ADDENDUM TO FINAL STATEMENT OF REASONS

Division of Workers' Compensation

Subject Matter of Regulations: Utilization Review and Independent Medical Review

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.

Independent Medical Review (IMR) was established by the Legislature in Senate Bill 863 (Statutes of 2012, Chapter 363). In creating IMR, the Legislature expressly found in Section 1(d), that the current system of resolving disputes over the medical necessity of requested treatment, set forth in the mandatory utilization review process of Labor Code section 4610, is costly, time consuming, and does not uniformly result in the provision of treatment that adheres to the highest standards of evidence-based medicine, thereby adversely affecting the health and safety of workers injured in the course of employment. The Legislature further found in Section 1(e) that having medical professionals – rather than administrative law judges - ultimately determine the necessity of requested treatment furthers the social policy of this state that promotes using evidence-based medicine to provide injured workers with the highest quality of medical care. The Legislature unequivocally stated that the best manner to implement this policy was by establishing a system of independent medical review. An independent medical review system, as also found by the Legislature in Section 1(f), using independent and unbiased medical expertise of specialists, can issue timely and medically sound determinations of disputes over appropriate medical treatment. This system is far superior to the existing process of appointing qualified medical evaluators (QME) to examine patients and resolve treatment disputes, a process which is costly and time-consuming, and prolongs disputes and causes delays in medical treatment for injured workers. (The current system can take up to 18 or 24 months for a decision. Independent Medical Review conversely, can be completed within 2 -3 months.) Further, the process of selection of QMEs can bias the outcomes.

Since IMR began on January 1, 2013 for injuries on or after date, and on July 1, 2013 for all dates of injury, the procedure has seen a staggering number of cases. From 78 IMR applications in March, to 350 in June, to 4,410 in July, to 15,731 in August (the procedure became applicable to all dates of injury on July 1), 13,999 in October, and 13,760 in December. Currently, there have been approximately 84,000 total IMR application filed with 7,885 final determinations issued by the Independent Medical Review Organization, Maximus Federal Services, Inc. There are still over 34,000 cases awaiting an eligibility determination and over 27,000 cases with complete information that are ready to proceed to a final determination. Of the utilization review decisions reviewed through the IMR process, 81 percent have been upheld; 19 percent have been overturned.

The proposed regulations will greatly assist in streamlining the processing of IMR applications, allowing eligibility findings and final determinations to be issued in a more expedient manner without incurring a significant backlog of new applications. Of note is the revised DWC Form IMR, which is incorporated by reference in section 9792.10.2. This form expressly provides that an injured worker must attach a copy of the utilization review decision to the IMR application. The current form, as adopted by the emergency regulations, did not expressly state this requirement. As noted above,

almost 40 percent of the IMR applications filed are awaiting an eligibility determination; a vast majority of these are due to the fact that a copy of the utilization review decision was not included with the application. (The Division is currently sending letters to injured workers allowing them up to 30 days before their application is deemed ineligible as incomplete.) By having the new form in place as soon as possible, many injured workers will avoid delays in the processing of their IMR applications. As shown above, this number will be in the thousands. Further, approval of the new IMR form will allow Maximus Federal Services to create an on-line application that will also greatly streamline the process.

Other provisions in the proposed regulations will also make the utilization review and IMR process more efficient. Clarification about the form in which a medical treatment is requested by a physician (section 9792.9.1(c)(2)) will give providers and claims administrators an improved means by which to reduce any ambiguity or questions over specific treatment requests. Clarification regarding the the process by which to request an extension of time to issue a utilization review decision (section 9792.9.1(f)) will promote communication to ensure that relevant medical information is timely exchanged between the provider and claims administrator. Regarding the IMR process, clarification regarding the eligibility of IMR applications (section 9792.10.3(a)) will assist the Division in quickly identifying those applications that are not eligible for review. This will include those utilization review denials that were based on the lack of information submitted by the provider to the treating physician; such cases are not ripe for IMR since the claims administrator has yet to determine if a proposed treatment is medically necessary. The requirement that claims administrators provide 12 months of an employee's medical records to the IMR reviewer has now been reduced to six months in the proposed regulations (section 9792.10.5(a)(1)(A)), which will significantly reduce the amount of time and effort for claims administrators to copy and produce the records for review, and, correspondingly, the amount of time and effort for the IMR reviewer to locate records relevant to make a medical necessity determination. The proposed further clarify that if a claims administrator fails to submit required medical records, the IMR reviewer cannot issue a final IMR determination based solely on the information provided by a utilization review determination (section 9792.10.6(b)(2)). This provision stresses the importance of claims administrators providing required records and informs the public that IMR reviewers will only act on first hand reports from treating physicians. The proposed procedure for issuing administrative penalties (sections 9792.10.6(i), 9792.12(c), and 9792.15) will allow DWC to appropriately address a claims administrator's failure to comply with their IMR obligations with more urgency than the procedure adopted in the emergency regulations. (Under the existing process, several years could go by before a penalty would issue on an IMR violation, for example the failure to include an IMR application in a utilization review decision denying treatment.)

IMR is now only means by which an injured worker can formally challenge a medical treatment determination by their claims administrator. The proposed regulations, based on the limited experience the Division has with the process to this point, will ensure that IMR is conducted in a timely fashion and will give confidence to the public that the system is a substantial improvement over the prior QME procedure.

CHANGES IN REGULATORY TEXT

After submission of these proposed regulations for review by the Office of Administrative Law, the Division made a number of changes to the proposed regulations as suggested by that Office. Those changes include: (1) the reinsertion or correction of underline/strikeout text that was inadvertently omitted from the final regulations submitted to OAL; (2) conforming the language of the regulations to the express statutory mandates; (3) correction to punctuation and grammar; (4) corrections to cross-references located within the regulations; and (5) corrections to form numbers. These

changes will not affect the meaning, interpretation or implementation of the regulations as the meanings of the regulations are apparent from the text of the regulations.

The changes are as follows:

Page Section and Issue

2 9785(b)(3): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Amend section to add underlined "review" following "independent medical" on line 6.

4 9785(g): Deletion of text.

- Delete "of Medical Treatment" on line 4 to reflect current name on DWC Form RFA.

6 9792.6(f): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add comma after "factual" on line 1.

9 9792.6.1(a): Deletion of text.

- Delete "for Medical Treatment" on lines 4-5 and 10-11 to reflect current name on DWC Form RFA.

9 9792.6.1(e): Deletion of strikeout text.

- Delete "~~necessary~~" in line 2 following citation to 9792.9.1(f).

10 9792.6.1(g): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add ", other than medical necessity," following "…or legal basis exists" on line 2.

10 9792.6.1(j): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add "or independent medical review" following "utilization review" on line 1.

11 9792.6.1(t)(1): Deletion of text.

- Delete "for Medical Treatment" on line 2 to reflect current name on DWC Form RFA.

12 9792.6.1(z): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add "although an employee's health records shall not be transmitted via electronic mail" following "parties" on line 2.

15 9792.9: Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Correct section title to delete "Utilization Review Decisions Issued Prior to July 1, 2013 for" and add, following January 1, 2013 ", Where the Request for Authorization is Received Prior

to July 1, 2013".

16 9792.9(b)(2): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add "either by decision of the Workers' Compensation Appeals Board or by agreement between the parties," following "recommended on line 3.

18 9792.9(h)(2): Correction of form number.

- Delete reference to DWC-CA form 10208.3 and reinsert existing DWC-CA form 10252.1.

20 9792.9(k)(7): Correction of form number.

- Delete reference to DWC-CA form 10208.3 and reinsert existing DWC-CA form 10252.1.

22 9792.9(*l*)(8): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

Add "or appropriate contact's" following "claim adjuster's" on line 3.

23 9792.9.1(a): Deletion of text.

- Delete "of Medical Treatment" on line 2 to reflect current name on DWC Form RFA.

23 9792.9.1(a)(1): Deletion of text.

- Delete "either" on third line up from the bottom as the sentence does not allow alternate methods of compliance.

24 9792.9.1(b)(1): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add "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" following "requested treatment" on line 3.

25 9792.9.1(b)(2): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add "either by decision of the Workers' Compensation Appeals Board or by agreement between the parties," following "recommended" on line 3.

25 9792.9.1(c)(3): Deletion of duplicative paragraph; Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Delete duplicate paragraph of subdivision (c)(3) that was incorrectly located between subdivision (c)(2)(A) and (c)(2)(B). In existing subdivision (c)(3), remove underscore text and add strikeout text ~~", but in no event more than 14 calendar days from initial receipt of the complete DWC Form RFA~~" following DWC Form RFA on line 4.

27 9792.9.1(e)(3): Grammatical change.

- Add comma after “requesting physician” on line 4.

28 9792.9.1(e)(5)(H): Adherence to statutory mandate.

- Delete “of receipt” on last line and replace with “after service,” which conforms to the express language of Labor Code section 4610.5(h)(1) regarding the timeframe in which an employee can request Independent Medical Review. Use of the term “of receipt” was not consistent with the statutory mandate and other sections of the proposed regulations.

28 9792.9.1(e)(5)(I): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

Add “or appropriate contact’s” following “claim adjuster’s” on line 3.

36 9792.10.1(d)(2): Correction of cross-reference.

- Correct citation from section 9792.10.6(c) to section 9792.10.6(e).

38 9792.10.3(b): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Remove underscore from “and the” on line 4, following “the employee’s attorney.”

39 9792.10.3(f): Correction of cross-reference.

- Correct citation from section 9792.10.6(c) to section 9792.10.6(e).

40 9792.10.4(b): Adherence to statutory mandate.

- Delete “claims administrator” on lines 4-5 and replace with “employer” which conforms to the express language of Labor Code section 4610.5(k). When the Division deleted the term “parties” from the subdivision, it inadvertently omitted reference to either the employer or the claims administrator. Subdivision (k) of section 4610.5 expressly provides that the administrative director shall immediately notify the employee and the employer as to whether a request for independent medical review has been approved for review. Subdivision (c)(4) of the statute defines “employer” as including an insurer, claims administrator, utilization review organization, or other entity acting on behalf of any of them.

41 9792.10.5(a)(1)(A): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add as last sentence: “If the requesting physician has treated the employee for less than six months prior to the date of the request for authorization, the claims administrator shall provide a copy of all reports relevant to the employee’s current medical condition produced within the described six month period by any prior treating physician or referring physician.”

42 9792.10.5(b)(1): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add "or within twelve (12) days if the notification was sent electronically," following "independent medical review on line 3. Add "shall receive" (no underscore) following "review organization" on line 6.

44 9792.10.6(a): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add "notice by" following "time upon" on line 1.

44 9792.10.6(d): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add "a list of the documents reviewed," following "condition" on line 3.

61 9792.12(a)(13): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add "respond to" (without underscore) following "failure to" on line 1.

64 9792.12(b)(5)(A): Correction of cross-reference.

- Delete incorrect reference to subdivision (c)(3)(B) of section 9792.9.1 and replace with correct reference to subdivision (f)(2).

65 9792.12(b)(5)(C): Correction of citation.

- Correct citation on line 4 to read "section 9792.9(~~b~~ c)(4)."

65 9792.12(b)(5)(F): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Remove underscore from "(F)."

65 9792.12(b)(5)(G): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Add underscore to "(G)." Reinsert "of Title 8 of the California Code of Regulations" following citation to section 9792.9.1(f)(2).

67 9792.15(a): Correction of underline/strikeout text or reinsertion of inadvertently omitted text.

- Underscore "(i)" following "sections 4610" on lines 5 and 7.