



California Workers' Compensation Institute

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December 20, 2013

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: 2nd 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 additional modifications to the regulations proposed for permanent adoption to implement Senate Bill 863 provisions regarding Independent Medical Review (IMR) and Utilization Review (UR) 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 Compensation Insurance Company, Everest National Insurance Company, Farmers Insurance Group, Fireman's Fund Insurance Company, The Hartford, ICW Group, 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.

Request for Authorization

The Institute strongly objects to modifications to the proposed revisions that will permit requests for authorization to be made in any form and to be presumed to be agreed to if the claims administrator fails to object within five working 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 do so timely, which will generate unnecessary treatment delays, disputes and penalties. Many large claims administrators must rely on OCR (optical character recognition) technology to timely identify requests. Requiring "Request for Authorization" to be clearly written at the top of the first page of a document does not mean it will be recognized as a request for authorization by OCR technology. Additional staff and other resources will be necessary to review every piece of incoming mail, slowing the approval process and unnecessarily increasing costs and administrative expenses.

The Institute also objects to modifications to the proposed revisions that would permit requests for authorization that fail to provide critical information, but that are made on the standard form to be presumed to be agreed to if the claims administrator fails to object within five working days. In this instance, the RFA form would be identified as the appropriate standard form, but the claims administrator may have failed to timely identify critical omissions. This too will generate unnecessary treatment delays, disputes and penalties.

If a deficient request is not identified within five working days:

- The injured employee may be subjected to deleterious or unnecessary medical services contrary to Labor Code section 4600. Labor Code sections 4600(a)-(b) require medical care that is reasonably required to cure or relieve the injured worker from the effects of his or her injury, which means treatment must be in accord with evidence-based guidelines adopted by the administrative director.

If a request is identified within five working days but does not include essential information:

- Treatment for the injured employee will be delayed because the claims administrator must spend time and resources rejecting the request as incomplete and listing every necessary element.

In these instances, both injured employees and claims administrators, and ultimately employers as well, will be penalized for the omissions of requesting physicians. The responsibilities of the primary treating physician and secondary physicians are described in CCR section 9785 and should be followed. Claims administrators send primary treating physicians a written copy of these responsibilities, and have generally been willing to assist and guide well-meaning physicians who are new to workers' comp with

their requests, thereby facilitating timely medical care for injured employees. But enabling deficient reports by regulation, penalizing claims administrators for them, and degrading and delaying medical care for injured employees is unacceptable.

The Institute urges the Administrative Director to facilitate the speedy provision of the highest quality medical care by restoring the requirement to submit requests for authorization on standard forms, completed with all the information necessary to determine medical necessity. If this requirement is not restored, some injured employees will be victimized by deleterious and unnecessary care and by treatment delays; claims administrators will be subjected to unjustified penalties, disputes, and unnecessary administrative expenses; and employers will incur the resulting additional costs and expenses.

Review of IMR Applications

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. The statutory reference to “designee” must be read to mean a designee within the Division, or a DIR employee; someone qualified to review the applications. 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 and IMR must 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.

(b)(3) 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.

Removing the prohibition to change the primary treating physician (PTP) before a dispute is resolved will result in confusion, disputes delays, and additional costs. If there are disputes over issues such as TD, PD, P&S status, or medical necessity, and the PTP is changed before the dispute is resolved, it is not clear whether findings on those disputes will be valid when the opinions, decisions or requests of new PTPs conflict with the findings. Removing the prohibition may also re-introduce or encourage the practice of doctor-shopping. The Institute urges the Administrative Director to restore the language.

§ 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(e)(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.

As noted in the introduction, the Institute strongly objects to modifications to the proposed revisions that will permit requests for authorization to be made in any form and to be presumed to be agreed to if the claims administrator fails to object within five working 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 do so timely, which will generate unnecessary treatment delays, disputes and penalties. Many large claims administrators must rely on OCR (optical character recognition) technology to timely identify requests. Requiring “Request for Authorization” to be clearly written at the top of the first page of a document does not mean it will be recognized as a request for authorization by OCR technology. Additional staff and other resources will be necessary to review every piece of incoming mail, slowing the approval process and unnecessarily increasing costs and administrative expenses.

See additional detail in the comments on this issue in the introduction and in other related sections throughout this document.

(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 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 be accompanied by documentation 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, if designated, the address, fax number, or e-mail address designated by the claims administrator for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

The Institute appreciates the modification that will help ensure the request for authorization is submitted to the proper recipient. We suggest requiring the treating physician to not only sign the request, but to also submit the request to a designated address, fax number or e-mail address if any. If this is not required, a treating physician would be permitted to ignore any designated address or fax number which may cause the injured employee’s treatment to be delayed, and unfairly trigger penalties.

(y) "Utilization review process" means 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 or relieve, treatment recommendations by physicians, as defined in [Labor Code section 3209.3](#), prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to [Labor Code section 4600](#). The utilization review process begins when the completed

DWC Form RFA, ~~or a request or authorization accepted as complete under section 9792.9.1(e)(2),~~ is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

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

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

(b)(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, ~~and the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.~~ The written decision shall contain the following information specific to the request:

The Institute believes that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent medical review organization, it removed applicant attorneys from the IMR process. The statute does not authorize the Administrative Director to require applicant attorneys to be copied on notices regarding either utilization review decisions or IMR. For example, Labor Code section 4610(g)(5) requires the employer to notify the physician and the employee if a utilization review decision can't be made within the 5 working day/14 day/30 day/72 hour timeframes, but does not require notice to an applicant's attorney.

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

(2)(A) Upon receipt of a ~~request for authorization as described in subdivision (e)(2)(B), or a~~ DWC Form RFA that does not identify the employee or provider, does not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity for the requested treatment, or is not signed by the requesting physician, a non-physician reviewer as allowed by section 9792.7 or reviewer must either regard the request as 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) business days from receipt. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

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; however, to avoid the delay and additional expenses associated with requesting and waiting for missing information, the Institute suggests the Administrative Director require a request for authorization to be complete. It is unreasonable to delay the injured employee's medical care and to penalize the claims administrator for a delay caused by the physician's failure to provide necessary information.

And as discussed in the introduction and in other comments, if requests for authorization are not confined to a standard form, then it may not be possible to identify it within five working days, if at all.

(d) Decisions to approve a request for authorization.

....

(3)(A) For retrospective review, a written decision to approve 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.~~

(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)(5), 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.

The Institute believes that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent medical review organization, it removed applicant attorneys from the IMR process. The statute does not authorize the Administrative Director to require applicant attorneys to be copied on notices regarding either utilization review decisions or IMR. For example, Labor Code section 4610(g)(5) requires the employer to notify the physician and the employee if a utilization review decision can't be made within the 5 working day/14 day/30 day/72 hour timeframes, but does not require notice to an applicant's attorney.

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

...

(3) For prospective, concurrent, or expedited review, a decision to modify, delay, or deny shall be communicated to the requesting physician within 24 hours of the decision, and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to

the requesting physician, and the injured worker, ~~and if the injured worker is represented by counsel, the injured worker's attorney~~ within 24 hours of the decision for concurrent review and within two (2) business days for prospective review and for expedited review within 72 hours of receipt of the request.

(4) 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 and medical information that is reasonably necessary to make a determination.

(5) The written decision modifying, delaying or denying treatment authorization shall be provided to the requesting physician, the injured worker, and 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:

....

(H) A clear statement 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, or the injured worker's representative, ~~or the injured worker's attorney~~ on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days of receipt of the decision.

The statute does not authorize the Administrative Director to require applicant attorneys to be copied on notices regarding either utilization review decisions or IMR. Labor Code section 4610(g) requires the employer to notify the physician and the employee if a utilization review decision can't be made within the 5 working day/14 day/30 day/72 hour timeframes, but does not require notice to an applicant's attorney.

Applicant attorneys are nowhere included in the Labor Code section 4610 and 4610.5 language and have no role in the UR dispute/IMR processes unless and until an IMR decision is challenged when a verified appeal may be filed with the appeals board. The Institute believes that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent medical review organization, it removed applicant attorneys from the process.

(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.

§ 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 written utilization review determination issued by the claims administrator under section 9792.9.1e(5). The request must be made on the Application for Independent Medical Review, DWC Form IMR, 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 submitting a DWC Form IMR with a written decision delaying a decision is not necessary since the delay is pending additional information. It is only appropriate to submit the form with a decision denying or modifying a request for authorization.

(b)(2)(A) The employee ~~or, if the employee is represented, the employee's attorney. If the employee's attorney files the DWC Form IMR, the form must be accompanied by a notice of representation or other document or written designation confirming representation.~~

Applicant attorneys are nowhere included in the Labor Code section 4610.5 language and have no role in the IMR process unless and until an IMR decision is challenged when a verified appeal may be filed with the appeals board. According to Labor Code section 4610.5(j) "A designation of an agent executed prior to the utilization review decision shall not be valid." The applicant attorney is not a valid designee if the designation of representation was executed prior to the utilization review decision. The Institute believes that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent medical review organization, it removed applicant attorneys from the IMR process.

Labor Code section 4610.5(j) states

"For purposes of this section, an employee may designate a parent, guardian, conservator, relative, or other designee of the employee to act

on his or her behalf. A designation of an agent executed prior to the utilization review decision shall not be valid. ...”

If the employee is represented by an attorney at the time of a UR decision, that language means the applicant’s attorney is not eligible to act on behalf of the employee for purposes IMR. Since the legislature moved the responsibility for deciding medically necessary treatment from the Board to the IMRO, there is no longer necessity for an attorney to argue on the medical necessity for treatment unless there is an appeal.

The statute also did not authorize the Administrative Director to require applicant attorneys to be copied on notices regarding either utilization review decisions or IMR. For example, Labor Code section 4610(g)(5) requires the employer to notify the physician and the employee if a utilization review decision can’t be made within the 5 working day/14 day/30 day/72 hour timeframes, but does not require notice to an applicant’s attorney.

(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 has** 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 ten (10) days after the receipt of the utilization review decision.

....

(3) Any determination by the claims administrator following an internal utilization review appeal that results in a modification of the requested medical treatment shall be communicated to the requesting physician and the injured worker, **and** the injured worker’s representative, **and if the injured worker is represented by counsel, the injured worker’s attorney** according to the requirements set forth in section 9792.9.1(e). The Application for Independent Medical Review, DWC Form IMR, that accompanies the written decision letter under section 9792.9.1(e)(5)(G) must indicate that the decision is a modification after appeal.

The statute does not authorize the Administrative Director to require applicant attorneys to be copied on notices regarding either utilization review decisions or IMR. Labor Code section 4610(g) requires the employer to notify the physician and the employee if a utilization review decision can’t be made within the 5 working day/14 day/30 day/72 hour timeframes, but does not require notice to an applicant’s attorney. Also, according to Labor Code section 4610.5(j) “A designation of an agent executed prior to the utilization review decision shall not be valid.” The applicant attorney is not a valid designee if the designation of representation was executed prior to the utilization review decision. The Institute believes that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent review organization, it removed applicant attorneys from the IMR process.

See comments on section 9792.10.1(b)(2)(A) for more detail.

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

The Institute recommends moving the section of the form where the injured employee may designate an individual as an agent to act on his or her behalf, to the DWC Form IMR.

Requiring the injured employee's designation with signature and date on the DWC Form IMR that includes the disputed medical treatment will validate that the representative was designated after the UR decision. According to Labor Code section 4610.5(j), "a designation of an agent executed prior to the utilization review decision shall not be valid." If the designation is made on a page separate from the IMR application form that includes the list of the disputed medical treatment, there is no way to prevent post-dating of the designation. If it must be on the DWC Form IMR completed by the claims administrator with the disputed treatment, it cannot be post-dated.

The Institute also recommends changing the recipient of the application from Maximus to the Administrative Director or the Administrative Director's designee at the DWC.

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. To avoid the financial conflict of interest described more fully in the introduction to these comments, the Institute believes the application must instruct the injured employee to submit the application either directly to the Administrative Director or to the Administrative Director's designee at the Division of Workers' Compensation.

§ 9792.10.3. Independent Medical Review – Initial Review of Application

(b) The Administrative Director may reasonably request additional appropriate information from the parties in order to make a determination that a disputed medical treatment is eligible for independent medical review. The Administrative Director shall advise the claims administrator, the employee, **if the employee is represented by counsel, the employee's attorney,** and the employee's provider requesting physician, as appropriate, by the most efficient means available.

The statute does not authorize the Administrative Director to require applicant attorneys to be copied on notices regarding either utilization review decisions or IMR. According to Labor Code section 4610.5(j) "A designation of an agent executed prior to the utilization review decision shall not be valid." The applicant attorney is not a valid designee if the designation of representation was executed prior to the utilization review decision. When the Legislature moved the

authority to resolve utilization review disputes from the Board to an independent review organization, it removed applicant attorneys from medical treatment dispute process.

See comments on section 9792.10.1(b)(2)(A) for more detail.

(c) The parties shall respond to any reasonable request made pursuant to subdivision (b) within five ~~business~~ (5) ~~business~~ 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 was previously reduced to five days from fifteen and now has been modified to five business days. Five business days provides inadequate 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. The Institute recommends allowing at least ten days for parties to respond. If, however, the Administrative Director decides to maintain the five working day time frame, the Institute recommends correcting the typographical error as indicated.

§ 9792.10.4. Independent Medical Review – Assignment and Notification

(b) Within one business day following receipt of the Administrative Director's 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 employee, ~~the claims administrator, if the employee is represented the employee's attorney~~, and the requesting physician in writing that the dispute has been assigned to that organization for review. The notification shall contain:

The Institute recommends correcting the inadvertent typographical omission of "claims administrator" by adding it as indicated, or by restoring "parties."

*The Institute also recommends deleting the represented employee's attorney from those that must receive the notice as the statute did not provide authority for the Administrative Director to require such notice regarding IMR. Labor Code section 4610.5(k) requires the Administrative Director or his or her designee to notify the **employee and the employer** in writing as to whether the request for independent medical review has been approved.*

See comments on section 9792.10.1(b)(2)(A) for more detail.

§ 9792.10.5. Independent Medical Review – Medical Records

(b)(1) Within fifteen (15) days following the mailing 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, ~~if represented the employee's attorney,~~ or any party identified in section 9792.10.1(b)(2), any of the following documents:

....

(2) The employee, ~~if represented the employee's attorney,~~ or any party identified in section 9792.10.1(b)(2) shall, concurrent with the provision of documents under subdivision (b), forward the documents provided under subdivision (b) on the claims administrator, except that documents previously provided to the claims administrator need not be provided again if a list of those documents is served.

(3) Any newly developed or discovered relevant medical records in the possession of the employee, ~~if represented the employee's attorney,~~ or any party identified in section 9792.10.1(b)(2), after the documents identified in subdivision (b) are provided to the independent review organization shall be forwarded immediately to the independent review organization. The employee, ~~if represented the employee's attorney,~~ or any party identified in section 9792.10.1(b)(2), shall concurrently provide a copy of medical records required by this subdivision to the claims administrator, unless the offer of medical records is declined or otherwise prohibited by law.

As also noted in comments on section 9792.10.1(b)(2)(A), applicant attorneys are nowhere included in the Labor Code section 4610.5 language and have no role in the IMR process unless and until an IMR decision is challenged when a verified appeal may be filed with the appeals board. According to Labor Code section 4610.5(j) "A designation of an agent executed prior to the utilization review decision shall not be valid." The applicant attorney is not a valid designee if the designation of representation was executed prior to the utilization review decision. The Institute believes that when the Legislature moved the authority to resolve utilization review disputes from the Board to an independent review organization, it removed applicant attorneys from the IMR process.

Labor Code section 4610.5(j) states:

"For purposes of this section, an employee may designate a parent, guardian, conservator, relative, or other designee of the employee to act on his or her behalf. A designation of an agent executed prior to the utilization review decision shall not be valid. ..."

If the employee is represented by an attorney prior to the time of a UR decision, that language indicates the applicant's attorney is not eligible to act on behalf of the employee for purposes IMR. Since the legislature moved the responsibility for deciding medically necessary treatment from the Board to the IMRO, there is no longer necessity for an attorney to argue on the medical necessity for treatment unless there is an appeal.

§ 9792.10.6. Independent Medical Review – Standards and Timeframes

(e) The independent review organization shall provide the Administrative Director, the claims administrator, the employee, ~~if represented the employee's attorney,~~ and the employee's provider with a final determination regarding the medical necessity of the disputed medical treatment. With the final determination, the independent review organization shall provide a description of the qualifications of the medical reviewer or reviewers and the determination issued by the medical reviewer.

*The Institute recommends deleting the represented employee's attorney from those that must receive the final determination as the statute did not provide authority for the Administrative Director to require such notice regarding IMR. Labor Code section 4610.6(f) requires the independent review organization to provide **the administrative director, the employer, the employee and the employer's provider** with the final determinations. For a more complete discussion see comments on section 9792.10.1(b)(2)(A).*

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

The provision of medical care is a crucial element in the workers' compensation system and therefore the statutes and regulations affecting the approval of treatment require that the reviews are expeditious, thorough, and accurate. The Legislature adopted evidence based medicine for the California workers' compensation system and established the Medical Utilization Treatment Schedule to define the "best medical care." Medical utilization review is the mechanism to implement the treatment guidelines and IMR is the procedure to finally determine the appropriate treatment.

The Legislature has decided that the social policy underlying the Medical Utilization Treatment Schedule, medical utilization review, and independent medical review is to promptly provide the best medical care to injured workers. Regulations that make that process unduly bureaucratic, impede the ability to review requested treatment, or impose excessive penalties that preclude legitimate statutory activity undermine that legislative policy decision.

The level of proposed penalties for utilization review and independent medical review enforcement is excessive and will impermissibly constrain the operation of section 4610, 4610.5, and 4610.6. The proposed penalty scheme under section 9792.12 narrows the scope of medical utilization review and is, therefore, in conflict with the statute. The current proposed regulations increase nearly every penalty, apply cumulative penalties, and fail to differentiate between harmless errors and material failures that have a significant adverse effect on the review of medical treatment. The new proposed penalties have, therefore, significantly exacerbated the problem. The problem, simply stated, is that the threat of excessive penalties will curtail legitimate medical utilization review activity that the statute permits.

Authority

The task imposed on state agencies by Government Code section 11342.2 is often very delicate. The statute allows:

“Whenever by the express or implied terms of any statute a state agency has authority to adopt regulations to implement, interpret, make specific or otherwise carry out the provisions of the statute, no regulation adopted is valid or effective unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute.”

It is the responsibility of the AD to interpret these statutes to make them specific, and to enforce their dictates. And, at the same time, the AD must permit the statutes to function in order to attain its legislative goals. Administrative regulations that alter or amend the statute or enlarge or impair the scope of the statute are void, and courts are obligated to strike down such regulations. Morris v. Williams (1967) 63 CR 689, 67 C2d 733, 433 P.2d 697.

Discussion

With every penalty regulation adopted, the Administrative Director is determining not only how to review medical treatment, but also whether medical utilization review (UR) will be meaningfully used at all. It is the Administrative Director’s stated intent to “provide a clear and effective disincentive to practices under which injured workers are improperly delayed or denied the medical treatment that has been recommended by their treating physicians.” For every penalty established in section 9712.12, whether it is a stated range, a cumulative penalty, or can be altered by mitigating factors, the Administrative Director is limiting the tools for medical utilization review that have been provided by statute.

The art of crafting proper penalty regulations is to balance the desired deterrent effect with sufficient latitude, so that the penalties do not impede claim management activities mandated or permitted by statute. The proposed penalty regulations are ostensibly aimed at bad actors, incompetent medical reviewers, and negligently processed or ignored treatment requests. But the by-product of that deterrence will be that in order to avoid the risk of excessive penalties, the claims administrator may have to avoid some utilization review modifications or denials.

The newly proposed penalty schedule requires claims administrators to reconsider the level at which utilization review should be conducted. This will essentially eliminate the cost-effective review of individual physical medicine procedures, including physical therapy and chiropractic care. Medical utilization review tools created by the Legislature will become prohibitive, resulting in an added administrative cost to the system, a lessened ability to control unnecessary and unreasonable medical treatment, and a higher system cost. By making effective utilization review impractical for certain levels of medical care, the Administrative Director is allowing poor quality treatment to go unchallenged. The result for injured workers is that medical care that does no harm, but does no good, will be allowed to continue in the workers' compensation system.

The proposed penalty regulations narrow the scope of permissible utilization review activity under the statute, and are, therefore, invalid. This applies to the individual penalties as well as the cumulative effect of the enforcement plan. The potential penalty for conducting permissible activity under the statute must be clearly stated at reasonable and fair levels, or the regulation is too intrusive into the authority of the statute.

§ 9792.12. Administrative Penalty Schedule

Sections 9792.12(a)(12)(13) and (14)

Recommendation: Strike these sections.

Discussion: In section 9792.9.1(c)(2), the AD has created a process by which a request for treatment may be made in any manner making it possible for a claims administrator to have “accepted” a request for authorization without ever having seen it. Under these sections, the penalty for failing to discover a hidden request for authorization is \$2,000. Such a penalty is only reasonable if the regulations continue to require that the request for authorization be stated in the appropriate, readily identifiable DWC Form RFA. It is not reasonable to penalize a claims administrator for failing to identify a request that is not provided on the standard form. As written, a request not on the standard form may not be identified as a request for authorization. See the introduction for additional detail.

As we have argued previously, it is preferable that the DWC request for authorization form continue to be used but if the AD retains the provisions of section 9792.9.1(c)(2), then the proposed penalty should be reduced to \$100 if the treating physician clearly meets the criterion for using the alternative means of requesting treatment in section 9792.9.1(c)(2)(B).

A similar problem exists with the \$100 penalties contained in section 9792.12(b)(4)(C) and (D) for the same reasons. A claims administrator should not be penalized for procedural failures that may be caused by a request for treatment that is not readily identifiable.

Cumulative Penalties

Recommendation

Many of the proposed penalties are cumulative, overlapping, and highly technical. We recommend that the penalties be revised to focus on specific conduct that has a clear, direct adverse impact on the completion of the IMR process.

Discussion

Utilization review and IMR are systems put in place by the Legislature to expedite the provision of the best possible medical care for each injured worker, as defined by evidence-based medical treatment guidelines. The statutory timelines require that both the UR decisions and the IMR determination be completed expeditiously. There is no question, then, that delays or omissions cannot be tolerated and penalties to enforce the appropriate conduct are justified.

Penalties for procedural or formatting errors or for conduct that is unrelated to the statutory objective should be eliminated. Provisions that penalize the same conduct in the same case with multiple violations should also be combined or eliminated to provide a clearer understanding of the obligations of the parties with regard to the process.

Material Errors

Recommendation

Every penalty schedule contained in section 9792.12 must include the mitigating concept of materiality. If the action, omission, or deficit does not materially affect the process, then a penalty is not warranted.

Discussion

The Institute appreciates the impact penalties can have as a deterrent to non-compliance, but the recourse to severe penalties should be limited to failures and deficits that have a direct detrimental impact on the operation of the provision of medical care, whether it is a failure to notify or the failure to respond to a request for additional medical records.

Section 9792.12(c)(1) and (2) are an example of the failure to consider materiality and proportionality. The failure to provide the IMR request form, subdivision (1), is a \$2,000 penalty. If the claims administrator provides the form with the UR decision but the form is incomplete, then the penalty schedule could easily exceed \$2,000. Nowhere do these regulations provide relief from purely technical defects that do not interfere with or impede in any way the operation of the IMR or the provision of medical care.

We recommend including instructions within the regulations ensuring that the penalties are proportionate to the violations and including additional provisions for mitigation as permitted under other administrative penalty provisions. The Administrative Director can achieve compliance and accountability with a more reasonable penalty schedule.

The Division and the workers' compensation community have experienced extensive and ongoing deficits and technical defects in the IMR process that have caused significant delays in the IMR process since the inception of the program. The AD needs to focus the deterrent effect of the penalties on significant failures that can be rectified by claims administrators and temper the corrective action contained in the penalty regulations.

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. Rupali Das, 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