California Workers' Compensation Institute
1999 Harrison St., Suite 2100, Oakland, CA 94612 (510) 251-9470 • www.cwci.org

July 25, 2024

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 – 45-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 (30.4% of the state's total annual self-insured payroll).

Insurer members of the Institute include AF Group/CompWest, AIG, Allianz Global Corporate and Specialty, 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, Liberty Mutual Insurance, North American Casualty Company, Preferred Employers Insurance, Republic Indemnity Company of America, 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, 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, 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 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" – Mandatory for Services On or After ~~July 1, 2021.~~ (SIX MONTHS AFTER EFFECTIVE DATE OF REGULATION).

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

~~☒Response to RFI, as included in: ☐Section A ☐Section B ☐Section C~~

~~Claims Administrator/URO Response:~~

~~Treatment Requested~~	~~Decision~~	~~Comments~~

~~Authorizing Agent Name:~~ ~~Signature:~~

Recommendations:

The Institute recommends that the mandatory date for using the PR-1 be amended to six months after the effective date of these regulations, consistent with § 9785.6 (g)(2).

The Institute also recommends that the Claims Administrator/URO Response section be deleted from pages 2 and 3 of the PR-1. Claims administrators and UROs have established processes for responding to treatment requests that include all information required by Labor Code § 4610(i)(5), and §§ 9792.9.1(d)(1) and 9792.9.1(e)(5) and are unlikely to repeat those responses on the PR-1. If the Claims Administrator/URO Response sections are deleted, the check box for RFA response on page one should also be deleted. If the Claims Administrator/URO Response sections are retained, the check boxes for Sections B and C should be deleted as any response would pertain to treatment requests in Section A only.

We also recommend that the instructions be amended to require that the treating physician submit only those sections that are relevant to that reporting, i.e., page 1 plus Section A, B and/or C. Requiring submission of sections that are not relevant will add unnecessary length to the PR-1, which will impact medical-legal record review charges.

§9786. Petition for Change of Primary Treating Physician.

(c)(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 5021, within 5 working days of the initial examination pursuant to Section 9785, subdivision (e)(1), the petition setting forth such allegation shall be filed within 90 days of the claims administrator's knowledge of the initial examination

Comment:

The Institute supports the addition of "claims administrator's knowledge" to the 90-day time limit.

(f) The physician may continue to serve as primary treating physician until an order of the Administrative Director issues granting the petition.

Comment:

The Institute supports the elimination of liability for payment for treatment by the primary treating physician while the Administrative Director considers the Petition for Change of Primary Treating Physician.

§9792.6.1. Utilization Review Standards—Definitions.

The 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.

Comment:

The Institute recommends deleting the date references consistent with § 9792.9.1, as they are no longer relevant.

(d) "Course of treatment" means the course of medical treatment set forth in the treatment plan contained on the "Doctor's First Report of Occupational Injury or Illness," Form 5021, found at California Code of Regulations, title 8, section ~~14006 or~~ 14006.1, or on the applicable physician reporting forms authorized by section 9785.

Recommendation:

The Institute recommends deleting the reference to section 14006 as this is the 1992 version of Form 5021. All links to the Form 5021 are directed to the 10/2015 version in section 14006.1.

(dd) "Working day" as used in this article is the same as "normal business day~~.~~" or "business day".

Recommendation:

The Institute supports the addition of subsection (dd) to clarify that "working day" is used interchangeably with "normal business day" in these regulations and recommends the addition of "business day" to the definition for consistency with subsection (cc).

§9792.7. Utilization Review Standards—Applicability

(c)(2) Utilization review plans that modify or deny treatment requests shall submit with their plan a completed DWC Form UR-01, "Application for Approval as Utilization Review Plan," set forth in section 9792.7.1, with an original signature by the applicant's medical director. The utilization review plan shall be submitted in compact discs or flash drives in word-searchable PDF format. The hard copy of the completed, signed original shall be maintained by the applicant and made available for review by the Administrative Director upon request. Electronic signatures in compliance with ~~California Government Code section 16.5~~ Civil Code section 1633.2 are acceptable.

Recommendation:

The Institute recommends using the Uniform Electronic Transactions Act, Civil Code section 1633.2 as the standard for electronic signatures, consistent with the proposed language in AB 2337 for electronic signatures on Compromise and Release agreements.

§9792.9. Utilization Review Standards - Timeframe, Procedures and Notice Content - For Injuries Occurring Prior to January 1, 2013, Where the Request for Authorization is Received Prior to July 1, 2013.

Comment:

The Institute supports the deletion of § 9792.9 to avoid redundancy.

§9792.9.4. Utilization Review — Decisions to Approve a Request for Authorization.

(b) For prospective, concurrent, or expedited review, a decision to approve a request for authorization of treatment shall be initially communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, secure electronic mail. If the initial communication is by telephone, written communication shall issue to the requesting physician within 24 hours of the decision for concurrent review and within two (2) business days for prospective review.

Comment:

The Institute supports the clarifications to the manner and the timeframe within which approval decisions should be communicated.

§9792.9.7. Utilization Review – Medical Treatment – First 30 Days of the Date of Injury.

(a)(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 the "Doctor's First Report of Occupational Injury or Illness" by the initial treating physician or in the PR-1 by subsequent treating physicians. ~~a request for authorization provided to the claims administrator in accordance with section 9785(h). 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.~~

Recommendations:

The Institute recommends that only non-exempt treatment requests be included in the request for authorization. Claims administrators treat the request for authorization form as exactly that; a request that triggers the utilization review process. Requiring the completion of the request for authorization form for treatment that is exempt from prospective utilization review will be confusing and is not necessary. If the proposed requirement is retained, this subsection should be clear that only section A of the proposed PR-1 should be submitted by the initial treating physician with the Doctor's First Report of Occupational Injury or Illness and not the complete PR-1.

§9792.9.8. Utilization Review — MTUS Drug Formulary.

~~(a) (2) Exempt drugs identified in subsection (1) must still be set forth in a request for authorization as required under section 9792.6.1(u), or in a manner agreed upon by the treating physician and the claims administrator.~~

(g) (1) The injured worker's initial treating physician shall describe in the treatment plan on the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, all drugs that are being prescribed ~~or~~and all exempt drugs that are being dispensed to treat the injured worker, and list on the request for authorization ~~required under section 9792.9.7(a)(4),~~ all non-exempt or unlisted drugs that are being prescribed~~ or dispensed~~. Subsequent primary treating physicians shall submit a request for authorization following their first visit with the injured worker indicating all non-exempt or unlisted drugs that are being prescribed ~~or dispensed~~ for treatment.

Recommendation:

As noted above, requiring the completion of the request for authorization form for treatment that is exempt from prospective utilization review will be confusing and is not necessary. The Institute therefore recommends that subsection (a)(2) be deleted, and subsection (g)(1) be amended.

§9792.9.8. Utilization Review — MTUS Drug Formulary.

(d) Notwithstanding subdivision (b), a request for authorization that requests both drugs and non-pharmaceutical treatment related to the same condition shall be reviewed under the timeframes set forth in section 9792.9.3 and section 9792.9.6 and the requirements of sections 9792.9.4 and 9792.9.5.

Comment:

The Institute requests clarification of the definition of "the same condition" for purposes of this subsection.

§9792.9.8. Utilization Review — MTUS Drug Formulary.

(g) (4) The claims administrator may conduct retrospective review of a drug prescribed or dispensed to the injured worker under subdivision (a) of ~~this~~ section 9792.9.7 only for the purpose of determining whether the use of the drug is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director under Section 5307.27.

Comment:

This subsection appears to refer to §9792.9.7. Utilization Review – Medical Treatment – First 30 Days of the Date of Injury, not §9792.9.8. Utilization Review – MTUS Drug Formulary.

§9792.10.1. Utilization Review -- Dispute Resolution~~— On or After January 1, 2013~~. This section applies 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 is communicated to the requesting physician on or after July 1, 2013,~~ regardless of the date of injury.

Recommendation:

The Institute recommends deleting the date references as they are no longer relevant.

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

[DWC Form IMR 06/2024)]

Requesting Physician Information:
Physician First Name: Middle Initial: Last Name:
Practice Name:
Address: Number/Unit:
State: Zip Code: Telephone Number:
NPI:

Recommendation:

The Institute recommends adding a field in the Requesting Physician Information section for the physician's NPI.

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

[DWC Form IMR 06/2024)]

~~**Proposed Treating Physician's Report (DWC Form PR-1) (06/2024)**~~ **Proposed DWC Form IMR (06/2024)**

Recommendation:

The footer on page 1 should be corrected to Proposed DWC Form IMR (06/2024).

§9792.10.8. Independent Medical Review – Payment for Review.

(2) For withdrawn reviews:

(A) $115.00 for each application where review is terminated by the independent review organization prior to the receipt of the documentation and information provided under section 9792.10.5 by a medical reviewer.

(B) If the review of an application and documentation and information provided under section 9792.10.5 is terminated by the independent review organization ~~during or~~ subsequent to the receipt of the documentation and information provided under section 9792.10.5 by a medical reviewer, 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 "during or subsequent to" in subsection (2)(B). Termination can only occur before or after the receipt of documentation. Subsection (2)(A) provides that the required payment for a withdrawn review is $115.00 if the review is terminated prior to receipt of documentation by the medical reviewer. If full payment is to be required at a point prior to receipt of the documentation and information a specific point in time is required, i.e., X days after the mailing of the NORFI.

§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 the proposed charge for a second or subsequent re-review be deleted. 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.

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
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