Reporting Duties of the Primary Treating Physician; Petition for Change of Primary Treating Physician

§9781. Employee's Request for Change of Physician.

(d)(2) F~~f~~urnish the name and ~~address~~ contact information of the person or entity to whom billing for treatment should be sent.;

~~(4)~~ (5) P~~p~~rovide the physician or facility with ~~(1)~~ the name, telephone number, fax number, email address, and physical address of the individual to whom a request for authorization shou~~l~~d be sent.;

(6) If applicable, provide the physician or facility with a list of medical treatment services that can be rendered without the submission of a request for authorization.

NOTE: *See the comment above regarding a standardized form with required information sent to PTP.*

§9785. Reporting Duties of the Primary Treating Physician.

(c) The primary treating physician, or a physician designated by the primary treating physician, shall make reports to the claims administrator as required in this section. A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. A claims administrator may designate any person or entity to be the recipient of its copy of the required report.

NOTE: *The DWC Medical Billing and Payment Guide (MBPG) contradicts §9785(c). The MBPG requires a Complete Bill to include "all required reports and supporting documentation."*

Sending the required reports constitutes the PTP fulfilling the requirement of sending "one copy of a required report to the claims administrator."

~~(3)~~ (c)(2) Secondary physicians, physical therapists, and other health care providers to whom the employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.

NOTE: *The requirement for the secondary providers to report to the PTP relieves the secondary providers from sending the reports to the claims administrator directly or sending a report with the bill.*

Currently, the MBPG requires that a "narrative report must be submitted when the bill is for Evaluation and Management services for a consultation."

1. *Consultation codes were eliminated.*
2. *There are no instances when the secondary provider is required to send a report with the bill for services.*

~~(4)~~ (c)(3) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall, unless good cause is shown, within 20 days of receipt of each report incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator.

NOTE:

1. *To submit the secondary providers' reports, does the PTP use the proposed PR-1 form?*
   a. *The proposed PR-1 form does not include secondary provider reports as an "applicable box." Should the PTP use "Other"*
2. *Is the PTP reimbursed for obtaining, incorporating or commenting and sending the secondary provider reports? If yes, how should the provider bill for these services?*

(f) A primary treating physician shall, unless good cause is shown, within 20 days report to the claims administrator when any one or more of the following occurs:

(2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a ~~new~~ need for referral to a secondary physician for treatment or consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices;

NOTE: *In (f)(2) the reasons listed in (A)-(E) are examples of additional treatments which require authorization. Accordingly, it appears (f)(2) conflates "change in treatment plan" with "Request for Authorization"*

1. *How is the PTP reimbursed for reporting "significant change?"*

(f)(7) The claims administrator reasonably requests appropriate additional information that is necessary to administer the claim. "Necessary" information is that which directly affects the provision of compensation benefits as defined in Labor Code Section 3207.

NOTE: *Claims administrators frequently request additional information. While the PR-1 provides an applicable box "Response to Request for Information," there is no mechanism in place for payment to providers for this service.*

(g)(2) On or after (SIX MONTHS AFTER EFFECTIVE DATE OF REGULATION), except for a response to a request for information made pursuant to subdivision (f)(7), reports required under subdivision (f) shall be submitted on the "Treating Physician's Report" form (DWC Form PR-1) contained in Section 9785.6, or in the form of a narrative report. If a narrative report is used, it must be entitled "Treating Physician's Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as the DWC Form PR-1. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-1: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code §139.3."

NOTES: *The PR-1 form is an excellent idea which will allow the DWC to collect more robust data on injuries, RFAs, treatment, work status.*

DaisyBill's data shows that currently, E/M downcoding is a systemic problem faced by all providers. DaisyBill believes providers can be incentivized to complete the PR-1 form if they were guaranteed a certain level of evaluation and management payment, such as level 99215.

We have many comments regarding the current state of the PR-1 draft form. Below we will highlight a few of these comments. For additional comments please contact us.

1. In the current iteration, it would be very difficult for a provider to complete this form and subsequently pull the PR-1 apart to disseminate sections to the correct recipients:
    a. Billing
    b. Utilization Review - Request for Authorization
    c. Employer - Work Status
2. The order of the first page should be reconsidered. Consider dividing the form as follows:
    a. Patient Demographics
        i. Injured Worker Name
        ii. DOB
    b. Physician Information
    c. Injury Information
        i. Employer
        ii. Injury Start Date
        iii. Claim Number
    d. Claims Administrator
        i. Name
        ii. Address
        iii. Contact Name
        iv. Claim Number
3. Vague and incorrect instructions
    a. When disseminating to the recipients, is the first page sent along with the appropriate section?
    b. Section A
        i. When sending Section A to utilization review, are other sections also sent?
        ii. This section references "the specific page number(s) of the attached medical report on which the requested treatment can be found." Is the provider expected to complete the PR-1 Section B and also attach a

separate medical report?

iii. Space is provided for only one medical treatment and one drug with instructions to "List additional requests on a separate sheet if the space below is insufficient." DaisyBill data indicates that most RFAs include multiple services and/or drugs. Instructions are needed clarifying for the format of the separate sheet.

iv. The surgical instructions are unclear, "For surgery requests, include full surgery orders (pre and post-op, if known)."

1. If surgery is considered to be different from Service/Good Requested, add a separate section: Request for Surgical Treatment.
2. Definition of "surgery" needed: HCPCS 10004-69990.
3. How is a "surgery order" different from a "medical report?" Is the information captured in the PR-1 Section B insufficient for requesting surgery?

v. Rendering Provider Name for requested services

c. Claims Administrator/Utilization Review Organization (URO) Response

i. Provide check boxes for the Decision types

1. Liability Disputed
2. Incomplete
3. Approved
4. Denied
5. Modified
6. Returned
    a. Requested Rendering Provider is not in MPN

Mark Sektnan January 15, 2019
American Property Casualty Insurers Association (APCI)

The following comments are offered by the American Property Casualty Insurers Association.

DWC Form RFA

The proposed regulations eliminate the requirement that a request for authorization be submitted on DWC Form RFA. We would encourage the Division to retain the form requirement. The DWC Form RFA is easy for mailroom employees to identify and forward to utilization review. A narrative report will be difficult for mailroom employees to identify as a request for authorization and is more likely to be misrouted, resulting in delays that will make it difficult to meet utilization review deadlines.

As between the DWC Form RFA and the proposed DWC Form PR-1, we prefer to the RFA. It is only one page, and it is easy to see at a glance what is being requested. The check boxes at the top (New Request, Expedited Review, Confirmation of Oral Request, and Resubmission) are useful and do not appear on the PR-1.

§ 9792.7(a)(6)

We would encourage the Division to allow either URAC Independent Review Organization Accreditation or URAC Workers Compensation Utilization Management Accreditation. The accreditation standards are similar, and allowing only one accreditation standard restricts the number of accredited review organizations available in the marketplace.

§ 9792.9.3(d)

We recommend clarifying that retrospective review is required only for emergency medical treatment or when utilization review is delayed pursuant to LC § 4610(*l*) and it is finally determined the employer is liable for treatment of the condition for which treatment is recommended.

§ 9792.9.6(a)(1)

Subdivisions (B) and (C) should be deleted because they are based on language that was deleted from LC § 4610 effective January 1, 2018, by SB 1160 § 4.5. *Compare* former LC § 4610(g)(5) *with* current LC § 4610(j)(2)

Ron Crowell, MD
President, COMP

January 15, 2019

California Occupational Medicine Physicians (COMP) appreciates the opportunity to provide comments on the proposed changes to the utilization review regulations and forms.

COMP is comprised of more than 100 occupational clinics throughout California. Our clinics treat over 150,000 injured workers each year. We focus on delivering end to end care that ensures the injured worker receives immediate and thorough treatment that will allow them to return to work as quickly as possible.

While we appreciate the Division's desire to improve the Workers' Compensation system we do have a number of concerns with the proposed PR-1 Form and regulations which are detailed below.

- The proposed draft regulations to require either the use of the newly drafted eight-page PR-1 report or a narrative report with the same information required in the PR-1 report is extremely worrisome to our members. At a time when CMS is proposing significant documentation changes that will reduce the administration burden on the clinician to allow them to focus more on patient care this proposal seems a step in the opposite direction. Additionally, we are not aware of any state that uses such a long form and we are unclear on what benefit this length of form will provide.
- Currently, regulations allow for the use of the two-page PR-2 report or a narrative report. These forms allow for an efficient means to communicate with claims administrators when there has been a change in the injured worker's medical treatment or status.

  The new eight-page form, whether it is on the state form or incorporated into a narrative format, will increase the medical record data and the time spent completing and in reviewing medical records during each patient visit. This will predictably decrease the face to face time that the clinician spends with his or her patient, which can lead to a reduction in the overall quality of care. This increased time spent related to the new PR-1 form, which is not reimbursable, would be particularly harmful to our occupational clinics which are high volume locations, without clear rational to the added benefit of the increased data.
- The use of the new PR-1 report appears to be replacing both the PR-2 and RFA forms. Given the RFA form and the PR-2 form used for two different purposes we are concerned claims administrators will be confused as a result of having to direct these forms to two different audiences (adjustors versus UR agents).

- In Section A of the PR-1 form, we are concerned that specifically asking the clinician to check either "yes" or "no" as to "whether the treatment is consistent with MTUS", may as a consequence lead to greater denials of treatment and lead to a greater number of peer-to-peer reviews. It is the function and responsibility of the utilization reviewer to authorize treatment based on MTUS criteria that has been detailed in the treatment plan. A simple yes or no answer doesn't provide proof of whether MTUS recommendations are being followed, and this could potentially be used incorrectly as evidence for treatment denial or authorization in the future.

- In Section C of the PR-1 form, the question on page eight asking how a medication MAY effect alertness or the ability to respond to an emergency is nebulous and clinically over-reaching. Most occupations do not require the employee to be first responders or require them as part of their usual and customary duty to respond to emergencies. In these unique situations, it is the responsibility of the clinician to provide how a given medication may negatively affect the patient, especially if they operate heavy machinery or are first responders in emergencies. However, requiring clinicians to answer this yes or no

question in every case again places an additional administrative burden that is clinically unnecessary and could negatively affect the employee and the employer. For instance, many medications "could" and "may" effect alertness.

The vast number of possible reactions to a given medication and the responses to this generic question will greatly vary from clinician to clinician. What will the employer do with this information if the Physician answers yes? It leaves an uncertain situation where injured workers likely will be unnecessarily removed from work or lead to greater documentation requirements when it is in fact unnecessary.

With our occupational clinics being focused on treating injured workers we are in a unique position to provide constructive feedback on making improvements to the Workers' Compensation system. Given the extent of the changes proposed in the draft regulations we recommend the Division create a working group of stakeholders to discuss the proposed changes. We believe this type of working group would help the Division hear in more detail the concerns we have raised along with getting feedback from other stakeholders leading to a stronger set of regulations.

Absent this working group we believe the net effect of this new PR-1 form and the regulations as currently drafted will result in increased costs to the Workers' Compensation system. These increased costs will be a step backward in providing high quality efficient care to injured workers.

Brian Allen,Vice President, Governmental Affairs Mitchell — January 15, 2019

We appreciate the opportunity to provide comments on the proposed rules. Mitchell International is a leading provider of managed medical care, managed pharmacy care, utilization review, bill review and independent medical review (along with other services) in workers' compensation systems across the country. Our comments are influenced by our vast experience working with California and other states in providing managed medical and pharmacy care and utilization review services. Thank you for your consideration of our comments.

<u>Article 5.5.1 Utilization Review Standards</u>

- Overall
  - Request that DWC maintain use of the term "reviewer" throughout the regulation. It is not clear why "physician" was added before the term "reviewer" to certain portions of the rule. Additionally, the term "non-physician" reviewer is not defined.

Recommend defining term.
- Request that DWC consistently use the words "accepted as complete" throughout the rule and replace uses of "accepted request" with "accepted as complete request".

- §9792.6.1 – Utilization Review Standards - Definitions – On or After January 1, 2013
  - (a) "Authorization": The proposed regulations remove language indicating approval of a request "… 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." It is understood that DWC has proposed removing all references to the "Request for Authorization," DWC Form RFA, but would request clarification for the purpose of removing the language regarding providing an approval utilizing a form. Does removal mean that approvals may not be provided utilizing a form initially submitted by the treating physician?
  - (e) "Delay": Mitchell supports removal of the definition of delay and use of the term throughout the utilization review regulations. However, please note that the termappears to have been meant to be deleted, but maintained in §9792.11(k)(1)(vi). Recommend that DWC brings this portion of the proposed rule into alignment with the rest of the regulations and delete "delay" after "…or was a result of…".
  - (u) "Request for Authorization": It is not clear what form the Provider may use when requesting treatment referenced within this definition. Recommend the following changes to the language to reference the PR-1 Form, Section A. Request for Authorization in proposed (u)(2) to clarify that the form they may use (added language is double underlined and removed is struck through): (2) "Completed," for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization identifies both the employee and the requesting provider; identifies with specificity all the recommended treatments in DWC Form PR-1: Treating Physician's Report utilizing the Section A. Request for Authorization ~~designated section for requests for authorization~~ if a form is used, or, on the first page if a narrative report is used; ~~identify with specificity a recommended treatment or treatments,~~ and is accompanied by documentation, issued or created no later than 30 days before the date of the request for authorization, which substantiates ~~substantiating~~ the need for the requested treatment. A request for authorization may be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.1(f).
    - (cc) "Working Day": Move definition of "business day" from definition for "working day" to avoid confusion with definition of "working day." "Business day" shall not include January 1, the third Monday in January, the third Monday in February, March 31, the last Monday in May, July 4, the first Monday in September, November 11, Thanksgiving Day, the day after Thanksgiving, and December 25. In addition, it does not include Saturday, Sunday, any Monday following any Sunday on which January 1st, February 12th, July 4th, September 9th, November 11th, or December 25th falls. Any Friday preceding any Saturday on which July 4th, September 9th, or December 25th falls.
    - Add a definition for "plain language" as used in proposed §9792.5. (e)(7) and (f) (1)(D)

- §9792.7 – Utilization Review Standards – Applicability
  - (c)(1): This subsection states that changes to DWC Form UR-01, Application For Approval as a UR Plan would have to be filed within 30 calendar days after a change is made. Any material modifications (as defined in §9792.6.1(n)) would have to be filed in writing 20 calendar days prior to implementation. Request that DWC confirm that this section means that any change that is not a change to the form would need to be filed with DWC 20 calendar days before it is implemented.
  - (d) and (e): These subsections outline DWC review and approval of plans. Request that DWC clarify or define what a "complete plan" is.

- §9792.9.5 – Utilization Review – Decisions to Modify or Deny a Request for Authorization
  - (e)(4): Request that DWC clarify if the changes to this portion of the rule require UR notifications that deny or modify a request to mirror what is set forth in the request for authorization (i.e. section of the form or page 1 of the narrative).
  - (e)(7): Request that DWC remove the following language: "<u>If the reason for the denial or modification is based on the requesting physician's failure to render a specific treatment identified in the applicable treatment guideline as a prerequisite to the requested treatment, the reviewing physician shall explain why the prerequisite treatment is appropriate for the employee.</u>" It is not appropriate to require the reviewer to state why treatment not requested is appropriate when it has not already been provided. A requesting provider should explain why their request is an exception to the guidelines. There is concern that requiring a reviewer to include these statements could be construed as making a treatment recommendation without seeing the patient
  - (f)(1)(A), (B) and (C): Request that DWC align this language with language in corresponding sections in (e)(1), (2) and (4).

- <u>§9792.9.8. Utilization Review — MTUS Drug Formulary</u>
  - (b)(1) and (2): There appears to be a time frame conflict in the requirements of these two sections. Subsection (b)(1) requires a decision on a non-exempt formulary drug within 5 business days. However, subsection (b)(2) requires a request for information within 2 business days and then instructs the reviewer to make a decision to deny the request for failure to respond to a request for authorization within 5 business days of requesting the information if it is not received (i.e. 7 business days).
  - (f)(2): These provisions conflict with the language in 9792.27.8 of the MTUS Drug Formulary that currently limits physician dispensing to a 7 day supply for an exempt drug if it is dispensed in the first 7 days following an injury. We recommend that this paragraph read: <u>(2) The treating physician may prescribe or dispense a drug under subdivision (a) of this section without the need to obtain prior authorization through prospective utilization review subject to the limitations in 9792.27.8 of the MTUS Drug Formulary.</u>
  - (f)(4)(A): We recommend removal of this provision. Requiring payment for medications prescribed that do not conform to the treatment guidelines runs contrary to the purposes of the guidelines – which are to ensure injured workers obtain necessary and appropriate care. Without some penalty on the dispensing physician, other than establishing a pattern of

behavior, payers will likely see an increase in costs related to paying for pharmacy care that does not conform to the MTUS guidelines. This provision seems to erode the gains made with the MTUS Drug Formulary. Payment for these medications is not an issue when dispensed by an in-network retail pharmacy since appropriate clinical controls are in place to control the dispensing of medication that falls outside the established guidelines.

- § 9792.11. Investigation Procedures: Labor Code § 4610 Utilization Review Violations
  - (t): The reference below to 9792.6.1(b) appears to be an incorrect reference to 9792.6.1(b). Assume the reference should be to the definition of "business day."
    - "If the date or deadline in sections 9792.9(b) and (c), ~~or~~ section 9792.9.3 ~~9792.9.1(c)~~, or section 9792.9.6 to perform any act related to utilization review practices falls on a weekend or holiday, for the purposes of assessing penalties, the act may be performed on the next ~~normal~~ business day, as defined by Labor Code section 4600.4, ~~and~~ Civil Code section 9 and section 9792.6.1(b). This subdivision shall not apply in cases involving concurrent or expedited review. The timelines in sections 9792.9(b) shall only be extended as provided under section 9792.9(g); the timelines in sections 9792.9.3 ~~9792.9.1(c)~~ shall only be extended as provided under section 9792.9.6 ~~9792.9.1(f)~~."

Stephen L. Kline, Esq.
General Counsel
EK Health

January 15, 2019

The definition of "material modification" with respect to the phrase, "change in a plan's operations or contracts" is overbroad & vague and needs to be clarified. The definition should be specific on what operational change warrants material modification.

For example, we would recommend that when a URO adds or subtracts a client from use of its UR Plan, that should be excluded from a material modification process as long as within 30 days of the addition or deletion of a client from the UR Plan, a simple letter is filed with DWC detailing the name, address of the changed client and the effective date of said change. This would eliminate the conflict between the 20 and 30 days of proposed 9792.7(c)(1).

Practically, there are client changes for many UROs with UR Plans frequently within a year.

9792.9.5 (f)(1)(G) does not set out any time limitation for the requesting provider to provide the information from a Request for more information (RFI) so that Reconsideration can be initiated.

We would offer for consideration that section should be modified as follows:

(G) A statement that the request for authorization of the treatment will be reconsidered upon receipt of the additional information, exam or test, or specialized consultation as long as the additional information, exam, or test is provided to utilization review within forty-five (45) days

from the date of the denial pursuant to section 9792.9.5. Any information, exam, or test results submitted to utilization review after that date shall be in accord with section 9792.9.1.

Our final suggestion the PR-1 should have a clear place for the requesting physician detailing why his/her request should be considered an expedited review (9792.6.1(j)). The Requesting physician has that obligation and that burden should have more support than just checking a box.

Theresa Fernandez, Director of Medical Management Services January 15, 2019
Regional Occupational Health, Kaiser Permanente

Kaiser Permanente appreciates the opportunity to comment on the proposed SB1160 regulations. We have provided general information about the section/page and our specific comments or questions are underlined.

Article 3.5 Medical Provider Network

Treatment and Change of Physicians Within MPN

§9767.6(f) – page 1
Kaiser Permanente supports the changes in this provision as physicians asked to provide care need a patient's medical history. The medical history needs to be provided before the first appointment with the new physician. We request a timeline be required for the employer or insured to provide the information – 20 days from the notification of a change of treatment physician.

Article 5. Pre-designation of Personal Physician; Request for Change of Physician; Reporting Duties of the Primary Treating Physician; Petition for Change of Primary Treating Physician

Employee's Request for Change of Physician

§9781(d)(3) – page 4
Kaiser Permanente supports the changes in this provision as physicians asked to provide care need a patient's medical history. The medical history needs to be provided before the first appointment with the new physician. We request a timeline be required for the employer or insured to provide information – 20 days from the notification of a change of treatment physician.

§9781(d)(6) – page 4
Allows for an agreement between the claims administrator and the physician/facility to have a list of medical treatment services that can be rendered without the submission of a request for authorization. This wording is under the section of Employee's Request for Change of Physician. Does this apply to all treatment regardless of whether there is a change of physician?

In other words, can the treating physician have this agreement with the claims administrator to render services which have been agreed upon to be pre-authorized without going through the utilization review process?

§9785.6 DWC Form PR-1 Treating Physician Report – page 10

Kaiser Permanente has multiple comments and questions regarding the PR-1:

(1) 9785.6(g)(1) and (2): The PR-1 is listed as being mandatory for services on or After January 1, 2019 with a 6-month grace period. The form is not approved at present. Establishing a due date for using the PR-1 should be determined after the form is finalized. The form cannot begin to be programmed until the final format is determined. By establishing a 7/1/19 due date, providers are actually being given less than a 6-month grace period. Due to the detail, length and complexity of the new form, a minimum of 2 years should be provided to implement the new PR-1 due to the need for budgeting, for programming and for physician education.
(2) On a first visit when a DFR is created, if treatment is being requested do both a DFR and PR-1 need to be submitted? This will produce duplicate paperwork and an excessive amount of forms. Can a DFR and only Section A of the PR-1 be submitted?
(3) The top section on Page 1 of the PR-1 has applicable boxes to check. The current PR-2 form has a text area accompanying the "other" box. There is no text box on the PR-1 form. There should be a text area accompanying the "other" box on the PR-1.
(4) There is a CPT/HPCS code on the PR-1. The DWC Form RFA also had this field but it was noted as "if known." The PR-1 form should have the same "if known" language.
(5) The Claims Administrator/Utilization Review Organization Response section only lists one service. Often, more than one service or a service and a drug are requested. What if more than one service or drug is authorized? It appears multiple forms would be required. We recommend sections for each item on one form.
(6) On the PR-1 form, page 7 C: Work Status, the text states "Employers may only receive Section B (Work Status)… This should state "Section C: Work Status," not Section B. Appears to be a typo.
(7) The length and complexity of the PR-1 should allow a larger reimbursement. When will the fee schedule be adjusted to allow a larger payment?

Article 5.5.1 Utilization Review Standards

Utilization Review Standards – Definitions

§9792.6.1(e) – page 14

The paragraph is deleted except for the word "Reserved." What does Reserved mean?

§9792.6.1(2) – page 16

Supporting documentation is required for a request for authorization. The paragraph as written states the documentation is required no later than 30 days ***before*** the date of the request for authorization. We believe the documentation is required no later than 30 days ***after*** the date of the request for authorization.

Utilization Review – MTUS Drug Formulary

§9792.9.7 (4) – page 34 and page 3 of the PR-1 form
Why is an RFA required for exempt drugs?

§9792.9.8 (a)(1) – page 37
The wording on section (a) states drugs can be dispensed to an injured worker without obtaining a prospective authorization. Section (1) states drugs identified as exempt on the MTUS Drug List. We interpret this section as stating that no request for authorization is needed for exempt drugs. Is our assumption correct? Meaning, there is no retrospective authorization required.

Kaiser Permanente looks forward to the hearing on all the proposed Regulations.

Rupali Das, MD, MPH, FACOEM, Medical Director
Senior Vice President, Medical Management

Sharon L. Hulbert, Assistant General Counsel
Vice President, Med-Legal
Zenith Insurance Company

January 15, 2019

Zenith Insurance Company appreciates the opportunity to provide forum comment. Zenith believes that utilization review successfully helps ensure that injured workers receive the care they need and minimize legal disputes over that treatment. The Division of Workers' Compensation continued efforts to revise and improve regulations plays a critical role by continually striving to improve the process in an ever changing environment. The comments set forth below are offered in in the same spirit: to help ensure clarity and reduce unintended consequences.

9785(d) allows transmission of medical reports by email. Anytime electronic transmission is utilized there should be a requirement that the transmission be done securely. We suggest adding a definition for "email transmission" that states "that email may be used by agreement of the parties but email transmissions must use appropriate encryption technology or file passwords to help ensure security of the transmissions". This will help ensure that all parties are aware that precautions are needed when email is used since providers are subject to HIPAA while workers' compensation carriers are not subject to HIPAA but are subject to applicable privacy laws.

9785(g) - Zenith believes there is opportunity to improve the quality of medical reports and the number of forms providers are required to use. While we fully support improvements, we are concerned that the new combined PR1 form is too long and that treatment requests need to be on the first page of any new form.

9792.6.1 (u)(1) - The section references 9785(h) but 9785(h) references this section. One section or the other needs to state the mandated form and processes, such as must submit a treatment request on Form PR1 along with documentation supporting the medical necessity of the requested treatment. The carrier or claims administrator may also accept a treatment request in another format that meets all requirements of the PR1, provided that the treatment request(s) are clearly set forth on the first page of the document and the document is clearly labeled at the top of the first page "Treatment Request". The carrier or administrator may in its sole discretion require use of the PR1 form and reject a request submitted in any other format.

9792.6.1 (u)(2) - Zenith proposes the following modifications to the definition of Completed:

> (2) "Completed" or "Complete" for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization identifies both the employee and the requesting provider; identifies with specificity all the recommended treatments in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used; ~~identify with specificity a recommended treatment or treatments,~~ and is accompanied by documentation, issued or created no more ~~later~~ than 30 days before the date of the request for authorization, which substantiates ~~substantiating~~ the need for the requested treatment. A request for authorization may be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.1(f).

9792.6.1 (u)(3) - states "The request for authorization ~~must be signed by the~~ treating physician and may be mailed…"

Zenith believes this strike out may be in error as the sentence makes no sense otherwise and the signature of the physician should be required on the request for authorization.

9792.6.1 (cc) - Zenith fully supports this modification as it will help eliminate unnecessary legal disputes. However, various sections of the law us "work day" or "working day" and other sections use "business day". To avoid disputes regarding intent, we recommend that definition be changed to state:

> "Working day", "work day" or "business day" …..

9792.7 (a)(6)(A) - Zenith recommends the following modification to 9792.7(a)(6)(A) to support plans that use a URAC certified third party to modify or deny treatment requests but still file a plan to support their utilization review program:

> (6)(A) For utilization review plans that modify or deny treatment requests, or utilization review plans that utilize a third party to modify or deny treatment requests, proof of accreditation of the reviewing entity through the Workers' Compensation Utilization Management Accreditation program administered by URAC.

9792.7 (e)(2) - Under this section, a UR plan has 30 days to bring a plan into compliance with the law. If they fail do so, then then the AD can withdraw the approval of the plan. Under, subsection e(3) the denial with be effective for 12 months. This seems overly harsh given that it frequently takes multiple back and forth interactions with the reviewers to correct a plan. This process can easily exceed 30 days simply because of the back and forth process that occurs between the company and the state reviewer. Therefore, Zenith recommends the section specifically state that the AD can extend the time to come into compliance based on the circumstances of an ongoing review and/or extend the time to come into compliance to 60 days from the date a non-compliance notice is issued to allow for the back and forth process that occurs during review of the UR plans.

9792.9.1(b) – Zenith proposes a modification to this section to allow the claims administrator, at its sole discretion, to reject treatment requests not submitted on a PR1 form if the claims administrator has elected to not accept requests in narrative. The following modification would allow this approach:

> Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it "not complete" and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt. A request for authorization accepted as complete shall be subject to investigation under section 9792.11 and the assessment of administrative penalties under section 9792.12. A claims administrator may use this same process to reject a treatment request if the claims administrator requires use of the PR1 Request for Authorization form.

9792.9.3 - Extension of timeframes is addressed in Section 9792.9.6. That section cross references this section, but this section makes no mention of the extension of time frames section. We suggest moving the extension of time frames section up so that it immediately follows the time frame section for logical flow and ease of research of time frames. The Extension of timeframes section may still be cross-referenced in this Timeframes section to alert

readers that they must read both sections to get a complete picture of applicable time frames. This will help avoid disputes and make the regulations more user friendly.

9792.9.4(a) - the second sentence, starting with "If additional information…" is incomplete. Either it was accidentally left in and should be stricken or the sentence needs to be completed.

9792.9.5(c) - When a decision to modify or deny is made, the injured worker and their attorney should always be notified. However, the "if" in this section implies that notice is required only if the provider was first notified by phone. To clarify that point, the following change is suggested:

> (c) (3) For prospective, concurrent, or expedited review, a decision to modify, delay, or deny a request for treatment on the basis of medical necessity shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or, if agreed to by the parties, secure electronic mail. The facsimile or electronic mail shall contain the information set forth in subdivision (e) or (f). If the ~~The~~ communication to the requesting physician is by telephone, it shall be followed by written notice ~~to the requesting physician~~. Written notice shall be provided to the requesting physician when applicable, the injured worker, and ~~if the injured worker is represented by counsel, the injured workers' attorney~~ any represented injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request.

9792.9.5(f)(1)(G) and (H) – These sections appear to imply that an internal appeal process is mandatory. Under the UR plan sections, having an internal appeal process was not mandatory but optional. Zenith therefore recommends the following changes:

> (H) Details about the claims administrator's internal utilization review appeals process, if applicable, if there is a dispute regarding the necessity of the requested information or a dispute as to whether the requested information was previously available to the claims administrator.
>
> (I) A statement that if the claims administrator's internal utilization review appeals, if any, process fails to resolve the dispute regarding the necessity of the requested information, or whether the requested information was previously available to the claims administrator, the injured worker may seek resolution of the dispute by filing a petition for determination of medical treatment dispute with the Workers' Compensation Appeals Board under California Code of Regulations, title 8, section 10451.2, subdivision (c).

9792.9.3 and 9792.9.6 - Zenith suggests adding a statement into sections 9792.9.3 and 9792.9.6 referencing that formulary review time frames are covered under 9792.9.8 to avoid confusion and direct users to the correct timeframe sections.

9792.9.7- The section heading indicates UR-Medical Treatment - Within/Beyond the First 30 days of the Date of Injury. However, the section really addresses treatment within the first 30 days. For clarity, we recommend removing the word "beyond" from the header.

9792.9.8 (b)(2)(A) - Zenith supports adding the ability to request additional information for treatment request of drugs not covered under (a), but is concerned that a 2 business day turn around is not operational. The provider must also have adequate time to respond and completing all of this within a 5 day period will be challenging. We recommend that a request for additional information be made within the time frame to make a decision (5 business days) and the provider be given 5 business days to respond. This may be more realistic for all parties concerned and should not result in any detriment to the injured employee since other processes are available to deal with life threatening situations.

9792.9.8(d) - Zenith believes the following section needs to be clarified as the first part mentions a decision to deny a "request for authorization" and later the sentence states "insofar as the drug is not included in a request for authorization under 9792.9.7(a)". We find this confusing. Would you please clarify the intent of this section?

9792.10.5 (a)(1) - this section still references a 15 day timeframe to submit medical records following a Notice of Assignment of IMR. This contradicts the 10 day timeframe utilized under 4610.5 (l). We recommend these two sections be aligned to avoid confusion.

9792.10.8 (c) - If the IMRO requests additional information on an IMR case, the claims administrator normally has 5 business days to respond. This section provides 2 business days to respond on formulary only cases, and 1 calendar day to respond on expedited cases. The 2 day formulary response is very tight turn around on what could be a high volume of IMRs. If a medication is prescribed for a life-threatening condition, then it would be covered under the expedited review timeline. If prescribed for non-emergency situations, 5 days would be sufficient to provide the additional information. Adding a different timeframe creates additional administrative burden for tracking and opportunities for error.

Schin Kapoor, DO, MBA, MPH, FACOEM January 15, 2019
Board President, WOEMA

The Western Occupational and Environmental Medical Association (WOEMA) appreciates the opportunity to comment on the draft SB 1160 regulations. WOEMA is the regional component of the American College of Occupational and Environmental Medicine (ACOEM), and our

members include PTPs, UR physicians, QMEs, and employer or insurer medical directors working within California's Workers' Compensation system. A few specific points:

1) **PR-1** – Combining the RFA with the progress report is a reasonable move. However, creating a usable PR-1 is less of a policy matter than a mechanical one. WOEMA suggests that DWC convene a workgroup specifically to work through the mechanics of the PR-1. The group members – physicians, insurers, UR entities, IT experts – would share the basic objective of creating the most workable form, and a real-time discussion of needs and trade-offs could save months of repeatedly issuing new drafts and collecting new comments. Additionally, we believe the PR-1 will need to be field-tested before it is rolled out across the system.

As it is, the current draft PR-1 presents some challenges:

a. The sheer length of the dual-purpose form would require physicians and claims administrators to leaf through multiple empty pages. Could the fields be made to expand or contract, according to whether they contain information?
b. To save on physician hassle, the physician should receive the form with the patient's name, claim number, injury date, birthday, employer, etc. already filled in.
c. Additional clarity should be added on when and how physicians need to reference MTUS or cite guidelines.
d. Ideally, Section 3 regarding work restrictions would focus less on certain categories of movement than on specific activities undertaken at work and home.
e. Needs to include clear documentation on prognosis and functional change from prior visit (improving, regressing, no change, etc).
f. Must allow for adequate lead time – perhaps 12 months – for IT systems to be modified to incorporate changes.
g. Needs discrete selections to help treating physicians call out factors of delayed recovery (pain avoidance behaviors, perception of poor workplace support, comorbidities, social factors, etc).

2) **Section 9792.7, Utilization Review Standards** – As we advocated for with the passage of SB 1160, we believe that URAC accreditation of UR providers is important but insufficient. URAC focusses on the ability of a UR entity to meet process requirements, rather the quality of the entity's medical decision-making. We believe all UR entities must have an internal quality control mechanism that includes random review of UR decisions for clinical quality (e.g., a peer-review of, say, 1/1000 cases). The QC mechanism should be described on the UR-01 application and be auditable by DWC.

3) **Section 9792.9.7(c)(1)(C)** provides that a physician with a "pattern or practice" of not following MTUS can be removed from an MPN. We agree with this position generally (although there are occasions in which a physician might elect to prescribe treatment or drugs outside of MTUS formulary on his or her own clinical judgment, and independent of whether carrier payment is assumed to be forthcoming). However, we believe physicians should be able to challenge that removal, and that each MPN should have its own appeals process. Referring all such disputes immediately to the WCAB seems arduous and unworkable.

Robert Ward, DC January 15, 2019

As usual, the DWC has done a very careful and thorough job of reviewing regulations for revision consistent with changes to the Labor Code. The proposed regulatory changes are commendable.

That being said, some constructive recommendations are humbly offered for consideration.

§9767.6. Treatment and Change of Physicians Within MPN

Subsection (f) describes a number of items that the insurer or employer must provide to a PTP within a MPN. However, there is no required timeframe for compliance, and apparently no penalty for failure to comply.
The DWC may wish to consider establishment of timeframes and penalties with regard to the requirements of 9767.6(f).

Subsection (g) restricts the employer/insurer from requesting a change from PTP within the MPN framework to only those physicians who have demonstrated a pattern and practice of providing treatment during the first 30 days after injury that is inconsistent with the MTUS. Requesting a change in PTP for failing to report as required, providing treatment inconsistent with the treatment plan, and/or for meaningful conflict of interest appears to have been removed as an option if the PTP is in the MPN.
There being no readily apparent benefit to such restriction, it is recommended that the reference to "(b)(6) of section 9786" be revised to read "(b) of section 9786".

§9781. Employee's Request for Change of Physician

Subsection (d) delineates the required communication from the claims administrator when the claims administrator is notified of the employee's selection of treating physician.
It is recommend that the DWC establish a minimum timeframe for completion of required communication under 9781(d), and appropriate outcomes for failure to comply.

§9785. Reporting Duties of the Primary Treating Physician

Subsection (i) [formerly (h)] as written requires that the permanent and stationary report be prepared by the primary treating physician.
The primary treating physician does have a duty to insure that such reporting is produced, but is not required to produce it themselves. LC4061.5 specifically permits the primary treating physician to utilize a consulting physician of their choice to prepare such reporting. The current regulatory language appears to contradiction this aspect of LC4061.5, and should be amended accordingly.

Subsection (l) [formerly (k)] states that the claims administrator shall reimburse the "primary treating physician for their reports submitted pursuant to this section as required by the Official Medical Fee Schedule."
There is no mention of reimbursement for the reporting of secondary treating physicians (as mandated in subdivision (e)(2) [formerly (e)(3)]), nor for the preparation of P&S reporting by a consulting physician per LC4061.5. This has in some instances resulted in an assertion by the claims administrator that they do not need to reimburse for such reporting, initiating needless disputes at the WCAB.
Accordingly, it is recommended that the language of subsection (l) be amended to read, "Claims administrators shall reimburse physicians for their reports submitted pursuant to this section as required by the Official Medical Fee Schedule."

§ 9792.6.1. Utilization Review Standards—Definitions – On or After January 1, 2013

Subdivision (u)(3) [formerly (t)(3)] has been amended by removal of the requirement for the treating physician to sign the request for authorization.
The request for authorization is an assertion by the treating physician that the treatment requested is necessary to cure and relieve the effects of the industrial condition, and as such attestation by the physician via signature may be an important component in the state's efforts to curtail fraud or abuse.

If the intent was to prevent a delay in review and delivery of care over the absence of a signature, then it would be sufficient to remove the physician signature as a component of a "complete" request for authorization. Subdivision (u)(2) (regulatory definition of "completed") already lacks the requirement for a signature. In order to achieve a procedural change that does not require a signature to proceed with UR, it may be preferable to amend the language of 9792.9.1(b) such that the meaning of "complete" is referenced to subdivision (u)(2) of 9792.6.1, rather than all of subsection (u).

§9792.7. Utilization Review Standards—Applicability

Proposed subdivision (c)(2) [formerly subsection (d)] begins with "Utilization review plans that modify or deny treatment requests shall submit with their plan a completed the DWC Form UR-01" The word "the" is superfluous, and appears to have been added in error.

§ 9792.8. Utilization Review Standards – Medically-Based Criteria

It has been proposed that the requirement for the URO to include relevant guideline materials in adverse determination notifications be removed (strikethrough of subdivision (a)(3).
It is strongly recommended that the requirement for adverse UR determinations to include relevant guidelines be retained. Otherwise, the burden for referencing and obtaining such guideline content falls to the applicant and/or their physician or representative as a necessity in any appeals or IMR process. Removal of this requirement creates a meaningful opportunity for an unethical URO to save process costs by simply failing to appropriately consider guidelines during the review process.

§9792.9.3. Utilization Review — Timeframes

Subsection (d) [formerly subdivision (a)(5)] includes a recommendation to redact the words "the request for authorization and medical".

It is strongly recommended that this language not be removed.

Tying the timeframe of retrospective review to the receipt of information only creates a technical risk of untimely review through no fault of the URO, with consequent seizure of medical decision making by a judge at the WCAB.
In the event that a PTP submits medical reporting that would support treatment; provides treatment; and then issues a retrospective request more than 30 days after submitting reporting, under the proposed redaction any UR of the request would by definition be untimely before the RFA was even received.

Such outcome would be inconsistent with the intent of the legislature regarding their desire that determinations of medical necessity be made by physicians.

Peggy Sugarman, PhD, Workers' Compensation Director
City & County of San Francisco

January 14, 2019

Thank you for the opportunity to review the draft regulations governing Utilization Review practice and policy. I am submitting comments on behalf of the City & County of San Francisco (CCSF), a self-insured, primarily self-administered public entity for workers' compensation.

1. **Proposed change to Section 9785(e)(2)**

We are opposed to the removal of the requirement that each new Primary Treating Physician (PTP) send in a Form 5021 following the initial examination. CCSF maintains a Medical Provider Network which allows a worker to choose (or change) PTPs freely within the MPN. The Form 5021 is often the only notice we have that the worker has changed doctors. Without the form, we will just be receiving new physician's reports which will make it difficult to identify who has taken on the role of the PTP.

2. **Proposed changes to the Requests for Authorization for Medical Treatment**

We are concerned that the elimination of the Request for Authorization (Form DWC RFA). While it appears that the proposed PR-1, as designed, is meant to be an all-inclusive form that combines treatment requests, basic reporting, and work status, the absence of any requirement to actually use the form places a huge burden on claims administrators and their Utilization Review partners.

The definition of a Request for Authorization in Section 9792.6.1(u) references Section 9785(h) – which reverse references 9792.6.1(u). This leaves a Request for Authorization as simply a request for authorization of medical treatment *in any form.* We are alarmed that a claims administrator must again search through narrative reports to see whether a request for treatment is present. We appear to have lost the requirement that a narrative report containing a request for authorization be clearly marked "Request for Authorization" at the top, even though you have required that it be in the first page of the narrative (see Section 9792.6.1[u][2] "completed").

From a practical and workflow standpoint, CCSF's URO directly obtains and scans all of medical reports, RFAs, and medical bills into their system. RFAs are identified by their index team and put into the adjusters "UR queue" for handling. From there, the adjuster decides whether to authorize treatment or to refer to formal Utilization Review. Likewise, medical bills with reports are processed/repriced and come into the adjuster's "billing queue" through a different part of their software system.

The proposed regulations thus place a burden on the indexing team at the URO to try to independently read and decide how to route the report. Does it contain a Request for Authorization? If not, it is routed in the adjusters daily mail queue – which may leave little to no time to find the buried RFA and increases the likelihood that the treatment request will not be promptly addressed. We *strongly* object to the loosening of the definition, and request that physicians be required to clearly mark any narrative report with "**Request for Authorization**" at the top.

The problem becomes magnified by the proposed language in Section 9792.9.1(b) which requires an "incomplete" request for authorization to be marked "not complete" and returned to the physician no later than 5 business days from receipt. Because the definition of an RFA, as proposed, is so loose, a physician who fails to submit a complete RFA may be able to prevail in what might be inappropriate and un-reviewed treatment just because we did not catch some request buried in an "incomplete" format. Virtually any report that contains a request could be deemed "incomplete" under these definitions. We strongly recommend that you return to the simple requirement that an RFA in a narrative format must contain "**Request for Authorization**" clearly marked at the top on the first page. In addition, we recommend that you strike the requirement that we return the "incomplete" RFA back to the physician completely. It's working under the current rules without these additional requirements because it would be administratively burdensome and increase our overall friction costs.

The proposals also allow claims administrators or reviewers to accept an incomplete or otherwise flawed Request for Information. We support this option in the interests of providing prompt medical treatment, but believe that subjecting an incomplete or flawed request to the same time and penalty requirements as if it were correctly done will produce an unintended result: Why would a claims administrator "accept" an incomplete or flawed RFA if by doing so they will be subject to the time and penalty provisions by doing so?

For example, if we receive a request for medical treatment that is not properly submitted or incomplete and it ends up in the adjuster's "mail queue" and not the "UR queue", it may be untimely by the time the adjuster sees it. It would be better for all if the adjuster could review

and approve it without worrying whether by doing so they could incur a penalty, and/or to force them into a useless circle of having to mark the request as "incomplete" and return it.

3. PTP Failure to Respond to a Request for Information – Section 9792.9.5(f)(1)(l)

We are likewise concerned about section 9792.9.5(f)(1)(I) where, if a denial is based on a PTP's failure to respond to a request for information, the WCJs get to determine whether the information, additional tests, examinations or consultations are necessary. So, again, we are moving backwards to put more medical decisions in the hands of the judges. If they are not allowed to determine the necessity of medical treatment, why would you think it necessary to allow a workers' compensation judge to determine whether the additional information or tests requested by the reviewing physician are necessary? We believe that this goes against the entire IMR statutory provisions that remove medical treatment decisions from judges and request that you to reconsider this provision. Clearly the WCAB has an interest in ensuring that the UR process is fair, and should be allowed to step in where the claims administrator is untimely in its review or where there is evidence of bias in the decision. But neither of those is at stake here, and the proposed revision weakens the entire construct of IMR being the panacea to ensure that only medically necessary treatment is provided.

4. Treatment and Change of Physicians Within MPN – Section 9767.6(f)

We are puzzled why you would require the employer or insurer to deliver all relevant medical records relating to the claim to the *initial primary treating MPN physician.* This is the physician that is creating that very record, conducting tests, and making recommendations. It would make more sense to require us to submit all relevant medical tests and reports to a *subsequent* PTP, rather than just notifying the subsequent PTP that they may have the records if they ask for it. But it makes no sense to send them to the initial primary treater who is creating the record in the first place and recommend that you strike that provision.

We would support a rule that requires that we send records to *subsequent* physicians who are not in the same practice group.

One question to consider here as well: At CCSF, many employees are have multiple claims over the course of their employment – particularly our public safety officers. Are you requiring here that we submit the records of prior claims to the initial treating physician?

5. Change of Treating Physician – Section 9767(g)

In this renumbered section, you allow employers who maintain or participate in a Medical Provider Network to request a Change of Treating Physician where we provide a showing that the provider has a pattern and practice of failing to render treatment consistent with the MTUS within the first 30 days of a claim as described in 9767(b)(6). We appreciate this option. However, the proposed regulation requires the employers to provide a panel of physicians that include chiropractors if requested by the employee. Because of the limitation on treatment visits for chiropractic care, it is possible that the worker would be precluded from selecting a chiropractor where the visits have exceeded 24. It will be very frustrating for all if we have to provide a panel of chiropractors when we know that there are no visits available, just to turn around and deny them. We recommend that you make some provision for this exception.

Eleni Blumenfeld-James, Senior Rule Attorney January 14, 2019
Aderant

We are writing to comment on proposed 8 CCR 9792.6.1(cc). 8 CCR 9792.6.1 indicates that "[t]he following definitions apply to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the decision on the request for authorization of medical treatment is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury." Proposed subsection (cc) then goes on to say:

"Working day" means any day other than a Saturday, Sunday, or a day declared by the Governor to be an official State holiday. "Business day" shall not include January 1, the third Monday in January, the third Monday in February, March 31, the last Monday in May, July 4, the first Monday in September, November 11, Thanksgiving Day, the day after Thanksgiving, and December 25.

The following rules in Subchapter 5.5.1 and the proposed amendments set deadlines in working days and business days. We understand that one of the goals of these proposed amendments is to expedite medical treatment for injured workers. However, we believe that creating these separate definitions will lead to confusion as to when documents are due, as these definitions are not used throughout all sections of the California Code of Regulations related to workers' compensation since they only apply to utilization reviews where the injury/illness occurred on or after January 1, 2013, or where the decisions re request for authorization is communicated on or after July 1, 2013. In addition, defining working days and business days differently adds to the complexity of determining what should be very simple and clear deadlines. This confusion and complexity may actually lead to delays in obtaining treatment for injured workers.
Further, the Labor Code does not have a similar general provision defining working days and business days, though it uses these terms in setting forth utilization review deadlines. This may lead to confusion as to how to count time periods when determining deadlines re utilization reviews.

We note there is a direct conflict in one instance, where Labor Code 4600.4 provides:

(a) A workers' compensation insurer, third-party administrator, or other entity that requires, or pursuant to regulation requires, a treating physician to obtain either utilization review or prior authorization in order to diagnose or treat injuries or diseases compensable under this article, shall ensure the availability of those services from 9 a.m. to 5:30 p.m. Pacific coast time of each normal business day.
(b) For purposes of this section "normal business day" means a business day as defined in Section 9 of the Civil Code.

Civil Code 9 states in part: "All other days than those mentioned in Section 7 are business days for all purposes . . ." and that optional bank holidays are not business days.

Civil Code 7 states that "[h]olidays within the meaning of this code are every Sunday and such other days as are specified or provided for as holidays in the Government Code of the State of California."

Government Code 6700 sets forth holidays, including the days listed in proposed 8 CCR 9792.6.1(cc), as well as other holidays such as February 12th (Lincoln's Birthday), September 9th (Admission Day), and the fourth Friday in September (Native American Day).

8 CCR 9792.9.1(a)(3) provides in part that, "Every claims administrator shall maintain telephone access and have a representative personally available by telephone from 9:00 AM to 5:30 PM Pacific Time, on business days for health care providers to request authorization for medical services."

Under the proposed definition of "business days" set forth in 8 CCR 9792.6.1(cc), a representative must be available on every day, including Saturdays and Sundays, except for "January 1, the third Monday in January, the third Monday in February, March 31, the last Monday in May, July 4, the first Monday in September, November 11, Thanksgiving Day, the day after Thanksgiving, and December 25." However, the Labor Code specifically uses a different definition of business days in discussing this requirement, as set forth above. These conflicting definitions create ambiguity as to when representatives must be available.

In addition, by defining business days as proposed, the regulations set up situations where documents could be due on weekends or state holidays. For instance, proposed regulation 8 CCR 9792.9.1(b) requires an incomplete request for authorization be returned to the physician no later than 5 days from receipt. If the request is received on February 12, 2019, for example, it must be returned to the physician on Sunday, February 17, 2019. This is inconsistent with the calculation of deadlines throughout the Title 8 regulations as well as the California codes.

Finally, the terms "working day" and "business day" appear to be used interchangeably in the regulations, however, with the proposed definition set forth in proposed 8 CCR 9792.6.1(cc), these two terms are defined in extremely different ways. For instance, see 8 CCR 9792.9.3(b) which says:

Prospective or concurrent decisions to approve, modify, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed <u>five (5) business days</u> from the date of receipt of the completed request for authorization.

In contrast, 8 CCR 9792.12(b)(8) states the deadline as 5 working days from receipt:

For each failure to make a decision under section 9792.9.3(b) <u>within 5 working days</u> of receipt of a complete or accepted the request for authorization in the case of a non-expedited prospective or concurrent review, or upon receipt of the requested information under section 9792.9.6(d): $500 for each day the failure is ongoing, up to a maximum of no more than $ 5,000 at which point the violation is also deemed to be a failure to respond to a complete or accepted request for authorization and the additional penalty for that failure attaches[.]

We respectfully suggest that the proposed amendments strike proposed subsection (cc) from 8 CCR 9792.6.1 in order to avoid creating confusion as to when items are due during the utilization review process and beyond. This would provide consistency in determining deadlines across the regulations. In the alternative, subsection (cc) could be revised to indicate that the terms "working day" and "business day" are synonymous and include only the proposed definition of working day.

Theodore A. Penny
Haight Brown & Bonesteel LLP

January 10, 2019

As published in the DWC forum the proposed regulations at §9792.7(a)(6)(A) require URAC accreditation. Specifically, utilization review plans "that modify or deny treatment requests, [must demonstrate] proof of accreditation through the Workers' Compensation Utilization Management Accreditation program administered by URAC." This provision creates significant uncertainty for the various entities involved in California utilization review, including claims administrators (§9792.6.1(b)), medical directors (§9792.6.1(o)), public sector organizations (§9792.7(a)(6)(B), and external utilization review organizations (§9792.7(c). In this comment we explain the origin of the uncertainty and our suggestion for a remedy that retains the purpose of requiring URAC accreditation while eliminating excessive regulation and costs.

URAC is defined at §9792.6.1(x) as a non-profit organization that "provides accreditation for workers' compensation utilization review programs." In fact, URAC provides accreditation programs for a wide variety of healthcare activities, including 12 certifications in Healthcare Management alone. Of these 12 accreditation programs, 2 of them require proof of adherence to standards that are important in the California utilization review process. These two are the "Independent Review Organization Accreditation" and the "Workers Compensation Utilization Management Accreditation." California claims administrators and other individuals and organizations that created utilization review programs complying with the highest ethical and educational standards have sought URAC accreditation through one or the other of these two programs.

The proposed regulations create uncertainty for those organizations who obtained URAC accreditation as an Independent Review Organization, and may be imposing unnecessary expenses, duplication of effort and diluting the very standards that the regulations seem intended to elevate. The URAC accreditation for "Independent Review Organization: Comprehensive Review (Internal & External Review)" version 5.0 (hereafter IRO) includes standards in "Clinical Staff Credentialing and Oversight Role", "Consumer Protection and Empowerment", "Reviewer Credentialing & Qualifications", "Conflict of Interest", and "Review Process" along with 13 other subjects. See URAC "Standards And Measures At A Glance", Independent Review Organization: Comprehensive Review (Internal & External Review, at https://www.urac.org/sites/default/files/standards_measures/pdf/STDGlance_IRO_Comp_0.pdf .

These subjects bring an organization with IRO accreditation fully within the standards set forth in California Labor Code §4610(g)(4).

The URAC accreditation for "Workers' Compensation Utilization Management v7.3" (hereafter WCUM) on first glance appears to impose measurements on more activities. But in this case, more is not better. The WCUM accreditation for instance does not set out standards for "Reviewer Credentialing & Qualifications" nor for "Conflict of Interest." See URAC "Standards And Measures At A Glance", Workers' Compensation Utilization Management, at https://www.urac.org/sites/default/files/standards_measures/pdf/Workers%20Comp%20UM%20Standards%20at%20a%20Glance.pdf. Further, several of the subjects separately listed in accreditation for WCUM, making it appear more rigorous, are found accumulated in a single subject in the IRO program, including Initial Case Assessment, Time Frames for External Review, Medical Necessity/Appropriateness Case Processing, and Decision Notice among others.

A detailed comparison of the two programs is not set out here as it is unnecessary for the purpose of this comment. Our point is that for those California organizations who have obtained URAC accreditation as an IRO it is an unnecessary and burdensome expense to require additional accreditation as a WCUM. The purposes of the proposed regulations, requiring exacting utilization review standards are met, and resources are conserved, by permitting accreditation in either program. Further, the financial burden on firms that already obtained IRO accreditation is significant. We have evidence, and on that believe, that URAC charges $32,000.00 for each accreditation, whether for IRO or WCUM. Where IRO organizations previously obtained internal and external accreditation from URAC, costing the organization $64,000.00, the regulation would impose a cost of another $32,000.00 for WCUM accreditation. In the absence of clear benefit to California's workers' compensation utilization review processes, requiring the WCUM where the IRO exists is an unnecessary and undue burden. Therefore, we urge that the regulations require URO accreditation as either an IRO or WCUM.

Kevin C. Tribout, Executive Director, Government Affairs — January 10, 2019
Optum Workers' Compensation and No-Fault Division

In reviewing the proposed regulations, we found that in general the regulations will improve existing processes and provide greater clarification regarding the issue of providing medications as related to the adopted MTUS Drug Formulary. We look forward to continued participation in development of these rules.

Respectfully, the OWCA division submits our feedback on two specific areas of the proposed rule as follows.

Page 16 - 9792.6.1(u)(3). We believe the wording of section may be incorrect or a typographical error and suggest the Division review and revise.

Page 38 - 9792.9.8(f)(4)(A). The proposed language seems confusing and appears to be in conflict with the underlying intent of both the adopted MTUS Treatment Guidelines and the MTUS Drug Formulary. In a plain reading of the language, it appears that a payer (insurer, TPA, ect.) will not be able to deny **any** medication that is indicated as an **exempt** drug based upon a determination that the drug was not consistent with the applicable guideline. If this is the intent of the proposed language in 9792.9.8(f)(4)(A), the payer will have no recourse to challenge the usage of **any** exempt drug regardless of the intended utilization by the treating physician. We respectfully request clarification from the Division as we fear this could create an unintended loophole for the unfettered usage of **exempt** drugs in California.

Brandy Williams, Utilization Review Manager/Med Review Inc. January 7, 2019
AdminSure Inc.

We would like to make a follow-up comment to Darlene Ondecker's comment regarding expedited review, 4(b).

It is unclear from the regulations what steps a claims administrator would take if the provider does not certify in writing the reason for the expedited review. What documentation would need to be provided at the time of audit if the claims administrator did not accept the request for authorization as an expedited review and reviewed with the normal timeframe?

Mildred Moss, B.S.N., R.N. January 2, 2019
Utilization Review Manager/MedReview Inc.
AdminSure Inc.

The previous IMR application listed a box for the AA and providers fax number. I noticed that this is not listed on the draft application. An email address is listed instead.

From my experience many providers do not provide an email. Adminsure will fax the IMR/determination letter to the AA, if applicable and the provider.

The proposed regulations, 9792.9.5 (C) note the following:

For prospective, concurrent, or expedited review, a decision to modify, ~~delay~~, or deny a request for treatment on the basis of medical necessity shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or, if agreed to by the parties, secure electronic mail. The facsimile or electronic mail shall contain the information set forth in subdivision (e) or (f). If the

~~The~~ communication is by telephone, it shall be followed by written notice to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request.

Should the fax number be included on the IMR application?

Darlene Ondecker, Compliance Manager — January 2, 2019
Rising Medical Solutions

Rising Medical Solutions would like to submit the following comments regarding the draft Physician Reporting and Utilization Review regulatory amendments posted on Dec. 17, 2018. Please see our comments beginning at the bottom of this page.

Article 3.5. Medical Provider Network §9767.6:
On page 1 and 2:
(f) The insurer or employer shall deliver to the initial primary treating MPN physician selected by the employee all relevant medical records relating to the claim, including the results of diagnostic and laboratory testing done in relation to the injured employee's treatment. The insurer or employer shall advise any subsequently selected MPN physician that any medical record or diagnostic and laboratory test result deemed relevant to that provider will be delivered upon request. The insurer or employer shall also advise all selected MPN physicians of the name, telephone number, fax number, email address, and physical address of the individual to whom a request for authorization should be sent.

Article 5. §9781. Employee's Request for Change of Physician:
On page 4:
(3) ~~arrange for the delivery~~ Deliver to the initially selected physician or facility or personal chiropractor or acupuncturist ~~of~~ all relevant medical records ~~information~~ relating to the claim, including the results of diagnostic and laboratory testing ~~all X-rays and the results of all laboratory studies~~ done in relation to the injured employee's treatment.~~;~~ ~~and~~

(4) Advise any subsequently selected physician or facility or personal chiropractor or acupuncturist that any medical record or diagnostic test result deemed relevant to that provider will be delivered upon request.

~~(4)~~ (5) P~~p~~rovide the physician or facility with ~~(1)~~ the name, telephone number, fax number, email address, and physical address of the individual to whom a request for authorization should be sent.~~;~~

(6) If applicable, provide the physician or facility with a list of medical treatment services that can be rendered without the submission of a request for authorization.

(7) Provide the physician or facility with (1) ~~if available, to be used to request authorization of treatment plans; (2)~~ the complete requirements of section 9785; and (2) ~~(3)~~ the required reporting forms under that section ~~set forth in sections 9785.2 and 9785.4. In lieu of providing the materials required in (1) and (2) and (3) immediately above,~~ In addition, the claims administrator shall ~~may~~ refer the physician or facility to the Division of Workers' Compensation's website where the applicable information and forms can be found at http://www.dir.ca.gov/DWC/dwc_home_page.htm.

9767.6 and 9781 Comments: We see the added requirement in 9767.6 (f) to deliver all relevant medical records, diagnostic and test results to the MPN initial PTP physician, and to advise all selected MPN physicians of the complete contact information for authorization request, is merely level setting the MPN regulations with the same requirements that have been in place (Section 9781 (3) and updated (5) for non-MPN claims. However, the additional requirement in 9767.6 (f) to advise any subsequently selected MPN physician, and in §9781. (d)(4) to advise subsequently selected physicians, that relevant medical records, and diagnostic test results are available upon request; places an additional unnecessary burden on the claim administrator. Additionally, requiring the claim administrator to provide the actual required reporting forms to the physician as added in §9781. (d)(7) rather than referring them to the DWC website to obtain, again places an unnecessary burden on them. In this day age, instructions how to access the online forms should suffice. It will also negatively impact our environment and efforts to conserve trees and natural resources if printed copies of the forms must be provided by the claim administrator.

California Utilization Review comments:

On page 14 (Definitions), "Delay" has been removed, and it says "Reserved."

a. Will there be a new definition added?
b. If not, is there another word or process taking the place of "Delay"?
c. Was the intention of "Delay" similar to a "Deferral" by the adjuster? (seems like it, on page 59 at the very top, where "delay" IS in the statement, preceded by "modify; withdrawal")

2. On the RFA, there is a box that says "Resubmission – Change of Material Facts."
   a. There have been times where this box is checked off by a provider without any additional or different information from the records submitted when the treatment was originally denied. We've also received RFAs with this box checked off after we (the URO) denied treatment, AND the denial was upheld in the IRO process literally 2-7 days prior. In these cases, the only additional information submitted was another recent office visit, which did not appear to contain any change in material facts.
   b. Can wording be added to require an explanation of what the change in material facts is/are, upon submission of the request for authorization (i.e., to prevent the carrier/TPA/employer from incurring a possibly unnecessary charge for another UR and possibly another IRO)?

c. We have seen an increase in Request for Authorizations being signed by a different physician than who actually saw the patient/claimant – we've identified that often, it is the Medical Director for that practice who is signing the Request for Authorization. This causes confusion at the URO level and may result in duplicate requests for treatment. Can consideration be given to requiring that the treater (i.e., the provider who saw and treated the patient/claimant during that visit) sign the Request for Authorization?

d. Along those lines, we also receive requests for authorization from a few practices that have numerous doctors of the same specialty. Once a treatment is denied to a pain management specialist (or an ortho, or a neurologist, etc.), we are under the impression that we still must review the same treatment by the same specialty doctor in the same practice if we receive another request for authorization. Can consideration be given to allowing a URO to "reject" a subsequent request for authorization if the same denied treatment is requested by the same specialty physician in the same practice, without a change of material facts (again, it would be helpful to require the physician to identify what that change of material facts is, if they check off the Resubmission box on the Request for Authorization). The same holds true for practices with physicians not of the same specialty.

3. On page 26:
(c) ~~(2)~~ If utilization review is deferred pursuant to this subdivision, and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, the time for the claims administrator to conduct retrospective utilization review in accordance with this section shall begin on the date the determination of the claims administrator's liability becomes final. The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a request for authorization ~~the DWC Form RFA~~ after the final determination of liability.

Just to clarify, then, are all treatment requests considered retrospective review when they were received prior to the determination that the claims administrator is liable for the condition (regardless of whether the treatment requested has actually been performed)?

4. On the RFA, there is a box that says "Expedited Review: Check box if employee faces an imminent and serious threat to his or her health."
   a. Page 27 indicates that:
   (c) ~~(4)~~ Prospective or concurrent decisions to approve, modify, ~~delay,~~ or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under subdivision (b) ~~(c)(3)~~ would be

detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (b) ~~(c)(3)~~.

b. Is this saying, then, that if there is no written reason as to why an "expedited" review is necessary, and the documentation on the doctor's note (containing the history and physical exam) doesn't make it clear that the worker's condition poses an imminent and serious threat, that the URO would not be bound by the 72-hour turn-around-time?

5. Page 31:
(H) Details about the claims administrator's internal utilization review appeals process if there is a dispute regarding the necessity of the requested information or a dispute as to whether the requested information was previously available to the claims administrator.
(I) A statement that if the claims administrator's internal utilization review appeals process fails to resolve the dispute regarding the necessity of the requested information, or whether the requested information was previously available to the claims administrator, the injured worker may seek resolution of the dispute by filing a petition for determination of medical treatment dispute with the Workers' Compensation Appeals Board under California Code of Regulations, title 8, section 10451.2, subdivision (c).

Why is an internal UR appeal process necessary, when the UR Letter already states that the request for authorization will be reviewed/reconsidered upon receipt of the additional information, exam or test, or specialized consultation? There is no need for ANY appeal process: internal *or* IMR, since the carrier and/or Utilization Review Organization has already said it would review the requested treatment when the additional information is received.

That being said, if you are going to keep H and I in there, is it mandatory that the carrier/URO have an internal utilization review appeal process? This question is asked since above on page 30, "(11) ~~(J)"~~ indicates that an internal utilization review appeals process is optional:
(11) ~~(J)~~ Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis.

6. Page 38:
(2) A dispute regarding a decision to modify or deny a request for authorization under this section based on a reason other than medical necessity shall be resolved only through the claims administrator's voluntary internal utilization review appeals process or by the Workers' Compensation Appeals Board after the filing of a petition for determination of medical treatment dispute under California Code of Regulations, title 8, section 10451.2, subdivision (c).
UR only deals with medical necessity. Therefore, a denial other than for medical necessity should involve an internal claims appeals process, not an internal utilization review appeals process.

Amy Holcomb, Director Utilization Review — December 31, 2018
Careworks

Could we get a more definitive definition of a business day for a UR decision?

There is conflicting information on your website as to when a request is due and Labor Code 4610.

The DWC website states Saturday and Sunday are not included in the time frame for determination of a decision. But Labor Code 4610 states UR is to follow that rule for determining when a request is due which does include Saturday in their timeframe.

Page 17:
(cc) "Working day" means any day other than a Saturday, Sunday, or a day declared by the Governor to be an official State holiday. "Business day" shall not include January 1, the third Monday in January, the third Monday in February, March 31, the last Monday in May, July 4, the first Monday in September, November 11, Thanksgiving Day, the day after Thanksgiving, and December 25.

Page 27:
(b) ~~(3)~~ Prospective or concurrent decisions to approve, modify, ~~delay,~~ or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed request for authorization ~~DWC Form RFA~~.

The DWC rules currently state a decision is due in 5 business days - do we count Saturdays in that time frame? Based on your definition of working day/business day it appears Saturday is a business day unless it falls within the exceptions noted above.
We really need a clear answer to defend our cases when the courts say they are late because Saturday is a business day in their eyes.

Mildred Moss, B.S.N., R.N., Utilization Review Manager — December 27, 2018
AdminSure Inc.

1) Per 9792.9.8 (b) (2) the "physician reviewer" can request information per 9792.9.6, however, 9792.9.6 allows for the claim administrator or reviewer to request information. 9792.9.6 does not specify "physician reviewer".

a. Will the claims administrator be able to request information?
    i. Information typically requested is dosage, quantity, and refill.
    ii. Seems like UR would increase cost for a "physician reviewer" to request this information.

2) 9792.9.8(b) (2) (A) – The physician reviewer shall request the information from the treating physician within two business days from the date of receipt of the request for authorization.
    a. What is the reasoning for two business days?
        i. Expedited review allows 72 hours in which to request information.
        ii. Most medication requests are not expedited or urgent.
    b. If UR receives the review from the claims administrator on business day three, then no request for information is allowed?
    c. Since the decision must be made within 5 business days I foresee an increase in UR physician review fees and denials.
    d. UR should be allowed to attempt to get the information up to the fifth business day if necessary.
3) 9792.9.8 (c) allows the "usual" timeframe when a medication is requested with a medical treatment.
    a. What is the reasoning behind the two different timeframes in this section?
    b. What makes it reasonable to extend the timeframe for medications in this instance and not when solely requested?