California Workers' Compensation Institute
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March 14, 2025

VIA E-MAIL – dwcrules@dir.ca.gov

Maureen Gray, Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
P.O. Box 420603
San Francisco, CA 94142

Re: Proposed Amendments to the Utilization Review Regulations – 15-Day Comment Period

Dear Ms. Gray:

These comments on proposed modifications to the text of rules related to the Utilization Review Regulations are presented on behalf of members of the California Workers' Compensation Institute (the Institute). Institute members include insurers writing 76% of California's workers' compensation premium, and self-insured employers with $92B of annual payroll (30.3% of the state's total annual self-insured payroll).

Insurer members of the Institute include AF Group/CompWest, AIG, AmTrust North America, Berkshire Hathaway Homestate Companies, CHUBB, CNA, CopperPoint Insurance Companies, Crum & Forster, EMPLOYERS, Everest Insurance, GUARD Insurance Companies, The Hanover Insurance Group, The Hartford, ICW Group Insurance Companies, Liberty Mutual Insurance, North American Casualty Company, Pie Insurance, Preferred Employers Insurance, Republic Indemnity , Sentry Insurance, State Compensation Insurance Fund, Travelers, WCF Insurance, Zenith Insurance Company, and Zürich North America.

Self-insured employer members include Albertsons Companies, Alliance of Schools for Cooperative Insurance Programs, BETA Healthcare Group Risk Management Authority, California Fair Services Authority, California Joint Powers Insurance Authority, California State University Risk Management Authority, Chevron Corporation, City and County of San Francisco, City of Los Angeles, City of Pasadena, Costco Wholesale, County of Los Angeles, County of Santa Clara Risk Management, Dignity Health, Disneyland Resort, East Bay Municipal Utility District, Grimmway Farms, Kaiser Permanente, Loma Linda University Health Risk Management, North Bay Schools Insurance Authority, Pacific Gas & Electric Company, San Diego Gas & Electric Company, Schools Insurance Authority, Shasta County Risk Management, Shasta-Trinity Schools Insurance Group, Southern California Edison, Southern

California Gas Company, Special District Risk Management Authority, Sutter Health, United Airlines, and the University of California.

Recommended revisions to the proposed regulations are indicated by double underscore and ~~strikeout~~. Comments and discussion by the Institute are identified by italicized text.

The Institute offers the following comments:

§ 9785.6. DWC Form PR-1: "Treating Physician's Report" – Optional for Services On or After (EFFECTIVE DATE OF REGULATION)

SECTION A. 1Request for Authorization (Non-Drug) ☐Check if Expedited Request

☐Resubmission, Change in Material Fact - Explain in detail in Additional Physician Comments below.

Additional Physician Comments (If ~~RX~~ treatment is not consistent with the MTUS, explain, cite above and attach documentation. May also include special circumstances or other pertinent information.) (See CCR, title 8, section 9792.21.1(b)(1).)

~~Send response to physician via: ☐ Fax ☐ Email ☐ Regular Mail~~

Recommendations:

The Institute recommends that emphasis be added to the resubmission selection so it is clear that only checking the box is not sufficient. While the form directions advise the physician to include documentation supporting the claim of change in material fact, the physician is not directed to where that documentation should be included.

The Notice of Modification to Text of Proposed Regulations and Forms states that the typographical error of RX rather than treatment was corrected; however, it was not corrected on the DWC Form PR-1.

The Institute recommends deletion of the newly added choices for the response to the requesting physician. Labor Code section 4610(i)(4)(A) requires that "Final decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, secure email." (emphasis added)

Claims administrators and UROs have established practices to comply with Labor Code notice requirements. Allowing providers to choose methods of notice that are not compliant with the Labor Code would result in duplicate efforts.

Comments:

The Institute supports the change from mandatory to optional for the use of the PR-1.

We also support the change in the instructions to require that the treating physician submit only those sections that are relevant to that reporting.

§ 9792.7.1. DWC Form UR-01: "Utilization Review Plan Application or Modification."

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

Recommendations:

The Institute recommends deletion of the language regarding unintended approval. The Division is responsible for the review and approval of all utilization review plans. The claims administrator or URO should be able to rely upon the approval of their policies and procedures to conduct utilization review internally or for their customers without concern of later consequences.

§ 9792.9.1. Utilization Review - Receipt of Request for Authorization; Acceptance of Defective Request.

~~(b)(2) Upon receipt of a request for authorization submitted via a non-designated address, e-mail address, or fax number; a claims administrator, non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as if it had been submitted via a designated point of contact, or, within five (5) business days from receipt, mark it as "Resubmission Required" and return it to the requesting physician with an attached letter or notice specifying the reason for the return of the request and the designated facsimile, email, or postal address to where the request should be re-sent. A request for authorization accepted as if it were submitted via a designated point of contact shall be subject to investigation under section 9792.11 and the assessment of administrative penalties under section 9792.12.~~

Recommendation:

The Institute recommends deleting this entire section. Government Code section 11346.8(c) allows a 15-day notice if a substantive change is "sufficiently related to the original text that the public was adequately placed on notice that the change could result from the originally proposed regulatory action." The Institute does not believe that this substantial change is sufficiently related to the original proposed modifications to be addressed in a 15-day comment period and that another 45-day notice is required.

As this section was added during a 15-day comment period rather than another 45-day comment period there is no Statement of Reasons to explain or support this burdensome and likely impossible task.

There is no definition of a "non-designated address" which could be virtually anything. Claims administrators may have multiple locations, different third-party administrators, email addresses for hundreds of employees, and multiple facsimile numbers for different departments. How would a claims administrator identify treatment requests that were submitted incorrectly and then return them to the requesting provider within five (5) business days of receipt, when the request may not have been received by the correct claims administrator at all?

Proposed section 9767.6(f) would require that the claims administrator provide all selected MPN physicians with "the relevant MPN identification number, name, telephone number, fax number, email address, and mailing address of the person or entity to whom a request for authorization and bills should be sent." The provider should then have the responsibility to submit treatment requests to the correct address. The claims administrator should not be required to hunt down errant requests, where even possible, and then respond to a provider that did not follow directions.

§ 9792.9.2. Utilization Review —Dispute of Liability; Deferral.

(a)(2)(B) A request for authorization of treatment for which UR would otherwise be precluded under Labor Code section 4610(k) cannot be deferred if the requesting physician expressly and unequivocally indicates or opines in the request for treatment that there has been a change in facts material to the basis of the prior denial of such same treatment. This includes, but is not limited to, when a physician marks the checkbox at the top of either the DWC Form RFA or the DWC Form PR-1 indicating that the report is a "Resubmission – Change in Material Fact," or, if the request is made in a narrative report, includes such express and unequivocal indication on the first page of the report. <u>The requesting physician must provide an explanation of why the change is material within the treatment request.</u> Such a request must be reviewed by a physician reviewer and any modification or denial of the request must comply with applicable requirements as set forth at section 9792.9.5.

Recommendation:

As noted in our recommendation for Form PR-1, the Institute recommends adding language advising the requesting physician that checking the box is not sufficient to support the resubmission of a prior request.

§ 9792.9.8. Utilization Review — MTUS Drug Formulary.

(b)(1)(A) The reviewer or physician reviewer shall request the information from the treating physician within ~~no less than~~ four (4) business days from the date of receipt of the request for authorization.

Recommendation:

The Institute recommends this edit for clarity.

§9792.10.8. Independent Medical Review – Payment for Review.

(a)(2)(B) If the review of an application and documentation and information provided under section 9792.10.5 is terminated by the independent review organization subsequent to the start of the record-gathering process under section 9792.10.5, the cost will be the same as if a determination under section 9792.10.6(b) had been issued by the medical reviewer.

Recommendation:

The Institute requests clarification of the term "the start of the record-gathering process" in subsection (2)(B). If full payment is to be required at a point prior to receipt of the documentation and information, a specific identifiable date, i.e., X days after the mailing of the NORFI is required.

§ 9792.10.8. Independent Medical Review – Payment for Review.

(3) Re-reviews: If it is determined that a re-review is required under Labor Code section 4610.6(h), the re-review shall be completed without any additional cost. ~~Each subsequent order for re-review on a single IMR case beyond the first re-review shall incur a fee of $295.00 to be paid by the claims administrator.~~

Recommendation:

The Institute recommends that only the second sentence of section 9792.10.8(a)(3) be deleted rather than the entire section. If the WCAB reverses an IMR determination resulting in the need for a re-review, the claims administrator should not be responsible for that cost. If the entire section is removed it will be unclear whether or not a claims administrator is responsible for re-review costs.

Thank you for the opportunity to comment. Please contact us if additional information would be helpful.

Sincerely,

Sara Widener-Brightwell

Sara Widener-Brightwell, SVP Claims and General Counsel
California Workers' Compensation Institute

SWB/pm

cc: Katrina Hagen, DIR Executive Director
George Parisotto, DWC Administrative Director
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Legal Committee
CWCI Regular Members
CWCI Associate Members