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April 4, 2013

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

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

RE: Written Testimony on Proposed Permanent Independent Medical Review Regulations Sections 9785, 9785.5, and 9792.6.1 – 9792.12

Dear Ms. Gray:

This written testimony on 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 80% of California's workers' compensation premium, and self-insured employers with $36B of annual payroll (20% 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, City and County of San Francisco, City of Santa Ana, City of Santa Monica, 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 Foundation Health Plan, Inc., 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 Legislature has created an entirely new statutory device for determining the appropriate treatment modalities for injured workers, and the Independent Medical Review (IMR) procedure is possibly the most complicated regulatory process in the workers' compensation system. The Institute wishes to acknowledge the remarkable effort expended by the staff of the Division of Workers' Compensation in concurrently crafting so many significant regulations to implement Senate Bill 863 in such a short period of time.

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

In particular, the Institute recommends that wherever possible, the DWC create a bright-line for the effective dates for the various sections. The Institute cites section 84 of SB 863 that expressly states the legislative intent to apply the new statutory provisions *"to all pending matters, regardless of injury, unless otherwise specified in this act …"* The correct effective date is essential in order to achieve the cost reductions projected by the Legislature and to establish a clear bright line to simplify implementation of these statutes.

For the revisions to utilization review, it is essential that the medical standards adopted by the Legislature, which are founded on evidence-based medicine, be strictly applied. 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, do not meet these standards, unless they are supported by medical evidence that is peer-reviewed and nationally recognized.

With regard to the proposed forms, the Institute wants to emphasize the need for clarity and simplicity. There should be no duplication, redundancy, or incomplete entries. Expedited review is reserved, by statute, for medical emergencies and there should be a consequence for filing an expedited review in bad faith.

The IMR application form initiates the IMR process and must be reviewed for eligibility by an impartial, disinterested entity -- the DWC -- before being assigned to the IMR contractor, which has a clear financial interest in the review. A physician's failure to properly complete the UR process should not be grounds for an independent medical review.

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.

(g) ~~As applicable in section 9792.9.1,~~ On and after (enter here either January 1, 2013 or the implementation date of the permanent regulations), 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 as an attachment documentation substantiating the need for the requested treatment.

> *The Administrative Director may make the request for authorization form effective on a going-forward basis. Having a bright-line effective date that applies to all requests for authorization on a going-forward basis will simplify the process by having a single standard in place, instead of two that depend on dates of injury and submission. If this recommendation is accepted, the standards that apply to requests will be clear to requesting physicians and claims administrators alike, averting the confusion and disputes that will otherwise arise regarding which form is a request for authorization. If the Administrative Director adopts the DWC Form RFA on the effective date of these regulations, the initial phrase "~~As applicable in section 9792.9.1,~~ On and after (enter here either January 1, 2013 or the implementation date of the permanent regulations)," will not be necessary and may be deleted.*

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

Request for Authorization, DWC Form RFA

> *See the Institute's recommended changes in the attached forms. One indicates the recommended changes in underscore and strikeout. The other is the form as recommended. The reasons for the recommended changes are summarized as follows:*
>
> - *To substantiate the requested treatment, the Doctor's First Report or Primary Treating Physician's Progress Report is attached to the Request for Authorization, as opposed to the Request being attached to the Report.*
>
> - *The term "equivalent narrative report" refers to the requirement in section 9785(f) for the narrative report to be equivalent to a PR-2. The section requires the narrative report to be entitled "Primary Treating Physician's Progress Report" in bold-faced type, to indicate the reason for the report, and contain the same information under the same headings in the same order as the Form PR-2.*

- *The name of the DWC Form PR-2 is "the Primary Treating Physician's Progress Report."*

- *"Physician" replaces "provider" on the form because the physicians have the responsibility for recommending treatment for injured employees. For example, Labor Code section 4610(a) says in pertinent part "…utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians…."*

- *Expedited review is requested on many requests for authorization even though injured employees in many of those cases are not facing an imminent and serious threat to their health. This unfairly slows the process for others who truly need immediate action. Requiring the requesting physician to certify imminent and serious threats to health under penalty of perjury and the reminder of consequences will discourage unwarranted requests for expedited Utilization Review and Independent Medical Review and help ensure emergency action for those who need it. If, by checking the Expedited Review box, the requesting physician is certifying under penalty of perjury that the employee has an imminent and serious threat to health, and is reminded of the potential consequences for not doing so in good faith, unwarranted requests for expedited Utilization Review and Independent Medical Review will be discouraged. This will help ensure emergency action for those who need it. Requiring the requesting physician to attach a written certification that the employee has an imminent and serious threat to health is a possible alternative, however checking the box and signing the form under penalty of perjury is less burdensome for the physician.*

- *Physician type needs to be identified on the form in addition to specialty to efficiently assign the appropriate type of physician reviewers and thereby speed the review process.*

- *Indicating on the form "the specific page number(s) of the accompanying medical report on which the requested treatment can be found" will not work for this form. If the physician does not state the requested treatment on the form, checking the "approved" box will be meaningless and the form will not accomplish its dual goals of facilitating communication between the physician and the claims administrator, and furnishing a verification of authorization for the requesting physician. The problem is understood – it is inefficient for the Primary Treating Physician (PTP) to enter elements of a treatment plan, or changes thereto more than once. The problem cries out for a single form to be used by the PTP for both a progress report and request for authorization. This could be accomplished by defining the progress report as a request for*

authorization (RFA) only if the RFA box is checked on that form. Many hundreds of stakeholder hours went into developing such a multi-use form several years ago. Inexplicably the form was not adopted.

- *"Services and goods" is more accurate for requested treatment than "procedures." Procedures do not cover the universe of requests.*

- *Likewise, the term "OMFS Codes" covers the whole universe of California workers' compensation medical services and goods. OMFS (Official Medical Fee Schedule) codes including CPT, HCPCS, DRGs, NDCs and others. OMFS codes must be used to bill for the medical service, so to the extent they are entered on the RFA form, there will be fewer billing disputes over codes billed and paid if the billing documentation supports those billed codes.*

- *"Facility" is best deleted because the facility may have to belong to a Medical Provider Network. Listing "Facility" in the heading may give the false impression the choice of facility is entirely his or hers.*

- *If liability for treatment is denied, for example because the claim is denied, certain language and rules apply when notifying employees and providers of the claim denial, and that notification is made in a separate letter.*

- *It is important to notify providers of the phone number, fax number and/or email address designated by a claims administrator for requesting authorization for medical treatment and related questions and tasks. Using designated contact information will ensure the most efficient communications and avoid delays and frustrations.*

Article 5.5.1 Utilization Review Standards

According to the dates specified in Labor Code section 4610.5, Independent Medical Review does not apply when the utilization review decisions on requested medical treatment are communicated prior to July 1, 2013 for injuries occurring prior to January 1, 2013. Senate Bill 863 provisions regarding utilization review do, however, apply to all issues that do not have final resolution. Section 84 of Senate Bill 863 says:

> *"This act shall apply to all pending matters, regardless of injury, unless otherwise specified in this act, but shall not be a basis to rescind, alter, amend, or reopen a final award of workers' compensation benefits, pursuant to Section 84 of Senate Bill 863"*

The proposed section 9792.6 is confusing and unnecessary. The Institute recommends that the Administrative Director delete the currently proposed text in

section 9792.6, and replace it with the modified text of the proposed section now numbered 9792.6.1.

If the Administrative Director decides not to delete this section, the Institute recommends the revisions that follow.

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

The Institute recommends the term "communicated" in the heading because that is the term used in the statute.

The following definitions apply to 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 request for authorization of medical treatment is made prior to July 1, 2013.

(b) "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 the request for authorization and course of treatment ~~Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the DWC Form PR-2~~.

The request for authorization and the course of treatment are defined in (q) and (e) of this section.

(c) "Claims Administrator" is a self-administered workers' compensation insurer, an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610. The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities.

(e) "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 DLSR 5021, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2 or in narrative form containing the same information required in the DWC Form PR-2.

(q) "Request for authorization" means a written confirmation of an oral request for a specific course of proposed medical treatment pursuant to Labor Code section 4610(h) or

a written request for a specific course of proposed medical treatment. An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours. Both the written confirmation of an oral request and the written request must be set forth on the "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021, section 14006, or on the Primary Treating Physician Progress Report, DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the PR-2 form. If a narrative format is used, the document shall be clearly marked at the top that it is a request for authorization.

~~As applicable in section 9792.9.1,~~ On and after (enter here either January 1, 2013 or the implementation date of the permanent regulations), 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~~ shall 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 as an attachment documentation substantiating the need for the requested treatment.

> *The Administrative Director may make the request for authorization form effective on a going-forward basis. Having a bright-line effective date that applies to all requests for authorization on a going-forward basis will simplify the process by having a single standard in place instead of two that depend on dates of injury and submission. If this recommendation is accepted, the standards that apply to requests will be clear to requesting physicians and claims administrators alike, averting the confusion and disputes that will otherwise arise regarding which form is a request for authorization.*
>
> *If the Administrative Director adopts the DWC Form RFA on the effective date of the regulations, the first paragraph of (q) and the initial phrase in the second paragraph "~~As applicable in section 9792.9.1,~~ On and after (enter here either January 1, 2013 or the implementation date of the permanent regulations)," will not be necessary and may be deleted.*

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

If the Administrative Director deletes the currently proposed text for section 9792.6 as recommended and replaces it with the modified text in this section now numbered 9792.6.1, "On or After January 1, 2013" will need to be deleted from the description in the heading and references to the sections elsewhere in these regulations will need to be corrected.

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 ~~request for authorization of medical treatment~~ utilization review decision is ~~made~~ communicated on or after July 1, 2013, regardless of the date of injury.

If the Administrative Director adopts the DWC Form RFA on the effective date of the regulations, this initial paragraph will not be necessary and may be deleted.

(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 a request for authorization and course of treatment ~~completed "Request for Authorization for Medical Treatment," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, 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.

The request for authorization and course of treatment are defined in (u) and (d).

(b) "Claims Administrator" is a self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code section 4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). ~~"Claims Administrator" includes any utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.~~ The claims administrator may utilize an entity contracted to conduct its utilization review responsibilities. ~~Unless otherwise indicated by context, "claims administrator" also means the employer~~ The claims administrator stands in the shoes of the employer.

If the definition for claims administrator "also means the employer," documents and reports that include confidential medical information that must be submitted to the claims administrator pursuant to these UR and IMR regulations, may be sent to insured employers. This would be a violation of HIPAA and CMIA. The claims administrator is the entity that administers the claim. Would it suffice to clarify that the claims administrator stands in the shoes of an insured employer? If not, the Administrative Director must add language that will prevent the submission of confidential medical information to an employer in violation of HIPAA or CMIA.

It is not necessary to include the utilization review organization in the "claims administrator" definition. A utilization review organization is not a claims administrator; it merely assists with a single aspect of a claim. Retaining the current language is preferable, or alternatively a "utilization review organization" could be separately defined.

Documents may be inappropriately submitted to an employer or utilization review organization if either is defined as a claims administrator. If so, in addition to medical confidentiality breaches, this may delay medical treatment and other benefits, and trigger disputes and penalties.

(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 DLSR 5021, found at California Code of Regulations, title 8, section 14006, or on the "Primary Treating Physician's Progress Report," DWC Form PR-2, as contained in section 9785.2 or in the equivalent narrative form containing the same information required in the DWC Form PR-2 as specified in section 9785(f).

Section 9785(f) states in pertinent part

"If a narrative report is used, it must be entitled "Primary Treating Physician's Progress 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. 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."

Adding the reference to section 9785(f) will clarify the requirements that apply.

(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.~~

~~(5) Generally accepted standards of medical practice.~~

~~(6) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.~~

Pursuant to Labor Code sections 4600, 4610(f) and 5307.27, the standards for utilization review are those listed in (1), (2) and (3). The additional, lower standards listed in (4), (5) and (6) apply to independent medical review pursuant to Labor Code section 4610.1(b)(2), but not to utilization review. If the Administrative Director does not delete (4), (5) and (6), the Institute recommends revising them as follows so that they comply with the Labor Code section 5307.27 standards to be evidence-based, peer reviewed, and nationally recognized:

(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.

Lowering the utilization review standards will increase medical costs and affect the anticipated Senate Bill 863 savings. The Division must determine the additional cost in the course of its rulemaking.

(u) "Request for authorization" means a written request for a specific course of proposed medical treatment. A request for authorization must be set forth on a "Request for Authorization for Medical Treatment (DWC Form RFA)," accompanied by the Doctor's First Report or Primary Treating Physician's Progress Report, completed by ~~a~~ the treating physician, as contained in California Code of Regulations, title 8, section 9785.5. "Completed," for the purpose of this section and for purposes of investigations and penalties, means that the form must identify the type of request by checking the appropriate box; ~~both~~ the employer; the employee as well as claim number or dates of birth and injury; ~~and~~ the provider, provider type, specialty, contact information; and identify with specificity ~~a~~ the recommended treatment or treatments. The form must be signed by the physician and ~~may~~ shall be submitted to the fax number, mailing address, or email address designated by the claims administrator.

The added elements are also necessary. Fields that are not necessary should be removed from the form.

Forms sent to an inappropriate fax number, mail address or email address result in unnecessary delays for the injured employee, claims administrator, and provider.

(x) “Utilization review decision” means a decision pursuant to Labor Code section 4610 to prospectively, concurrently, or retrospectively modify, delay, or deny a request for authorization, based in whole or in part on medical necessity to cure or relieve~~, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services~~ pursuant to Labor Code sections 4600 or 5402(c).

The request for authorization is defined in (u).

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

Parties that mutually agree to do so should be permitted to communicate in writing by electronic mail written agreement.

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

This section applies to ~~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 where the utilization review decision ~~request for authorization~~ is ~~made~~ communicated prior to July 1, 2013.

(b) Utilization review of a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

(1) If the claims administrator disputes its liability for the requested medical treatment under this subdivision, it may, no later than five (5) business 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 only contain the following information specific to the request:

A single written deferral notice pursuant to Labor Code sections 3751(b) or 138.4 and CCR sections 9811 or 9812(i) will suffice.

(k) A written decision modifying, delaying or denying treatment authorization under this section, when the decision is communicated prior to July 1, 2013, shall be ~~provided~~ communicated to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information:

The Institute recommends the term "communicated" because that is the term used in the statute.

(*l*) A written decision modifying, delaying or denying treatment authorization under this section, ~~sent~~ communicated on or after July 1, 2013, shall be ~~provided~~ communicated to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information:

The Institute recommends the term "communicated" because that is the term used in the statute.

(6) The Application for Independent Medical Review, DWC Form IMR, with all fields completed by the claims administrator, except for the signature of the employee and date signed, ~~to be completed by the claims administrator~~ shall be provided to the employee. The written decision provided to the injured worker~~, and if the injured worker is represented by counsel, the injured worker's attorney~~ shall include an addressed envelope, which may be postage-paid, for mailing the DWC Form IMR to the Administrative Director or his or her designee.

There is no statutory authority for requiring an addressed envelope for the employee's attorney. There is only statutory authority requiring the form to go to the employee and to include an addressed envelope.

§9792.9.1. Utilization Review Standards--Timeframe, Procedures and Notice – For Injuries Occurring 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 ~~request for authorization~~ utilization review decision is ~~made~~ communicated on or after July 1, 2013, regardless of the date of injury.

The trigger is the date a utilization review decision is communicated, rather than the date a request for authorization is made.

(a) The request for authorization for a course of treatment must be in written form set forth on the "Request for Authorization for Medical Treatment (DWC Form RFA)," as contained in California Code of Regulations, title 8, section 9785.5.

(C) In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the DWC Form RFA shall be deemed to have been received by the claims administrator five days after ~~the latest date the sender wrote on the document~~ mailing.

The document could be mailed long after the last date the sender wrote on the document.

(b) Utilization review of a medical treatment request made on the DWC Form RFA may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

(1) If the claims administrator disputes liability under this subdivision, it may, no later than five (5) business days from receipt of the DWC Form RFA, 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 only contain the following information specific to the request:

A single written deferral notice pursuant to Labor Code sections 3751(b) or 138.4 and CCR sections 9811 or 9812(i) will suffice.

(D) A plain language statement advising ~~the injured employee~~ that any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

This advice is not only for the employee, it is also for the provider and applicant attorney.

(c) The utilization review process shall meet the following timeframe requirements:

(1) The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA when counting calendar days, and the first business day after the receipt of the DWC Form RFA when counting business days, 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 DWC Form RFA.

When counting business days, the business day number one is the first business day after receipt.

(2) If the DWC Form RFA does not identify the employee, employee's claim, ~~or~~ provider, provider type and specialty and contact information, ~~does not identify a~~ specific recommended treatment~~,~~; or is not signed under penalty of perjury by the requesting physician~~,~~; or is not submitted together with a substantiating Doctor's First Report Form or Primary Treating Physician's Progress Report, a non-physician reviewer as allowed by section 9792.7 or reviewer must either treat the form as complete and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete" no later than five (5) 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 added information is also necessary.

(d) Decisions to approve a request for authorization~~.~~:

(4) Unless (d)(3) is applicable, r~~R~~etrospective decisions to approve modify, delay, or deny a request for authorization shall be made within 30 days of receipt of the medical information that is reasonably necessary to make this determination.

Section 9792.9.1(d)(3) deems any timely payment or partial payment of a medical bill for services requested retroactively on the DWC Form RFA to be a retrospective approval.

(e) Decisions to modify, delay, or deny a request for authorization.

(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 information that is reasonably necessary to make this determination.

Section 9792.9.1(d)(3) deems any timely payment of a medical bill for services requested retroactively on the DWC Form RFA to be a retrospective approval.

(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 and shall only contain the following information specific to the request:

The injured worker may not designate a representative before the receipt of the decision pursuant to Labor Code section 4610.5(j).

(G) The Application for Independent Medical Review, DWC Form IMR, with all fields, except for the signature of the employee, to be completed by the claims administrator.~~.~~ The written decision provided to the injured worker ~~, and if the injured worker is represented by counsel, the injured worker's attorney,~~ shall include an addressed

envelope, which may be postage-paid, for mailing the DWC Form IMR to the Administrative Director or his or her designee.

There is no statutory authority for requiring an addressed envelope for the employee's attorney.

There is an unnecessary period and space on the second line.

§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.

This section applies ~~to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for~~ either: (1) regardless of the date any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, is communicated to the requesting physician in regard to an occupational injury or illness occurring on or after January 1, 2013; or (2) if the ~~request~~ decision on any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, is ~~made~~ communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

The proposed language suggests that the section applies to requests for authorization. The recommended changes clarify that the section applies in either of the two circumstances specified in Labor Code section 4610.5 (a).

(a) If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved

in accordance with Labor Code sections 4610.5 and 4610.6, except if the delay or denial was based on the lack of information reasonably requested from the physician that is necessary to make a determination pursuant to section 9792.9.1(f)(1)(A) and (f)(2), or (g). Neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review or the Workers' Compensation Appeals Board only pursuant to Labor Code section 4610.6(h) ~~under this Article~~.

> *Resources must not be wasted on IMR if the physician failed, when requested pursuant to section 9792.9.1(f) or (g), to supply medical information necessary to make a determination. Section 9792.9.1(f), in pertinent part, and (g) state:*
>
> > *(f)(1) "The timeframe for decisions specified in subdivision (c) may only be extended with a written notice of delay by the reviewer under one or more of the following circumstances:*
> >
> > *(A) The reviewer is not in receipt of all of the necessary medical information reasonably requested."*
> >
> > *(f)(2) "If subdivisions (f)(1)(A), (B) or (C) above apply, 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 specify the information requested but not received, 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"*
> >
> > *(g) "Whenever a reviewer issues a decision to deny a request for authorization based on the lack of medical information necessary to make a determination, the claims administrator's file must document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail."*
>
> *The Workers' Compensation Appeals Board may only overturn the decision pursuant to Labor Code section 4610.6(h).*

(b)(1) A request for independent medical review must be communicated by an eligible party by mail, facsimile, or electronic transmission to the Administrative Director, or the Administrative Director's designee, within 30 days of service of the utilization review decision and concurrently copied to the claims administrator. 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.

It is important that the claims administrator know as soon as a request is filed for the following reasons:

- *The claims administrator can notify the Administrative Director of any circumstances that have changed and that may affect IMR eligibility. This will avoid some unnecessary independent reviews and the associated administrative burdens and costs*
- *Because the timeframes for submitting documents for independent medical review are so short, the early notice is necessary to will allow additional time for the claims administrator to prepare documents for timely submission*
- *The claims administrator can verify that the form has not been changed*
- *The requirement will deter alterations to the completed form and submission of inaccurate information*

If this recommendation is not accepted, the Administrative Director could instead notify the claims administrator of the IMR request on the same day the form is received.

(b)(3) If expedited review is requested for a decision eligible for independent medical review, the Application for Independent Medical Review, DWC Form IMR, shall include, unless the initial utilization review decision was made on an expedited basis, a certification from the employee's treating physician signed under penalty of perjury indicating that the employee faces an imminent and serious threat to his or her health as described in section 9792.6.1(j).

Signing under penalty of perjury may discourage unwarranted expedited requests that are already being reported.

(e) The following requirements shall be met prior to a concurrent review decision to deny authorization for medical treatment and to resolve disputes:

(1) In the case of concurrent review, medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is consistent with the Medical Treatment Utilization Schedule and appropriate for the medical needs of the employee.

Medical care must be reasonably required as defined by Labor Code Section 4600(b).

(2) 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.

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

See the Institute's recommended changes in the attached forms. One indicates the recommended changes in underscore and strikeout. The other is the form as recommended. The reasons for the recommended changes are summarized as follows:

- *Relocating the instruction to submit a copy of the utilization review decision with the application to the bottom of the form where the employee is instructed on submitting the application will increase the likelihood that both forms are submitted together as required.*

- *If expedited utilization review was necessary, expedited independent review is also presumed necessary. It is useful to include on the form whether or not the utilization review was expedited.*

- *"Completion of this section is required" is unnecessary verbiage that should be removed from 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, date of birth 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. 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.*

- *Some of the fields and information has been relocated on the form to more efficiently utilize space on the form.*

- *Only disputed medical treatment needs to be included on this form. All the requested medical treatment is on the Request for Authorization and the Utilization Review decision.*

- *Recommended changes are necessary to clarify that the disputed treatment is to be entered as described by the physician on the request for authorization.*

- *Provide additional space to identify services or goods.*

- *It is necessary to identify services or goods:*
    - *whose 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*
    - *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.*

  These circumstances can be submitted on the form as proposed or may be more efficiently supplied on this form in a table similar to the one in the Requested Treatment section of the RFA form.

- *Requiring the injured employee's original signature when requesting the review will ensure that the employee is aware of, and wishes this independent review.*

- *Incorporating employee's designation authorization and designee relationship into the Consent to Obtain Medical Records section under one original employee signature is efficient, and will associate the designee with the consent to obtain medical records indicated on the form.*

- *Specifying in the Consent to Obtain Medical Records and Designation section that the consent applies to the disputed treatment identified on this application form will prevent any potential misunderstanding over what may be included or whether the consent or designation can apply to other treatment.*

- *In the Filing Information section, "together with the utilization review decision" is recommended to replace "and any attachments" to clarify that the utilization review must be submitted with the application form and so that the injured employee is not led to believe he or she should submit supporting medical records with the application.*

- *The deletion of Maximus as the destination of the application for initial review is recommended because there is an evident financial conflict of interest as described elsewhere in this testimony. 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.*

- *The direction to send a copy concurrently to the claims administrator and reference to the preferred notification method will ensure the claims administrator is informed as quickly as possible that an application has been submitted as described elsewhere in this testimony.*

- *The employee needs to be warned in the instructions that the utilization review decision is final unless IMR is requested within 30 days of the date the utilization review decision was mailed.*

The Institute recommends deleting the Employee Right to Provide Information section from the Instruction page because that information will be provided in the notice of eligibility letter and it is not necessary to provide it twice.

The Institute also recommends removing duplicate and unnecessary language from the Instruction and Designation pages so that the content can fit into one page for efficiency and clarity. If the Administrative Director retains the third page, the additional expense for producing and mailing the additional page must be considered and disclosed in the regulatory process.

§ 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 and whether an expedited review is necessary under the standards in Labor Code sections 4610(g)(2) and 4610.5(n). Any entity designated to initially receive and/or review the application shall have no financial interest in the independent medical review. In making this determination, the Administrative Director shall consider:

Labor Code section 4610.5(k) permits the Administrative Director to use a designee to review requests and to notify the employee and employer whether or not the request was approved. The Institute believes that the designee may have no financial interest in the Independent Medical Review. At present, the Independent Medical Review Organization (IMRO) is receiving and initially reviewing the IMR application. This is clearly a conflict of interest because the IMRO has a direct financial interest in the review.

(1) The timeliness, accuracy and completeness of the Application;

The application must be accurate as well as timely and complete.

(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.

The parties should also be permitted to appeal a determination that a dispute is eligible for independent medical review.

§ 9792.10.4. Independent Medical Review – Assignment and Notification

Within one business day following a finding that the disputed medical treatment is eligible for independent medical review, the independent review organization delegated the responsibility by the Administrative Director to conduct independent medical review pursuant to Labor Code section 139.5 shall notify the parties in writing that the dispute has been assigned to that organization for review. The notification shall contain:

(e) For regular review, a statement that within fifteen (15) calendar days of the date designated on the notification, if the notification was provided by mail, fax or email ~~or within twelve (12) calendar days of the date designated on the notification if the notification was provided electronically~~, the independent review organization must receive the documents indicated in section 9792.10.5. For the notification provided to the claims administrator, the statement shall provide that, pursuant to Labor Code section 4610.5(i), in addition to any other fines, penalties, and other remedies available to the Administrative Director, the failure to comply with section 9792.10.5 could result in the assessment of administrative penalties up to $5,000.00.

Five days are allowed for serving within California pursuant to CCR section 10507. Superior court provides for the proposed standard, however CCR 10507 applies to workers' compensation and the superior court standard does not.

(g) 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 signed under penalty of perjury 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.

Signing under penalty of perjury may discourage unwarranted expedited requests that are already being reported.

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) Within fifteen (15) days following the mailing, faxing or emailing of the notification from the independent review organization that the disputed medical treatment has been assigned for independent medical review~~, or within twelve (12) days if the notification was sent electronically,~~ or for expedited review within twenty-four (24) hours following receipt of the notification, the independent medical review organization shall receive from the claims administrator all of the following documents:

Five days are allowed for serving within California pursuant to CCR section 10507. Superior court provides for fewer days for notification sent electronically, however CCR 10507 applies to workers' compensation and the superior court standard does not.

(b) (1) Within fifteen (15) days following the mailing, faxing or emailing of the notification from the independent review organization that the disputed medical treatment has been assigned for independent medical review, ~~or within twelve (12) days if the notification was sent electronically,~~ or for expedited review, within twenty-four (24) hours following receipt of the notification, the independent medical review organization shall receive from the employee, or any party identified in section 9792.10.1(b)(2), any of the following documents:

> *Five days are allowed for serving within California pursuant to CCR section 10507. Superior court provides for fewer days for notification sent electronically, however CCR 10507 applies to workers' compensation and the superior court standard does not.*

§ 9792.10.6. Independent Medical Review – Standards and Timeframes

(a) The independent medical review process may be terminated at any time upon notice by the claims administrator to: 1) the Administrative Director or entity designated to receive and initially review the application for review before the review is determined eligible and assigned to the independent medical reviewer; or 2) the independent review organization after the assignment.

> *It is necessary to allow the opportunity for the claims administrator to terminate the review process before it is assigned to an independent medical reviewer to avoid an unnecessary independent review and the associated administrative burdens and costs.*

(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.*

Thank you for considering these comments.

Sincerely,

Brenda Ramirez
Claims and Medical Director

BR/pm

cc: Destie Overpeck, DWC Acting Administrative Director
Christine Baker, DIR 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