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

NOTICE OF RULEMAKING AFTER EMERGENCY ADOPTION

Workers' Compensation – Utilization Review and Independent Medical Review

NOTICE IS HEREBY GIVEN that the Administrative Director of the Division of Workers' Compensation (hereinafter "Administrative Director"), pursuant to the authority vested in her by Labor Code Sections by Labor Code sections 59, 133, 4603.5, and 5307.3, has adopted regulations on an emergency basis to implement the provisions of Labor Code section 4610, 4610.5, and 4610.6 as amended or enacted by Senate Bill 863 (Chapter 363, stats. of 2012, effective January 1, 2013).

The regulations 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. The regulations implement, interpret, and make specific Labor Code sections 4610, 4610.5, and 4610.6.

The emergency regulations listed below became effective on January 1, 2013, and will remain in effect for a period of 180 days from January 1, 2013. The purpose of this rulemaking is to adopt the emergency regulations on a permanent basis.

PROPOSED REGULATORY ACTION

The Division of Workers' Compensation proposes to 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, relating to utilization review and independent medical review.

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

Adopt section 9792.10.7	Independent Medical Review – Implementation of Determination and Appeal
Adopt section 9792.10.8	Independent Medical Review – Payment for Review
Adopt section 9792.10.9	Independent Medical Review – Publishing of Determinations
Adopt section 9792.12	Administrative Penalty Schedule for Labor Code §4610 Utilization Review and Independent Medical Review Violations

TIME AND PLACE OF PUBLIC HEARING

A public hearing has been scheduled to permit all interested persons the opportunity to present statements or arguments, either orally or in writing, with respect to the subjects noted above. The hearing will be held at the following time and place:

Date: April 4, 2013
Time: 10:00 A.M. to 5:00 P.M., or until conclusion of business
Place: Elihu Harris State Office Building – Auditorium
1515 Clay Street
Oakland, California 94612

The State Office Building and its Auditorium are accessible to persons with mobility impairments. Alternate formats, assistive listening systems, sign language interpreters, or other type of reasonable accommodation to facilitate effective communication for persons with disabilities, are available upon request. Please contact the State Wide Disability Accommodation Coordinator, Kathleen Estrada, at 1-866-681-1459 (toll free), or through the California Relay Service by dialing 711 or 1-800-735-2929 (TTY/English) or 1-800-855-3000 (TTY/Spanish) as soon as possible to request assistance.

Please note that public comment will begin promptly at 10:00 a.m. and will conclude when the last speaker has finished his or her presentation or 5:00 p.m., whichever is earlier. If public comment concludes before the noon recess, no afternoon session will be held.

The Acting Administrative Director requests, but does not require, that any persons who make oral comments at the hearing also provide a written copy of their comments. Equal weight will be accorded to oral comments and written materials.

WRITTEN COMMENT PERIOD

Any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action to the Department of Industrial Relations, Division of Workers' Compensation. The written comment period closes at **5:00 P.M., on April 4, 2013.** The Division of Workers' Compensation will consider only comments received at the Division by that time. Equal weight will be accorded to comments presented at the hearing and to other written comments received by 5 P.M. on that date by the Division.

Submit written comments concerning the proposed regulations prior to the close of the public comment period to:

Maureen Gray
Regulations Coordinator
Division of Workers' Compensation, Legal Unit
P.O. Box 420603
San Francisco, CA 94142

Written comments may be submitted by facsimile transmission (FAX), addressed to the above-named 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.

Unless submitted prior to or at the public hearing, Ms. Gray must receive all written comments no later than **5:00 P.M., on April 4, 2013.**

AUTHORITY AND REFERENCE

The Acting Administrative Director is undertaking this regulatory action pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, and 5307.3.

Reference is to Labor Code sections 3209.3, 4061, 4061.5, 4062, 4600, 4604.5, 4610, 4610.5, and 4610.6.

INFORMATIVE DIGEST / POLICY STATEMENT OVERVIEW

Labor Code section 4610 requires utilization review for all requests for medical services to treat occupational injuries. Treatment requests, generally made by an injured worker's primary treating physician, must be reviewed to determine if the proposed treatment is medically necessary under the guidelines set forth in the Division of Workers' Compensation's (DWC) Medical Treatment Utilization Schedule (MTUS), which was adopted by the Administrative Director under Labor Code section 5307.27. Decisions to approve requests for treatment can be made by non-physician reviewers, such as claims adjustors, while decisions to delay, modify, or deny treatment requests must be made by a physician reviewer. A decision to delay treatment may be made if the physician reviewer has not received all information from the requesting treating physician that is necessary to make a decision, and such information has been requested but not yet provided. A decision to modify treatment may be made if the requested treatment is deemed necessary, but specific elements of the request are not within the guidelines of the MTUS or are not appropriate for the injured worker's condition. A decision to deny may be made if the requested treatment is not medically necessary under the MTUS guidelines or if a legal basis exists upon which to deny treatment (i.e., the requested treatment is for a denied body part).

Currently, an injured worker seeking review of an adverse utilization review decision must select a Qualified Medical Evaluator (QME) under Labor Code section 4062. The QME must examine the injured worker and then issue a comprehensive medical report which rules on the propriety of the initial treatment request. Either the injured worker or the claims administrator may object to the QME decision by litigating the issue before a Workers' Compensation Administrative Law Judge (WCALJ). It is generally recognized that the procedure by which to challenge an adverse UR decision, selecting a QME with possible litigation afterword, is both complex and time-consuming.

Labor Code sections 4610.5 and 4610.6, as enacted in SB 863, implement an independent medical review (IMR) process 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.

In order to ensure that IMR decisions will only address the question of medical necessity, Labor Code section 4610 was amended to allow claims administrators to defer utilization review on medical necessity decisions until other issues – such as those affecting liability – have been ultimately decided.

Under newly-enacted sections 4610.5 and 4610.6, IMR can only be requested by an injured worker following a denial, modification, or delay of a treatment request through the utilization review (UR) process. Employers and claims administrators cannot request review of treatment authorizations. With

the adverse UR decision, the claims administrator must provide a form for the injured worker to request IMR. An injured worker can be assisted by an attorney or by his or her treating physician in the IMR process. Upon a finding that the request is eligible for IMR, i.e., has no unresolved liability issues, an assigned physician reviewer, selected under stringent standards by the contracted independent medical review organization, will review relevant medical records supplied by both parties and apply recognized treatment guidelines to determine if the requested medical treatment is appropriate for the injured worker's condition. Section 4610.5(c)(2) requires the application of a hierarchy of standards that are to be utilized, headed by the MTUS adopted by the Administrative Director as the highest source for evaluating the appropriateness of medical treatment.

Under section 4610.6(d), the IMR process must be completed within 30 days following receipt of all records. IMR appeals will be considered by a workers' compensation judge. However, the IMR physician reviewer's decision on the medical necessity of the medical treatment cannot be overturned by a judge. A decision can only be overturned on the basis of fraud, conflict of interest, or mistake of fact.

The proposed regulations will provide the public with clear guidelines for the mandated IMR process and set forth the obligations that injured workers and claims administrators must meet in order for the process to work. The regulations will 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.

The described regulations were adopted as emergency regulations, effective January 1, 2013. This rulemaking would make the regulations permanent. Changes to the text of the regulations that have been made after the adoption of the emergency regulations are shown in italics. These proposed regulations implement, interpret, and make specific the above sections of the Labor Code and Government Code as follows:

Section 9785. Reporting Duties of Primary Treating Physician.

- The section sets forth the reporting duties of the employee's primary treating physician. The section is amended to expressly provide that IMR is the procedure for disputing adverse medical treatment decisions, rather than the QME process of Labor Code sections 4061 and 4062.

- *Subdivision (b)(3) and (4) have been updated to reflect the statutes providing dispute resolution procedures involving decisions of the primary treating physician.*

- The reference to repealed Labor Code section 4636 is deleted in subdivision (f)(6).

- Added subdivision (g) expressly provides that a written request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, must be set forth on the Request for Authorization of Medical Treatment," DWC Form RFA, contained in section 9785.5

- In compliance with Labor Code section 4658.7, and corresponding emergency regulations filed by DWC, added subdivision (i) provides that a primary treating physician, upon finding that the employee is permanent and stationary as to all conditions and that the injury has resulted in permanent partial disability, shall complete the "Physician's Return-to-Work & Voucher Report" (DWC-AD 10133.36) and attach the form to a permanent and stationary medical report.

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

- This section is the form to be used by treating physicians to request the authorization of proposed medical treatment under Labor Code section 4610. The form contains identifying

information regarding the injured worker, the provider, and the claims administrator, and requires specific information regarding the proposed treatment (i.e., diagnosis, frequency, duration, quantity). The form will assist in defining treatment requests and will promote communication between the provider and the claims administrator, thereby reducing disputes that could be subject to IMR.

- *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.

- Based on Labor Code section 4610.5 (a), the regulation is amended to provide that the definitions for an occupational injury or illness occurring prior to January 1, 2013 if the request is made prior to July 1, 2013.

- *The definitions of "dispute liability" and Medical Treatment Utilization Schedule" are added to conform with amendments to Labor Code section 4610 and to ensure that their meaning, as used in the regulations, will be clear to the regulated public. The section is re-lettered to accommodate the new additions.*

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

- Based on Labor Code section 4610.5 (a), the regulation is added to provide definitions for key terms regarding utilization review (UR) standards for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the request is made on or after July 1, 2013, regardless of the date of injury.

- Definitions that vary from section 9792.6 include "authorization," which now specifies the completed "Request for Authorization for Medical Treatment," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5 (subdivision (d)), "claims administrator," which includes the Uninsured Employers Benefits Trust Fund (UEBTF) and any utilization review organization (subdivision (c)), "disputed liability," which means an assertion by the claims administrator that a factual or legal basis exists that precludes 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 (subdivision (h)), and "request for authorization," which requires that a request be made on the DWC Form RFA (subdivision (s)).

- Definitions of "delay," "deny," and "modification" are added to ensure that their meaning, as used in the regulations, will be clear to the regulated public.

- *The section is amended to clarify that it applies to where a request for authorization of medical treatment is made is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.*

- *Definitions set forth in section 9792.10.1, as effective January 1, 2013, have been relocated to this section. The definitions include "disputed medical treatment," "medically necessary" and "medical necessity," and "utilization review decision." The definition of "approval" has been deleted. The definition of "written" has been amended to provided that an employee's health records shall not be transmitted via electronic mail. The section is re-lettered to accommodate the new additions/deletion.*

Section 9792.7. Utilization Review Standards—Applicability.

- *Subdivision(a)(3) was amended to conform with the amendment to Labor Code sections 4610(c) and (f)(2) regarding the application of the Medical Treatment Utilization Schedule to utilization review.*

- *Subdivision (b)(3) was amended to reference the added section 9792.9.1 in regarding to non-physician reviewers.*

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

- *This 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.*

- Subdivision (b) is added to conform to amended Labor Code section 4610(g)(7) and (8), which allows UR to be deferred if there is a dispute regarding liability. The subdivision sets forth the procedure by which to defer UR and, upon a determination regarding liability - *either by decision of the Workers' Compensation Appeals Board or by agreement between the parties* - when the UR procedure recommences. *Subdivision (b)(1) has been amended from the emergency regulations to provide that the 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.*

- Renumbered subdivisions (h)(2) and (k) deletes references to obsolete forms.

- Subdivision (*l*) sets forth the requirements of a written UR decision modifying, delaying or denying treatment authorization, if the decision is sent on or after July 1, 2013. The letter must include the Application for Independent Medical Review, DWC Form IMR-1, with all fields, except for the signature of the employee, to be completed by the claims administrator. *The injured worker or their attorney must be provided with an addressed envelope for mailing the form.* This application is mandated under Labor Code section 4610.5(f). The mandatory language in subdivision (*l*)(8) is revised to be in plain language, as required by Labor Code section 138.4.

- Subdivision (o) is added to comply with Labor Code section 4610(g)(6), which mandates that, absent a change in material facts, a UR decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator.

- *Subdivision (k) is amended to clarify its application to a written decision modifying, delaying or denying treatment authorization sent when the decision is communicated prior to July 1, 2013.*

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

- This section was added to apply to either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where a treatment request is made on or after July 1, 2013, regardless of the date of injury.

- This section sets forth UR timeframes and procedures in light of the changes mandated by SB 863. Significant changes include the required use of the "Request for Authorization for Medical

Treatment (DWC Form RFA)," as contained in California Code of Regulations, title 8, section 9785.5. This form will assist in defining treatment requests so that disputes regarding ambiguous requests, or those that are not compliant with the MTUS, can be resolved prior to the initiation of the IMR process.

- *Subdivision (c)(2) is amended to provide that a DWC Form RFA may be returned to the provider by a non-physician reviewer or reviewer for resubmission if the form does not identify the employee or provider, does not identify a recommended treatment, or is not signed by the requesting physician. The claims administrator must either treat the form as complete and comply with the utilization review timeframes or return the form to the requesting physician for completion*

- Subdivision (b) conforms to amended Labor Code section 4610(g)(7) and (8), which allows UR to be deferred if there is a dispute regarding liability. The subdivision sets forth the procedure by which to defer UR and, upon a determination regarding liability - *either by decision of the Workers' Compensation Appeals Board or by agreement between the parties* - when the UR procedure recommences. *Subdivision (b)(1) has been amended from the emergency regulations to provide that the 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.*

- The timeframes in the proposed regulation match those of existing section 9792.9. However, they are restructured in a more logical order to match the type of UR decision that is being rendered by the claims administrator.

- Written decisions to delay, deny, or modify a UR request, the requirements of which are set forth in subdivision (e), include the Application for Independent Medical Review, DWC Form IMR-1. *The injured worker or their attorney must be provided with an addressed envelope for mailing the form.*

- *Subdivision (e)(5)(J) is amended to provide that a voluntary, internal utilization review appeal process neither triggers, delays, nor bars an employee's recourse to IMR.*

- Subdivision (f) clarifies the procedure to follow when a claims administrator notifies the provider of an allowed extension of the UR timeframes (based on the lack of information submitted with the request or the need for an additional test or specialized consultation.

- Subdivision (h) is included to comply with Labor Code section 4610(g)(6), which mandates that, absent a change in material facts, a UR decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator.

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.

- This section is amended to clarify its application to UR decisions issued prior to July 1, 2013 for occupational injuries occurring prior to January 1, 2013. References to obsolete forms are deleted in subdivision (a)(4).

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

- This section applies to any request for authorization of medical treatment for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2*) if the request is made on or after July 1, 2013, regardless of the date of injury.*

- *The definitions set forth in the emergency regulation effective January 1, 2013, have been deleted from this section and have been moved, if applicable, to section 9792.6.1. The section has been re-lettered to accommodate the deletion.*

- Subdivision (a) reaffirms Labor Code section 4610.5's mandate that all treatment disputes must be resolved by the IMR procedure. Subdivision (b) now sets forth the timeframe in which to request IMR, the requirement that the Application for Independent Medical Review, DWC Form IMR-1, be used, the parties who are eligible to seek review of a treating physician's treatment recommendation, and requirement for a physician certification if an expedited review is sought.

- Subdivision (c) sets forth the timeframes for sending an IMR request if liability is disputed or if the claims administrator fails to provide the form with its adverse decision letter.

- Subdivision (d) provides that the employee may utilize the claims administrator's internal appeal process to resolve treatment disputes. Any such internal appeal must be completed within 15 days of the UR decision.

- Subdivision (e) requires that medical care should not be discontinued in the case of concurrent review until a plan has been agreed upon. *The provision in the emergency text regarding notification of non-physician provider of goods of an adverse utilization review decision has been deleted.*

Section 9792.10.2. Application for Independent Medical Review, DWC Form IMR-1.

- This section is the form to be used by the employee to apply for IMR. The contents of the form are mandated by Labor Code section 4610.5(f). The form will be completed by the claims administrator and will accompany the adverse UR decision letter.

- *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.

- This section sets forth the process by which the Administrative Director determines, based on an initial review of the IMR application, whether the medical treatment dispute is eligible for IMR.

- Subdivision (a) sets forth several reasons why an application may be deemed ineligible, including an untimely filing, a duplicate filing, or one in which a liability determination must be made prior to the initiation of IMR.

- *Subdivision (a) is amended to provide that the Administrative Director shall determine, within 15 days following receipt of the application and all appropriate information to make a determination, whether the disputed medical treatment identified in the application is eligible for IMR. The definition of "disputed medical treatment" is deleted as the term is defined in section 9792.6.1.*

- *Subdivision (a)(4) is amended to provide that in making an eligibility determination, the Administrative Director must consider: any assertion by the claims administrator that a factual or legal basis exists that precludes liability on the part of the claims administrator for the requested medical treatment; and the employee's date of injury. The provision in the emergency regulation effective January 1, 2013 allowing the Administrative Director to consider other, unspecified reasons has been deleted.*

- Subdivision (b) and (c) allow the Administrative Director to request, and the parties to submit,

additional documentation addressing the issue of eligibility.

- Determinations of ineligibility are issued by the Administrative Director; such determinations are subject to appeal before Workers' Compensation Appeals Board within 30 days of receipt of the determination.

Section 9792.10.4. Independent Medical Review – Assignment and Notification.

- This section implements Labor Code section 4610.5(k) by setting forth the procedure by which the independent medical review organization (IMRO) notifies the parties that the IMR application is eligible for IMR review. The IMRO will advise the parties of: the IMRO contact information; the disputed medical treatment subject to review, with pertinent information such as provider name and UR decision date; whether the review is expedited; and the documents that must be provided by the parties to conduct a review.

- The claims administrator is advised that the failure to comply with the document production section – section 9792.10.5 - could result in the assessment of administrative penalties up to $5,000.00 per day.

- Subdivision (g) provides that a regular IMR review could be converted into an expedited review if, subsequent to the receipt of the IMR application, the IMRO receives from the employee's treating physician a certification that the employee faces an imminent and serious threat to his or her health.

Item 12 – Section 9792.10.5. Independent Medical Review – Medical Records.

- This section sets forth the documents that must be provided by the claims administrator, and may be provide by the injured worker, in order to conduct IMR. The documents to be provided by the claims administrator are mandated by Labor Code section 4610.5(*l*) and (m). The documents to be provided by the employee is set forth at Labor Code section 4610.5(f)(3). The parties may also submit any newly developed or discovered relevant medical records.

- The parties are to submit the documents concurrently, within fifteen (15) days following the mailing of the IMRO assignment notification (12 days if the notification is sent by electronic mail), or, for expedited review, within (24) hours following receipt of the notification. *Subdivision (b)(1), applicable to the employee, has been amended so as the language corresponds with the claims administrator's timeframes in subdivision (a)(1).*

- *Subdivision (a)(2) and (c) have been amended to delete references to the service of documents. The list of documents or additional documents must be forwarded to other party; formal service is not required.*

- *Subdivision (a)(2) is further amended to provided that the claims administrator must submit a copy of all reports of the requesting physician relevant to the employee's current medical condition produced within six months prior to the date of the request for authorization. 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 must submit a copy of all relevant medical reports produced within the last six months by any prior treating physician or referring physician.*

- Subdivision (c) allows the IMRO to request additional documents or information necessary to make a determination that the requested treatment is medically necessary.

Section 9792.10.6. Independent Medical Review – Standards and Timeframes.

- This section sets forth the process by which a medical reviewer assigned by the IMRO reviews all necessary evidence and issues an IMR determination as to whether the disputed medical treatment is medically necessary based on the specific medical needs of the employee and the medical treatment guidelines. Subdivision (b) allows the IMRO, upon written approval of the Administrative Director, to use more than one reviewer if it is found that the employee's condition and the disputed medical treatment is sufficiently complex such that a single reviewer could not reasonably address all disputed issues.

- Subdivision (d) sets forth the required elements of an IMR determination.

- Subdivision (e) provides that the IMRO shall provide the Administrative Director and the parties with a final IMR determination. The final IMR determination shall include a description of the qualifications of the medical reviewer, the determination issued by the medical reviewer. The IMRO must, in compliance with Labor Code section 4610.6(f), keep the names of the reviewer confidential. Under subdivision (h) the final IMR determination is deemed to be the determination of the Administrative Director and is binding on all parties.

- Subdivision (g) sets forth the timeframes for the IMRO to issue a final IMR determination. For a regular review, the deadline is within thirty (30) days of the receipt of the IMR application and all supporting documents. For expedited review, the deadline is within three (3) days of the receipt of the IMR application and supporting documentation. The deadlines may be extended for up to three days in extraordinary circumstances or for good cause.

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

- This section applies Labor Code section 4610.6(j)'s mandate as to how and when final IMR determinations are implemented, and provides that a claims administrator is subject to administrative penalties for a failure to timely implement a decision.

- Subdivision (c) and (d) provide and clarify the time and manner by which a claims administrator can appeal a final IMR determination to the Workers' Compensation Appeals Board (WCAB), as allowed by Labor Code section 4610(h).

- Subdivision (h) implements Labor Code section 4610.6(i) by providing the procedure for reassigning an IMR review should the WCAB reverse and remand the final IMR determination.

Section 9792.10.8. Independent Medical Review – Payment for Review.

- Labor Code section 4610.6 requires that the costs of IMR and the administration of the IMR system be borne by employers through a fee system established by the Administrative Director. The Administrative Director must establish a reasonable per-case reimbursement schedule to pay the costs of IMR reviews, which may vary based on the type of medical condition under review and on other relevant factors. This section sets forth the reasonable costs of the IMR process. The amounts were determined by the contracted IMRO, Maximus Federal Services, Inc., in consultation with DWC. Factors considered in the fees were: whether the physician reviewer was a M.D. or a D.O.; whether the review was performed on a regular basis or was expedited; and whether the review was withdrawn.

- Subdivision (c) provides that the aggregate total fee owed by the claims administrator for IMR reviews conducted during the prior calendar month shall be paid to the IMRO within thirty (30) days of the billing. A 10 percent increase will be applied if the invoice is not paid within ten (10) days after it becomes due.

- Subdivision (d) provides that the IMR fee is non-refundable and not subject to discount or rebate. Any discount involving the fee will be submitted to the Administrative Director for informal resolution.

Section 9792.10.9. Independent Medical Review – Publishing of Determination.

- This section implements Labor Code section 4610.6(m), providing that the Administrative Director may publish the results of independent medical review determinations after removing all individually identifiable information, including, but not limited to, the employee, all medical providers, the claims administrator, any of the claims administrator's employees or contractors, or any utilization review organization.

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

- *Subdivisions(c)(1)(A) and (c)(2) have been amended to reference the added section 9792.6.1 regarding the definition of "request for authorization."*

- *Subdivision (j)(4) was amended to delete a duplicative reference to sections 9792.6(l) and 9792.7(b) of Title 8 of the California Code of Regulations.*

- *Subdivisions (o) and (p) were amended to reference the added section 9792.9.1 in regard to the timeline for filing and receiving documents.*

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

- This section is amended to set forth the administrative penalties that may be assessed against claims administrators for violating their UR and IMR obligations. Mandatory penalties include:

- For the failure to timely communicate a written decision modifying, delaying, or denying a treatment authorization: $250 per day, up to a maximum of $5,000.

- For the failure to provide an IMR Application: $2,000.

- For the failure to include in a written decision modifying, delaying, or denying a treatment authorization notification of the IMR process: $2,000.

- For the failure to include in a written decision modifying, delaying, or denying a treatment authorization notification of the voluntary internal appeal process and that such a process is not a bar to pursuing IMR: $2,000.

- For the failure to timely provide IMR information requested by the Administrative Director: $100.00 for each day the response is untimely, up to a maximum of $5,000.00.

- For the failure to timely provide all mandatory IMR information: $250.00 for each day the response is untimely under section 9792.10.3(c), up to a maximum of $5,000.00.

- For the failure to timely implement a final IMR determination of the Administrative Director: $500.00 for each day up to a maximum of $5,000.00.

- For the failure to timely pay a fee invoice sent by the IMRO: $250.

- *Section (b)(5)(F) has been restored*.

Objective and Anticipated Benefits of the Proposed Regulations:

The objective of the regulations is to refine the procedure for requesting medical treatment under the utilization review mandate of Labor Code section 4610, and for establishing the independent medical review program mandated by Labor Code sections 4610.5 and 4610.6. The proposed regulations will benefit: (1) injured workers, who will have adverse utilization review decision, those that either deny, delay, or modify a treatment recommendation made by the employee's treating physician, reviewed in a prompt and efficient manner by a non-biased medical expert; (2) claims administrator, who will experience significant cost savings by having medical treatment disputes resolved through IMR rather than the expensive and lengthy QME process with review through the WCAB; (3) medical providers, who can refine their medical treatment recommendation through access to IMR determinations published by the Division.

Determination of Inconsistency/Incompatibility with Existing State Regulations:

The Acting Administrative Director has determined that this proposed regulation is not inconsistent or incompatible with existing regulations. After conducting a review for any regulations that would relate to or affect this area, the Acting Administrative Director has concluded that these are the only valid regulations that implement the 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.

DISCLOSURES REGARDING THE PROPOSED REGULATORY ACTION

The Acting Administrative Director has made the following initial determinations:

- Mandate on local agencies and school districts: None

- Cost or savings to any state agency: It is estimated that the proposed regulations will result in a savings of $866,000 for the State Compensation Insurance Fund, a quasi-state agency, per year beginning in the Fiscal Year 2013-14. The Division may also experience unquantifiable savings based on a reduced number of litigated cases involving medical treatment dispute.

- Cost to any local agency or school district which must be reimbursed in accordance with Government Code sections 17500 through 17630: None

- Other nondiscretionary cost or savings imposed on local agencies: It is estimated that the proposed regulations will result in a savings of $3.25 million annually for local government.

- Cost or savings in federal funding to the state: None

- Cost impacts on a representative private person or business: The division is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

- Statewide adverse economic impact directly affecting businesses and individuals: Although the proposed action will directly affect businesses statewide, including small businesses, and individuals, the Acting Administrative Director concludes that the adverse economic impact, including the ability of California businesses to compete with business in the other states, will not be significant.

- Significant effect on housing costs: None.

  Results of the Economic Impact Analysis/Assessment

  The Acting Administrative Director concludes that it is (1) unlikely that the proposal will create any jobs within the State of California, outside of those created by the independent review organziation, (2) unlikely that the proposal will eliminate any jobs within the State of California, (3) unlikely that the proposal will create any new businesses with the State of California, (4) unlikely that the proposal will eliminate any existing businesses with the State of California, and (5) unlikely that the proposal would cause the expansion of the business currently doing business within the State of California.

  Benefits of the Proposed Action: 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.

  Small Business Determination: The Acting Administrative Director has determined that the proposed regulations affect small business.

CONSIDERATION OF ALTERNATIVES

In accordance with Government Code section 11346.5(a)(13), the Acting Administrative Director must determine that no reasonable alternative considered or that has otherwise been identified and brought to the Acting Administrative Director's attention would be more effective in carrying out the purpose for which the actions are proposed, or would be as effective and less burdensome to affected private persons than the proposed actions, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

The Acting Administrative Director invites interested persons to present reasonable alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

PUBLIC DISCUSSIONS OF PROPOSED REGULATIONS

The text of the draft proposed regulations was made available for pre-regulatory public comment from December 3 – 7, 2012 through the Division's Internet website (the "DWC Forum").

AVAILABILITY OF INITIAL STATEMENT OF REASONS, TEXT OF PROPOSED REGULATIONS, RULEMAKING FILE AND DOCUMENTS SUPPORTING THE RULEMAKING FILE / INTERNET ACCESS

An Initial Statement of Reasons and the text of the proposed regulations in plain English have been prepared and are available from the contact person named in this notice. The entire rulemaking file will be made available for inspection and copying at the address indicated below.

As of the date of this Notice, the rulemaking file consists of the Notice, the Initial Statement of Reasons, proposed text of the regulations, pre-rulemaking comments and the Economic Impact Statement (Form STD 399). Also included are studies and documents relied upon in drafting the proposed regulations.

In addition, the Notice, Initial Statement of Reasons, and proposed text of the regulations being proposed may be accessed and downloaded from the Division's website at www.dir.ca.gov. To access them, click on the "Proposed Regulations – Rulemaking" link and scroll down the list of rulemaking proceedings to find the Independent Medical Review link.

Any interested person may inspect a copy or direct questions about the proposed regulations and any supplemental information contained in the rulemaking file. The rulemaking file will be available for inspection at the Department of Industrial Relations, Division of Workers' Compensation, 1515 Clay Street, 17th Floor, Oakland, California 94612, between 9:00 A.M. and 4:30 P.M., Monday through Friday. Copies of the proposed regulations, Initial Statement of Reasons and any information contained in the rulemaking file may be requested in writing to the contact person.

CONTACT PERSON FOR GENERAL QUESTIONS

Non-substantive inquiries concerning this action, such as requests to be added to the mailing list for rulemaking notices, requests for copies of the text of the proposed regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file may be requested in writing at the same address. The contact person is:

Maureen Gray
Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
P.O. Box 420603
San Francisco, CA 94142
E-mail: mgray@dir.ca.gov

The telephone number of the contact person is (510) 286-7100.

CONTACT PERSON FOR SUBSTANTIVE QUESTIONS

In the event the contact person above is unavailable, or for questions regarding the substance of the proposed regulations, inquiries should be directed to:

George Parisotto
Division of Workers' Compensation
P.O. Box 420603
San Francisco, CA 94142
E-mail: gparisotto@dir.ca.gov

The telephone number of this contact person is (510) 286-7100.

FORMAT OF REGULATORY TEXT.

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, thus: ~~deleted language~~.

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

Additional Proposed Text Noticed for 45-Day Comment Period:

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 and emergency regulatory text noticed for the 45-day comment period are indicated by double strike-through: ~~deleted language~~ or ~~deleted language~~.

AVAILABILITY OF CHANGES FOLLOWING PUBLIC HEARING

If the Acting Administrative Director makes changes to the proposed regulations as a result of the public hearing and public comment received, the modified text with changes clearly shown will be made available for public comment for at least 15 days prior to the date on which the regulations are adopted.

AVAILABILITY OF THE FINAL STATEMENT OF REASONS

Upon its completion, the final Statement of Reasons will be available and copies may be requested from the contact person named in this notice or may be accessed on the Division's website at www.dir.ca.gov.

AUTOMATIC MAILING

A copy of this Notice, the Initial Statement of Reasons, and the text of the regulations, will automatically be sent to those interested persons on the Acting Administrative Director's mailing list.

If adopted, the regulations as amended will appear in California Code of Regulations, title 8, section 9785, then commencing with section 9792.6. The text of the final regulations also may be available through the website of the Office of Administrative Law at www.oal.ca.gov.