STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

FINAL STATEMENT OF REASONS

Subject Matter of Regulations: Utilization Review and Independent Medical Review

California Code of Regulations, title 8, Article 5.5.1
Sections 9785, 9785.5, 9792.6, 9792.6.1, 9792.9, 9792.9.1, 9792.10, 9792.10.1, 9792.10.2, 9792.10.3, 9792.10.4, 9792.10.5, 9792.10.6, 9792.10.7, 9792.10.8, and 9792.10.9 and 9792.12

The Acting Administrative Director of the Division of Workers' Compensation (hereinafter "Acting Administrative Director"), pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, and 5307.3, has amended or adopted the following regulations:

Amend section 9785	Reporting Duties of the Primary Treating Physician
Adopt section 9785.5	Request for Authorization Form, DWC Form RFA
Amend Article 5.5.1	Utilization Review Standards; Independent Medical Review
Amend section 9792.6	Utilization Review Standards-Definitions - For Utilization Review Decisions Issued Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013
Adopt section 9792.6.1	Utilization Review Standards—Definitions – On or After January 1, 2013
Amend section 9792.9	Utilization Review Standards--Timeframe, Procedures and Notice Content – For Injuries Occurring Prior to January 1, 2013
Adopt section 9792.9.1	Utilization Review Standards--Timeframe, Procedures and Notice – On or After January 1, 2013
Amend section 9792.10	Utilization Review Standards--Dispute Resolution– For Utilization Review Decisions Issued Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013
Adopt section 9792.10.1	Utilization Review Standards--Dispute Resolution – On or After January 1, 2013
Adopt section 9792.10.2	Application for Independent Medical Review, DWC Form IMR
Adopt section 9792.10.3	Independent Medical Review – Initial Review of Application
Adopt section 9792.10.4	Independent Medical Review – Assignment and Notification
Adopt section 9792.10.5	Independent Medical Review – Medical Records
Adopt section 9792.10.6	Independent Medical Review – Standards and Timeframes
Adopt section 9792.10.7	Independent Medical Review – Implementation of Determination and Appeal
Adopt section 9792.10.8	Independent Medical Review – Payment for Review
Adopt section 9792.10.9	Independent Medical Review – Publishing of Determinations

Adopt section 9792.12 Administrative Penalty Schedule for Labor Code §4610 Utilization Review and Independent Medical Review Violations

REQUEST AND GOOD CAUSE FOR EFFECTIVE DATE UPON FILING WITH THE SECRETARY OF STATE

This rulemaking revises the emergency regulations. Changes have been made to the regulatory text since the emergency regulations became effective on January 1, 2013. It is important and necessary that these regulations are effective upon filing with the Secretary of State so that there is clarity and consistency for the public.

UPDATE OF INITIAL STATEMENT OF REASONS AND INFORMATIVE DIGEST

As authorized by Government Code §11346.9(d), the Acting Administrative Director hereby incorporates by reference the entire Initial Statement of Reasons prepared in this matter. Unless a specific basis is stated below for any modification to the regulations as initially proposed, the necessity for the amendments to existing regulations and for the adoption of new regulations as set forth in the Initial Statement of Reasons continues to apply to the regulations as now adopted.

The Acting Administrative Director notes that Senate Bill 375 (Chapter 287, Stats. 2013), signed by the Governor on September 9, 2013 and effective January 1, 2014, amended Labor Code section 4610.5 as follows:

- Subdivision (g)(3): The citation to subdivision (e) was corrected to subdivision (f).
- Subdivision (i): The word “plan” in the second sentence was replaced with “employer.”

All modifications from the initially proposed text of the regulations are summarized below.

1. Section 9785. Reporting Duties of the Primary Treating Physician

(b)(3) Amend subdivision to: (1) include express reference to “independent medical review” with statutory references; and (2) delete the last sentence: “No other primary treating physician shall be designated by the employee unless and until the dispute is resolved.”

(g) Amend to reinsert: “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.”

Reasons for Changes:

Subdivision (b) was amended to clarify that medical treatment disputes under the utilization review (UR) process of Labor Code section 4610 are resolved by independent medical review. The last sentence was deleted to recognize the right of the employee to

change their treating physician under Labor Code sections 4600 and 4601. A claims administrator's decision to deny a treatment recommendation should not preclude an employee from seeking another physician. Based on comments, the deleted sentence is reinstated to specify that the DWC Form RFA must be accompanied by documentation substantiating the need for the recommended treatment.

2. Section 9785.5. Request for Authorization Form, DWC Form RFA

a. Heading now reads: "Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment."

b. "Treating Physician" is now "Requesting Physician."

c. Requested Treatment section:

- The heading is amended to read: "List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient."
- Insert "required" under "Diagnosis" heading.
- Substitute "Service/Good" for "Procedure"
- Amend to state that the ICD-Code and Service/Good Requested is required, and the CPT/HCPCS Code should be listed if known.
- Delete "Facility" from "Other Information" column.

d. In Claims Administrator Response box, add Utilization Review Organization (URO) and insert "see separate letter" following "Liability for treatment is disputed checkbox.

e. Instructions:

- In the Overview section, insert "for the employee's treating physician" in the first sentence. Delete second sentence and replace with "A Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment must be attached." Delete the sentence "The intent of the form is to facilitate communication back and forth between the provider and the claims administrator, and also to furnish a verification of authorization for the requesting provider. Additional sheets should be used if appropriate." Insert as last sentence: "The DWC Form RFA is not a separately reimbursable report under the Official Medical Fee Schedule, found at California Code of Regulations, title 8, section 9789.10 et seq."

- In the "Checkboxes" section of the instructions, the second bullet point is replaced with the following: "Review should be expedited based on an imminent and serious threat to the employee's health. A request for expedited review must be supported by documentation substantiating the employee's condition."

- Under “Routing Information,” replace “provider” with “treating physician” and “physician,” respectively.

- Conform “Requested Treatment” section to changes made on the face of the form.

- In the “Claims Administrator/URO Response” section; (1) delete reference to section 9792.9; and (2) delete “Use of the DWC Form RFA is optional when communicating requests” and replace with “Use of the DWC Form RFA is optional when communicating approvals of treatment.”

Reasons for Changes:

The DWC Form RFA was changed based on comments that required specificity regarding the inclusion of supporting documents and accuracy regarding the treatment requested for the injured worker. The language of the form and organization of the Requested Treatment section was simplified and clarified to the extent possible to conform to industry practice. Five fields for treatment requests were included to clarify that more than one treatment request could be made on the DWC Form RFA. On the instruction page, extraneous language was deleted and, for clarification, physicians were advised that the form is not reimbursable under the Official Medical Fee Schedule.

3. Article 5.5.1 Utilization Review Standards; Independent Medical Review

The heading for Article 5.5.1 was amended to expressly include Independent Medical Review.

Reason for Change

The article now encompasses both the UR process and the IMR process.

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

Preface: Amend to reinstate language of emergency regulations effective January 1, 2013: “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 decision on the request is communicated to the requesting physician prior to July 1, 2013.”

(f) The definition of “Disputed liability” is amended to include a medical basis as a reason that would preclude compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.

Reason for Change

The preface was reinstated to conform to statutory language of Labor Code section 4610.5. The definition of “disputed liability” was amended based on comment that

indicated a medical reason might in fact exist for a claims administrator to dispute liability for the occupational injury or the treatment itself on grounds other than medical necessity.

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

Preface: Amend to reflect correct dates and circumstances on which the subdivision is effective - for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the decision on the request for authorization of medical treatment is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(a) The definition of "Authorization" is amended to allow authorization to be based on the proposed medical treatment set forth in either the "Request for Authorization for Medical Treatment," DWC Form RFA, or a request for authorization for authorization of medical treatment accepted by the claims administrator under subdivision 9792.9.1(c)(2). The subdivision is further amended to provided that authorization can be given using the response section of the Form RFA, if that form was initially submitted by the treating physician.

(b) The definition of "Claims Administrator" is amended to delete of "Unless otherwise indicated by context, "claims administrator" also means the employer."

(e) The definition of "Delay" is amended to be a determination, based on the need for additional evidence as set forth in subdivision 9792.9.1(f), that the timeframe requirements for the utilization review process provided in subdivision 9792.9.1(c) cannot be met.

(f) The definition of "Denial" is amended to be a decision by a physician reviewer that the requested treatment or service cannot be authorized.

(g) The definition of "Disputed liability" is amended to include a medical basis as a reason that would preclude compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.

(h) The definition of "Disputed medical treatment" is amended to delete "delayed."

(k) The definition of "Expert Reviewer" is amended to include a requirement that the expert reviewer not be an employee of the claims administrator or the utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.

(m) The definition of "Immediately" is amended to change "24 hours" to "one business day," and to delete "after learning the circumstances that would require an extension of the timeframe for decisions specified, in subdivision (c) and (f)(1) of section 9792.9.1."

(r) The definition of "Medically necessary" and "medical necessity" is deleted. The remaining subdivisions are re-lettered.

(u) The definition of "Request for authorization" is re-lettered as subdivision (t) and divided into subdivisions. Proposed subdivision (t)(1) provides that that unless accepted by a claims administrator under section 9792.9.1(c)(2), a request for authorization must be set forth on the "Request for Authorization for Medical Treatment" (DWC Form RFA). 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. Proposed subdivision (t)(2) provides that "Completed," for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization must identify both the employee and the provider, and identify with specificity a recommended treatment or treatments. Proposed subdivision (t)(3) provides that the request for authorization must be signed by the treating physician and may be mailed, faxed or e-mailed. By agreement of the parties, the treatment physician may submit the request for authorization with an electronic signature.

(x) The definition of "Utilization review decision" is re-lettered as subdivision (w) and is amended to delete "based in whole or in part on medical necessity to cure or relieve."

(z) The definition of "Utilization review process" is re-lettered as subdivision (y) and is amended to include a decision to approve a treatment request. Additionally, the subdivision is amended to delete "Utilization review does not include determinations of the work-relatedness of injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed." The last sentence in the definition is amended to provide: "The utilization review process begins when the completed DWC Form RFA, or a request or authorization accepted as complete under section 9792.9.1(c)(2), is first received by the claims administrator…."

Reasons for Changes:

The preface is amended to conform to the statutory language of Labor Code section 4610.5(a). The definition of "Authorization" is amended to account for the acceptance of non-compliant requests for authorization under section 9792.9.1(c)(2). The deletion of "employer" in the definition of "Claims Administrator" was made based on comments indicating that the inclusion of the term could obscure the varying obligation applied to each separate entity. "Delay" is amended to accurately define the term in line with its use in section 9792.9.1. "Denial" is also amended to accurately define the term in line with its use in section 9792.9.1. "Disputed liability" is amended to include a medical basis as a reason that would preclude compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment. "Disputed medical treatment" is amended to delete "delayed" since a delay is not a trigger for IMR. "Immediately" is only mean "one business day" based on comments that it would be impractical to impose hour requirements on UR obligations. The definition of "Medically necessary" and "medical necessity" is deleted as the definition, taken from Labor Code section 4610.5(c)(2), only apply to determinations by IMR reviewers. "Request for authorization" is amended to clarify what is considered a request for authorization, and what it must contain to be complete, and how it must be transmitted. Clarification was necessary since comments indicated confusion regarding the circumstances that would support the rejection or return of an incomplete form to the provider. "Utilization review decision" was amended in recognition of the fact that a UR decision may not necessarily involve a determination of medical necessity. Correspondingly, "utilization review process" was amended to

include approvals for accuracy, acknowledge that a UR decision may not necessarily involve a determination of medical necessity, and to account for alternate requests for authorization under section 9792.9.1(c)(2).

6. Section 9792.9. Utilization Review Standards--Timeframe, Procedures and Notice Content – For Injuries Occurring Prior to January 1, 2013

Title and preface: Substitute "received" for "made" in title of subdivision. Substitute "submitted" for "made in the first sentence of the preface. Substitute "received" for "made" in the last sentence.

Reasons for Changes:

Based on comments, the words were changed for accuracy and to conform with the timeframe mandates of Labor Code section 4610.5.

7. Section 9792.9.1. Utilization Review Standards--Timeframe, Procedures and Notice – On or After January 1, 2013

Preface: Amend to provide that: "This section applies to any request for authorization of medical treatment, submitted under Article 5.5.1 of this Subchapter, for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the decision on the request is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury."

(b)(1) The subdivision is amended to delete the word "only" in the last sentence.

(c) The first sentence of the subdivision is amended to read: "Unless additional information is requested necessitating an extension under subdivision (f)…."

(c)(2)(A) Subdivision (c)(2) is now identified as subdivision (c)(2)(A) and is amended to read: "Upon receipt of a request for authorization as described in subdivision (c)(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."

(c)(2)(B) Subdivision (c)(2)(B) is added to read: "The claims administrator may accept a request for authorization for medical treatment that does not utilize the DWC Form RFA, provided that: (1) "Request for Authorization" is clearly written at the top of the first page of document; (2) all requested medical services, goods, or items are listed on the first page; and (3) the request is accompanied by documentation substantiating the medical necessity for the requested treatment.

(c)(3) Delete "but in no event more than 14 calendar days from initial receipt of the complete DWC Form RFA."

(c)(3)(A) Renumber subdivision as (c)(4). Amend to provide: “Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under subdivision (c)(3) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (c)(3).”

(c)(3)(B) Delete subdivision.

(c)(3)(C) Delete subdivision.

(c)(3)(5) Renumber as subdivision (c)(5); add “request for authorization” and reinsert “medical information that is reasonably necessary to make this determination request for authorization.”

(d)(1) Delete “set forth in a DWC Form RFA.” Include “the date the complete request for authorization was received.”

(d)(3)(B) Amend to replace the erroneous citation to subdivision (c)(4) with the correction citation, subdivision (c)(5).

(e)(3) Add “the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney” as parties entitled to receive written notice of a decision to modify, delay, or deny a treatment request.

(e)(4) Include “request for authorization” and reinsert “and medical information that is reasonably necessary to make a determination.”

(e)(5) Amend to provided that the written decision shall be signed by either the claims administrator or the reviewer, and shall only contain the information set forth in the subdivision.

(e)(6) Add subdivision addressing additional requirements for a concurrent review decision to deny authorization for medical treatment. The requirements were formerly found at section 9792.10.1(e).

(e)(5)(G) Amend first sentence to read; “The Application for Independent Medical Review, DWC Form IMR. All fields of the form, except for the signature of the employee, to must be completed by the claims administrator.” Delete “and if the injured worker is represented by counsel, the injured worker’s attorney.” Add sentence stating that prior to March 1, 2014, any version of the DWC Form IMR adopted by the Administrative Director under section 9792.10.2 may be used by the claims administrator in a written decision modifying, delaying or denying treatment authorization.

(e)(6) Add subdivision to provide additional requirements that must be met prior to a concurrent review decision to deny authorization for medical treatment: (A) 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 appropriate for the medical needs of the employee; and (B) medical care provided during a concurrent review shall be medical treatment that is medically necessary to cure or relieve from the effects of the industrial injury. The subdivision was previously found in section 9792.10.1.

(f)(1) Delete "with a written notice of delay by the reviewer."

(f)(1)(A) Amend subdivision to read: "The claims administrator or reviewer is not in receipt of all of the information reasonably necessary to make a determination."

(f)(2)(A) Amend to provide that: "If the circumstance under subdivision (f)(1)(A) applies, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request for authorization.

(f)(2)(B) Renumber as subdivision (f)(2)(B). Amend subdivision to provide that if "any of the circumstances set forth in subdivisions (f)(1)(B) or (C) above are deemed to apply following the receipt of a DWC Form RFA or accepted request for authorization, the reviewer shall, within five (5) business days from the date of receipt of the request for authorization, 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 additional examinations or tests required, or the specialty of the expert reviewer to be consulted."

(f)(3) Add new subdivisions (f)(3)(A) and (f)(3)(B). The former provides that if information reasonably necessary to make a determination is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer, or non-physician reviewer as allowed, shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information. The latter provides that if the results of the additional examination or test, or the specialized consultation, is not received within thirty (30) days from the date of the request, the reviewer shall deny the request for authorization with the stated condition that the request will be reconsidered upon receipt of the results of the additional examination or test or the specialized consultation.

(f)(3)-(5) The existing subdivision (f)(3)-(5) is renumbered as (f)(4)-(6).

Reasons for Changes:

The preface is amended to conform to the statutory language of Labor Code section 4610.5(a).

Subdivision (b)(1) is amended to delete the word "only," as a notification of a UR deferral could contain information outside of the required elements.

Subdivision (c) was amended to expressly account for the circumstances warranting an extension of the UR timeframes, which are now in subdivision (f).

Subdivision (c)(1) and (2) were amended to provide claims administrators with an option to process incomplete requests for authorization or those that do not use the DWC Form RFA. As the DWC Form RFA is new to workers' compensation, the Division believes it is fair to initially not only give physicians a measure of flexibility in using the form, but to allow claims administrators the option to return a non-complaint request and ask for the use of the correct form. Based on comments, which suggest that many requested treatment could go unnoticed if any document is submitted, and that three business days is far too short a period of time in which to review requests, the Division has extended the period of time for the review to five business days, and has narrowed the requirements to a document that has "request for authorization" written at the top and all treatment requests listed on the first page. For clarification, subdivision (c)(2)(A) requires that the DWC Form RFA must contain identifying information and documentation substantiating the medical necessity of the treatment request. This is the basic information necessary for UR to proceed.

Subdivision (c)(3) was amended as the circumstances warranting an extension of the UR timeframes have been moved to subdivision(f).

Subdivision (c)(4) was amended based on comments indicating that many physicians do not provide evidence that the injured worker's condition is of such a serious state that an expedited review is warranted. Give the constricted timeframe for expedited UR, the subdivision now requires documented proof of the injured worker's condition and expressly allows claims administrators to covert an expedited request into a regular review if there is no evidence that such a review is necessary.

Subdivisions (c)(3)(B) and (c)(3)(C) were deleted as the provision regarding the circumstances by which to extend the UR deadlines were moved to subdivision (f).

Subdivisions (c)(3)(5) and (d)(1) were amended to acknowledge that UR timeframes run from the receipt of the request for authorization and the information necessary to make a determination.

Subdivision (e)(3) was amended to recognize that an injured worker has the right to be represented by an attorney in the workers' compensation claim and appeal process. See, for example, Labor Code section 5700. Given the tight timeframes of the IMR process, it is necessary to involve the employee's counsel, if they are represented, in the medical treatment dispute at an early stage.

Subdivision (e)(4) was amended to clarify the timeframe for a retrospective UR determination.

Subdivision (e)(5) was amended to provide that an adverse UR shall be signed by either the claims administrator or the reviewer, and shall only contain the information set forth in the subdivision. There is no statutory requirement that a UR determination letter be signed by the reviewing UR physician (although they must make the decision itself).

Subdivision (e)(5)(G) was amended to clarify the obligations of the claims administrator to complete the form, and to remove the requirement that an addressed envelope be

sent to injured worker's attorney, as that is not required by Labor Code section 4610.5(f). To assist claims administrators in transitioning to the new IMR form, the regulation allows that prior to March 1, 2014, any version of the DWC Form IMR adopted by the Administrative Director may be used.

Subdivision (e)(6) was added to relocate the requirements for a concurrent review denial, which was previously found in section 9792.10.1. Medical care provided during such a review was changed from that reasonably required to that reasonably necessary to conform the statutory language of Labor Code section 4610(g)(3)(B).

The purpose of amended subdivision (f) is to standardize the procedures by which requests for additional information, additional tests, or an additional consultation are made. Based on comment, the period to request information is now five business days from receipt of the request for authorization, and the period of time for issuing a decision based on the failure of the providing physician to provide the information has been clarified (14 days for requesting information; 30 days for an additional test or consultation).

8. Section 9792.10. Utilization Review Standards--Dispute Resolution– For Utilization Review Decisions Issued Prior to July 1, 2013 for Injuries Occurring Prior to January 1, 2013

Amend section title to replace "Issued" with "Communicated."

(a)(4) Delete reference to specific WCAB form. (Form WCAB 1, and a Declaration of Readiness to Proceed (expedited trial), DWC-CA form 10208.3.)

Reasons for Changes:

The title is amended to conform to the statutory language of Labor Code section 4610.5(a). Subdivision (a)(4) was amended to delete references to all form citations which are essentially unnecessary since the section is no longer in use.

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

Preface: Amend to reflect correct dates and circumstances on which the subdivision is effective - for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the decision on the request for authorization of medical treatment is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(b)(1) Amend first sentence by substituting "filed" for "communicated" and "with" for "to." Include in second sentence "must be" prior to "…submitted with a copy of the written decision…." Also amend to provide that the a request for independent medical review must be filed within 30 days of service of the written utilization review decision determination issued by the claims administrator under section 9792.9.1(e)(5). The subdivision is further amended to provide that at the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the adverse utilization review decision, to the claims administrator.

(b)(2)(A) Amend to provide that 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.

(b)(3) Amend to specify that if expedited review is requested for a utilization review decision eligible for independent medical review, the request for Independent Medical Review, shall include, unless the initial utilization review decision was made on an expedited basis, written certification from the employee's treating physician with documentation confirming that the employee faces an imminent and serious threat to his or her health.

(c)(1) Amend to replace erroneous citation, subdivision (b)(2), with correct citation, subdivision (b)(1).

(c)(2) Amend the subdivision to provide: "If the claims administrator provides the employee with a written utilization review determination modifying, delaying, or denying a treatment request that does not contain the required elements set forth in section 9792.9(l) or section 9792.9.1(e) at the time of notification of its utilization review decision…."

(d)(1) Amend last sentence of new subdivision (d)(1) to provide: "Any request by the employee 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.

(d)(2) The subdivision is added to read: "A request for an internal utilization review appeal must be completed, and a determination issued, by the claims administrator within thirty (30) days after receipt of the request under subdivision (d)(1). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6(c) that determines the medical necessity of the disputed medical treatment." The existing subdivision (d)(2) is now renumbered as (d)(3).

(d)(3) Add subdivision (d)(2) to provide that any determination following an internal utilization review appeal that results in a modification of the requested medical treatment shall be communicated under the requirements of section 9792.9.1(e) and that the accompanying DWC Form IMR must indicate that the decision is a modification after appeal.

(e) Delete subdivision and move to section 9792.9.1(e)(6).

Reasons for Changes:

The preface is amended to conform to the statutory language of Labor Code section 4610.5(a).

Subdivision (b)(1) is amended to clarify the form that must be filed by the injured worker in order to initiate the IMR process and the time in which to file the form. The subdivision expressly provides that a copy of the adverse UR decision must be included, a necessity in order to determine eligibility, and that a copy of the IMR application, without a copy of the UR determination, must be sent to the claims administrator. Since

the goal of IMR is to expeditiously provide medical treatment, notification to the claims administrator that the IMR is being sought at the earliest possible point in the process may provide for an early resolution of the treatment dispute.

Subdivision (b)(2)(A) recognizes that an injured worker has the right to be represented by an attorney in the workers' compensation claim and appeal process.

Based on comments that the IMR process may be subject to a large number of unwarranted requests for expedited review, subdivision (b)(3) has been amended to correspond to the standards set for an expedited UR review in section 9792.9.1(c)(4). Unless expedited review was initially conducted in UR, a physician must submit written documentation confirming the injured worker's serious condition.

Subdivision (c)(2) clarifies that that time for filing a IMR application does not commence until an injured worker receives a UR determination letter with all the required elements of section 9792.9.1(e).

Subdivision (d) clarifies the requirements for an internal appeal process that is conducted by claims administrator concurrent with the timeframes for IMR. Based on comments, that an employee should filed expeditiously for an internal review and that the review should have a set deadline, the Division has found that it reasonable that a request should be made within 10 days following the UR decision and that any decision should be made within 30 days after receipt of the request. This timeframe should allow the claims administrator sufficient time to review a decision and, if necessary, authorize or modify the treatment request. Subdivision (d)(3) clarifies that only a modification of a treatment request following an internal appeal should be accompanied by an new IMR application. A new IMR application for a denial would only be a duplicate of one previously submitted.

Subdivision (e) was appropriately moved to section 9792.9.1(e)(6).

10. Section 9792.10.2. Application for Independent Medical Review, DWC Form IMR

a. Simplify the filing instructions at the top of the form.

b. Amend "Type of Review to insert "Utilization." Delete "Required."

c. Add checkbox indicating "Modification after Appeal."

d. Delete "Completion of this section is required" from information and treatment sections.

e. Add "employer name," "fax number," and employee attorney information to employee information section. Delete redundant references to "employee" and combine address, city, state, and zip into one field.

f. "Requesting Physician" replaces "Treating Physician."

g. Delete redundant references to “claims administrator” in third section, combine address, city, state, and zip into one field and add field for fax number.

h. Substitute “disputed” for “requested” in medical treatment section. Amend text in box to read: “Describe with specificity all the requested medical services, goods, or items that were denied or modified.” Separate fields are added for the date of the utilization review determination, and for the claims administrator to indicate whether liability for the medical treatment is disputed on grounds other than medical necessity. The field for the claims administrator to specify each requested medical services, goods, or items that were denied or modified is separated into four lines. Claims administrators are instructed to use additional pages if the space is insufficient.

i. Combine signature line with section “Consent to Obtain Medical Records.” Under “Request for Review and Consent to Obtain Medical Records,” the third to last sentence is revised to read: “These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury.”

j. Delete filing information section; relocate language to top of page.

k. Instructions:

- The “Instructions for Completing the Application for Independent Medical Review Form” is restructured and simplified for clarity. The second paragraph in the text box at the top of the page is amended to read: “If you decide not to participate in the IMR process you may lose your right to challenge the denial, delay, or modification of medical treatment referred to on Page One of the Application for Independent Medical Review.”

- Modify “How to Apply” paragraph using bullet points and additional information regarding the filing of the form.

- The fifth bullet point provides that the IMR application must be received by Maximus Federal Services, Inc. within thirty-five (35) days from the mailing date of the written utilization review determination letter. “Determining Your Eligibility for IMR” has been deleted and replaced with contact information for the Division’s Information and Assistance Officers.

l. The “Authorized Representative Designation for Independent Medical Review” form has been changed to correct spelling errors and add a field for an attorney’s State Bar Number.

Reasons for Changes:

Labor Code section 4610.5(f) mandates that the DWC Form IMR be only one page. The challenge for the Division was to create a one page form that contains all the statutory elements, provides identifying information, and contains sufficient information about the disputed medical treatment such that Division could determine based on the application alone whether the request is eligible for IMR. Based on comments by the public and experience with the IMR application adopted as an emergency regulation, the Division finds the proposed form sufficient to meet all needs. A checkbox indicating “Modification

after Appeal" was added to accommodate the internal appeal requirements of section 9792.10.1(d). Attorney information was added to the form so that communications could reach the injured worker's counsel in a more expedient fashion. The use of requesting physician is more accurate and distinguishes between the injured worker's primary treating physician and the secondary physician actually rendering treatment. The Disputed Medical Treatment section was reorganized to plainly define the issues that need to be determined through IMR. Four fields for separate treatment disputes were included to clarify that more than one treatment dispute could be made on the DWC Form IMR. The Request for Review and Consent to Obtain Medical Records was combined for clarity and the provision regarding HIV records was revised to plainly inform injured workers as to when those records may be relevant. The language of the instruction page has been simplified to inform injured workers of their rights and obligations for filing the form, and the timeframe for filing the form has been plainly stated (35 days following mailing of the UR decision) so as to avoid confusion. Extraneous language that did not directly relate to the filing of the form, i.e., the process of eligibility, was deleted so as not to confuse the parties. Errors on the "Authorized Representative Designation for Independent Medical Review" form have been corrected and a field for an attorney's State Bar Number to promote better communication between the attorney and the IMRO.

11. Section 9792.10.3. Independent Medical Review – Initial Review of Application

(a)(3) Amend to provide that the Administrative Director shall consider for the purpose of determining eligibility any assertion by the claims administrator, other than medical necessity, that a factual, medical, or legal basis exists that precludes liability on the part of the claims administrator for an occupational injury or a claimed injury to any part or parts of the body.

(a)(4) Amend to provide that the Administrative Director shall consider for the purpose of determining eligibility any assertion by the claims administrator, other than medical necessity, that a factual, medical, or legal basis exists that precludes liability on the part of the claims administrator for a specific course of medical treatment requested by the treating physician.

(a)(6) Amend to provide that the Administrative Director shall consider for the purpose of determining eligibility the "failure by the requesting physician to respond to a request by the claims administrator under section 9792.9.1(f) for information reasonably necessary to make a utilization review determination, for additional required examinations or tests, or for a specialized consultation."

(b) Amend to provide that the Administrative Director shall contact the employee's counsel, if the employee is represented by counsel, and the requesting physician if additional information is needed to determine eligibility.

(c) Amend subdivision to provide that the parties shall respond to any reasonable request made by the Administrative Director under subdivision (b) within five business (5) days following receipt of the request.

(f) Add subdivision (f) which provides that the Administrative Director shall retain the right to determine the eligibility of a request for independent medical review under this

section until an appeal of the final independent medical review determination issued under section 9792.10.6 (c) that determines the medical necessity of the disputed medical treatment has been filed with the Workers' Compensation Appeals Board, or the time in which to file such an appeal has expired.

Reasons for Changes:

Subdivisions (a)(3) and (a)(4) were changed based on comments indicating that a medical reason may exist for a claims administrator to deny liability for injury or for the treatment itself on grounds other than medical necessity.

Subdivision (a)(6) was added as a grounds for determining eligibility in recognition that a denial of a treatment request based on the failure of the requesting physician to respond to a request by the claims administrator for information reasonably necessary to make a utilization review determination may not constitute a medical necessity dispute. It may be that upon submission of the information the treatment will be authorized; in the absence of the information, the claims administration simply does not have the opportunity to reach any type of decision.

Subdivision (b) was amended to expressly include the employee's counsel and the requesting physician in the information exchange process. Their inclusion may expedite an eligibility determination and ultimately the IMR process for that dispute.

Subdivision (c) was amended to provide a reasonable time for a claims administration to provide information regarding an eligibility determination. As initially proposed, 15 days was found to be excessive for the transfer of what should be easily accessible documents. Upon review of comments, 5 business days was determined to be reasonable.

Subdivision (f) was added to expressly provide that the Administrative Director retains the right to review the eligibility of an IMR request through the life of the process or until an appeal is filed with the WCAB. The right of an adjudicatory body to determine its own jurisdiction regarding any case or claim is well-settled. Should any facts arise during the IMR process indicating that the request is ineligible (i.e., the claim is denied), the Administrative Director must be able to deem the request ineligible.

12. Section 9792.10.4. Independent Medical Review – Assignment and Notification

Title Amend title to read "Consolidation, Assignment, and Notification."

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

(b) Existing language is placed under new subdivision (b) and renumbered.

(b)(1) Amend subdivision to provide that the assignment notification shall be issued by the IMRO within one business day following receipt of the Administrative Director's eligibility determination. The notice shall go to the employee's counsel, if represented, and include the date of the request for authorization, if available. ((b)(2)).

(c) Existing language is placed under new subdivision (c). Amend to provide that a regular IMR review can be converted to an expedited review if the requesting physician provides a written certification with supporting documentation verifying that the employee faces an imminent and serious threat to his or her health. Correct citation to section 9792.6.1(j).

Reasons for Changes:

Subdivision (a) allows the IMRO to consolidate two or more eligible IMR applications by a single employee for resolution in a single determination if the applications involve the same requesting physician and the same date of injury. Based on comments concerned about single IMR applications being filed for single treatment requests, this procedure will expedite treatment reviews by having a single reviewer analyze all related treatment for an single injured worker, eliminate the duplication of effort on the part of claims administrators in providing documents, and result in cost savings since multiple fees for the individual cases will not be required.

Subdivision (b) was amended to insure that the IMR process will be conducted in a timely fashion. The inclusion of the employee's counsel may expedite an eligibility determination and ultimately the IMR process for that dispute.

Subdivision (c) was amended to insure that requests for an expedited IMR review are based on documented evidence submitted by the requesting physician. The will preclude erroneous or meritless requests that could initiate the costly and accelerated expedited process.

11. Section 9792.10.5. Independent Medical Review – Medical Records

(a)(1)(B) Amend to provide that the claims administrator must include an IMR application that was included with the written adverse UR determination. Neither the written determination nor the application's instructions should be included.

(a)(1)(C) Amend to provide that the information required to be submitted, that which was provided to the employee by the claims administrator concerning the utilization review decision, does not include the utilization review decision itself.

(a)(2) Amend to expressly provide that the copies of documents to be provided to the employee by the claims administrator shall not include mental health records withheld from the employee pursuant to Health and Safety Code section 123115(b).

(b)(1) Amend to specifically include the employee's attorney as a party who may submit documents on behalf of the employee.

(b)(2) Amend to specifically include the employee's attorney as a party who may forward documents or a document list on the claims administrator. Amend to substitute "forward" for "serve."

(b)(3) Amend to specifically include the employee's attorney as a party who may submit any newly developed or discovered relevant medical records to the independent review organization

Reasons for Changes:

Subdivisions (a)(1)(B) and (a)(1)(C) were amended to exclude the adverse UR determination as a document that must be provided by the claims administrator. This acknowledges that the determination must be provided by the employee at the initiation of the IMR process so a further mandate would be duplicative. The IMR application itself is requested so that the application filed by the employee can be compared with the one provided to the employee by the claims administrator in order to ensure that they are the same document.

Subdivision (a)(2) is amended to ensure that mental health records that may be detrimental for the employee to review, as set forth in Health and Safety Code section 123115(b), are properly excluded from the copies of medical records that must be provided under this section.

Subdivision (b)(1), (2), and (3), are amended to specifically include the employee's attorney as a party who may submit documents on behalf of the employee. The inclusion of the employee's counsel may expedite an eligibility determination and ultimately the IMR process for that dispute.

13. Section 9792.10.6. Independent Medical Review – Standards and Timeframes

(a) Amend subdivision to read: "The independent medical review process may be terminated at any time upon notice by the claims administrator to the independent review organization that the disputed medical treatment has been authorized."

(b)(1) The proposed subdivision (b) is divided into two sections. Amend new subdivision (b)(1) to provide that "medically necessary" for the purpose of independent medical review means medical treatment that is reasonably required to cure or relieve the employee of the effects of their injury and based on the standards set forth in Labor Code section 4610.5(c)(2).

(b)(2): Amend to provide that if a claims administrator fails to submit the documentation required under section 9792.10.5(a)(1), a medical reviewer may issue a determination as to whether the disputed medical treatment is medically necessary based on both a summary of medical records listed in the utilization review determination issued under section 9792.9.1(e)(5), and documents submitted by the employee or requesting physician under section 9792.10.5(b) or (c). No independent medical review determination shall issue based solely on the information provided by a utilization review determination.

(d) Amend subdivision to delete regulatory citation.

(e) Amend to specifically include the employee's attorney as a party who receives the final determination from the independent review organization.

(g)(1)(A) A new subdivision is added to address the timeframe for issuing a determination on independent medical review requests that are consolidated under section 9792.10.4(a). The subdivision reads: “If two (2) or more requests for independent medical review are consolidated under section 9792.10.4(a), the thirty (30) day period for the independent review organization to complete its review and make its final determination shall begin upon receipt of the last filed application for independent medical review that was consolidated for determination and the supporting documentation and information for that application.”

(g)(1)(B) A new subdivision is added to address the timeframe for issuing a determination on a request for independent medical review when, subsequent to the filing of the request, the claims administrator modifies its utilization review decision under section 9792.10.1(d)(3). The subdivision reads: “If, under section 9792.10.1(d)(3), an internal utilization review appeal modifies a utilization review determination for which an application for independent medical review was previously filed under section 9792.10.1(b), the thirty (30) day period for the independent review organization to complete its review and make its final determination shall begin upon receipt of the application for independent medical review requesting review of the modified treatment, and the supporting documentation and information for that application.”

(i) Add subdivision (i) to provide that upon receipt of credible information that the claims administrator has failed to has failed to comply with its obligations under the independent medical review requirements set forth in Labor Code sections 4610.5 or in sections 9792.6 through 9792.10.8 of this Article, the Administrative Director shall, concurrent or subsequent to the issuance of the final determination issued by the independent review organization, issue an order to show cause under section 9792.15 for the assessment of administrative penalties against the claims administrator under section 9792.12(c).

Reasons for Changes:

Subdivision (a) is amended to clarify the circumstance that would allow the claims administrator to unilaterally terminate the IMR process: authorization of the disputed medical treatment.

Subdivision (b)(1) is amended to provide a direct reference to the IMR reviewer of the standard for medical necessity in IMR: that set forth in Labor Code section 4610.5(c)(2). Duplication of the standard in the regulations is unnecessary.

Subdivision (b)(2) is added to allow an IMR reviewer to issue a determination should a claims administrator not provide the required documents under section 9792.10.5(a)(1). The goal of IMR is to expedite treatment for injured workers by having medical experts make the final determination regarding the medical necessity of treatment requests. If a claims administrator, after full notice, fails to participate in the IMR process in clear violation of their obligations, the IMR process should not be brought to a halt if, following the submission of medical records by the employee and the requesting physician, sufficient evidence exists for the IMR reviewer to make a medical necessity determination. The regulation fully acknowledges the participation of the employee; an IMR determination will not be made solely based on the records summarized in the adverse UR determination.

Subdivision (d) eliminates the regulatory citation; the standard for review is clear under Labor Code section 4610.5(c)(2).

Subdivision (e) is amended to specifically include the employee's attorney as a party who receives the final determination from the independent review organization. This acknowledges the integral role the employee's attorney plays in the IMR process.

Subdivision (g)(1)(A) and (g)(1)(B) were added to specify the timeframes for issuing an IMR determination in two situation where two or more IMR applications may be filed: the consolidation of IMR requests under section 9792.10.4(a) and an IMR request for review of a modified treatment following an internal review (section 9792.10.1(d)(3)). In both situations, the 30-day timeframe for decision begins following the last filed IMR application.

Subdivision (i) is added to establish a new penalty procedure for IMR violations. As noted above, the overriding purpose of IMR is to resolve medical treatment disputes in an expeditious manner. Realizing the importance of avoid delay in the system, the Legislature enacted Labor Code section 4610.5(i) to authorize the Administrative Director to assess administrative penalties for a claims administrator's failure to promptly comply with any IMR obligation. Rather than the random UR investigation and audit process of section 9792.11, in which years could go by before a file is audited for violations, the Division found that violations could be more efficiently remedied, and future conduct more quickly deterred, by an 'Order to Show Cause" procedure that would bring more immediacy in correcting the underlying conduct. The faster assessment of penalties will provide an added incentive for claims administrator to comply with the IMR rules.

14. Section 9792.10.7. Independent Medical Review – Implementation of Determination and Appeal

(a) Amend to specify that the claims administrator shall promptly implement the final determination of the Administrative Director unless an appeal is filed under subdivision (c) or else liability for the treatment is disputed as described in subdivision (a)(3).

(a)(3) A subdivision is added to provide that, if, at the time of receiving the final determination the claims administrator is disputing liability for the medical treatment on grounds other than medical necessity, implementation of the final determination shall be deferred until the liability dispute has been resolved.

(b) Amend subdivision to provide that upon receipt of credible information that the claims administrator has failed to implement the final determination as required in subdivision (a), the Administrative Director shall issue an order to show cause under section 9792.15 for the assessment of administrative penalties against the claims administrator under section 9792.12(c).

Reasons for Changes:

Subdivision (a) is amended, and subdivision (a)(3) is added to specify that a claims administrator must promptly implement an IMR determination unless an appeal is filed under subdivision (c) or else liability for the treatment is disputed. Subdivision (a)(3)

clarifies that the IMR determination is deferred until the liability dispute is resolved. The initial version of the regulation did not specify the status of the determination during this process.

Subdivision (b) is amended to reflect the new IMR penalty structure. See "Reasons for Changes" regarding section 9792.10.6(i).

15. Section 9792.11. Investigation Procedures: Labor Code § 4610 Utilization Review Violations.

(c)(1)(A) Amend subdivision to require a routine investigation at least once every five (5) years. Further amend subdivision to correct citation to definition for request for authorization: section 9792.6.1(t).

(c)(2)(A) Amend subdivision to correct citation to definition for request for authorization: section 9792.6.1(t).

(j)(4) Amend subdivision to correct citation to section 9792.10.1.

Reasons for Changes:

Subdivision (c)(1)(A) was amended to require a routine investigation of claims administrator's UR and IMR files at least once every five (5) years. This period aligns with the timeframe for Audit Unit investigation under section 10106.1(b). The remaining amendments in the section correct regulatory citations.

16. Section 9792.12. Administrative Penalty Schedule for Labor Code §4610 Utilization Review and Independent Medical Review Violations

(a) Amend first sentence of subdivision to read: "Mandatory Utilization Review Administrative Penalties." Amend subdivision to delete "the independent medical review process required by Labor Code sections 4610.5 and 4610.6."

(a)(8) Amend subdivision to substitute "without documenting the amended request" for "to possess an amended written request for treatment authorization."

(a)(12) Amend subdivision to substitute "a complete DWC Form RFA or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted" for "the request for authorization."

(a)(13) Amend subdivision to substitute "a complete DWC Form RFA or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted" for "the request for authorization."

(a)(14) Amend subdivision to substitute "a complete DWC Form RFA or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted" for "the request for authorization."

(b) Amend subdivision to provide "Additional Utilization Review Penalties and Remediation."

(b)(4)(C) Amend subdivision to allow for the assessment of an administrative penalty for, prospective or concurrent review, the failure to make a decision to approve or modify or deny the request for authorization in a timely manner following the receipt of the completed DWC Form RFA, an accepted request for authorization, or of the requested information. Correct citation to section 9792.9.1(f)(4).

(b)(4)(D) Amend subdivision to allow for the assessment of an administrative penalty for, retrospective review, the failure to make a decision to approve or modify or deny the request for authorization in a timely manner following the receipt of the completed DWC Form RFA, an accepted request for authorization, or of the requested information. Correct citations to section 9792.9.1(h)(4), and section 9792.9.1(e)(4) and (f)(6).

(b)(5)(C) Amend subdivision to include citation to section 9792.9.1(e)(3). Delete "of Title 8 of the California Code of Regulations."

(b)(5)(D) Amend subdivision to substitute "send a written notice of the" in place of "communicate a."

(c) Add new subdivision (c) to provide for Independent Medical Review Administrative Penalties. The subdivision lists specific violations and the amount to be assessed as an administrative penalty for each. The violations are as follows:

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

(c)(2) A subdivision is added to allow for the assessment of administrative penalties for the failure of the claims administrator to complete all applicable fields of the Application for Independent Medical Review, DWC Form IMR, found at section 9792.10.2, that is provided with a written utilization review determination that delays, denies, or modifies a treatment recommendation. The proposed penalties are as follows:

- $500 for a failure to provide the Employee Name, Address, Phone Number, and Date of Injury;
- $500 for a failure to provide the Requesting Physician Name, Address, Specialty, and Phone Number;
- $500 for a failure to provide the Claims Administrator Name, Adjustor/Contact Name, Address, and Phone Number;
- $500 for a failure to complete any field under the section heading "Disputed Medical Treatment."
- $100 for a failure to provide any field not identified above.

The remaining paragraphs of subdivision (c) are renumbered.

(c)(3) For the failure to include in a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(l) or 9792.9.1 a clear statement that advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the Application for Independent Medical Review, DWC Form IMR,

set forth at section 9792.10.2, within 30 days of service of the utilization review decision: $1,000.

(c)(4) For the failure to include in a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(l) or 9792.9.1 a statement detailing the claims administrator's internal utilization review appeals process for the requesting physician, if any, and a statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis: $1,000.

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

(c)(6) For the failure to timely provide all information required by section 9792.10.5(a) and (c): $500.00 for each day the response is untimely up to a maximum of $5,000.00.

(c)(7) For the failure to authorize services found to be medically necessary by the independent medical review organization in the final determination issued under section 9792.10.6 within either five (5) business days of receipt of the determination, or sooner if appropriate for the employee's medical condition, or five (5) business days from the date the determination is final, if an appeal of the determination has been filed under Labor Code section 4610.6(h): $1,000.00 for each day up to a maximum of $5,000.00.

(c)(8) For the failure to reimburse for services already rendered that has been found to be medically necessary by the independent medical review organization in the final determination issued under section 9792.10.6 within twenty (20) days after receipt of the final determination, or within twenty (20) days from the date the determination is final if an appeal of the determination has been filed under Labor Code section 4610.6(h), subject to resolution of any remaining issue of the amount of payment pursuant to Labor Code sections 4603.2 to 4603.6, inclusive: $500.00 for each day up to a maximum of $5,000.00

(c)(9) For the failure to timely pay an invoice sent from the designated independent medical review organization under section 9792.10.8(c): $250.

(d) Add new subdivision (d) to provide that the Administrative Director, or his or her designee, may assess both an administrative penalty under either Labor Code sections 4610.5 and 4610.6, and a civil penalty under Labor Code section 129.5(e), based on the same violation(s).

(e) Existing subdivision (c) is re-lettered as subdivision (e). Amend to replace "subsection 9792.12(a) and (b) above" with "this section."

Reasons for Changes:

Subdivision (a) is amended to specify that the subdivision applies only to mandatory UR penalties. Penalties for IMR violations have been moved to subdivision (c).

Subdivision (a)(8) has been amended to clarify that the conduct subject to penalty is the failure to document that an amended request has been made by the requesting physician. The existing regulation was confusing.

Subdivisions (a)(12) through (a)(14) are amended to take into account the alternative request for authorization allowed under section 9792.9.1(c)(2).

Subdivision (a)(18) through (a)(25) have been relocated into the new subdivision (c) to account for the new IMR penalty procedure.

Subdivision (b) is amended to specify that the subdivision applies only to additional UR penalties.

Subdivision (b)(4)(C) and (b)(4)(D) are amended to: (1) take into account the alternative request for authorization allowed under section 9792.9.1(c)(2); and (2) take into account the revisions of section 9792.9.1(e) and (f).

Subdivision (b)(5)(C) was amended to remove extraneous language.

Subdivision (b)(5)(D) was amended to align the violation with the regulatory requirements set forth in section 9792.9(d) or section 9792.9.1(d)(3) and (e)(4).

Subdivision (c) was added to accommodate the new procedure for assessing IMR administrative penalties. As noted in the "Reasons for Change" under section 9792.10.6(i), the overriding purpose of IMR is to resolve medical treatment disputes in an expeditious manner. Realizing the importance of avoid delay in the system, the Legislature enacted Labor Code section 4610.5(i) to authorize the Administrative Director to assess administrative penalties for a claims administrator's failure to promptly comply with any IMR obligation. Rather than the random UR investigation and audit process of section 9792.11, in which years could go by before a file is audited for violations, the Division found that violations could be more efficiently remedied, and future conduct more quickly deterred, by an 'Order to Show Cause" procedure that would bring more immediacy in correcting the underlying conduct. The faster assessment of penalties will provide an added incentive for claims administrator to comply with the IMR rules.

With one exception, the listed penalty schedule is the same as those initially proposed in subdivision (a). The Division has found the proposed amounts assessed as administrative penalties are reasonable and in proportion to the nature, severity, frequency and duration of the particular types of violations for which they are imposed. Based on comments, the Division has distinguished between the failure by a claims administrator to provide a DWC Form IMR in an adverse UR determination ((c)(1)), and the failure to complete applicable fields of a provided form ((c)(2)), with the severity of the penalty based on the importance of the field in processing an IMR application.

Subdivision (d) has been added to expressly provide that the conduct subject to a penalty under the IMR sections is also subject to the assessment of a civil penalty under Labor Code section 129.5(e). The penalty sections are not mutually exclusive.

Subdivision (e) is amended to allow the IMR penalties in subdivision (c) to be mitigated as allowed under the factors in section 9792.13.

17. Section 9792.15. Administrative Penalties Pursuant to Labor Code §§ 4610, 4610.5, and 4610.6 - Order to Show Cause, Notice of Hearing, Determination and Order, and Review Procedure.

Amend title to include statutory reference to Labor Code sections 4610.5 and 4610.6.

(a) Amend subdivision to include statutory reference to Labor Code sections 4610.5 and 4610.6.
(b)(2) Amend subdivision to limit its application to administrative penalties assessed under section 4610(i).

(b)(3) Add subdivision to provide that for administrative penalties assessed under sections 4610.5(i), and 4610.6(k), the order to show cause shall include the basis for the penalty assessment, including a statement of the alleged violations and the amount of each proposed penalty.

(b)(4) Add subdivision to provide that an order to show cause must include a description of the methods for paying or appealing the penalty assessment

Reasons for Changes:

The subdivisions are amended to allow the Administrative Director to issue an Order to Show under the provisions of this section for the assessment of administrative penalties under section 9792.12(c). See "Reasons for Changes" in regard to section 9792.12(c).

THE FOLLOWING ADDITIONAL NON-SUBSTANTIVE/CORRECTIONS WITHOUT REGULATORY EFFECT WERE MADE TO THE TEXT OF THE REGULATIONS AFTER THE CLOSE OF THE FINAL COMMENT PERIOD

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

(y): Amend to correct a typographical error amending the word "or" to "for."

2. Section 9792.9.1. Utilization Review Standards--Timeframe, Procedures and Notice – On or After January 1, 2013.

(c)(2): Amend to eliminate a duplicative "the."

3. Section 9792.10.3. Independent Medical Review – Initial Review of Application.

(c) Amend to correct a typographical error amending "five business (5) days" to "five (5) business days."

4. Section 9792.10.4. Independent Medical Review – Consolidation, Assignment, and Notification

(b) To correct an inadvertent omission and comply with Labor Code section 4610.5(k), add "claims administrator" as a party to receive the notification of an IMR assignment.

LOCAL MANDATES DETERMINATION

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district. The proposed amendments do not apply to any local agency or school district.
- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. The proposed amendments do not apply to any local agency or school district.
- Other nondiscretionary costs/savings imposed upon local agencies: None. The proposed amendments do not apply to any local agency or school district.

CONSIDERATION OF ALTERNATIVES

The Division considered all comments submitted during the public comment periods, and made modifications based on those comments to the regulations as initially proposed. The Acting Administrative Director has now determined that no alternatives proposed by the regulated public or otherwise considered by the Division of Workers' Compensation would be more effective in carrying out the purpose for which these regulations were proposed, nor would they be as effective and less burdensome to affected private persons and businesses than the regulations that were adopted or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

SUMMARY OF COMMENTS RECEIVED AND RESPONSES THERETO CONCERNING THE REGULATIONS ADOPTED

The comments of each organization or individual are addressed in the following charts.

The public comment period was as follows:

Initial 45-day comment period on proposed regulations:

February 19, 2013 through April 4, 2013

First 15-day comment period on modifications to proposed text:

September 27, 2013 – October 11, 2013

Second 15-day comment period on modifications to proposed text:

December 7, 2013 - December 21, 2013

Third 15-day comment period on modifications to proposed text:

December 12, 2013 – December 26, 2013