



California Workers' Compensation Institute

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VIA E-MAIL to dwcrules@dir.ca.gov

Maureen Gray, Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

RE: 1st 15-Day Comments on Modifications to Proposed Permanent Independent Medical Review (IMR) Regulations Sections 9785, 9785.5, and 9792.6.1 – 9792.12

Dear Ms. Gray:

These comments on modifications to the regulations proposed for permanent adoption to implement Senate Bill 863 provisions regarding Independent Medical Review (IMR) and utilization review are presented on behalf of members of the California Workers' Compensation Institute (the Institute). Institute members include insurers writing 71% of California's workers' compensation premium, and self-insured employers with \$46B of annual payroll (27% of the state's total annual self-insured payroll).

Insurer members of the Institute include ACE, AIG, Alaska National Insurance Company, AmTrust North America, Chubb Group, CNA, CompWest Insurance Company, Crum & Forster, Employers, Everest National Insurance Company, Farmers Insurance Group, Fireman's Fund Insurance Company, The Hartford, Insurance Company of the West, Liberty Mutual Insurance, Pacific Compensation Insurance Company, Preferred Employers Insurance Company, Springfield Insurance Company, State Compensation Insurance Fund, State Farm Insurance Companies, Travelers, XL America, Zenith Insurance Company, and Zurich North America.

Self-insured employer members are Adventist Health, Agilent Technologies, Chevron Corporation, City and County of San Francisco, City of Santa Ana, City of Torrance, Contra Costa County Schools Insurance Group, Costco Wholesale, County of San Bernardino Risk Management, County of Santa Clara Risk Management, Dignity Health, Foster Farms, Grimmway Enterprises Inc., Kaiser Permanente, Marriott International, Inc., Pacific Gas & Electric Company, Safeway, Inc., Schools Insurance Authority, Sempra Energy, Shasta County Risk Management, Southern California Edison, Sutter Health, University of California, and The Walt Disney Company.

Introduction

The California Workers' Compensation Institute supports comments on the modifications to proposed permanent Independent Medical Review (IMR) regulations submitted by the California Chamber of Commerce and the California Coalition on Workers' Compensation (CCWC); and by the American Insurance Association (AIA). In addition, the Institute offers recommendations in an effort to create greater clarity, precision, and efficiency.

The Institute strongly objects to the modifications to the proposed revisions that would permit requests for authorization to be made in any form and to be presumed to be agreed to if not objected to within three business days. If providers are not required to submit requests via a standard request form, the claims administrator may not be able to identify a request or may not be able to identify such a request timely, and that will generate unnecessary treatment delays, disputes and penalties. Many physicians object to completing and submitting two separate forms – the Primary Treating Physician's Progress Report (PR-2) and the Request for Authorization (DWC Form RFA). Instead the Institute recommends integrating the two forms into a single DWC Form RFA/PR-2. This will eliminate duplication and redundancy.

The IMR application form initiates the IMR process and must be reviewed for eligibility by the Administrative Director or her impartial, disinterested designee before being assigned to the IMR contractor, which has a clear financial interest in the review. Doing so will also help reduce the large backlog of pending independent medical reviews. A physician's failure to properly complete the Utilization Review (UR) process should not be grounds for an independent medical review. We also note that expedited review is reserved, by statute, for medical emergencies and believe there should be a consequence for filing an expedited review in bad faith.

The standards for utilization review need to be consistent with the standards for independent medical review. It is essential that the medical standards adopted by the Legislature, which are founded on evidence-based medicine, are strictly applied for utilization review, and harmonize with the standards for Independent Medical Review (IMR). Expert opinion, generally accepted standards of medical practice, or treatments likely to provide a benefit to the patient for which other treatments are not clinically efficacious will meet these standards when supported by medical evidence that is peer-reviewed and nationally recognized.

The following specific changes recommended to the proposed regulatory language are indicated by italicized and highlighted **underscore** and **strikeout**. The Institute's comments and discussion on the recommendations are *italicized*.

§9785. Reporting Duties of the Primary Treating Physician.

(a)(1) The “primary treating physician” is the **treating** 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.

The addition of “treating” provides a more complete definition.

(b)(3) **Except for determinations pursuant to Labor Code section 4610, If** the employee disputes a medical determination made by the primary treating physician, including a determination that the employee should be released from care, the dispute shall be resolved under the applicable procedures set forth in Labor Code sections 4060, 4061, 4062, 4600.5, 4616.3, or 4616.4. If the employee objects to a decision made pursuant to Labor Code section 4610 to modify, delay, or deny a treatment recommendation, the dispute shall be resolved by independent medical review pursuant to Labor Code section 4610.5, if applicable, or otherwise pursuant to Labor Code section 4062. No other primary treating physician shall be designated by the employee unless and until the dispute is resolved.

The recommended addition clarifies that all PTP determinations except for those subject to Labor Code section 4610 are resolved under the procedures in the sections listed in the first sentence.

(g) As applicable in section 9792.9.1, a written request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, must be set forth on the “Request for Authorization of Medical Treatment,” DWC Form RFA, contained in section 9785.5. **A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include or attach information to substantiate the need for the requested treatment.**

The Institute recommends restoring this language as it is important to identify when the submission confirms an earlier oral request, and information substantiating the need for treatment remains necessary.

§9785.5. Request for Authorization Form, DWC Form RFA.

Request for Authorization, DWC Form RFA

We have attached samples of two alternative DWC RFA forms. Treating physicians have commented that they do not want to complete two forms that contain duplicate information. It appears that the Division has responded by allowing requests for authorization “in a manner that does not utilize the DWC Form RFA.” If providers are not required to submit requests via a standard request form, the claims administrator may not be able to identify a request or not be able to identify such a request timely, and that will generate unnecessary treatment delays, disputes and penalties.

Because many physicians object to completing and submitting both the Primary Treating Physician’s Progress Report (PR-2) and the Request for Authorization (DWC Form RFA), the Institute recommends replacing the two forms with a single standard form that integrates aspects of both, and that must be used both to request authorizations for treatment and as a progress report. This will eliminate duplication and redundancy for treating physicians, will enable claims administrators to quickly identify every request for authorization, and will facilitate timely medical care for injured employees.

The first sample DWC RFA Form is modeled on the current PR-2 Form. A request for authorization is easily indicated by checking a field at the top of the form. The form can be used as an optional FAX-back method for authorizing requested goods and services. The main advantage of this form is that physicians, who must use the form, are used to this basic format and will therefore be able to easily transition to it. Programming changes may also be minimized.

The second sample DWC RFA Form is an amalgam of the proposed DWC RFA Form and the PR-2 Form. It contains all the information on each form without duplication. It, too, easily identifies a request for authorization and it, too, can be used as an optional FAX-back method to authorize requested goods and services. Although the form is less familiar to physicians, it includes some additional information, has a bit more capacity for requests, and includes instructions for requesting authorization and for responding to requests.

The Institute would support either form, (but not both!).

§ 9792.6. Utilization Review Standards—Definitions – For Utilization Review Decisions Issued Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013.

(f) “Dispute liability” means an assertion by the claims administrator that a factual **medical** or legal basis exists that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.

Liability determinations are sometimes based on medical determinations.

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

(a) “Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on ~~either~~ a completed “Request for Authorization for Medical Treatment,” DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, ~~or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2);~~ that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the “Request for Authorization for Medical Treatment,” DWC Form RFA if that form was initially submitted by the treating physician.

See the comments on a required form for submitting requests for authorization in the introductory paragraphs of this document, the comments on section 9785.5, and similar comments on other sections throughout this document.

~~(c) “Complete request for authorization” is one that is submitted on the DWC Form RFA with all applicable fields completed, the need for the requested treatment substantiated, the form signed by the treating physician, and reasonably requested additional information has been supplied.~~

A definition is needed so that it is clear what constitutes a complete request for authorization. If this additional subsection is accepted, it will be necessary to alphabetically reorder the definitions.

(f) “Denial” means a decision by a physician reviewer that the requested treatment or service ~~is not cannot be~~ authorized.

Some might argue over whether or not a physician reviewer is capable of authorizing. “Is not” is the accurate term to use in this definition.

(k) “Expert reviewer” means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual's scope of practice, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information. ~~The expert reviewer shall not be an employee of the claims administrator or the utilization review organization under contract to provide or conduct the claims administrator’s utilization review responsibilities.~~

The DWC's modification implies there is something improper about a claims administrator or URO having a specialist on staff. It is not improper and is in fact, appropriate for an expert reviewer to be an employee of the claims administrator or its utilization review organization. It can also be a practical necessity to meet the abbreviated workers' compensation utilization review timelines in California.

(r) "Medically necessary" and "medical necessity" mean medical treatment that is reasonably required to cure or relieve the employee of the effects of their injury and based on the following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:

(1) The Medical Treatment Utilization Schedule.

(2) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(3) Nationally recognized professional standards.

(4) Expert opinion **that is based on evidence that is peer-reviewed and nationally recognized.**

(5) Generally accepted standards of medical practice **that are nationally recognized, evidence-based, and published in peer-reviewed national journals.**

(6) Treatments that are likely to provide a benefit to a patient, **according to articles published in evidence-based, peer-reviewed and nationally recognized journals, for conditions for which other treatments are not clinically efficacious.**

The Institute recommends restoring the definition for "medically necessary" and "medical necessity" with the modifications indicated in bold. It is important that all participants know the standards that must be followed for treatment plans, utilization review and independent medical review.

The standards for utilization review must remain consistent with Labor Code sections 4600, 4610(f) and 5307.27. The recommended modifications are necessary to harmonize these sections and the standards for Independent Medical Review in Labor Code section 4610.5(c). The recommended modifications are consistent with Labor Code section 5307.27 standards which are required to be evidence-based, peer reviewed, and nationally recognized.

See also the comments in the introduction to these comments.

(t)(1) ~~Unless accepted by a claims administrator under section 9792.9.1(e)(2),~~ A request for authorization must be set forth on a "Request for Authorization for Medical Treatment (DWC Form RFA)," completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5. ~~Prior to March 1, 2014, any~~

version of the DWC Form RFA adopted by the Administrative Director under section 9785.5 may be used by the treating physician to request medical treatment.

See the comments on a required form for submitting requests for authorization in the introductory paragraphs of this document, the comments on section 9785.5, and similar comments on other sections throughout this document.

The Institute recommends requiring the use of the form adopted in this rulemaking on a going-forward basis for all requests for review submitted after the permanent regulations are implemented, or starting on a date certain, to avoid confusion and dispute over the instructions and rules that should apply.

(t)(2) “Completed,” for the purpose of this section and for purposes of investigations and penalties, means that information specific to the request has been provided by the requesting treating physician for all fields indicated on the DWC Form RFA, the request for authorization must including information identifying both the employee and the provider, and identifying with specificity a recommended treatment or treatments, and substantiating the need for the requested treatment.

In order to respond to requests and validate the need for treatment within the required timeframe, it is vital that the treating physician complete all applicable fields on the form so that the administrator can quickly confirm that it is a request for authorization of treatment; identify the claim as well as the specific treatment that is being requested; and contact the treater with a response or if clarification or additional information is needed.

(t)(3) The request for authorization must be signed by the treating physician and may be mailed, faxed or e-mailed to the designated mailing address, fax number, or email address. By agreement of the parties, the treatment treating physician may submit the request for authorization with an electronic signature.

The first recommended modification will ensure the request for authorization is submitted to the proper recipient. If it is not, the short timeframes may not be met, causing the injured employee’s treatment to be delayed, and the triggering of penalties.

(w) “Utilization review decision” means a decision pursuant to Labor Code section 4610 to approve, modify, delay, or deny a treatment recommendation or recommendations pursuant to a request for authorization submitted by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code sections 4600 or 5402(c).

Clarification is needed that a utilization review decision follows a request for authorization.

§9792.9.1. Utilization Review Standards--Timeframe, Procedures and Notice – For Injuries Occurring On or After January 1, 2013.

(c) Unless an extension is requested under subdivision (f), the utilization review process shall meet the following time requirements:

(2) ~~Unless the treating physician fails to utilize the DWC Form RFA, or If the treating physician requests a course of treatment in a manner that does not utilize the DWC Form RFA, or if~~ the DWC Form RFA does not identify the employee or provider, does not identify a recommended treatment, or is not signed by the ~~requesting treating~~ physician, a non-physician reviewer as allowed by section 9792.7 or reviewer must either ~~respond to regard~~ the request as ~~though it were~~ a complete DWC Form RFA and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked “not complete,” specifying the reasons for the return of the request, no later than ~~five (5) three (3)~~ business days from receipt. The timeframe for a decision on that returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

The Institute points out that it is the responsibility of the treating physician to submit a complete request for authorization to ensure the provision of timely medical treatment to his or her patient. At a minimum, the physician must submit the request on the required form, identify the employee, provider and recommended treatment, and sign the form. It will not be enough to supply the name of the employee because that will not be sufficient to identify the claim, -- especially when the employee has a common name. As discussed in the introduction and in other comments, if requests for authorization are not confined to a standard form they may not be identified within three or five working days, or at all because requests for authorization may be hidden in voluminous medical reports and other information. Only if the physician meets these minimum requirements should any response be required within any mandated timeframe.

Responding to requests for authorization within five working days is a Herculean task. Reducing that time to three working days to respond in writing to vague, incomplete and deficient requests with specific reasons for returning them is draconian, unrealistic and will be expensive. Albeit unintended, these requirements will result in non-compliant physicians further increasing the cost of utilization review and discouraging utilization review. The Institute does not believe that the Administrative Director has statutory authority to apply or enforce a three-day response to deficient requests for authorization.

(d)(3)(B) Payment, or partial payment consistent with the provisions of California Code of Regulations, title 8, section 9792.5, of a medical bill for services requested on the DWC Form RFA, within the 30-day timeframe set forth in subdivision (c)(~~45~~), shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete. A document indicating that a payment has been made for the requested services, such as an explanation of review, may be provided to the injured employee who received the medical services, and his or her

attorney/designee, if applicable, in lieu of a communication expressly acknowledging the retrospective approval.

Subdivision (c)(4) was renumbered (c)(5).

(e)(4) **Unless (d)(3) is applicable, for** ~~For~~ retrospective review, a written decision to deny part or all of the requested medical treatment 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 the request for authorization.

This appears to conflict with Section 9792.9.1(d)(3) which deems any timely payment of a medical bill for services requested retroactively on the DWC Form RFA to be a retrospective approval. If (d)(3)(B) applies, a response under (e)(4) will not be necessary. This recommended modification will clarify that (e)(4) will not apply if an explanation is supplied under (d)(3)(B).

(e)(5) The written decision modifying, delaying or denying treatment authorization 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 only contain the following information specific to the request:

This section conflicts with Labor Code section 4610.5(j) which prohibits the injured worker from designating a representative before the receipt of the decision. The recommended deletion will eliminate the conflict.

(e)(6)(B) Medical care provided during a concurrent review shall be medical treatment that is reasonably required to cure or relieve from the effects of the industrial injury **pursuant to Labor Code section 4610(g)(3)(B).**

We suggest adding this Labor Code reference that includes specific additional requirements.

(f)(2)(A) If information reasonably necessary to make a determination is not provided with DWC Form RFA **or other accepted request for authorization,** 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.

See introduction and other comments on the necessity for a standard DWC Form RFA.

(f)(2)(B) If any of the circumstances set forth in subdivisions (f)(1)(A), (B) or (C) are deemed to apply following the receipt of a DWC Form RFA **or accepted request for authorization,** the reviewer shall immediately 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 information reasonably necessary to make a determination, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered.

See introduction and other comments on the necessity for a standard DWC Form RFA.

(f)(3)(A) If the information reasonably necessary to make a determination under subdivision (f)(1)(A) that is requested by the reviewer or non-reviewer physician ~~reviewer~~ under subdivision (f)(2)(A) is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for ~~authorization for~~ retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

The first recommended modification is merely to correct a typographical error.

“(f)(2)(A)” appears to have been unintentionally omitted.

The last recommended modification is for clarity and consistency.

§9792.10. Utilization Review Standards--Dispute Resolution-- For Utilization Review Decisions ~~Issued~~ Communicated Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013.

This section applies ~~to if the decision on~~ any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for an occupational injury or illness occurring prior to January 1, 2013, ~~if the decision on the request~~ is communicated to the requesting physician prior to July 1, 2013.

The proposed language suggests that the section applies to certain requests for authorization. According to Labor Code section 4610.5(a), however, IMR applies to injuries occurring on or after January 1, 2013, and to any injury where the decision on requests for authorization is “communicated to the requesting physician on or after July 1, 2013.” The changes the Institute recommends clarify that the section applies where those IMR conditions do not apply.

§ 9792.10.1. Utilization Review Standards--Dispute Resolution – On or After January 1, 2013.

(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 utilization review

decision. The request must be made on the Application for Independent Medical Review, DWC Form IMR **completed by the claims administrator**, and must be 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.

The recommended modification clarifies that the eligible party must submit the form completed by the claims administrator that is sent accompanies the written decision.

(d)(1) Nothing in this section precludes the parties from participating in an internal utilization review appeal process on a voluntary basis provided the employee and, if the employee is represented by counsel, the employee's attorney, have been notified of the 30-day time limit to file an objection to the utilization review decision in accordance with Labor Code sections 4610.5 and 4610.6. Any request by the injured worker or treating physician for an internal utilization review appeal process conducted under this subdivision must be submitted to the claims administrator within **fifteen (15) ~~ten (10)~~** days after the receipt of the utilization review decision.

The injured employee has thirty days from the receipt of the UR decision to request an IMR, therefore fifteen days is doable within the timeframe. Those using an internal UR process report seeing up to 50% of the determinations overturned during the internal process, primarily because the initial denial was based on lack of documentation necessary to make a decision when the requesting physician failed to respond to a request for information necessary to make a determination, and the information came in during the 15-day timeframe. If the number of days is reduced from fifteen to ten, the number of IMR requests will increase unnecessarily.

§ 9792.10.2. Application for Independent Medical Review, DWC Form IMR

See the Institute's recommended changes in the attached form. The reasons for the recommended changes are summarized as follows:

- *There is a typographical error in the spelling of "independent" in the box near the top of the form.*
- *It is not clear why the EAMS case number and the 22-digit WCIS Jurisdictional claim number (JCN) are required. They are not necessary in the application process for independent review, nor are they useful for performing independent review. It has been suggested that they are necessary as replacements for the Social Security number here, however the Social Security number is also unnecessary. The claim number, or the employee name, and date of injury, which are included on the form, provide the*

identification that is necessary, are less burdensome, and can and are used by the Division to crosswalk to the EAMS and JCN numbers in the event they are necessary. The date of birth can be added for additional identification. If the Administrative Director retains these requirements, the additional time and expense needed to provide that information must be considered and disclosed in the regulatory process.

- *Recommended changes are necessary to clarify that the disputed treatment is to be entered as described by the physician on the request for authorization.*
- *It is necessary to identify services or goods:*
 - *For which the medical necessity is disputed during utilization review but that are also disputed for reasons other than medical necessity because this will alert the Administrative Director that IMR must be delayed until the non-medical necessity dispute is resolved.*
 - *That are delayed or disputed because the physician did not submit the reasonably requested medical information that is necessary to review the request for authorization, because the IMR application should be ineligible until the necessary information is timely submitted for a request for authorization and the claims administrator completes the utilization review.*
- *Requiring the injured employee's original signature on the IMR form completed by the claims administrator when requesting the review will ensure that the employee is aware of, and wishes this independent review.*
- *We note a typographical error which can be corrected by replacing “singed” with “signed.”*

In addition, the deletion of Maximus as the destination of the application for initial review is recommended as there is an evident financial conflict of interest as noted also in the introduction to these comments. The Institute believes the application must instead instruct the injured employee to submit the application either directly to the Division of Workers' Compensation or to a designated entity that has no such conflict of interest. Doing so will also help reduce the large backlog of independent medical reviews.

§ 9792.10.3. Independent Medical Review – Initial Review of Application

(a) Following receipt of the Application for Independent Medical Review, DWC Form IMR, pursuant to section 9792.10.1(b), the Administrative Director shall determine, within 15 days following receipt of the application and all appropriate information to make a determination, whether the disputed medical treatment identified in the application is eligible for independent medical review. **If the Administrative Director assigns a designee to review the eligibility for independent review pursuant to Labor**

Code section 4610.5(k), the designee shall have no financial interest in the independent medical review. In making this determination, the Administrative Director shall consider:

The Institute believes that the IMR application form must be reviewed for eligibility by the Administrative Director or her impartial, disinterested designee before being assigned to the IMR contractor, which has a clear financial interest in the review. Doing so will also reduce the current IMR contractor's workload which may help reduce the large backlog of pending independent medical reviews.

(a)(3) Any assertion by the claims administrator that a factual, medical or legal basis exists that precludes liability on the part of the claims administrator for an occupational injury or a claimed injury to any part or parts of the body.

Liability can be denied based on a medical determination.

(a)(4) Any assertion by the claims administrator that a factual, medical or legal basis exists that precludes liability on the part of the claims administrator for a specific course of treatment requested by the treating physician.

Liability can be denied based on a medical determination.

(a)(6) The failure by the requesting physician to respond to a request by the claims administrator under section 9792.9.1(f) for information reasonably necessary to make a utilization review determination, for additional required examinations or tests, or for a specialized consultation.

The Institute is in full support of this modification. Until the physician provides requested information necessary for a UR determination, an application should not be eligible for IMR, thereby preventing Independent Review when necessary information is not submitted, preventing end runs around UR when requested information is sent directly to IMR instead of to UR, and eliminating unnecessary IMR costs.

(c) The parties shall respond to any reasonable request made pursuant to subdivision (b) within five (5) fifteen (15) days following receipt of the request. Following receipt of all information necessary to make a determination, the Administrative Director shall either immediately inform the parties in writing that a disputed medical treatment is not eligible for independent medical review and the reasons therefor, or assign the request to independent medical review under section 9792.10.4.

The timeframe to respond to the request has been reduced to five days from fifteen. Five days is an unreasonably short time in which to identify the request, locate and obtain the requested information and to transmit the information to the Administrative Director, particularly if information must be obtained from third parties or disparate locations. If the Administrative Director must make a

determination within fifteen days of receipt of the IMR application “and all appropriate information to make a determination,” as now proposed in sub-section (a), the Institute recommends restoring the fifteen-day timeframe in which parties must respond. If however the Administrative Director must make a determination within fifteen days of receipt of the IMR application (regardless of the date “all appropriate information to make a determination” is received), the Institute recommends instead allowing ten days for parties to respond.

(e) The parties may appeal an eligibility determination by the Administrative Director ~~that a disputed medical treatment is not eligible for independent medical review~~ by filing a petition with the Workers' Compensation Appeals Board.

Parties must be able to appeal a determination that a disputed medical treatment is either not eligible or is eligible.

§ 9792.10.4. Independent Medical Review – Assignment and Notification

(a) The independent review organization delegated the responsibility by the Administrative Director to conduct independent medical review pursuant to Labor Code section 139.5 (IMRO) may consolidate two or more eligible applications for independent medical review by a single employee for resolution in a single determination if the applications involve the ~~the~~ same requesting physician and the same date of injury.

The Institute supports the consolidation of requests by the same physician for treatment of the same injured employee for the same date of injury. Individual requests for treatment that are -- or should be -- part of the same treatment plan should be considered together. The medical necessity of an individual service or good is dependent on the other services and goods that are also requested.

(c) Review conducted on a regular basis shall be converted into an expedited review if, subsequent to the receipt of the Application for Independent Medical Review, DWC Form IMR, the independent review organization receives from the employee's treating physician a certification that the employee faces an imminent and serious threat to his or her health as described in section 9792.10.6.1(j). The independent review organization shall immediately notify the parties by the most efficient means available that the review has been converted from a regular review to an expedited review.

There is no section 9792.10.6.1(j). This is likely just a typographical error and the section intended is 9792.6.1(j).

§ 9792.10.5. Independent Medical Review – Medical Records

(a)(1)(B) A copy of ~~the written determination by the claims administrator issued under section 9792.9.1(e)(5) that notified the employee and the requesting physician that the disputed medical treatment was denied, delayed or modified. The copy should not include~~

the application for independent medical review included with the determination pursuant to sections 9792.10.1(b) and 9792.10.2 . The application's instructions may be excluded.

An application for IMR is ineligible if it is not submitted with the written determination issued by the claims administrator or reviewer pursuant to 9792.9.1(e)(5). If IMR is found eligible and is assigned for independent medical review, the IMRO is already in receipt of the determination and another copy is not necessary.

Even though the IMR application form instructions prohibit any changes to the application, many applications have been, and continue to be altered. We therefore, suggest including the original application in the package of documents that go to the IMRO so that the reviewer has the required information. This requirement may also discourage the practice of altering the application.

(a)(2) The claims administrator shall, concurrent with the provision of documents under subdivision (a), forward to the employee or the employee's representative a notification that lists all of the documents submitted to the independent review organization under subdivision (a). The claims administrator shall provide with the notification a copy of all documents that were not previously provided to the employee or the employee's representative, excluding mental health records withheld from the employee pursuant to Health and Safety Code section 123115(b). If any of the documents have not been previously served on the employee or the employee's representative and the employee or the employee's representative requests a copy of a report on the list, the claims administrator shall forward a copy of the requested report to the employee or the employee's representative. If mental health records are withheld from the employee pursuant to Health and Safety Code section 123115(b) the claims administrator shall advise the employee in writing upon receipt of a request from the employee for a copy of a record being withheld pursuant to Health and Safety Code section 123115(b).

Filtering out mental health records will create administrative problems and costs. We recommend requiring instead that an itemization of the medical records be served on the employee and their representative with a notice that the employee or the employee's representative may request to be served with any report on the list if they advise the claims administrator that they do not have a copy of it in their possession. Mental health records would be excluded from the requirement of service on the employee, but a response outlining the reason that the reports can't be served on the employee would be required in the event that an employee requested those records.

§ 9792.10.6. Independent Medical Review – Standards and Timeframes

(d) The determination issued by the medical reviewer shall state whether the disputed medical treatment is medically necessary. The determination shall include the employee's medical condition, a list of the documents reviewed, a statement of the disputed medical treatment, references to the Medical Treatment Utilization Schedule and specific medical

and scientific evidence utilized pursuant to section 9792.6.1(r), and the clinical reasons regarding medical necessity.

Labor Code section 4610.5(c)(2) requires the MTUS to be applied and relied on unless it is inapplicable to the employee's medical condition. The determination must reference the Medical Treatment Utilization Schedule (MTUS) because it is the highest ranked standard, and if the MTUS is inapplicable to the employee's medical condition, the report should reference the reason it is inapplicable.

If the Institute's recommendation to restore a modified definition for "medically necessary" and "medical necessity" is accepted, we recommend restoring the reference to section 9792.6.1(r) regarding the standards that the independent medical reviewer must use. As we note in the introduction, and in comments on section 9792.6.1, the Institute firmly believes that the standards must be supported by medical evidence that is peer-reviewed and nationally recognized.

(i) Upon receipt of credible information that the claims administrator has failed to comply with its obligations under the independent medical review requirements set forth in Labor Code sections 4610.5 or in sections 9792.6 through 9792.10.8 of this Article, the Administrative Director shall concurrent or subsequent to the issuance of the final determination issued by the independent review organization, issue an order to show cause under section 9792.15 for the assessment of administrative penalties against the claims administrator under section 9792.12(e) send complete documentation to the audit unit for review and assessment of appropriate administrative penalties when the claims administrator undergoes its next regularly scheduled "PAR" or "non-random" audit.

It is unnecessary, duplicative and overly punitive to conduct a separate summary proceeding for a claims administrator's alleged failure to comply with the IMR requirements because audit and penalty schedules already exist to deter noncompliance. Adding this separate summary proceeding will amount to a piling-on of penalties for the same act. In instances where a credible complaint is made against a claims administrator, the complaint should be logged in the claims administrator's file and investigated during the subsequent PAR or targeted audit per 9792.11(c)(2)(A)(B).

§ 9792.10.7. Independent Medical Review – Implementation of Determination and Appeal.

(b) Upon receipt of credible information that the claims administrator has failed to implement the final determination as required in subdivision (a), the Administrative Director shall issue an order to show cause under section 9792.15 for the assessment of administrative penalties against the claims administrator under section 9792.12(e) send complete documentation to the audit unit for review and assessment of appropriate administrative penalties when the claims administrator undergoes its next regularly scheduled "PAR" or "non-random" audit.

It is unnecessary, duplicative and overly punitive to conduct a separate summary proceeding for a claims administrator's alleged failure to comply with the IMR requirements because audit and penalty schedules already exist to deter noncompliance. Adding this proceeding will amount to a piling-on of penalties for the same act. In instances where a credible complaint is made against a claims administrator, the complaint should be logged in the claims administrator's file and investigated during the subsequent PAR or targeted audit per 9792.11(c)(2)(A)(B).

§ 9792.10.8. Independent Medical Review – Payment for Review

(c) The aggregate total fee owed by the claims administrator for the prior calendar month shall be paid to the independent medical review organization within ~~thirty (30)~~ **forty-five (45)** days of the billing. If the aggregate total fee is not paid within ten (10) days after it becomes due, there shall be added an additional amount equal to 10 percent, plus interest at the legal rate, which shall be paid at the same time but in addition to the total aggregate fee.

The timeframe for payments to the independent medical review organization should be consistent with payments to providers under Labor Code section 4603.2. We suggest extending the timeframe in this section to forty-five days.

§ 9792.12. Administrative Penalty Schedule for Utilization Review and Independent Medical Review Violations

(a)(12) For failure to respond to a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted~~ by the injured employee's requesting treating physician, in the case of a non-expedited concurrent review: \$ 2,000;

(a)(13) For failure to respond to a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted~~ by the injured employee's requesting treating physician, in the case of a non-expedited prospective review: \$ 1,000;

(a)(14) For failure to respond to a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted~~ by the injured employee's requesting treating physician, in the case of a retrospective review: \$ 500;

The Institute urges the DWC to delete the modified language referencing the alternative request for authorization under section 9792.9.1(c)(2). There should only be one uniform and identifiable request for authorization form. See the introduction and comments on section 9792.9.1(c)(2) and elsewhere in this

document. Only a valid DWC Form RFA should be subject to UR standards, timeframes, procedures and penalties.

(b)(4)(C) For failure to make a decision to approve or modify or deny the request for authorization, within five (5) working days of receipt of a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2)~~ submitted by the injured employee's requesting treating physician, or receipt of the requested information for prospective or concurrent review, and to communicate the decision as required by section 9792.9(h)(3) and section 9792.9.1(f) (4);

The Institute urges the DWC to delete the modified language referencing the alternative request for authorization under section 9792.9.1(c)(2). There should only be one uniform and identifiable request for authorization form. See the introduction and comments on section 9792.9.1(c)(2) and elsewhere in this document. Only a valid DWC Form RFA should be subject to UR standards, timeframes, procedures and penalties.

(b)(4)(D) For failure to make and communicate a retrospective decision to approve, modify, or deny the request, within thirty (30) working days of receipt of a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2)~~ submitted by the injured employee's requesting treating physician, or receipt of the requested information, as required by section 9792.9(h)(4) and section 9792.9.1(e)(4), and (f)(6);

The Institute urges the DWC to delete the modified language referencing the alternative request for authorization under section 9792.9.1(c)(2). There should only be one uniform and identifiable request for authorization form. See the introduction and comments on section 9792.9.1(c)(2) and elsewhere in this document. Only a valid DWC Form RFA should be subject to UR standards, timeframes, procedures and penalties.

(c)(1) For the failure to provide the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, with all applicable fields completed by the claims administrator, with a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(l) or 9792.9.1: ~~\$2,000~~.

The proposed penalty is overly punitive for what can amount to a nonmaterial administrative error that will have little if any effect on the IMR process. Under this section, a claims administrator would face a \$2,000 fine for failing to fill out any one of the fields on the IMR application. This type of administrative error does not rise to the same level as failing to provide an injured worker with an IMR application and, as such, should not impose the same level of punishment.

We suggest that the DWC create a three-tiered penalty scheme for IMR applications:

1. ***Nonmaterial failure to complete IMR application form fields:*** A penalty of no more than \$100 should be assessed against the claims administrator for a non-material administrative error that does not have a significant effect on the IMR application process.
2. ***Material failure to complete IMR application form fields:*** A penalty of no more than \$500 should be assessed for material errors that have a significant effect on the IMR application process.
3. ***Failure to provide IMR application with the complete written decision modifying, delaying or denying treatment:*** A penalty of no more than \$2,000 should be assessed for failure to provide the IMR application to the injured worker with the complete written decision.

The total amount of the penalty should be at the discretion of the Administrative Director and should be based on an analysis of the severity of the violation, the effect on the IMR process and efforts undertaken to remedy the error.

~~(c)(2) For the failure to include in a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(1) or 9792.9.1 a clear statement that advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, within 30 days of service of the utilization review decision: \$1,000.~~

~~(c)(3) For the failure to include in a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(1) or 9792.9.1 a statement detailing the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a 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: \$1,000.~~

Subdivisions (c)(2) and (c)(3) are redundant and should be struck. Essentially, there are now three sets of penalties for the same act – failing to provide a complete statement to an injured worker along with a decision to modify, delay or deny treatment. Section 9792.12(c)(1) penalizes claims administrators for failure to provide this statement, while sections 9792.12(c)(2)-(3) provide penalties for deficient statements. There is little operative distinction between the different violations, and this will likely lead to a piling-on of penalties on claims administrators for essentially one violation.

We suggest that the DWC strike these sections and address these penalties through the penalty scheme recommended in section 9792.12(c)(1).

(c)(4) For the failure to timely provide information requested by the Administrative Director under section 9792.10.3(b): \$500.00 for each day the response is an untimely response under section 9792.10.3(c), up to a maximum of \$5,000.00.

There is no statutory authority for assessing penalties against a claims administrator for failing to timely provide the Administrative Director with requested information and there is little need for this penalty. If a claims administrator fails to provide the requested information, the Administrative Director may move forward with independent medical review and base the decision solely on the information already provided. This risk already serves as a deterrent to delaying the submission of requested information. The Institute suggests a non-cumulative penalty of no more than \$500.00.

(c)(7) For the failure to reimburse the reasonable amount of service in accordance with applicable fee schedules for services already rendered that has been found to be medically necessary by the independent medical review organization in the final determination issued under section 9792.10.6 within twenty (20) days after receipt of the final determination, or within twenty (20) days from the date the determination is final if an appeal of the determination has been filed under Labor Code section 4610.6(h), subject to resolution of any remaining issue of the amount of payment pursuant to Labor Code sections 4603.2 to 4603.6, inclusive: \$500.00 for each day up to a maximum of \$5,000.00.

IMR decisions determine whether a treatment is medically necessary, not the appropriateness of the amount billed for the treatment. This section needs clarification to accommodate situations where the amount billed for treatment is in dispute. As this section is currently drafted, a claims administrator has 20 days to reimburse the provider for services rendered that have been found medically necessary by the independent medical review organization. A dispute over the amount of payment for the service may arise and continue beyond these 20 days. In a situation where the claims administrator reimbursed the provider the reasonable amount of the service pursuant to a fee schedule - even if it is not the billed amount – the claims administrator should not face penalties.

Thank you for all the effort put into these regulations and for considering our comments.

Sincerely,

Brenda Ramirez
Claims and Medical Director

BR/pm
Attachments

cc: Christine Baker, DIR Director
Destie Overpeck, DWC Acting Administrative Director
Dr. Das Rupali, DWC Executive Medical Director
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Legal Committee
CWCI Regular Members
CWCI Associate Members
California Chamber of Commerce
California Coalition on Workers' Compensation
American Insurance Association