STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

NOTICE OF MODIFICATION TO TEXT OF PROPOSED REGULATIONS AND FORMS
Second 15-Day Revision

Subject Matter of Regulations:
Workers' Compensation – Utilization Review and Independent Medical Review

TITLE 8, CALIFORNIA CODE OF REGULATIONS, ARTICLE 5 AND ARTICLE 5.5 OF CHAPTER 4.5, SUBCHAPTER 1

NOTICE IS HEREBY GIVEN, pursuant to Government Code section 11346.8(c) that the Acting Administrative Director of the Division of Workers' Compensation, proposes to modify the text of the following proposed amendments to Title 8, California Code of Regulations:

Section 9785	Reporting Duties of the Primary Treating Physician
Section 9785.5	Request for Authorization Form, DWC Form RFA
Article 5.5.1	Utilization Review Standards; Independent Medical Review
Section 9792.6.1	Utilization Review Standards—Definitions – On or After January 1, 2013
Section 9792.9	Utilization Review Standards--Timeframe, Procedures and Notice Content – For Injuries Occurring Prior to January 1, 2013
Section 9792.9.1	Utilization Review Standards--Timeframe, Procedures and Notice – On or After January 1, 2013
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
Section 9792.10.1	Utilization Review Standards--Dispute Resolution – On or After January 1, 2013
Section 9792.10.2	Application for Independent Medical Review, DWC Form IMR
Section 9792.10.3	Independent Medical Review – Initial Review of Application
Section 9792.10.4	Independent Medical Review – Assignment and Notification
Section 9792.10.5	Independent Medical Review – Medical Records
Section 9792.10.6	Independent Medical Review – Standards and Timeframes
Section 9792.10.7	Independent Medical Review – Implementation of Determination and Appeal
Section 9792.11	Investigation Procedures: Labor Code § 4610 Utilization Review Violations.

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

PRESENTATION OF WRITTEN COMMENTS AND DEADLINE FOR SUBMISSION OF WRITTEN COMMENTS

Members of the public are invited to present written comments regarding this proposed modification. **Only comments concerning the proposed modification to the text of the regulations will be considered and responded to in the Final Statement of Reasons.**

Written comments should be addressed to:

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

The Division's contact person must receive all written comments concerning the proposed modifications to the regulations no later than 5:00 p.m. on December 21, 2013.

Written comments may be submitted by facsimile transmission (FAX), addressed to the contact person at (510) 286-0687. Written comments may also be sent electronically (via e-mail), using the following e-mail address: dwcrules@dir.ca.gov

Due to the inherent risks of non-delivery by facsimile transmission, the Acting Administrative Director suggests, but does not require, that a copy of any comments transmitted by facsimile transmission also be submitted by regular mail.

Comments sent to other e-mail addresses or facsimile numbers will not be accepted. Comments sent by e-mail or facsimile are subject to the deadline set forth above for written comments.

AVAILABILITY OF TEXT OF REGULATIONS AND RULEMAKING FILE

Copies of the original text, the modified text with modifications clearly indicated and the entire rulemaking file, are currently available for public review during normal business hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays, at the offices of the Division of Workers' Compensation. The Division is located at 1515 Clay

Street, 17th Floor, Oakland, California. Please contact the Division's regulations coordinator, Ms. Maureen Gray, at (510) 286-7100 to arrange to inspect the rulemaking file.

FORMAT OF PROPOSED MODIFICATIONS

Text of Emergency Regulations Effective January 1, 2013:

Deletions from the original codified regulatory text made by the emergency regulatory text effective January 1, 2013, are indicated by single strike-through: ~~deleted language~~.

Additions to the original codified regulatory text made by the emergency regulatory text effective January 1, 2013, are indicated by single underlining: added language.

Additional Proposed Text Noticed for 45-Day Comment Period:

Deletions from the emergency regulatory text noticed for the 45-day comment period are indicated by strike-through underlining: ~~deleted language~~.

Additions to the original codified regulatory text and emergency regulatory text noticed for the 45-day comment period are indicated by double underlining: added language.

Newly proposed deletions from the original codified regulatory text noticed for the 45-day comment period are indicated by double strike-through: ~~deleted language.~~

Proposed Text Noticed for 15-Day Comment Period on Modified Text:

The proposed text is indicated by bold underlining, thus: **added language**. Deletions are indicated by bold strikeout, thus: **~~deleted language~~**.

Proposed Text Noticed for 2nd 15-Day Comment Period on Modified Text:

The proposed text is indicated by Ariel font, wavy underline and bold italic, thus: ***added language***. Deletions are indicated by Ariel font, bold italic double strikeout, thus: ***~~deleted language.~~***

SUMMARY OF PROPOSED CHANGES

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

(b)(3) Amend to 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."

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

For clarity, the DWC Form RFA modified during the Division's first 15-day comment period on modifications made to the proposed text of the regulations and forms (comment period ending October 11, 2013) is deleted and replace with a new form that is substantially the same but with several changes. The changes are as follows:

1. "Treating Physician" is now "Requesting Physician."

2. Under "Requested Treatment: section, the instruction 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."

3. Under "Requested Treatment: section, amend to state that the ICD-Code and Service/Good Requested is required, and the CPT/HCPCS Code should be listed if known.

4. On the second page, in the "Overview" section of the instructions, the following sentence is deleted: "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."

5 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."

6. In the "Routing Information" section of the instructions, provide that the form can be mailed, faxed, or e-mailed to the address, fax number, or e-mail address designated by the claims administrator for this purpose.

7. In the "Requested Treatment" section of the instructions, the first bullet point is replaced with the following: "List the diagnosis (required), the ICD Code (required), the specific service/good requested (required), and applicable CPT/HCPCS code (if known)."

8. In the "Claims Administrator/URO Response" section of the instructions, 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."

3. Article 5.5.1. Utilization Review Standards

Amend title of Article to read: "Utilization Review Standards; Independent Medical Review."

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.

(k) The definition of "Immediately" is amended to delete references to section 9792.9, subdivisions (b)(1) and (2), (c), and (g)(1).

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

(f) The definition of "Denial" is amended to replace "cannot be" with "is not."

(g) The definition of "Disputed liability" is amended to include a medical basis – other than medical necessity - 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.

(k) The definition of "Expert Reviewer" is amended to delete the 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 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."

(t) Proposed subdivision (t)(2) of the definition of "Request for authorization" is amended to provide: ""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, identify with specificity a recommended treatment or

treatments and be accompanied by documentation substantiating the need for the requested treatment." The first sentence of Subdivision (t)(3) is amended to read: "The request for authorization must be signed by the treating physician and may be mailed, faxed or e-mailed to, if designated, the address, fax number, or e-mail address designated by the claims administrator for this purpose." The last sentence of the subdivision is amended to substitute "treating physician" for "treatment physician."

(y) The last sentence in the definition of "Utilization review process" 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…."

6. 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."

(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)(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)(5) Amend to provide: "Retrospective decisions to approve modify, delay, or deny a request for authorization shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination."

(d)(1) Amend to specify that a decision to approve a request for information shall specify 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)(4) Amend to provide: "For retrospective review, a written decision to deny part or all of the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination."

(e)(5)(G) Amend to delete duplicate period after the first sentence.

(e)(6)(A) Amend to provide that medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve the employee from the effects of the industrial injury.

(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) Amend to: (1) delete the reference to subdivision (f)(1)(A); (2) replace the word "immediately" with "within five (5) business days from the date of receipt of the request for authorization;" and (3) delete the phrase "the information requested by not received reasonably necessary to make a determination."

(f)(3)(A) Amend to replace "non-reviewer physician under subdivision" with "non-physician reviewer."

(f)(3)(B) Amend to provide that if the requested test or consultation is not received within thirty (30) days from the date of the request for authorization, the reviewer shall deny the treating physician's request 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.

7. 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."

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

(b)(1) 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). Further amend to provide that the request must be made on the Application for Independent Medical Review, DWC Form IMR, completed by 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).

(d)(2) Amend to now 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 (c)(2) is now renumbered as (c)(3).

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

For clarity, the DWC Form IMR modified during the Division's first 15-day comment period on modifications made to the proposed text of the regulations and forms (comment period ending October 11, 2013) is deleted and replace with a new form that is substantially the same but with several changes. The changes are as follows:

1. The Employee section is revised and reorganized to now include information on the employee's attorney (if known).

2. "Requesting Physician" replaces "Treating Physician."

3. Under "Disputed Medical Treatment," 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.

4. Under "Disputed Medical Treatment," 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.

5. 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."

6. The "Instructions for Completing the Application for Independent Medical Review Form" is restructured and simplified for clarity. 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.

7. 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.

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

(a)(3) Amend to allow a claims administrator to assert that a medical basis, other than medical necessity, 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 allow a claims administrator to assert that a medical basis, other than medical necessity, precludes liability on the part of the claims administrator for a specific course of requested medical treatment requested by the treating physician.

(b) The last sentence of the subdivision is amended to read "The Administrative Director shall advise the claims administrator, the employee, if the employee is represented by counsel, the employee's attorney, and the requesting physician, as appropriate, by the most efficient means available."

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

(f) Add subdivision (f) to read: "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."

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

(a) Amend to delete duplicate word "the."

(b) Amend to replace "parties" with "employee, if the employee is represented the employee's attorney, and the requesting physician."

(b)(2) Amend to provide that the independent review organization will provide the date of the request for authorization in the notification if it is available.

(c) Amend to provide that an independent medical review conducted a regular basis will be converted to an expedited review if the independent review organization receives from the employee's treating physician written certification with supporting documentation verifying that the employee faces an imminent and serious threat to his or her health. Further amend to correct the regulatory citation to section 9792.6.1(j).

12. Section 9792.10.5. Independent Medical Review – Medical Records

(a)(1)(B) Amend to provide that the claims administrator must include a copy of the Application for Independent Medical Review, DWC Form IMR, that was included with the written determination, issued under section 9792.9.1(e)(5), that notified the employee that the disputed medical treatment was denied, delayed or modified. Neither the written determination nor the application's instructions should be included.

(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.

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

(b) The proposed subdivision (b) is divided into two sections. New subdivision (b)(1) contains the language of the previously proposed subdivision. New subdivision (b)(2) allows a designated reviewer discretion to issue a determination when no records are provided by the claims administrator. Under this subdivision, the reviewer "may, if possible, issue a determination as to whether the disputed medical treatment is medically necessary based on a summary of medical records listed in the utilization review determination issued under section 9792.9.1(e)(5), and any documents submitted by the employee or requesting physician under section 9792.10.5(b) or (c)."

(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."

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

(a) Amend to specific 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.

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

(c)(1) Amend to delete "with all applicable fields completed by the claims administrator."

(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)(7) Renumbered as subdivision (c)(8). Amend to provide that the failure to reimburse the undisputed amount for services already rendered that is found to be medically necessary by an independent medical review determination within the required timeframe is subject to the assessment of an administrative penalty.