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

INITIAL 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

1. Introduction.

This Initial Statement of Reasons ("ISOR") describes the purposes, rationales, and necessity of the Division of Workers' Compensation's (DWC) proposed amendments to existing utilization review regulations and proposed new regulations to implement the statutorily mandated independent medical review (IMR) program, which went into effect on January 1, 2013. The purpose of the IMR program is to ensure that medical treatment decisions in workers' compensation cases will be made by a conflict-free medical expert applying sound medical decisions that are based on a hierarchy of evidence-based medicine standards. This Initial Statement of Reasons (ISOR) fulfills the requirements of California's Administrative Procedure Act (see Government Code section 11340 et seq.).

Under Senate Bill 863 (Statutes of 2012, Chapter 363), DWC has been authorized to establish an IMR program which is similar in structure to that used by the Department of Managed Health. (See California Health and Safety Code, sections 1370.4 and 1374.30 through 1374.36.) As of January 1, 2013, for injuries occurring on or after that date, and as of July 1, 2013, for all dates of injury, IMR will be used to decide disputes regarding medical treatment in workers' compensation cases. The authorizing statutes, Labor Code sections 139.5, 4610.5, and 4610.6, require DWC to contract with an independent medical review organization (IMRO) and institute a procedure whereby utilization review decisions issued under Labor Code section 4610 that delay, deny, or modify a medical treatment request by an injured worker's treating physician can be appealed for review to an independent physician assigned by the IMRO. Under the proposed IMR program, a treating physician, following a review of medical records designated by statute, must issue a decision as to whether the requested medical treatment is necessary under existing medical treatment guidelines. By statute, the physician's decision is an order of DWC's Administrative Director, and cannot be appealed to either the Workers' Compensation Appeals Board (WCAB) or civil courts as to the issue of medical necessity. The IMR program as proposed by DWC will ensure the delivery of quality medical care in the most efficient, effective manner possible while protecting the rights of all parties.

To implement the IMR program mandated by SB 863, DWC proposes to amend Article 5.5.1 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, sections 9785, 9792.6, 9792.9, 9792.10, and 9792.12 and adopt Article 5.5.1 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, sections 9785.5, 9792.6.1,

9792.9.1, 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. These regulations were initially adopted under the emergency regulatory process on December 31, 2012 (see OAL File No. 2012-1219-04E). These proposed emergency regulations are substantially similar to those enacted on December 31, 2012 under the emergency rulemaking process.

DWC welcomes comments on the ISOR and on the proposed regulations that the ISOR describes. Please see the accompanying Notice of Rulemaking for instructions on how to submit comments electronically, on paper, and orally at the DWC hearing on the proposed regulations.

2. Technical, Theoretical, or Empirical Studies, Reports, or Documents.

- Department of Industrial Relations' contract (DIR Agreement # 41230038) with Maximus Federal Services, Inc. to provide Independent Medical Review Services.

- Workers' Compensation Insurance Rating Bureau's (WCIRB) Evaluation of the Cost Impact of SB 863 as updated on October 12, 2012.

3. Problem Addressed with this Rulemaking.

This rulemaking allows the Division to establish and administer the IMR program in compliance with SB 863's mandate, as reflected in Labor Code section 4610, 4610.5, and 4610.6, by detailing the procedures by which a dispute over a medical treatment recommendation made by an injured worker's treating physician is resolved by a bias-free reviewing physician assigned by an independent review organization designated by the Administrative Director. The rules establish a more effective process of utilization review, set forth the mandatory elements of an adverse utilization review decision, the timeframes under which to request IMR, the mandatory form that must be used by an injured worker, and the procedure that must be followed by the parties and the review organization in order to ensure that the timely, efficient IMR program envisioned by the Legislature is realized.

4. Specific Technologies or Equipment.

None.

5. Reasonable Alternatives to the Proposed Regulations and Reasons for Rejecting Those Alternatives.

The Administrative Director has not identified any effective alternative, or any equally effective and less burdensome alternative to the regulation at this time. The public is invited to submit such alternatives during the public comment process.

6. Duplication or Conflicts with Federal Regulations (Gov. Code section 11346.2(b)(7)

The proposed regulations do not duplicate or conflict with any federal regulations. There are no federal regulations that prescribe rules for workers' compensation interpreters.

7. The Specific Purpose, Rationale, and Necessity of Each Section of the Proposed Amendments (Government Code section 11346.2(b)(1))

The specific purpose, rationale, and necessity of each section of the proposed amendments, in accordance with Government Code section 11346.2(b)(1), is provided below.

Section 9785. Reporting Duties of the Primary Treating Physician.

Specific Purpose:

This section sets for the requirements and timeframes regarding medical reporting and other communications between the employee's primary treating physician and the claims administrator to ensure the provision of medical benefits for an occupational injury. The section specifies how medical disputes are resolved between the employee and his or her primary treating physician, the types of medical reports that must be filed with the claims administrator, the circumstances under which such reports are filed, and the various deadlines for filing each type of report.

Necessity:

The section is amended to reflect SB 863's mandate that disputes regarding medical treatment recommendations must be resolved through Labor Code section 4610.5's IMR procedure rather than the Qualified Medical Evaluator procedures set forth at Labor Code section 4062. The amendments to subdivision (b)(3) and (4) are necessary to advise the public of the additional dispute resolution procedures involving decisions of the primary treating physician found in Labor Code sections 4060, 4600.5, 4616.3, and 4616.4. Subdivision (g) is necessary to implement the requirement that treating physicians use the DWC Form RFA when making a medical treatment recommendation under 8 C.C.R. § 9792.9.1. Subdivision (i) is added to reflect SB 863's mandate, set forth in Labor Code section 4658.7(b)(1), that the Division create a form to trigger the provision, if necessary, of a supplemental job displacement benefit. The form, the Physician's Return-to-Work & Voucher Report (DWC-AD 10133.36), was recently adopted as an emergency regulation. (See OAL File No. 2012-1214-01 E.)

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

Specific Purpose:

This section sets forth the mandatory form by which a treating physician requests medical treatment for an employee under Labor Code section 4610. The form contains identifying information regarding the employee, the providing physician, the claims administrator, and the type of treatment requested (i.e., an expedited request). A table is included for the physician to specifically indicate the requested treatment, indicating the diagnosis, the diagnosis code (the International Classification of Diseases (ICD) Code), the procedure requested, the procedure code (the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Code), and other information pertinent to the request (frequency, duration, quantity, etc.). The claims administrator can utilize the form to respond to the physician and to whether the request is approved, denied, or modified.

Necessity:

The DWC Form RFA is necessary to define a treatment request subject to utilization review and remove ambiguities regarding the scope of the request; specificity and clarity in treatment recommendations at the beginning of the utilization review process will reduce disputes and may preclude the need for IMR later on. Further, since utilization review and IMR obligations carry extensive administrative penalties for non-compliance, it is important for the Division to create a clear guideline – in this case a mandatory form - as to what is or is not a valid treatment request. Only necessary information is requested; the use of a fillable form will reduce administrative burdens placed on the physician completing the form.

The version of the DWC Form RFA (01/2013) that the Division seeks to adopt in this rulemaking differs from the version adopted as an emergency regulation (version 12/2012). The new version adopts a more user-friendly form.

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.

Specific Purpose:

This section lists and defines the terms used in the utilization review regulations. The purpose of the definitions is to implement, interpret, and make specific Labor Code section 4610, and to ensure that the meanings of the terms are clearly understood by the workers' compensation community.

Necessity:

It is necessary to define each of the key terms used in the utilization review regulations to ensure that their content and meaning are clearly understood by the workers' compensation community. The section has been amended to: (1) provide that the regulation is applicable to occupational injuries occurring prior to January 1, 2013 where a request for authorization for medical treatment was made prior to July 1, 2013, to comply with Labor Code section 4610.5(a)(2) and the applicability of IMR to resolve treatment disputes; (2) add the definition of "dispute liability," to allow for the deferral of utilization review under Labor Code section 4610(g)(7); add the definition of "Medical Treatment Utilization Schedule," for consistency with Labor Code section 4610(c)(1). The section is re-lettered to accommodate the new additions.

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

Specific Purpose:

This section lists and defines the terms used in the utilization review regulations for requests made on or after January 1, 2013. The purpose of the definitions is to implement, interpret, and make specific Labor Code section 4610, 4610.5, and 4610.6, and to ensure that the meanings of the terms are clearly understood by the workers' compensation community.

Necessity:

It is necessary to define each of the key terms used in the utilization review and IMR regulations to ensure that their content and meaning are clearly understood by the workers' compensation community. The section applies to any treatment request made using the DWC Form RFA where a decision to delay, deny, or modify the request is subject to IMR. Definitions that differ from the current regulatory definitions in section 9792.6 include: an amended version of "authorization" in subdivision (a), which accounts for the DWC Form RFA; "delay" in subdivision (e), "denial" in subdivision (f), and "modification" in subdivision (s) to clarify the types of decisions that are subject to IMR; "dispute liability" in subdivision (g) to define that circumstances that would allow for the deferral of utilization review under Labor Code section 4610(g)(7); "disputed medical treatment" in subdivision (h) to specify the medical treatment decision under review by IMR; "medically necessary" and "medical necessity" in subdivision (r) to clarify the standards used to determine whether a requested medical treatment is appropriate for an employee's condition; and "utilization review decision" in subdivision (x) to define the event that would trigger IMR obligations. The definition of "request for authorization" has been amended from the current regulatory definition to account for the mandatory use of the Form RFA. The definition of "written" is amended to allow electronic mail, although expressly providing that an employee's health records may be transmitted by electronic mail. The amendment is made to facilitate communication between the employee's treating physician and the claims administrator.

Section 9792.7. Utilization Review Standards—Applicability.

Specific Purpose:

The purpose of this section is to set forth the applicability of the utilization review rules. The section informs the claims administrator to establish and maintain a utilization review process for treatment, and sets forth the requirements of the utilization review process/plan. The section further provides that treatment protocols or standards governing the utilization review process shall be consistent with the Medical Treatment Utilization Schedule adopted by the Administrative Director pursuant to Labor Code section 5307.27. The section further requires that the complete utilization review plan be filed by the claims administrator, or by the external utilization review organization contracted by the claims administrator to perform the utilization review, with the Administrative Director, and that it be made available to the public upon request by the public.

Necessity:

It is necessary to set forth who the utilization review rules apply to and to ensure that the process is understood by the claims administrator and public. The necessity to conform treatment guideline to the Medical Treatment Utilization Schedule is based on the amendments to Labor Code sections 4610(c) and (f)(2). The amendment to subdivision (b)(3), regarding non-physician reviewers, is necessary to accommodate added section 9792.9.1.

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

Specific Purpose:

The purpose of this section is to set forth the timeframe, procedures and notices required in the utilization review process for injuries occurring prior to January 1, 2013. Subdivision (b) has been added to set forth the procedure whereby a claims administrator can defer utilization review of a medical treatment recommendation based on either a dispute regarding liability for the occupational injury or a dispute over the recommended treatment on grounds other than medical necessity. Subdivisions (h)(2) and (k)(7) have been amended to reflect the current forms used by the Workers' Compensation Appeals Board and the Division of Workers' Compensation (the Application for Adjudication of Claim, Form WCAB 1, and the Declaration of Readiness to Proceed (expedited trial), DWC-CA form 10208.3). Subdivision (k) is amended to limit the subdivision's application to adverse utilization review decisions (those to delay, deny, or modify a treatment request) communicated prior to July 1, 2013 and to add optional language regarding how an employee may obtain additional information regarding the utilization review decision. Subdivision (*l*) sets forth the requirements of an adverse decision letter that must be used when an adverse utilization review decision is communicated on or after July 1, 2013. These requirements include the DWC Form IMR, which must be used to request IMR. Subdivision (o) is added to provide that a utilization review decision remains in effect for 12 months, unless a further request for the same treatment is supported by a documented change in material facts.

Necessity:

This section is necessary to inform the claims administrator and the public of the timeframe, procedures and notices required in the utilization review process. For clarity, the section was amended to reflect its application to an occupational injury or illness occurring prior to January 1, 2013 where the request for authorization is made prior to July 1, 2013. The procedure to defer utilization review based on a liability dispute is necessitated by Labor Code section 4610(g)(7) and (8), which mandates deferral under that circumstance. The amendment in subdivision (b)(1) providing that a written decision need not be sent if the requesting physician had previously been notified under the subdivision of the reasons for the deferral of utilization review for a specific course of treatment, is necessary to reduce duplication and multiple denials for the same requested treatment. The form numbers cited in subdivisions (h)(2) and (k)(7) are bases on those currently in effect: the Application for Adjudication of Claim, Form WCAB 1, is a rule of the Workers' Compensation Appeals Board under 8 C.C.R. section 10408, the Declaration of Readiness to Proceed (expedited trial) is now found at 8 C.C.R. section 10208.3. The amendment/addition of procedures for adverse decision letters based on whether a treatment request was made prior to or on or after July 1, 2013 is necessary under Labor Code section 4610.5(a), which sets forth the eligibility requirements for IMR based on an employee's date of injury. The optional language in subdivision (k)(8) reflects the mandate of Assembly Bill 335 (Statutes of 2011, Chapter 544) that notices to injured workers are provided in plain language. (See Labor Code section 138.4.) The additions of subdivision (o) is necessitated by Labor Code section 4610(g)(6), which expressly provides that utilization review decisions must remain in effect for 12 months and that request for the same treatment must be based on a change in material facts.

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

Specific Purpose:

The purpose of this section is to set forth the timeframe, procedures and notices required in the utilization review process in circumstances where the request for authorization of medical treatment is made on or after January 1, 2013. It informs the claims administrator that a request for authorization of medical treatment must be made on the DWC Form RFA and the transmission scenarios that determine when the form is received. Subdivision (b) sets forth the procedure whereby a claims administrator can defer utilization review of a medical treatment recommendation based on either a dispute regarding liability for the occupational injury or a dispute over the recommended treatment on grounds other than medical necessity. Subdivision (c) advises the workers' compensation community about the timeframes for the utilization review process mandated under Labor Code section 4610 based on the type of review (prospective, retrospective, and concurrent), and the requirements for decisions to approve a request for authorization, and for decisions to modify, delay, or deny a request for authorization based on the type of review. The section advises of the required elements of adverse decision letter (that which delays, denies, or modifies a treatment request), which includes the application for IMR. Further, the section advises of the procedure whereby the claims administrator can delay a utilization review decision based on the need for additional information from the provider or the need for an additional examination or specialized consultation. This section also informs the claims administrator that authorization may not be denied on the basis of lack of information without documentation reflecting an attempt to obtain the necessary information from the physician by either facsimile or mail. Subdivision (h) finally advises that a utilization review decision remains in effect for 12 months, unless a further request for the same treatment is supported by a documented change in material facts.

Necessity:

This section is necessary to inform the claims administrator and the public of the timeframe, procedures and notices required in the utilization review process on and after January 1, 2013. The section is applicable to utilization review procedures for injuries on or after January 1, 2013, and for all utilization review procedures when the request of authorization is made on or after July 1, 2013, regardless of the date of injury. These date conditions are necessary to comply with Labor Code section 4610.5(a) and (b) mandate regarding the applicability of IMR to resolve treatment disputes. Under this proposed regulation, utilization review under Labor Code section 4610 is triggered by the DWC Form RFA. As noted above, this form is necessary to define a treatment request subject to utilization review and remove ambiguities regarding the scope of the request; specificity and clarity in treatment recommendations at the beginning of the utilization review process will reduce disputes and may preclude the need for IMR later on. Further, since utilization review and IMR obligations carry extensive administrative penalties for non-compliance, it is important for the Division to create clear guidelines – in this case a mandatory form and express requirements regarding the transmission of the form - as to what is or is not a valid treatment request. The timeframes set forth in the section regarding the utilization review process are necessary to implement the express terms of Labor Code section 4610(g). The mandatory elements of an adverse decision letter in subdivision (e)(5) are necessary to clearly explain to an injured worker

the basis for the decision and the grounds for seeking review. These elements take into consideration the IMR process now mandated by Labor Code sections 4610.5 and 4610.6, but also the mandate of Assembly Bill 335 (Statutes of 2011, Chapter 544) that notices to injured workers be provided in plain language. (See Labor Code section 138.4.) Further, the section encompasses SB 863's amendments to Labor Code section 4610 by: (1) setting forth a procedure in subdivision (b) to defer utilization review if there is a dispute regarding liability over the workers' compensation claim or the requested treatment on grounds other than medical necessity (see Labor Code section 4610(g)(7) and (8)); (2) providing in subdivision (d)(3)(B), that for retrospective review, payment of a bill is considered an approval and that a document showing payment has been made, such as an explanation of review is sufficient notice to the employee (see Labor Code section 4610(g)(1)); and (3) expressly providing in subdivision (h) that utilization review decisions must remain in effect for 12 months and that a request for the same treatment must be based on a change in material facts (see Labor Code section 4610(g)(6)). The amendment in subdivision (b)(1) following the approval of the emergency regulaitons, providing that a written decision need not be sent if the requesting physician had previously been notified under the subdivision of the reasons for the deferral of utilization review for a specific course of treatment, is necessary to reduce duplication and multiple denials for the same requested treatment.

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.

Specific Purpose:

The purpose of this section is to set forth the dispute resolution procedures applicable to utilization review decisions issued prior to July 1, 2013 for injuries occurring prior to January 1, 2013. Subdivision (a)(4) has been amended to reflect the current forms used by the Workers' Compensation Appeals Board and the Division of Workers' Compensation (the Application for Adjudication of Claim, Form WCAB 1, and the Declaration of Readiness to Proceed (expedited trial), DWC-CA form 10208.3).

Necessity:

The section has been amended to provide that the regulation is applicable only to the dispute resolution procedures applicable to utilization review decisions issued prior to July 1, 2013 for injuries occurring prior to January 1, 2013. This limitation is necessary to comply with Labor Code section 4610.5(a)(2) and the applicability of IMR to resolve treatment disputes. The form numbers cited in subdivision (a)(4) are based on those currently in effect: the Application for Adjudication of Claim, Form WCAB 1, is a rule of the Workers' Compensation Appeals Board under 8 C.C.R. section 10408, the Declaration of Readiness to Proceed (expedited trial) is now found at 8 C.C.R. section 10208.3.

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

Specific Purpose:

The purpose of this section is to set for the procedure for eligible parties to initiate the IMR process on or after January 1, 2013. The workers' compensation community is advised that if medical treatment recommended by the employee's treating physician is not approved by the claims administrator, the only dispute resolute procedure is the IMR process set forth in Labor Code sections 4610.5 and 4610.6. The section advises that neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the claims administrator if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by IMR or the WCAB. Further, the section advises the workers' compensation community that IMR is initiated by an eligible party – as defined by subdivision (b)(2) - filing the Application for Independent Medical Review, DWC Form IMR within 30 days after service of the adverse utilization review decision (a copy of the decision must be included). Eligible parties include the employee, or if the employee is represented, the employee's attorney, a representative of the employee, or a provider of emergency medical treatment. The employee's treating physician may join in a request for IMR, but cannot seek review on their own. The section further advises that for an expedited review, unless the initial utilization review decision was made on an expedited basis, a certification from the employee's treating physician indicating that the employee faces an imminent and serious threat to his or her health must be included with the application. Additionally, subdivision (c) advises of circumstances allowing for an extension to the 30-day filing deadline; if liability for treatment is disputed and resolved, and if the claims administrator has not complied with the requirements regarding an adverse utilization review decision. The section also advises that the parties may participate in a claims administrator internal voluntary appeal process, provided the employee is notified about the IMR filing deadline. Finally, the section advises that medical care cannot be discontinued if concurrent IMR review is being performed (i.e., that conducted while the employee is receiving in-patient care).

Necessity:

This section implements Labor Code section 4610.5(f) through (j)'s mandate regarding the procedure by which an injured worker, or their representative, initiates IMR on or after January 1, 2013, and is necessary to inform the workers' compensation community of the dispute resolution process applicable to utilization review decisions. It is first noted that the definitions included in the emergency regulation effective January 1, 2013 have been deleted from this section and moved, if appropriate, to section 9792.6.1 for clarity and to avoid duplication. The section in part restates the provisions of Labor Code section 4610.5(f) through (j), which is necessary for the purpose of clarity in that the statute establishes a comprehensive and detailed procedure for initiating IMR. Rather than simply delegating to the Division authority to establish this program, the Labor Code provisions specify the nature of the form that must be filed by the employee, who is allowed to file, the timeline for filing, and the circumstances allowing for an extension to the deadline. Since this program is entirely new to workers' compensation in this state, a restatement of statutory provision is beneficial so that affected parties can analyze and review program procedures and the timeframes for exercising statutory rights in one set of rules. Subdivision (e), regarding concurrent review, follows the

mandate of Labor Code section 4610(g)(3)(B) that medical care must not be discontinued during the review process while the employee is receiving in-patient care and is necessary to ensure that an injured worker is at all times receiving care medically necessary to cure and relieve their injury.

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

Specific Purpose:

This section sets forth the mandatory form by which an employee, his or her representative, or provider of emergency medical treatment requests IMR under Labor Code section 4610.5. The DWC Form IMR contains identifying information regarding the employee, the providing physician, the claims administrator, and the type of treatment requested. The form further includes a checkbox to indicate the type of review requested (i.e., regular or expedited review), and a consent to release records statement. The form is signed by the requestor and sent to the Independent Review Organization designed by the Division to conduct IMR. The form is to be completed by the claims administrator and included in the decision letter that either denies, delays, or modifies a treatment request by the employee's treating physician.

Necessity:

The DWC Form IMR is necessary to conform to Labor Code section 4610.5(f)'s mandate that the Administrative Director prescribe a form for an employee to initiate IMR. The form contains all elements required by statute; the requested information is reasonable and will allow the review organization and the Division to link documents that are submitted later in the IMR process.

The version of the DWC Form IMR (01/2013) that the Division seeks to adopt in this rulemaking differs from the version adopted as an emergency regulation (version 12/2012).

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

Specific Purpose:

The purpose of this section is to advise the workers' compensation community of the procedure by which the Administrative Director shall conduct a preliminary review of IMR applications to determine whether the disputed medical treatment identified in the application is eligible for IMR. In making this determination, the Administrative Director shall consider the timeliness and completeness of the application, any previous application for IMR regarding the same recommended treatment, any assertion by the claims administrator regarding liability for the claim or the requested treatment, and the employee's date of injury. The section further advises that the Administrative Director may reasonably request additional appropriate information from the parties in order to make an eligibility determination. Any response by the parties to such a request must be made within 15 days following receipt of the request. The section finally advises that, unless the claims administrator agrees that the case is eligible for IMR, a request for IMR shall be deferred if at the time of a utilization review decision the claims administrator is also disputing liability for the treatment for any reason besides medical necessity.

Necessity:

This section implements Labor Code section 4610.5(k)'s mandate that the Administrative Director or his or her designee (in this case, the Independent Review Organization) shall expeditiously review IMR applications and immediately notify the parties in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. It is necessary to list the various considerations of the Administrative Director in making the eligibility determination in order to clarify for the workers' compensation community the factual and legal considerations that may preclude IMR. It is further necessary to allow the Administrative Director to request additional information from the parties addressing eligibility to account for circumstances where the one-page IMR application is not fully completed or completed inaccurately. Subdivision (d) expressly conforms to Labor Code section 4610's mandate that, subject to the claims administrator's approval, IMR be deferred if a dispute exists over liability for treatment outside of medical necessity.

Section 9792.10.4. Independent Medical Review – Assignment and Notification.

Specific Purpose:

This section advises the workers' compensation community of the procedures that must be followed by the Independent Review Organization following a determination that an application for IMR is eligible. The section advises that within one business day following a finding that the application is eligible for IMR; the review organization must notify the parties in writing that the dispute has been assigned to that organization for review. The notification must contain identifying information regarding the organization and the underlying treatment request (taken from the IMR application), a statement whether IMR will be conducted on a regular or expedited basis, and a statement as to when required documentation must be submitted by the parties. The notification to the claims administrator advises that the failure to comply with the document submission could result in the assessment of administrative penalties up to $5,000.00. The section further advises that a review conducted on a regular basis shall be converted into an expedited review upon receipt of a certification from the employee's treating physician that the employee faces an imminent and serious threat to his or her health. In this situation, the review organization must contact the parties about the conversion by the most efficient manner available.

Necessity:

This section implements Labor Code section 4610.5(k)'s mandate that the Administrative Director or his or her designee (in this case, the Independent Review Organization) shall expeditiously review IMR applications and immediately notify the parties in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. The timing of the notification – within one business day following a finding of eligibility – and its contents are reasonable and necessary for IMR to be conducted in prompt manner. Subdivision (g), allowing for the conversion of the review from regular to expedited, is necessary to conform to Labor Code section 4610.6(d)'s mandate that a review shall be expedited upon receipt of information indicating that a serious threat to the employee's health exists.

Section 9792.10.5. Independent Medical Review – Medical Records.

Specific Purpose:

The purpose of this section is to specify those medical records, to be submitted by the claims administrator and employee that are necessary for the Independent Review Organization to review in order to issue a complete and accurate IMR determination addressing the medical necessity of a recommended medical treatment. The section advises the workers' compensation community of the time frame in which the documentation must be submitted by the parties and the category of documents. From the claims administrator, the documents include a copy of relevant medical reports relevant to the employee's current medical condition produced within six months prior to the date of the request for medical treatment, the adverse utilization review decision, correspondence with the employee, and documents relied upon in reaching the utilization review decision. Documents already provide to the employee by the claims administrator need not be provided again if a notification is given to the employee that lists all of the documents sent to the Independent Review Organization. From the employee, the documents include the treating physician's recommendation or other medical information indicating that the disputed medical treatment is medically necessary, or any additional material that the employee believes is relevant. Any newly developed or discovered relevant medical records found in the possessed of either the claims administrator or the employee must be forwarded immediately to the review organization with a copy forwarded to the other party. The workers' compensation community is further advised that, following the submission of the mandatory documents, the independent review organization may reasonably request appropriate additional documentation or information necessary to make an IMR determination. The requested documents must be provided within 5 business days. The section finally advises that that confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

Necessity:

This section restates the express statutory requirements of Labor Code section 4610.6, subdivisions (*l*) through (o), and implements Labor Code section 4610.5(f)(C). A restatement in this section is necessary for the purpose of clarity in that Labor Code section 4610.5 and 43610.6 establish comprehensive and detailed procedures for the IMR program. Rather than simply delegating to the Division authority to establish this program, the Labor Code provisions specify the documents that must be filed or submitted by the parties, the timelines for filing, the nature of the review that will be conducted, the required elements in a decision, and the obligations of the parties once a decision is issued. Since this program is entirely new to workers' compensation in this state, a restatement of statutory provision is beneficial so that affected parties can analyze and review program procedures and the timeframes for exercising statutory rights in one set of rules. Further, the 15 day deadline for the simultaneous submission of documents (24-hours for expedited review) by the parties is necessary to ensure that IMR is completed in an expeditious manner while affording all parties the right to submit those documents that are relevant to the case. (This timeframe takes into consideration Code of Civil Procedure sections 1010.6 and 1013(a), which extend certain deadlines to act or respond to documents that are served by mail (5 additional days) The Division feels this extension is necessary to obviate any prejudice resulting from a delay in the

receipt of a request for additional documents.) In this regard, the requirement that relevant medical records for the employee extending six months back be submitted to IMR is necessary to ensure that the IMR physician reviewer fully understand the extent of the employee's condition and to refute any contention that a medical treatment decision was made on incomplete evidence. The six-month period is reasonable and will not place an excessive burden for providing documents on claims administrators. The 5-day period in which the parties must respond to a review organization request for additional documentation is necessary and reasonable in order to ensure that IMR is conducted in a prompt manner.

Section 9792.10.6. Independent Medical Review – Standards and Timeframes.

Specific Purpose:

This section describes for the regulated community the obligations of the independent review organization upon receipt of all information necessary to conduct an independent medical review. The section further advises the workers' compensation community that more than one medical review may be used if the employee's condition is sufficiently complex such that a single reviewer could not reasonably address all disputed issues. Also included in the section are the requirements for an IMR determination by a medical reviewer: it must be in plain language, where possible, and include the employee's medical condition, a statement of the disputed medical treatment, references to the applicable medical and scientific evidence used to reach a determination, and the clinical reasons regarding the medical necessity of the recommended treatment. The final determination issued by the review organization must include the qualifications of the medical reviewer or reviewers and a copy of each reviewer's determination. (If the reviewers' are evenly split as to whether the disputed medical treatment should be provided, the final decision shall be in favor of providing the treatment.) The section further provides that the independent review organization shall keep the names of the reviewer, or reviewers if applicable, confidential in all communications with entities or individuals outside the independent review organization. The section additionally provides notice to the workers' compensation community of the deadlines for the review organization to issue an IMR decision (30 days of the receipt of the IMR application and supporting documentation for regular review, 3 days for an expedited review, with 3 additional days added to both reviews for good cause), and that the final determination is deemed to be the determination of the Administrative Director and shall be binding on all parties.

Necessity:

This section restates the express statutory requirements of Labor Code section 4610.6, subdivisions (a) through (g). A restatement in this section is necessary for the purpose of clarity in that Labor Code section 4610.5 and 43610.6 establish comprehensive and detailed procedures for the IMR program. Rather than simply delegating to the Division authority to establish this program, the Labor Code provisions specify the documents that must be filed or submitted by the parties, the timelines for filing, the nature of the review that will be conducted, the required elements in a decision, and the obligations of the parties once a decision is issued. Since this program is entirely new to workers' compensation in this state, a restatement of statutory provision is beneficial so that affected parties can analyze and review program procedures and the timeframes for exercising statutory rights in one set of rules. Further, it is necessary to set forth

standards for IMR decisions to ensure consistency in the decision making process. Allowing the use of two reviewers is necessary in complex cases to allow for a more comprehensive review of the employee's condition and to ensure the accuracy of the final determination.

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

Specific Purpose:

The purpose of this section is to: (1) set forth the obligations of the claims administrator upon an IMR determination that a requested medical treatment – denied by the claims administrator's utilization review process – is medically necessary; and (2) advise the parties to IMR that the Administrative Director, upon a reversal of an IMR determination by the Workers' Compensation Appeal Board, with either refer the case to a different review organization designated by the Administrative Director to provide IMR services, or, if there is only one review organization, to a different IMR physician review within that organization.

Necessity:

This section restates the express statutory requirements of Labor Code section 4610.6, subdivisions (h) through (k). A restatement in this section is necessary for the purpose of clarity in that Labor Code section 4610.5 and 43610.6 establish comprehensive and detailed procedures for the IMR program. Rather than simply delegating to the Division authority to establish this program, the Labor Code provisions specify the documents that must be filed or submitted by the parties, the timelines for filing, the nature of the review that will be conducted, the required elements in a decision, and the obligations of the parties once a decision is issued. Since this program is entirely new to workers' compensation in this state, a restatement of statutory provision is beneficial so that affected parties can analyze and review program procedures and the timeframes for exercising statutory rights in one set of rules.

Section 9792.10.8. Independent Medical Review – Payment for Review.

Specific Purpose:

The purpose of this section is to inform the workers' compensation community of the fees that must be paid in order to conduct IMR under Labor Code section 4610.5 and 4610.6. The section sets forth the 2013 and 2014 schedule of fees for IMR, taking into account fees for both regular and expedited reviews, and whether a review is conducted by a physician who holds an M.D. or D.O. degree. Additionally, the section sets forth the amount of a reduced fee for a withdrawn IMR review, the determining factor being the point in time when an assigned IMR physician reviewer is provided with all documentation and information necessary to conduct a full review. To facilitate payment, the section sets forth a payment procedure; claims administrators will be sent a monthly invoice by the designated independent medical review organization setting forth the fees incurred during the prior month for reviews conducted by IMR physicians. Payment is to be made within 30 days after billing, with an additional fee to be paid for late payment. Any disputes regarding payments made by the claims administrator is to be informally resolved by the Administrative Director

Necessity:

The section is necessary to comply with the mandate of Labor Code section 4610.6(*l*), which expressly provides that the cost of IMR is to be borne by claims administrators through a fee established by the Administrative Director. The statute further requires that the Administrative Director, after considering any relevant information on program costs, shall establish a reasonable, per-case reimbursement schedule to pay the costs of IMR and the cost of administering the IMR system. Further Labor Code section 139.5(a)(2) provides that to implement IMR by January 1, 2013, the Administrative Director is authorize to contract – on substantially the same terms and without competitive bidding – with a review organizations providing IMR under contract with the Department of Managed Health Care (DMHC) to provide IMR services under Labor Code sections 4610.5 and 4610.6.

The Department of Industrial Relations has contracted (DIR Agreement No. 41230038) with Maximus Federal Services, Inc. (Maximus), to provide IMR services under the Labor Code mandates. Maximus is also currently providing IMR services under contract to DMHC. The fees set forth in the regulation are taken from the terms of the contract and are considered by the Administrative Director to be reasonable for the services provided. The payment procedure set forth in the regulation is necessary to ensure that Maximus is promptly and efficiently compensated for the dispute resolution services they are providing to the Division.

Section 9792.10.9. Independent Medical Review – Publishing of Determinations.

Specific Purpose:

The purpose of this section is allow the Division to publish the results of IMR determinations after removing all individually identifiable information as defined in Labor Code section 138.7 (i.e., information that would identify the employee, all medical providers, the claims administrator, any of the claims administrator's employees or contractors, or any utilization review organization).

Necessity:

Labor Code section 4610.6 (m) expressly authorizes the Division to "publish the results of independent medical review determinations after removing individually identifiably information." By publishing such results, treating physicians and utilization review physicians in the workers' compensation community will be advised as to specific medical treatments that have been considered medically necessary and appropriate for specific conditions under the existing guidelines. Knowledge of such determinations by the community will likely reduce future disputes over medical treatment recommendations. Further, it is necessary for the purpose of clarity and consistency to define "individually identifiable information" with reference to Labor Code section 138.7, since that statute expressly defines the term.

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

Specific Purpose:

This section describes the investigation process to be used by the Administrative Director, or his or her delegees, to investigate potential and suspected violations of Labor Code section 4610. The purpose of the section is to implement, interpret and make specific the manner in which the Division's employees will conduct such an investigation, the types of businesses, records and places the Division may review during the investigation, and how utilization review investigations may relate to audit investigations conducted by the Division pursuant to Labor Code sections 129 and 129.5.

Necessity:

This section is necessary to explain to the workers' compensation community how investigations of suspected utilization review procedure violations will be initiated, conducted and coordinated by the Division. The amendments to subdivisions (c), (j), (o), and (p) are necessary to accommodate the obligations set forth in added sections 9792.6.1 and 9792.9.1.

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

Specific Purpose:

The purpose of this section is to describe and make specific the types of violations committed by employers and claims administrators that are subject to the assessment of administrative penalties allowed under Labor Code sections 4610(i), 4610.5(i), and 4610.5(k). The section has been amended to allow for the assessment of penalties for a failure to comply with the utilization review obligations set forth in the newly added section 9792.9.1, and to include penalties for identified violations of the newly established IMR obligations. The intent in establishing this schedule of penalties is 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.

Necessity:

Labor Code sections 4610(i), 4610.5(i), and 4610.5(k) expressly authorize the Division to assess administrative penalties for a failure by an employer or claims administrator to comply with the utilization review and IMR obligations established by the Division. Section 9792.9.1, which applies to utilization review conducted after January 1, 2013, essentially mirrors the existing standards in section 9792.9. It is necessary to add the new section into the current penalty structure for consistency with the existing penalties and also to identify and assess administrative penalties for those violations of IMR obligations that would obstruct SB 863's goal of providing an efficient means of resolving medical treatment disputes. Those violations have been identified as:

- A failure to timely communicate a written decision modifying, delaying, or denying a treatment authorization (subdivision (a)(18));
- The failure to provide a completed DWC Form IMR with the written adverse decision letter (subdivision (a)(19));
- The failure to provide a clear statement of the IMR procedure (subdivision (a)(20));
- The failure to detail the claims administrator's internal utilization review appeals process with a statement that it does not preclude recourse to IMR (subdivision (a)(21));
- The failure to timely provide information requested by the Administrative Director to determine IMR eligibility (subdivision (a)(22));
- The failure to timely provide all required information necessary to conduct IMR (subdivision (a)(23));
- The failure to timely implement a IMR determination (subdivision (a)(24)); and
- The failure to timely pay an invoice sent from the designated independent medical review organization (subdivision (a)(25)).

Further, it is necessary to expressly state for the workers' compensation community the amount of the potential penalty for violating various parts of the requirements regarding utilization review and IMR. The 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.

8. Economic Impact Analysis

Evidence Supporting Finding of No Significant Statewide Adverse Impact Directly Affecting Business.

The Administrative Director has determined that the proposed regulations will not have a significant adverse impact on business. Based on the WCIRB's Evaluation of the Cost Impact of SB 863 as updated on October 12, 2012, it is estimated that IMR will divert up to 18% of the approximate 120,000 workers' compensation disputes that are presently being referred to qualified medical evaluators (QMEs) annually. The average cost of a QME examination is $1,653 where the cost of an IMR will be $650 in most cases. Based on this cost difference alone, IMR will produce direct savings to California employers of $21,665,000 in addition to unquantified savings from improved efficiency of dispute resolution. (This would include reduced litigation costs and the adjustment of medical treatment patterns based on the dissemination by the Division of IMR decisions.) Self-insured employers (30% of all employers, measured by market share) will enjoy those savings directly. Insured employers will enjoy those savings indirectly by way of the impact on the price of insurance. The 3,000 physicians who conduct QME examinations are not the same physicians who will perform IMR, but all or nearly all are physicians who conduct this medical-legal work as independent contractors in addition to their medical practices. An 18% decline in revenue for QMEs is unlikely to cause a measurable decrease in businesses or jobs because QME work is only part of the physicians' medical practice. Similarly, the expansion of the IMR business sector through a network of independent reviewers is unlikely to produce a measurable increase in businesses or jobs. The overall reduction in workers' compensation costs, however, is expected to have a favorable effect on business activity in California.

Creation or Elimination of Jobs within the State of California

The Administrative Director has determined that the proposed regulations will not have a significant adverse impact on jobs within the State of California. The proposed utilization review and IMR regulations implement a statutory mandate to transfer the dispute resolution procedure for medical treatment recommendations away from the now lengthy and costly QME procedures in Labor Code section 4062, with possible litigation before the WCAB, to an efficient review process before an independent physician review assigned independent review organization designated by the Administrative Director. A physician may experience some impact on their income based on the reduction of QME work, however, such an impact may be negligible since QME work is only part of the physicians' medical practice. Based on the volume of IMR in the workers' compensation system, unquantifiable IMR physician review jobs may be created, but the number is unlikely to produce a measurable increase in jobs.

Creation of New or Elimination of Existing Businesses Within the State of California, or the Expansion of Business Within the State of California

The Administrative Director has determined that the proposed regulations will not create, eliminate, or expand businesses within the State of California. The proposed utilization review and IMR regulations implement a statutory mandate to transfer the dispute resolution procedure for medical treatment recommendations away from the now lengthy and costly QME procedures in Labor Code section 4062, with possible litigation before the WCAB, to an efficient review process before an independent physician review assigned independent review organization designated by the Administrative Director. Physicians whose medical practices include QME may experience a loss of income based on the reduction of QME work. However, such a loss may be negligible since QME work is only part of the physicians' medical practice; other opportunities may increase thereby limiting income losses. There may be the creation of new IMR review organizations that may contract with the Division for IMR work. However, the number is unlikely to produce a measurable increase in business within the state.

Benefits of the Regulations

The proposed regulations will create a more efficient, less costly way of reviewing medical treatment decisions made by claims administrators. Under the existing system, an injured worker who seeks review of a claims administrator's decision to delay, deny, or modify a medical treatment recommendation by the worker's treating physician must invoke the tediously slow, expensive QME process with possible WCAB litigation afterward. The IMR process set forth in the regulations will allow a bias-free medical expert, using recognized treatment guidelines, to issue a medical necessity determination within a limited time frame, thereby ensuring that the worker receive quality medical care in the most efficient manner possible. The regulations have been drafted to streamline the IMR process while allowing the parties due process. The IMR system will produce at least $21 million in system costs, allow independent medical experts to make medical treatment decisions, and allow injured workers to receive appropriate medical care in an expeditious and efficient manner.