

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.11(c)(1)	Commenter requests that a routine investigation be done every 2 years, instead of the proposed “every 3 years.”	Theodore Miller November 27, 2006 Written Comment	We disagree because more frequent investigations are disruptive to the business and would require additional DWC staff resources. The current DWC audits occur only once every 5 years. However, the regulations provide for target investigations where credible information indicates the possible existence of a UR violation and the regulations are revised to provide for a one-year return investigation if the performance rating was less than 85%.	Section 9792.11 (c)(1)(B) is revised to provide for a return investigation in one year if the performance rating was less than 85%.
Section 9792.11(j)(7)	Commenter requests that the “unique identifying number” not be the injured employee’s Social Security Number. Commenter suggests using the claim number or WCAB case number instead.	Theodore Miller November 27, 2006 Written Comment	We agree. The unique number will be different for each request for authorization.	None.
Section 9792.11(j)(8)	Commenter requests that the Division include a record of when the injured employee and/or any legal personnel were notified.	Theodore Miller November 27, 2006 Written Comment	We disagree. The data requested in (j) is needed to select the requests for authorization. Once the actual files and records for the requests for authorization are produced, the investigators will be able to determine when the injured employee or legal personnel were notified.	None.
Section 9792.11	Commenter requests that if the claims adjustor notifies the physician about needing updated medical dictation or a more detailed explanation or issues a denial, that the injured employee be notified as well.	Theodore Miller November 27, 2006 Written Comment	This comment goes beyond the scope of these regulations. The UR regulations (section 9792.6-.10) set forth the notice requirements.	None.
Section 9792.11(n)(1)	Commenter states that the claims adjustor/insurance company should make an address available that accepts proof of service.	Theodore Miller November 27, 2006 Written Comment	This comment goes beyond the scope of these regulations. The purpose of the subsection at issue is to clarify when the request for authorization is deemed received if there is no proof	None.

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			of service. The UR regulations (section 9792.9(a)(2)) set forth when the request for authorization is deemed received when there is a proof of service attached.	
Section 9792.11	Commenter states that the insurer should provide a local telephone and fax number. Commenter states that as an injured employee he does not have a fax machine and the charges to fax a non-local number are expensive.	Theodore Miller November 27, 2006 Written Comment	Disagree. This section concerns the date the requests for authorizations are deemed received. The request for authorization is from the physician, not the injured worker.	None.
General Comment	Commenter questions what is meant by the term competent and how does the insurance company (especially the UR dept) prove they are competent? Commenter opines that decisions need to be made by physicians in UR that are board certified in the area of the injured worker's primary diagnosis. Commenter states that claims adjusters also need to be competent in the area of the injured worker's primary diagnosis.	Theodore Miller November 27, 2006 Written Comment	Agree. This comment refers to Section 9792.12(a)(6). The term "competent" was deleted in the last revision.	None.
General Comment	Commenter provides a recount of his personal experience as an injured worker and his distress that the insurance carrier has impeded his recovery by continually denying treatment of his injury.  Commenter states that there is an urgent need for change but provides no suggested change to the proposed language.	Professor Jose Perez December 4, 2006 Written Comment	The comment does not address the specific regulations.	None.
General Comment	Commenter states that the utilization review procedures as currently practiced in California are being used to delay and deny treatment. Commenter states that the current reliance on ACOEM Guidelines should be rescinded or substantially modified.	Robert L. Weinmann, MD Union of American Physicians & Dentists December 6, 2006 Written Comment	Disagree. The requirement to rely on ACOEM is set forth in Labor Code section 4610(c).	None.
General Comment	The current proposed UR Enforcement	David Mitchell	We disagree. The changes made to	None.

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	<p>Regulations depart substantially from the earlier drafts sent out for public comment. Government Code §1346.8 requires that the changes be (1) non-substantial and solely grammatical in nature or (2) “sufficiently related to the original text that the public was adequately placed on notice that the change could result from the originally proposed regulatory action” in order to avoid the 45 day requirement. As set forth in more detail below, we submit that the scope of the changes requires an entirely new 45 day comment period and new hearings, rather than the 15 day comment period as presently being utilized, and that the currently proposed regulations are therefore contrary to law and cannot be approved by OAL on that basis.</p> <p>From the broadest public policy and legislative intent standpoint, we note that the newly proposed regulations are a substantial departure from what was originally aired, and will negate the legislative purpose behind enactment of medical treatment standards and utilization review. The newly proposed regulations are of the gravest concern to payors (employers, insurers and claims administrators), and should also be alarming for utilization review providers, as well as treating physicians and patients, for the following reasons:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> The clear legislative intent behind adoption of standards for reasonable and necessary medical treatment is that employees receive proven effective medical treatment consistent with the</li> </ul>	<p>Republic Indemnity December 5, 2006 Written Comment</p>	<p>these sections are sufficiently related the 45 day version of the UR penalty regulations. The proposed changes concern the investigation procedures, the penalty schedule, the penalty adjustment factors, liability for penalty assessments, and the Order to Show Cause, Determination and Order and Review Procedure.</p> <p>Disagree re: the (a) penalties. The penalties set forth in section 9792.12(a) are for serious violations of the UR requirements, such as failure to have a UR plan, failure to</p>	<p>Section 9792(b) will be revised to provide a performance rating based on the number of violations in each of four</p>

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	<p>ACOEM guidelines or other scientific evidence based medicine in accordance with Labor Code §4600(b) and Labor Code §5307.27. As is clearly evident from reading the AD’s “Initial Statement of Reasons” which accompanied the July 2006 proposed adoption of a medical treatment schedule and proposed Rules 9792.20 – 9792.23, the treatment guidelines were also intended to stem the alarming tide of rising costs driven by excessive utilization of routine medical procedures, diagnostics and physician visits. Pursuant to Labor Code §4610, utilization review is the process legislatively adopted to implement that legislative policy for relying on evidence-based medicine and controlling improper treatment recommendations. The utilization review process helps to assure that injured workers do not fall prey to unscrupulous practitioners performing unnecessary, unproven and potentially harmful medical procedures which can needlessly drive up costs, increase lost time from work and related wage loss, and result in greater permanent impairments which can adversely impact the worker’s future ability to find appropriate employment. But the proposed fines and penalties are so severe that they will actively discourage implementation of the statutory mandate for utilization review, and drastically undermine the legislative purpose.</p> <p><input type="checkbox"/> Many of the problems attributed to the</p>		<p>have a medical director, failure to respond to a request for admission.</p> <p>Agree re: the penalties set forth in subdivision (b). These penalties are for lesser violations – violations concerning timeliness and notice requirements. We agree to revise to allow an 85% passing rate and to reduce the increased penalty multiplier for return investigations.</p> <p>Disagree. Labor Code section 4610(c) provides that “Each</p>	<p>categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p> <p>None.</p>

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	<p>UR process arise due to inconsistent decisions between payors addressing the same kinds of physician requests, the absence of adopted treatment schedules, and the low burden of proof currently applicable to rebut the ACOEM guidelines until a treatment schedule is formally adopted. This problem has arisen because ACOEM, although statutorily adopted, doesn't cover everything. Thus other information, of varying quality and validity, has been used to support or oppose treatment requests. Currently in development is the Official Medical Treatment Utilization Schedule under Labor Code §5307.27 (see proposed regulations §§9792.20 – 9792.23). There is a critical distinction between the standards applicable <u>prior</u> to the AD adoption of treatment regulations vs. the standards applicable to treatment <u>post</u> adoption of treatment regulations. That difference is that with adoption of the medical treatment utilization schedule, we will for the first time have a requirement for “evidence-based, peer-reviewed, nationally recognized standards of care ... that shall address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases.” The treatment schedule, upon adoption, will be “presumed correct” under Labor Code §4604.5, and rebuttable only by <i>scientific</i> evidence</p>		<p>utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to the adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines [ACOEM]. These policies and procedures shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.” Thus, the statute anticipated UR to be effective prior to the AD's adoption of guidelines. (Additionally, the AD will be filing the Medical Treat Utilization Standards with OAL in the first week of May.) Until the AD adopts new guidelines, UR shall be consistent with ACOEM. The proposed regulations are not unnecessary.</p>	

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	<p>(unlike the rebuttal standard pre-adoption, which does not require scientific evidence). This is a significant change in the standard which will be applicable. Under this circumstance, to initiate harsh UR penalties prior to the adoption of official medical treatment utilization guidelines under LC 5407.27 and Rules 9792.20, et seq is, quite frankly, putting the cart before the horse. The proposed regulations, insofar as they are the product of concerns over UR guidelines which are about to be superseded under Labor Code §5307.27, are unnecessary and thus fail to comply with OAL requirements.</p> <p><input type="checkbox"/> Utilization Review is a process designed to internally resolve treatment issues in an expedited fashion. If the penalties for technical errors in the UR process are so severe that they discourage performing UR on the more routine treatment authorization requests ... the ones which the AD specifically found were excessively prescribed ... we may see one or all of the following undesirable outcomes: (1) the benefit of UR to the <u>payors</u> will be reduced because the risk of liability for a technical defect in performing UR will overshadow the cost savings; (2) the benefit of UR to the <u>patient</u> (that they not receive unnecessary, unproven and potentially harmful treatment) will be outweighed by the risk of liability for a technical defect in the process; (3) the benefit of UR to</p>		<p>With regard to the concern that the penalties address technical errors, we agree to revise the penalties listed in section 9792.12(b) to allow an 85% passing rate. This will allow for some margin of error on the technical violations for timeliness, notice content and service. We will also reduce the multiplier that increases the (b) penalties on return investigations. However, the penalties in the (b) subdivision are only \$100 or \$50 each, which could hardly be described as severe.</p>	<p>Section 9792(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation,</p>

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	<p>California <u>employers</u> in reducing costs and premiums will be reduced; (4) The benefit of UR to the <u>physicians and patients</u> will be lost if, to avoid the risk of liability for a technical defect in the UR process, payors instead opt to use the lengthy and cumbersome dispute resolution process of Labor Code §4062, et seq., which can be 90+ days, rather than the expedited processes of UR, as expressly allowed by the Court of Appeal in the <u>Sandhagen</u> decision.</p> <ul style="list-style-type: none"> <li data-bbox="464 641 966 909">□ With the new two-year cap on temporary total disability applicable in most cases, it is counterproductive for the AD to implement a system which would encourage payors to elect the longer dispute resolution process inherent within Labor Code §4062 rather than to use the more expedited UR procedures under Labor Code §4610.</li> <li data-bbox="464 950 966 1364">□ Despite initial concerns within the medical community when MPNs were first authorized, most employers and insurers have established MPN's which have been extremely inclusionary of nearly all physicians ... on the assumption that physician compliance with the statutory mandates can be regulated through effective utilization review rather than by excluding doctors who historically recommended unnecessary, unproven and potentially harmful medical procedures. But if the level of monetary fines and penalties</li> </ul>		<p>The comment goes beyond the scope of these regulations and is based on the <i>Sandhagen</i> Appellate Court decision which is pending review at the Supreme Court.</p> <p>With regard to the concern that the penalties address technical errors, we agree to revise the penalties listed in section 9792.12(b) to allow an 85% passing rate. This will allow for some margin of error on the technical violations for timeliness, notice content and service. We will also reduce the multiplier that increases the (b) penalties on return investigations. However, the penalties in the (b) subdivision are only \$100 or \$50 each, which could hardly be described as severe.</p>	<p>the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p> <p>None.</p> <p>The (b) penalties are being revised as stated above.</p>

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	<p>remains heightened as currently proposed, so that technical errors in the utilization review process causing no harm to the claimant are going to be so severely penalized, then employers and insurers will have significant incentives to reconsider their currently inclusionary MPNs with an eye to replacing them with very exclusionary MPNs. Many of the physicians currently available to treat injured workers through the large MPNs may be excluded under the more restrictive MPNs designed to allow only those physicians whose recommendations have historically been in line with Labor Code §4600(b). This would have the unfortunate result of further restricting worker choices of treating physicians.</p> <p><input type="checkbox"/> Up to now, many payors have chosen to allow the claimants to stay with their personally chosen physicians, and not to disrupt that longstanding physician-patient relationship by moving the patient into the newly established MPNs. However, if patient-chosen physician behavior cannot be effectively regulated due to excessively punitive utilization review fines and penalties, then payors will have significant incentives to disrupt those relationships and to move the patients from their current physicians into an MPN limited to only those physicians whose recommendations have historically been in line with Labor Code §4600(b). This would have the unfortunate result of further restricting worker choices of</p>		<p>To the extent this comment addresses the right of claims administrators to tailor physicians included in their MPNs, the comment goes beyond the scope of these regulations.</p> <p>With regard to the concern that the penalties address technical errors, we agree to revise the penalties listed in section 9792.12(b) to allow an 85% passing rate. This will allow for some margin of error on the technical violations for timeliness, notice content and service. We will also reduce the multiplier that increases the (b) penalties on return investigations. However, the penalties in the (b) subdivision are only \$100 or \$50 each, which could hardly be described as severe.</p>	<p>The (b) penalties are being revised as stated above.</p>

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General Comment	<p>treating physicians.</p> <p>Public policy and legislative intent considerations aside, the proposed UR Enforcement Regulations contain numerous technical defects which render them defective and require that they not be approved by OAL. As is more specifically set forth herein, the proposed regulations are inconsistent with the legislative intent, exceed the statutory grant of authority, impermissibly restrict an innocent individual's ability to obtain employment, penalize innocent behavior, and contravene OAL requirements with regard to authority, necessity, clarity, consistency and non-duplication. These include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>□ Unlike the statutory requirement for the AD to approve an MPN as set forth in Labor Code §4616(b), there is no such legislative authority in regard to the establishment of a Utilization Review program. Rather, Labor Code §4610(c) only requires that the UR "policies and procedures, and a description of the utilization process" be filed with the AD. Approval of the UR program by the AD is not authorized by the enabling statute. Nonetheless, the regulations as currently proposed are largely aimed at the content of the UR program rules and regulations, and penalize the content separately from the timeliness of the performance of the UR function effectively and improperly subjecting the UR policies and procedures to AD approval. Thus, the proposed regulations are contrary to law and cannot</li> </ul>	David Mitchell Republic Indemnity December 5, 2006 Written Comment	<p>Disagree and agree.</p> <p>Disagree re: the (a) penalties. The penalties set forth in section 9792.12(a) are for serious violations of the UR requirements, such as failure to have a UR plan, failure to have a medical director, failure to respond to a request for admission.</p> <p>Agree re: the penalties set forth in subdivision (b). These penalties are for lesser violations – violations concerning timeliness and notice requirements. We agree to revise to allow an 85% passing rate and to reduce the increase factor for return investigation.</p>	Section 9792(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation,
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	<p>be approved by OAL.</p> <ul style="list-style-type: none"> <li>□ The statutory grant of authority contained within Labor Code §4610(i) makes no provision for a separate audit under Labor Code §4610. The only statutory authority for the AD to conduct an audit remains under Labor Code §129 and 129.5. Insofar as the proposed regulations would allow for an audit of UR separately from an audit under Labor Code §129 or 129.5, the regulations are contrary to law and therefore cannot be approved by OAL.</li> <li>□ The AD's audit authority and penalty assessment authority is limited by Labor Code §129.5 in terms of the monetary amount of fines and penalties which may be assessed. Labor Code §129.5 mandates that less severe conduct is to be punished by up to \$100. The most serious is to be punished by up to \$5,000. The proposed UR enforcement penalties, reaching into the hundreds of thousands of dollars, are grossly in excess of those express statutory limits, wholly unauthorized, and as such cannot be approved by OAL.</li> </ul>		<p>Disagree. Labor Code section 133 provides authority for the AD to do all things necessary in the exercise of any power conferred upon it in the code. Labor Code section 4610(i) provides authority for the AD to impose penalties for failure to comply with the UR requirements.</p> <p>Disagree. See above.</p>	<p>the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p> <p>None.</p> <p>None.</p>
Section 9792.11(c)(1)	The AD's audit authority for frequency of audits is limited by Labor Code §129(a) to routine audits every 5 years, Labor Code §129(b)(1) to profile audits every 5 years, Labor Code §129(b)(2) every two years for subjects failing a full compliance audit. Therefore, proposed Rule 9792.11(c)(1) which would allow a routine audit every three years	David Mitchell Republic Indemnity December 5, 2006 Written Comment	Disagree. Labor Code section 4610 does not refer to Labor Code section 129 or require an investigation concurrent with the PAR audit. Labor Code section 129 provides authority to audit insurers, self-insured employers, and TPAs. Section 4610 provides for penalties	We agree to revise .11(c) to perform the UR investigations of claims administrators every five years. The URO investigations will be performed every three years.

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	is contrary to the legislative grant of authority and cannot be approved by OAL.		against any entity that fails to meet the UR requirements, which includes utilization review organizations. Nonetheless, we agree to revise .11(c) to perform the UR investigations of claims administrators every five years. The URO investigations will be performed every three years.	
Sections 9792.11(b) and (c)	The use of the terms “utilization review process investigation” [Proposed Rule 9792.11(b)] and “utilization review investigation” [Proposed Rule 9792.11(c)] is internally contradictory and confusing and therefore cannot be approved by OAL.	David Mitchell Republic Indemnity December 5, 2006 Written Comment	We agree.	The section will be revised to state “utilization review investigation.”
Section 9792.11(c)(1)	The use of the term “routine investigation” in proposed rule 9792.11(c)(1) includes reference to a frequency of “once every three (3) years” and a reference to “once every five (5) years” and is thus internally contradictory and confusing and therefore cannot be approved by OAL. Additionally the three-year provision is contrary to the legislative grant of authority as set forth in Labor Code §129(a) and separately cannot be approved by OAL.	David Mitchell Republic Indemnity December 5, 2006 Written Comment	We agree to revise this section. The investigation of claims administrators will occur once every five years concurrent with the PAR audit. The investigation of the UROs will occur once every three years. We disagree that the authority to investigate is controlled by Labor Code section 129.	We agree to revise this section. The investigation of claims administrators will occur once every five years concurrent with the PAR audit. The investigation of the UROs will occur once every three years.
Sections 9792.11; 9792.13; 9792.14; and 9792.15	The regulations inconsistently refer to “ <u>person</u> subject to Labor Code Section 4610” [9792.11(j)(7), 9792.11(j)(8), 9792.11(k), 9792.11(l), 9792.11(n)(1), 9792.11(o), 9792.13(a)(8), 9792.15(e), 9792.15(h), ] and “ <u>entity</u> subject to Labor Code Section 4610 [9792.11(a), 9792.13((a)(2), 9792.14(a), 9792.14(b), 9792.15(a)], thus creating uncertainty and confusion regarding to whom they apply, and thus cannot be approved by OAL.	David Mitchell Republic Indemnity December 5, 2006 Written Comment	We agree.	These section will be revised to be consistent and state claims administrator or utilization review organization.

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	<p>The Court of Appeal in <u>Sandhagen</u> held that although having a UR program is mandatory, doing UR in every case is not mandatory. Directly contrary to this judicial holding are the UR enforcement regulations, which require the claims administrator to respond to every request for authorization and set a penalty for failing to do so. In effect, the enforcement regulation penalizes something the law does not require to be done. As such this regulation lacks legal authority under required standards for OAL approval as set forth in Gov. C. 11349 - 11349.1 and cannot be approved by OAL.</p>	<p>David Mitchell Republic Indemnity December 5, 2006 Written Comment</p>	<p>We agree to clarify .11(f) to state that the penalties shall only be imposed if “the request was subject to the Labor Code section 4610 utilization review process.” It should be noted that <i>Sandhagen</i> is under review by the Supreme Court.</p>	<p>We agree to clarify .11(f) to state that the penalties shall only be imposed if “the request was subject to the Labor Code section 4610 utilization review process.”</p>
<p>Section 9792.11(k)(1) and 9792.11(q)</p>	<p>Unlike certain governmental agencies for which there is express authority, the invoking of CCP 1822.50, et seq. is not authorized by statute as a tool available to the Administrative Director. Nor is CCP 1822.50 applicable to the circumstances herein, as the procedure is obviously intended to relate to safety issues necessitating search of a premises arising out of building, fire, safety, plumbing, electrical, health, labor, or zoning laws which require inspection of a particularly involved location. As such, although access to records may be appropriate (for which there is subpoena power and related enforcement), <u>inspection of the premises</u> is not reasonably within the scope of legitimate needs of the Administrative Director to perform its function. That going on the premises is unnecessary is implicit when one considers 9792.11(k)(1) which expressly allows certified copies to be sent to the AD in lieu of original files, and 9792.11(q) which allows delivery of the files to the AD in lieu of going</p>	<p>David Mitchell Republic Indemnity December 5, 2006 Written Comment</p>	<p>We agree to delete reference to CCP section 1822.50 in former section 9792.11 (e), now (h). We disagree that the AD does not have a right to on site investigations. Labor Code section 133 provides authority for the AD to do all things necessary in the exercise of any power conferred upon it in the code. The inspection of records may reveal factual concerns that can only be resolved by performing an on site inspections.</p> <p>Disagree that there is no authority to inspect premises. Labor Code section 133 provides authority for the AD to do all things necessary in the exercise of any power conferred upon it in the code. Labor Code section 4610(i) provides authority for the AD to impose penalties for failure to comply with the UR requirements.</p>	<p>We will delete the reference to CCP 1822.50.</p>

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	to the premises where the files are maintained. Therefore, this procedure cannot be approved by OAL as it fails the requirement of both “necessity” and “authority” as required by Gov. C. 11349 - 11349.1, and is internally inconsistent with the authorized alternative of delivery of the files to the AD.			
Section 9792.11(e)	<p>Contained within proposed Rule 9792.11(e) is reference to CCP §1822.50, which involves a judge of a court of record issuing an inspection warrant. Presumably, this would be Superior Court, as the WCAB’s enabling legislation does not empower it to issue such search warrants. Because the Labor Code makes provisions for criminal prosecutions under various circumstances, and because UR enforcement under Labor Code §4610 is coupled with enforcement under Labor Code §§129 and 129.5, case law mandates Fourth Amendment protection and a showing of “probable cause” for such an inspection warrant. Since a “routine audit” lacks any “probable cause” it would violate Constitutional precepts to adopt the inspection warrant statute as authority for ordering such an audit. As such this provision cannot be approved by OAL.</p> <p>The procedures of CCP §1822.50 are unnecessary and a duplication in light of the regulatory authority granted under Labor Code §129, 129.5 and 4610, and thus contrary to OAL requirements.</p>	David Mitchell Republic Indemnity December 5, 2006 Written Comment	We agree to delete reference to CCP section 1822.50 in former section 9792.11 (e), now (h).	We agree to delete reference to CCP section 1822.50 in former section 9792.11 (e), now (h).
Section 9792.11(g)	Proposed Rule 9792.11 describes routine and non-routine “investigation” of UR. That rule goes on, in 9792.11(g) to adopt the definitions contained within Rule 10100.1. Rule 10100.1	David Mitchell Republic Indemnity December 5, 2006 Written Comment	We agree to delete subdivision (g).	Subdivision (g) will be deleted.

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	defines an “investigation” as relating solely to a determination of payment of benefits ... not the timeline of UR procedures. As such it is confusing, contradictory and inconsistent and cannot be approved by OAL.			
Section 9792.11(i) and 9792.12(b)(5)	The premature publication of audit results, as called for under 9792.11(i) is particularly troubling. Even if all of the audit violations are ultimately found unsubstantiated, the premature circulation of the AD’s report would have a condemnatory effect. When found innocent, you can’t “unring the bell.” At the very least, no publication should occur until all appeals are exhausted. As currently written, this subsection has no legitimate regulatory purpose and thus fails to meet OAL approval standards. Furthermore, the provisions of 9792.11(i) regarding publication of audit results conflicts with the provisions of 9792.12(b)(5) which limits such publication to that point in time when all appeals have become final. This internally conflicting provision is a separate and independent reason the regulations cannot be approved by OAL.	David Mitchell Republic Indemnity December 5, 2006 Written Comment	We agree. The report will not be required to be sent or posted until the results are final.	Section 9792.11(i) (now (v)) will be revised to clarify that the notice is not required until any and all appeals are final. Section 9792.12(b)(5) (now (6)) will be revised to state the posting will not occur until the final investigation report or if a hearing was held, until all appeals are final.
Section 9792.11(j)	The requirement of proposed Rule 9792.11(j), in terms of developing data elements and statistical information within 7 days per 9792.11(j), is unreasonable. There is no regulatory requirement that this kind of data be kept. Nor do the various legacy computer systems in use provide a convenient means to do so. If such information is going to be required, it will necessitate substantial retooling of the current programming of each and every payor and/or UR provider’s computer systems. The industry has just	David Mitchell Republic Indemnity December 5, 2006 Written Comment	We agree to revise (k) to allow 14 days to produce the data elements.	Subdivision (k) will be revised to allow 14 days to produce the data elements. The 7 day time period will be removed from subdivision (j).

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	<p>undergone substantial data restructuring to comply with WCIS under Rule 9701 et seq. WCIS has taken several years to develop and has been implemented in stages. The data sought by Rule 9792.11(j)(4) and 9792.11(j)(7) should not be required unless and until integrated with WCIS, and a reasonable period of time allowed to phase in the data elements requirements.</p>			
<p>Section 9792.12(b)(2)(b) and (c)</p>	<p>Proposed Rules 9792.12(b)(2)(b) and 9792.12(b)(2)(c) conflict in that they contain exactly the same language <u>except</u> the percentage adjustment in (b) is 20% while the percentage of adjustment in (c) is 40%. These thus are contradictory and conflicting, and as such cannot be approved by OAL.</p>	<p>David Mitchell Republic Indemnity December 5, 2006 Written Comment</p>	<p>We agree.</p>	<p>This section is revised. The sections now states (b)(3)(A) – the penalty will be multiplied by two for a second investigation; (B) the penalties will be multiplied by five for a third investigation; and (C) the penalties will be multiplied by ten for a fourth investigation.</p>
<p>Section 9792.11(p)</p>	<p>There is a conflict between existing Rule 10102 regarding time frames for retention of claims files vs. proposed Rule 9792.11(p). The former provides for retention until the last audit is final, while the latter proposes a five-year retention from last final audit. These rules would directly conflict with one-another, and thus cannot meet the criteria for OAL approval.</p> <p>The proposed regulations fail to take into account that the Labor Code and its UR provisions does not apply where medical treatment is provided in accordance with Labor Code §4600(d)(3), but instead is</p>	<p>David Mitchell Republic Indemnity December 5, 2006 Written Comment</p>	<p>We agree. Former subdivision (p) now (r) will be revised. UROs will be required to maintain records for 3 years. Claims administrators will be required to maintain files per section 10102.</p> <p>We agree. Subdivision (f) will be revised to state that the penalties only apply if the request was subject to the Labor Code section 4610 utilization review process.</p>	<p>Former subdivision (p) now (r) will be revised. UROs will be required to maintain records for 3 years. Claims administrators will be required to maintain files per section 10102.</p> <p>Subdivision (f) will be revised to state that the penalties only apply if the request was subject to the Labor Code section 4610</p>

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	<p>governed by the Health &amp; Safety Code. The proposed regulation does not provide for any exemption to comply with this statutory requirement. Therefore, the regulation is contrary to express provisions statute and cannot be approved by OAL.</p> <p>The proposed regulations fail to take into account that the Labor Code and its UR provisions do not apply where medical treatment is provided in accordance with Labor Code §4600(d)(4), but instead is governed by the Insurance Code. The proposed regulation does not provide for any exemption to comply with this statutory requirement. Therefore, the regulation is contrary to the express provisions of statute and cannot be approved by OAL.</p>		We agree. See above.	utilization review process.
Section 9792.12(a)	<p>The magnitude of the fines proposed in 9792.12, and particularly those under 9792.12(a) are of an unprecedented degree. When compared with the WCIS or 129.5 audit penalties, their magnitude is particularly egregious. As “Single Instance Mandatory Administrative Penalties” these can add up to hundreds of thousands of dollars without any showing of any harm resulting. It is respectfully submitted that these constitute a punitive award greater than that allowed under Constitutional principles of Due Process as enunciated by the US Supreme Court in <u>BMW of North America v. Gore</u>, and <u>State Farm Mutual Auto Ins. Co v. Campbell</u>, and by the California Supreme Court in <u>Simon v. San Paolo US Holding Co.</u> and <u>Johnson v Ford Motor Co.</u> in terms of the “grossly excessive” standard, the ratio of punitive</p>	David Mitchell Republic Indemnity December 5, 2006 Written Comment	Disagree. . In each of the following cases, the court considers the issue of whether a civil penalty that has been imposed is unconstitutional. In general, penalties are found to be constitutional where various factors are considered including; 1) degree of culpability, 2) prior misconduct, 3) the concern of creating a financial bonanza that would ill serve public policy, and 4) the sophistication and financial strength of the assessed. “Legislature may constitutionally impose reasonable penalties to secure obedience to statutes enacted under the police power so long as those enactments are procedurally fair and reasonably related to a proper legislative goal.” <u>Kinney v. Vaccari</u>	All of the (a) penalties will be revised for clarity.

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	<p>award to actual harm, and the failure to take into account the factors mandated by these judicial decisions.</p> <p>The above-referenced Supreme Court decisions outline how the Due Process Clause of the Fourteenth Amendment to the Federal Constitution makes the Eighth Amendment's prohibition against excessive fines applicable to the States, thus imposing substantive limits on a State's discretion in this area. They articulate several benchmarks which can result in a penalty award being unconstitutional, and as applicable herein, the proposed regulations are in violation of that Constitutional standard.</p> <p>One of the criteria used to determine the validity of a punitive award under both <u>BMW</u> and <u>Johnson</u> is the ratio of actual damages to punitive damages, and in no instance have they upheld a punitive award more than 10 times the actual damages. However, the proposed regulations herein would allow for a punitive award amounting to \$300,000 [see, e.g., 9792.12(a)(1) thru 9792.12(a)(2)] even where the technical defect caused no harm to anyone and the UR decisions were all 100% correct! Similar excessive fines exist throughout the entire proposed administrative penalties. As such, the proposed penalty scheme cannot pass Constitutional muster.</p>		<p>(1980) 27 Cal.3d 348, 352.</p> <p>In <u>Hale v. Morgan</u> (1978) 22 Cal.3d 388, the Supreme Court analyzed former Civil Code §789.3, which authorized a penalty of \$100 per day against a landlord who wilfully deprived a tenant of utility services for the purpose of evicting the tenant. The defendant in <u>Hale</u> was a cable television installer, who owned a small mobile home park and rented spaces to four or five mobile homes. Plaintiff moved a mobile home into the park without defendant's consent and then, after negotiating a small monthly rental, failed to pay rent for several months. When the defendant retaliated by cutting off his water and electrical lines, plaintiff filed an action for statutory penalties under section 789.3. The trial court found that defendant had wilfully cut off utility services for 173 days and imposed penalties in the amount of \$17,300. The monthly rental, however, was only \$65, or \$780 per year. The Supreme Court concluded that under the circumstances in this case, the penalties were excessive and therefore, violated the due process provisions of the Constitution. The amount of the penalty was not discretionary and did not take into account any ameliorating factors (such as degree of culpability, prior misconduct,</p>	

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			<p>ability to pay, effect on business and such other matters as justice may require.) The statute also “permits the occasional experienced and designing tenant to ambush an unknowing landlord converting the single wrongful act of the latter into a veritable financial bonanza.” <u>Id.</u> <b>Additionally, the fixed penalties were imposed upon potential defendants who may vary greatly in sophistication and financial strength.</b> On the factor of financial circumstances, the <u>Hale</u> court faulted the discretionless penalty for former section 789.3 in part because: “A large corporate landlord which callously and by design pursues a policy of ‘shock’ eviction suffers no greater penalty than the elderly widow of modest means who, dependent on the income of a single unit, ignorant of the penalty procedures of the law, exhausted by the machinations of a wily and recalcitrant tenant, and no longer willing or able to bear the expense of utilities for an occupant who refuses to pay rent, finally terminates the tenant’s utility services in order to speed his departure.” <u>Hale</u>, supra, 22 Cal.3d at pp. 399-400.</p> <p>In contrast, the court in <u>Kinney v. Vaccari</u> (1980) 27 Cal.3d 348, found penalties of \$36,000 applied under the same statute as discussed in <u>Hale</u></p>	

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			<p>to be, “both proportioned to the landlord’s misconduct and necessary to achieve the penalty’s deterrent purposes,” and therefore not constitutionally excessive. The differences in this case from <u>Hale</u> were: (1) the landlord in <u>Kinney</u> had little or no provocation for his conduct; (2) the tenants made an effort to mitigate damages by tendering their rent payments; and (3) the landlord’s conduct in this case was egregious. He turned off the utilities in an extremely harsh winter, depriving the tenants of hot water, heat and cooking facilities. Seven of the plaintiffs were minors and one gave birth during the time period. Finally, (4) the amount of the penalty could not be called confiscatory. It did not exceed the value of the premises.</p> <p>In <u>City and County of San Francisco v. Sainez</u> (2000) 77 Cal. App. 4th 1302, the owners of multi-unit rental property argued that the civil penalties assessed against them for violations of the housing and building codes violated their due process and excessive-fines protections of the state and federal Constitution. The owners due process challenge was based on <u>Hale v. Morgan, supra</u>, 22 Cal.3d 388. The city relied upon <u>Kinney v. Vaccari, supra</u>. Although the owners</p>	

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			<p>argued that the \$1000 a day fine was more draconian than the fine in <u>Hale</u>, the court points out that the \$1000 a day fine is comparable to the \$600 a day (\$100 times the six units) upheld as reasonable in <u>Kinney</u>, two decades ago, for the same number of units. In the <u>Sainez</u> case, the penalties are paid to the City, as opposed to tenants, and therefore there is no concern of penalties creating a “veritable financial bonanza” that ill-serves public policy. Also served is the legitimate police power device of ‘securing obedience” to the code requirements through penalties. Further, although the trial judge expressed concern that an accumulated penalty might, be too severe in light of a defendant’s overall culpability and financial circumstances, the total here was not impermissibly disproportionate “to the conduct” or to defendants’ “net worth.” In <u>Sainez</u>, the defendants owned 14 rental properties, had a yearly rental income of \$276,000, and could be characterized as sophisticated in their dealings with the City and property management. As stated in <u>Sainez</u>, “while neither <u>Hale</u> nor <u>Kinney</u> considered or had evidence of total net worth, both decisions suggest that net worth can bear on the due process question.” <u>Id.</u></p> <p>Finally, in <u>Ojavan Investors, Inc. v.</u></p>	

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			<p><u>California Coastal Commission</u> (1997) 54 Cal.App.4<sup>th</sup> 373, real estate investment corporations argued that a fine of almost \$10 million was excessive. The statute in this case gave the trial court some discretion in determining the amount of the fines. The trial court considered five factors: (1) the nature, circumstance, extent, and gravity of the violation; (2) whether the violation was susceptible to restoration or to other remedial measures; (3) the sensitivity of the resource affected by the violation; (4) the cost to the state of bringing the action; and (5) with respect to the violator, any voluntary restoration or remedial measures undertaken, any prior history of violations, the degree of culpability, <b>economic profits, if any resulting from or expected to result as a consequence of the violation</b>, and such other matters as justice may require. Among the factors the trial court found to be egregious were defendants' culpability and the profits made and expected to be made. Distinguishing this statute from the one analyzed in <u>Hale</u>, the court pointed out that the trial court considered five factors listed above and that the consideration of the ameliorating factors distinguished the statute from the one in <u>Hale</u>. The fines were proportionate to the number of violations and to the</p>	

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			<p>defendants' flagrant disregard for the law.</p> <p>The "grossly excessive" line of cases cited by the commenter generally requires that punitive damages should be less than 10 times the amount of compensatory damages in civil damage cases. These penalties do not involve civil damages.</p> <p>We agree to revise (a)(1) for clarity. We dispute the comment that the penalties under (a)(1) and (a)(2) would total \$300,000. Subdivision (a)(1) and (a)(2) are for failure to have a UR plan and failure to designate a medical director, and each is for \$50,000. These two violations are the bases of the entire UR program and a requirement that has been present since 2003. There is simply no reason why a claims administrator should not have a UR plan with a medical director except for an intentional decision not to follow the law for monetary reasons. Therefore, the penalty must be high enough to deter misconduct.</p>	
Section 9792.14(a)	Proposed Rule 9792.14, although modified, remains significantly flawed. The scope of 9792.14(a), insofar as it implies investigation or audit of issues or files other than utilization review, exceeds the scope of a 4610 investigation and is therefore impermissible.	David Mitchell Republic Indemnity December 5, 2006 Written Comment	Disagree. This subdivision explains that whichever entity is responsible for the violation may be held responsible for the UR penalty.	None.
Section 9792.14(b)	Proposed rule 9792.14(b) unfairly penalizes a principal for conduct of a UR agent who,	David Mitchell Republic Indemnity	Disagree. The claims administrator and UR agent may clarify liability	None.

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	<p>unbeknownst to the principal, has violated the UR statutes. Absent a showing that the principal “knew or should have known” of the independent contractor UR company’s failures, it serves no legitimate regulatory purpose to make the principal liable for the audit penalties. As such, it is both unnecessary and contrary to the legislative purpose behind the statutory enforcement of the UR process.</p>	<p>December 5, 2006 Written Comment</p>	<p>responsibilities within the contract, however, per the UR regulations at 9792.6 et seq. it is the claims administrator’s responsibility to maintain the UR process and meet the time frames of UR.</p>	
<p>Section 9792.14(c)</p>	<p>The “successor liability” created by 9792.14(c) based solely upon having either “substantial continuity of business operations” or “substantially the same work force” remains of serious concern. If there is a “bad actor” at a company and it goes out of business, and a new company takes over the accounts and all the “good actors” from that prior company, then the new company is threatened with liability. What the AD has created by this regulation, due to lack of definition of these terms, is the probability that the “good actors” won’t be hired at other companies. This serves no legitimate regulatory purpose. If it is the AD’s intent that the “bad actors” not continue in the industry, then that should be addressed separately either in the adjuster certification regulations or more clearly in these regulations by specifying how these people would be identified. As currently proposed, the insured would have a difficult time finding insurance after an unfavorable UR audit, and the good claims adjusters on the account would have a difficult time finding jobs ... when the poor UR audit was neither of their responsibilities. This regulation is therefore</p>	<p>David Mitchell Republic Indemnity December 5, 2006 Written Comment</p>	<p>We disagree. The purpose of this section is to prevent a claims administrator from simply changing its name or merging with another entity to avoid paying for the UR penalties that were assessed against it.</p>	<p>None.</p>

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	not tailored to address a legitimate regulatory concern, and should not be approved by OAL.			
General Comment	Commenter uses her son's workers' compensation experience to support the proposed regulations. She does not offer any specific criticism or modification to the proposed language.	Kay C. Cook December 6, 2006 Written Comment	No response required.	None.
Section 9792.11(c)(2)(A)	<p>This section, which enables the Administrative Director or his or her designee to conduct a non-routine investigation based on receipt of factual information or <b>a complaint</b> containing facts indicating the possible existence of a violation of Labor code section 4610 or sections 9792.6 through 9792.12, lacks clarity. Unlike CCR §§101 06 and 10106.1, "a complaint" is not adequately defined herein, nor does the proposal address how the gravity, frequency in relation to inventory or treatment authorization requests received, will be taken into account. In addition, the proposal does not address the issue of how the validity of the complaint will be assessed.</p> <p><b>Recommendation:</b> Clarify what constitutes a complaint, making it clear that a non-routine investigation shall only be conducted based on credible complaints supported by appropriate documentation. No anonymous complaints should be considered. A non-routine investigation, based on factual information or complaints, should only be initiated after consideration of overall frequency, gravity of and credibility of complaints filed. One complaint should not constitute a trend and should not result in the initiation of a non-routine audit.</p>	Stephen Festa Senior Vice President Chief Claims Officer Employers Insurance Group December 7, 2006 Written Comment	<p>We agree to clarify. We disagree that the complaint must have documentation or that it cannot be anonymous. However, the regulations will be revised to state that the special target investigation shall be based on credible information indication the possible existence of a violation of Labor Code section 4610 or the UR regulations. Former subdivision (o) now (q) provides that the AD will provide to the claims administrator or UR organization a written description of the complaint that triggered the investigation and allow the investigation subject an opportunity to respond. The regulations will also describe how a complaint may be made and that the complaints will be reviewed and investigated to determine if they are credible.</p> <p>Complainants may forward complaints in any manner, written or oral, with or without using the form. Therefore, it the form does not need to be part of the regulations. The investigating unit will confirm/investigate the allegations in</p>	<p>Subdivision .11(c) will be revised to state that the special target investigation shall be based on credible information indication the possible existence of a violation of Labor Code section 4610 or the UR regulations.</p> <p>Subdivision (e) will be added to state: (e) Complaints concerning utilization review procedures may be submitted with any supporting documentation to the Division of Workers' Compensation using the complaint form that is posted on the Division's website at: <a href="http://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf">http://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf</a> Complaints should be mailed to DWC Medical Unit-UR, PO Box 420603, San Francisco,</p>

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	<p>Failure to clarify valid/credible complaints opens the door for abuse and excessive filings. We have no desire to prevent legitimate complaints, but rather to clarify what a credible complaint is and the documentation required to support the complaint.</p> <p>If clarification is not written into the regulations then commenter suggests adding language that discourages applicant's attorneys, medical providers or injured workers from filing false, fraudulent or intentionally misleading complaints, which otherwise will result in unfounded and unnecessary non-routine audits.</p>		<p>the complaint to determine if it is credible prior to proceeding with an investigation.</p> <p>We disagree that a fraud warning is needed. There is no required format or method for a complaint. They may be oral or written. Many injured workers are not aware of the legal requirements of UR but have concerns that their treatment requests have been denied. The investigation unit can then determine if it appears that there has been an UR violation before an investigation is initiated.</p>	<p>CA 94142-0603, attention UR Complaints or emailed to DWCMangedCare@dir.ca.gov. Complaints received by the Division of Workers' Compensation will be reviewed and investigated, if necessary, to determine if the complaints are credible and indicate the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.</p>
Section 9792.11(i)	<p>Commenter supports the requirement to notify affected employers of final findings and violations assessed. However, the present draft requires the notification to be provided prior to the conclusion of the appeal process. While a decision may be "final", if an appeal process is available which would govern the ultimate disposition of the matter, notification of affected parties should await that outcome. Therefore, the claims administrator, utilization review organization or other person performing utilization review services for an employer should not be required to provide the notification until the appeal process has been exhausted. Providing an affected employer with findings and violations prior to having an opportunity to appeal will lead to confusion for employers and can seriously misrepresent actual outcomes.</p>	<p>Stephen Festa Senior Vice President Chief Claims Officer Employers Insurance Group December 7, 2006 Written Comment</p>	<p>We agree.</p>	<p>This subdivision will be revised so that the requirement to notify the employer of the final findings will not occur until thirty-one calendar days after the service of the Order if no answer has been filed, within 15 calendar days after any and all appeals have become final.</p>

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Section 9792.11(j)	<p>This section enables the Administrative Director, at his or her discretion, to determine whether advanced notice will render an investigation less useful. Commenter recommends amending this section to be consistent with CCR §10107(b) which enables the Administrative Director to, at his or her discretion, waive notice of the audit for any <b><i>non-routine</i></b> investigation. Routine investigations should have a mandatory notification process and be subjected to a notification process no less than thirty (30) calendar days in advance of the date for commencement of an onsite investigation.</p> <p>Commenter also recommends amending the time frame allowed to deliver to the Administrative Director, or his or her designee, all requested information and records from seven (7) calendar days to fourteen (14) calendars. The amount of information required is significant and requires an additional amount of time to properly and accurately compile. In addition, changing the time frame to fourteen days is consistent with CCR §10107(a).</p>	<p>Stephen Festa Senior Vice President Chief Claims Officer Employers Insurance Group December 7, 2006 Written Comment</p>	<p>Agree.</p> <p>Agree. Subdivision (k) will allow 14 days to produce the information.</p>	<p>This subdivision will be revised to clarify it is only with regard to a target investigation that the AD has discretion to forego notice.</p> <p>Subdivision (k) will be revised to allow 14 days to produce the information.</p>
Section 9792.11(j)(7)	<p>Upon receipt of the notice of a routine or non-routine investigation, the claims administrator, utilization review organization or other person performing utilization review processes for the employer is required to deliver to the Administrative Director all requested information and records. Section 9792.1(j)(7) mandates providing "a list of each and every utilization review case or request received at the investigation site during the time period specified by the Administrative Director, or</p>	<p>Stephen Festa Senior Vice President Chief Claims Officer Employers Insurance Group December 7, 2006 Written Comment</p>	<p>Agree to delete (j)(7). However, disagree that accepted UR decisions should be excluded. Subdivision (j)(1) will also be revised to require information regarding requests for authorization "to the extent the system identifies" it in electronic format. Accepted requests for authorization need to be review to determine that they are also done in a timely manner.</p>	<p>Subdivision (j)(7) will be deleted. Subdivision (j)(1) will also be revised to require a description of the system used to identify each request for authorization (if applicable). "To the extent the system identifies any of the following information in</p>

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	<p>his or her designee."</p> <p>CCR §9792.6(s) defines the utilization review process, in part, as "utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny based on whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600." Based on this definition, every request for authorization is subject to the utilization review process.</p> <p>The requirement to provide a list containing each and every utilization review case is not cost effective, is cumbersome, and will require significant system enhancements as well as additional staff to accomplish. Commenter suggests amending the section to eliminate reference to each and every utilization review case, and instead apply the provision only to those utilization review cases or requests received and referred to a Reviewer or Expert Reviewer.</p>		<p>Disagree. The revised subdivision will require requests for authorization from a three month calendar period only.</p> <p>Disagree. The claims administrator does not need to change the system it currently has – the information is requested based on the extent to which the system currently identifies the information.</p>	<p>an electronic format, the claims administrator or utilization review organization shall provide in an electronic format a list of each and every request for authorization received at the investigation site during a three month calendar period specified by the Administrative Director, or his or her designee and the following data elements: i) a unique identifying number for each request for authorization if one has been assigned; ii) the name of the injured worker; iii) the claim number used by the claims adjuster; iv) the initial date of receipt of the request for authorization; v) the type of review (expedited prospective, prospective, expedited concurrent, concurrent, retrospective, appeal); vi) the disposition (approve, deny, delay, modify, withdrawal); and, vii) if applicable, the type of person who withdrew the request (requesting</p>

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				physician, claims adjuster, injured employee or his or her attorney, or other person). In the event the claims administrator or utilization review organization is not able to provide the list in an electronic format, the list shall be provided in such a form that the listed requests for authorization are sorted in the following order: by type of utilization review; type of disposition; and date of receipt of the initial request.
Section 9792.12(a)(5)	<p>This provision proposes a penalty of up to \$25,000 if a non-physician reviewer (person other than a reviewer, expert reviewer or medical director, as defined in section 9792.6 of Title 8 of the California Code of Regulations) modifies a request for treatment without possessing at the time of approving the modification an amended written request for treatment authorization as provided under section 9792.7(b)(3) of Title 8 of the California Code of Regulations.</p> <p>This section sets up claims administrators for failure and supports continued delays in authorizing medical care. CCR §9792.9(b)(1) requires prospective or concurrent decision be made in a timely fashion that is appropriate</p>	<p>Stephen Festa Senior Vice President Chief Claims Officer Employers Insurance Group December 7, 2006 Written Comment</p>	<p>We agree to revise. The revision will allow the non-physician review to obtain the amended request after the approval has taken place.</p> <p>The statute does not allow a non-physician reviewer to modify a physician's written request. Labor Code section 4610(e) states: "No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests</p>	<p>Subdivision (a)(5) (now 8) will be revised to state: "For failure of a non-physician reviewer ... who approves an amended request to possess an amended written request for treatment authorization ...when a physician has voluntarily withdrawn a request in order to submit an amended request: \$25,000."</p>

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	<p>for the nature of the injured worker's condition, not to exceed five (5) working days from the date of receipt of the written request for authorization. Non-physician reviewers endeavor to authorize medical care as quickly as possible. Non-physician reviewers initiate verbal communications with the requesting physician to discuss applicable criteria. The requesting physicians are given the option of modifying their treatment authorization request. In instances where the requesting physician concurs with the modification, approval is granted verbally followed by written notice within 24 hours.</p> <p>The above section, however, will delay approval of medical care as a non-physician reviewer will now be required to request and possess a written confirmation of the requesting physician's agreement to voluntarily withdraw a portion of all of the treatment prior to approving. Given the five day requirement, non-physician reviewers will be forced, pursuant to CCR §9792.9(b)(2), to extend the time frame up to 14 days and <u>will</u> likely seek the assistance of a reviewer in the event the requesting physician is not responsive in providing a written modification.</p>		<p>for authorization of medical treatment for reasons of medical necessity to cure and relieve.” 8 CCR 9792.6(o) defines a request for authorization as a written confirmation or an oral request for a specific course of proposed medical treatment. “An oral request for authorization must be followed by a written confirmation of the request within 72 hours.” 8 CCR section 9792.7(b)(2) states: “A non physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization.” Thus, in order to be in compliance with the statute and UR regulations, unless the UR file contains an amended written request, the non-physician reviewer is in violation of the UR requirements.</p>	
Section 9792.12(a)(5)	<p>This section is vague in that it does not establish a specified time frame in which the requesting physician is required to submit an amended request.</p> <p>Commenter suggests requiring the written</p>	<p>Stephen Festa Senior Vice President Chief Claims Officer Employers Insurance Group December 7, 2006</p>	<p>We agree. See above. In order to allow flexibility but still fall within the requirements of the statute and UR regulations, as long as there is documentation from the physician that the request was amended, no</p>	<p>Subdivision (a)(5) (now 8) will be revised as stated above.</p>

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	notice of approval, pursuant to CCR §9792.9(3), to clearly illustrate the treatment requested, the agreed modification, and a contain language requiring the requesting physician to submit a written modification of the treatment authorization within a specified time frame. The regulation should state that if the physician does not submit a written modification or a request for utilization review within the timeframe, the written notice of approval is deemed approved. We believe that this is appropriate given the current requirements of the law and the realities of how claim administrators and physicians communicate regarding treatment authorization requests.	Written Comment	penalty will be assessed. This will allow the documentation to be sent after the verbal approval has been give and will confirm that the physician did amend the request....	
Section 9792.12	Commenter requests that the Division add this section to Title 8, which sets penalties for violations of the review process.	Catherine Porter Staff Attorney Worksafe Law Center December 8, 2006 Written Comment	We agree.	We will adopt the regulations as soon as the division is satisfied that they are ready.
Section 9792.12	Commenter requests that the Division adopt a higher level of penalties than those proposed.	Catherine Porter Staff Attorney Worksafe Law Center December 8, 2006 Written Comment	We disagree. Many of the penalties were increased in the last revision and we believe they are now generally at appropriate levels.	None.
Section 9792.12	Commenter requests that the Division set minimum penalties, and suggests a minimum of \$10,000 for section 979212(a)(2) and a similar structure for the remaining subsections.	Catherine Porter Staff Attorney Worksafe Law Center December 8, 2006 Written Comment	Disagree. The subdivision (a) penalties may only be reduced if one of the factors listed in .13 apply.	None.
General Comment	Commenter believes that the regulations will discourage claims administrators from doing utilization review in fear of the penalties when the division should be encouraging more cases to come through the utilization review	Sharon Douglas, CEO RehabWest Inc. December 10, 2006 Written Comment	Agree in part. The (a) penalties are for very severe violations, such as the failure to even have a plan or failure to have a medical director. However, we agree to allow a pass rate for the	Subdivision (b)(1) will be added to allow an 85% pass rate for the (b) violations. If the claims administrator receives

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	process.		(b) violations of 85%.	85% or better, it is not required to pay the penalties following a routine audit. Also, if the investigation subject does worse than 85%, the amounts for the penalties for return investigations will be increased: on a second investigation the penalties will be multiplied by two, and not exceed \$100,00; on a third investigation the penalties will be multiplied by five and not exceed \$200,000; and on a third investigation, the penalties will be multiplied by ten and not exceed \$400,000.
Section 9792.11(i)(3)	Commenter suggests the addition of the word “may” before “post a copy of the final report...”	Sharon Douglas, CEO RehabWest Inc. December 10, 2006 Written Comment	Disagree. The requirement to provide notice of the final report is mandatory.	None.
Section 9792.11(n)(1)	Commenter suggests that the Division change the references “calendar days” to “business days.”	Sharon Douglas, CEO RehabWest Inc. December 10, 2006 Written Comment	Disagree. This is consistent with time requirements of the CCP.	None.
Section 9792.12(a)(1)(A)	Commenter suggests adding “or contracted” after “and who is employed.”	Sharon Douglas, CEO RehabWest Inc. December 10, 2006 Written Comment	Agree to revise.	Subdivision .12(a)(1)(A) is deleted. Subdivision (a)(5) is revised to include the words “to employer or designate...”
Section 9792.12(a)(2)	Commenter suggests the following language:  A maximum of \$50,000 for failing to employ	Sharon Douglas, CEO RehabWest Inc. December 10, 2006	Agree to revise.	Subdivision (a)(5) is revised to include the words “to employer or

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><b>or contract with</b> a physician as a medical director in section 9792.6(1) of Title of the California Code of Regulations, whether employed <b>or contracted</b> in a permanent or acting capacity, who has the express authority and responsibility for all utilization review decisions issued on the employer’s behalf, as required by sections 9792.6(1) and 9792.7(b) of Title 8.”</p>	Written Comment		designate...” Subdivision (a)(5) is revised to include the words “to employer or designate...”
Section 9792.12(a)(5)	<p>Commenter suggests the following language:  “. . . modifies a request for treatment without possessing at the time of approving the modification an amended written request for treatment authorization <b>which may be received by facsimile from the treater’s office</b> as provided under section 9792.7(b)(3) of Title 8 of the California Code of Regulations.”</p>	<p>Sharon Douglas, CEO  RehabWest Inc.  December 10, 2006  Written Comment</p>	<p>Disagree with the recommendation. The UR regulations defined how the requests may be sent.</p>	<p>Subdivision (a)(5) now (8) is revised to state: For failure of a non physician reviewer...who approves an amended request to possess an amended written request for treatment authorization as provided under section 9792.7(b)(3) when a physician has voluntarily withdrawn a request in order to submit an amended request: \$25,000.</p>
Section 9792.12(a)(8)	<p>Commenter recommends inserting “by” before “the medical treatment utilization schedule.....”</p>	<p>Sharon Douglas, CEO  RehabWest Inc.  December 10, 2006  Written Comment</p>	<p>Agree – ‘by’ is already there.</p>	<p>None.</p>
Section 9792.12(b)(3)(D)	<p>Commenter suggests the following language:  “. . . within (5) working days of receipt of the information <b>or within 14 calendar days from receipt of the initial request for authorization, whichever comes first</b> for prospective or concurrent review, or for failure to communicate the decision as required by section 9792.9(g)(3) of Title 8.</p>	<p>Sharon Douglas, CEO  RehabWest Inc.  December 10, 2006  Written Comment</p>	<p>We agree to revise this section.</p>	<p>The section now states: (C) For failure to make a decision to approve or modify or deny the request for authorization, within five (5) working days of receipt of the requested information for prospective or concurrent</p>

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				review and to communicate the decision as required by section 9792.9(g)(3).
Section 9792.12(b)(3)(E)	Commenter suggests that the section should read “within thirty (30) calendar days” instead of “within 30 working days.”	Sharon Douglas, CEO RehabWest Inc. December 10, 2006 Written Comment	We disagree. Section 9792.9(g)(4) does not state if it is working or calendar days, so for purposes of the penalties, we are clarifying the longer period.	None.
Section 9792.12(b)(3)(F)(10)	Commenter suggests the following language: “. . . along with his or her telephone number <b>or the telephone number of the medical director</b> in the United States, and hours of availability in accordance with section 9792.9(k) of Title 8 of the California Code of Regulations.”	Sharon Douglas, CEO RehabWest Inc. December 10, 2006 Written Comment	Disagree. This subdivision is deleted and instead the section references the UR regulation.	Subdivision (b)(3)(F) (10) now (b)(4)(E) is deleted. The (F) section is revised to state: For failure to include in the written decision that modifies, delays or denies authorization, all of the items required by section 9792.9(j)
Section 9792.12(b)(4)(D) and (E)	Commenter suggests inserting the word “calendar” where it addresses the number of days in these sections.	Sharon Douglas, CEO RehabWest Inc. December 10, 2006 Written Comment	Disagree. These regulations refer to the UR regulations which set forth the timeframes.	None.
General Comment	<p>Commenter opines that the requirement that UR decisions be made by doctors is not enough to make sure that UR decisions are made according to ACOEM or other evidence based guidelines. Commenter provides his own experience as an example of this.</p> <p>Commenter states that the burden of proof that the UR review follows the law should fall on the insurer.</p> <p>Commenter opines that the law needs to require that there is enough information in UR review so judges and attorneys can check</p>	Dr. K. Diemer December 11, 2006 Written Comment	<p>No specific recommendation is set forth here.</p> <p>This comment goes beyond the scope of these penalty regulations. The standards that are discussed address the UR regulations and requirements, not these UR penalty regulations.</p>	None.

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	<p>compliance with the law. Commenter suggests the following requirements:</p> <ul style="list-style-type: none"> <li>• UR must enclose actual statements from evidence that supports the treatment decision. Citations alone are not enough and are clearly being misused.</li> <li>• Description of peer review evidence used, i.e. review number of papers as well as the standard quality grades for each paper. Typically, this information is included in evidence based guidelines.</li> <li>• Statement of whether guideline used is for acute or chronic condition.</li> </ul> <p>Commenter also feels that some retroactive measures are needed so that medical bills that occurred because of improper UR review can be reimbursed.</p>			
Section 9792.11(c)	This subdivision describes the types of utilization review investigation that may be conducted. According to paragraph (2) a non-routine investigation may be based on a complaint containing facts indicating a possible violation. The Division recently announced a new form, DWC UR Complaint Form 1, that apparently is to be used for the purpose of reporting complaints. If this is the intent, commenter suggests that this subdivision be amended to reference this new form.	Linda F. Atcherley President California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment	Agree.	New subdivision (e) is added to refer to the complaint form that may be used.
Section 9792.11(f)	This subdivision provides that these penalty regulations apply only to "conduct which occurred on or after the effective date of these regulations." In connection with the new	Linda F. Atcherley President California Applicants' Attorneys Association	Disagree. The medical unit is currently acting on complaints that it receives by contacting the parties and trying to resolve the disputes.	None.

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	<p>complaint form referenced above, DWC UR Complaint Form 1, this rule makes no sense. The effect of this rule would be to prohibit the Division from taking any enforcement action with regard to a complaint form sent in before the effective date of these regulations. Thus, the Division would have violations reported on these forms, but would have no ability to take any action in response. Consistent with the judicial interpretation of the effective date of SB 899 changes [see, for example, <i>Kleeman v. Workers' Comp. Appeals Bd.</i> (2005) 127 Cal.App.4th 274, which held that SB 899 applies to all cases that were not yet final at the time of its effective date], we urge that this subdivision be amended to provide that these regulations will apply to all utilization review investigations conducted after the effective date of the regulations regardless of the date on which the conduct occurred.</p>	<p>via Mark Gerlach December 11, 2006 Written Comment</p>	<p>However, applying the penalties retroactively may cause due process violations.</p>	
Section 9792.11(i)	<p>This subdivision requires the claim administrator to notify "affected employers" of any final report of findings of violations. Other provisions in these regulations provide for the assignment of penalties for various types of violations. However, there is nothing in these regulations that requires any notification of either the injured worker or the worker's physician. Again, referencing the new DWC UR Complaint Form 1, the form includes a "check box" to indicate whether the form is being submitted by an injured worker, attorney, provider, or other person. Commenter believes that where the Division investigates such a complaint, the party submitting the complaint form should be</p>	<p>Linda F. Atcherley President California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment</p>	<p>We disagree. If the employer is aware of the violations caused by the claims administrators or URO it can make market choices to improve the services for its employees.</p>	None.

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	notified, and that the injured worker should <u>always</u> be notified of the resolution of an investigation.			
Section 9792.11(k)	This subdivision states that an investigation will consist of "no less than thirty-two" UR case files. Note first that the number of claims to be reviewed for an FCA is set forth in CCR §10107.1(d)(1). It is the commenter's understanding that the sample size chart in this section is actuarially based. Commenter recommends that the UR penalty audit sizes be based on this chart. Commenter understands that the sample size in a PAR audit is smaller, but strongly urge the use of the FCA sample sizes because the penalty amounts established under proposed §9792.12(b)(3) and (4) are only \$100 or \$50 per violation. Thus, under the current proposal, a UR penalty audit could reveal that every one of the 32 cases reviewed does not meet the time requirements of Labor Code §4610(g), and the total penalty assessed would be just \$1,600. This is clearly not sufficient to act as a meaningful disincentive against such egregious conduct. Although subsequent comments will recommend that these penalty amounts be increased, we also strongly urge that the sample sizes be significantly enlarged.	Linda F. Atcherley President California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment	We agree. The sample will be a random sample based on the audit regulations 10107.1.	New subdivision (d) will set forth the random sample size. The maximum will now be 59 requests for authorization.
Section 9792.12	It is noted that all of the penalty amounts are specified as "a maximum of..." but no minimum penalty is included. Commenter suggests that a minimum amount, equal to half the maximum amount, be specified for each individual subdivision or paragraph that includes a penalty amount. The inclusion of a minimum amount will increase the incentive to comply with the UR statutes and	Linda F. Atcherley President California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment	We agree to revise. The penalties must be assessed as written unless one of the mitigating factors listed in 9792.13 applies.	The penalties listed in 9792.12 (a) and (b) have been revised. The (a) penalties must be assessed as written unless one of the mitigating factors listed in 9792.13 applies. The penalties in (b) are all \$50 or \$100,

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	regulations, and will also prevent unnecessary litigation by UR firms over the amount of the penalty assessment.			unless they are abated or waived because the pass rate was 85% or better, or unless a mitigating factor applies.
Section 9792.12(a)(3)	This paragraph establishes the penalty where a reviewer makes a decision to deny or modify a treatment request where that treatment is outside the scope of practice of that physician, but proposes to delete the qualifying phrase "or professional competence" from this paragraph. The statutory language in Labor Code §4610(c) clearly requires <u>both</u> that the reviewing physician be "competent to evaluate the specific clinical issues involved in the medical treatment services" <u>and</u> that the "services are within the scope of the physician's practice." Commenter strongly urges that this paragraph be amended to reinstate the deleted phrase "or professional competence."	Linda F. Atcherley President California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment	Disagree. While the commenter is correct that the statute requires that the physician be "competent," the standard is too difficult to determine in terms of a record review. It would require a deposition to determine and the determination would be subject to dispute.	None.
Section 9792.12(a)(6)	This paragraph establishes a penalty of up to \$25,000 for failure to authorize and provide treatment under Labor Code §5402(c). This proposed penalty demonstrates again the need to establish a minimum penalty. Unless this section establishes a minimum penalty of at least \$10,000 (which would be accomplished by setting the minimum at 50% of the maximum, as proposed earlier), it could be to the advantage of the employer/insurer to refuse to provide the required treatment and pay a penalty of a lesser amount.	Linda F. Atcherley President California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment	Disagree. This section is being deleted for other reasons. As stated above, the penalty amounts are the amounts that must be assessed unless a reason listed in 9792.13 exists.	This section will be deleted.
Section 9792.12(b)(1)	The proposed language states that the "basic penalty amount shall be waived only the first time the violation is found..." Commenter is unclear as to the intent of this language. As	Linda F. Atcherley President California Applicants' Attorneys Association	Disagree. This section is revised to provide that the penalty amount may be waived after a routine investigation if the investigation	The section is revised to clarify that after a routine investigation the penalty may be waived.

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	<p>written, it appears that this language mandates that the penalties be waived, where specified conditions are met, regardless of any other circumstances. In general, commenter disagrees with the proposal to waive <u>any</u> part of this penalty. All of the penalties in this section are set up as maximum amounts where the penalty can range from that maximum down to \$1. Commenter believes that it is inappropriate to also provide that these penalties will be waived for the first violation. Alternatively, if it is determined that this waiver is appropriate, commenter recommends that this language be amended to provide that the "basic penalty amount <u>may</u> be waived...." to give the Division flexibility in applying this waiver.</p>	<p>via Mark Gerlach December 11, 2006 Written Comment</p>	<p>subject agrees to stipulate to an abatement. The abatement will require the investigation subject to correct the problems and agree to a return investigation. Again, the penalties will only be reduced if one of the 9792.13 adjustment penalties apply.</p>	
Section 9792.12(b)(2)	<p>Commenter is unclear as to the exact meaning of this paragraph. Commenter believes that the \$50 and \$100 penalties in subdivision (b) are inadequate to provide the necessary incentive to UR firms, and should be increased. If this paragraph defines a progressively higher penalty for a repeat offender, commenter strongly supports this new provision. Commenter does not see any difference in wording, except the percentage amount, between subparagraphs (B) and (C). Furthermore, if it is intended that the penalty enhancement in subparagraph (C) apply to a <u>fourth</u> investigation at a particular location, commenter believes that the language should be amended to include other possible penalties, including notification of the Department of Insurance or another agency for possible revocation of license.</p>	<p>Linda F. Atcherley President California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment</p>	<p>Agree to revise this section.</p>	<p>This section is revised to clarify that if the AD returns for a return investigation and the subject fails to meet the performance standard of 85%, the penalty shall not be waived. The following subdivisions set forth the amounts for the penalties: on a second investigation the penalties will be multiplied by two, and not exceed \$100,00; on a third investigation the penalties will be multiplied by five and not exceed \$200,000; and on a third investigation, the penalties will be</p>

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				multiplied by ten and not exceed \$400,000.
Section 9792.12(b)(5)	In order to conform with proposed §9792.11(i)(3), which <u>requires</u> the Administrative Director to post on the website a copy of the final report of violations (a requirement commenter supports), this paragraph should be amended to provide that the Administrative Director " <u>shall</u> post" the penalty amounts on the website.	Linda F. Atcherley President California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment	We agree.	The section will be revised to state: "shall"
Section 9792.12(c)	This subdivision provides that the penalty amounts specified in §9792.12(a) "may, in the discretion of the Administrative Director, be reduced..." As noted earlier, the penalty amounts specified in §9792.12(a) are all <u>maximum</u> amounts, with no minimum specified. As earlier recommended, commenter strongly believes that a minimum of 50% of the maximum value should be adopted for all penalties. Even with this amendment, however, the exact amount of the penalty would still be up to the discretion of the Administrative Director. Consequently, this subdivision is superfluous and should be deleted. Alternatively, all penalty amounts in §9792.12(a) should be established as set amounts, and the words "a maximum of" should be deleted from each of the paragraphs in subdivision (a).	Linda F. Atcherley President California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment	We agree to revise. The penalties must be assessed as written unless one of the mitigating factors listed in 9792.13 applies.	The penalties listed in 9792.12 (a) and (b) have been revised. The (a) penalties must be assessed as written unless one of the mitigating factors listed in 9792.13 applies.
Section 9792.13	This section sets forth factors to be considered by the Administrative Director in order to adjust a penalty amount imposed under §9792.12. For the reasons described above, commenter recommends that this section be deleted, or that the words "a maximum of" be deleted from each of the paragraphs in subdivisions (a) and (b) of §9792.12.	Linda F. Atcherley President California Applicants' Attorneys Association via Mark Gerlach December 11, 2006 Written Comment	We agree.	The words 'a maximum of' have been deleted from 9792.12 (a) and (b).

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Section 9792.11(j) and (k)	These sections should have 14 calendar days (rather than 7 calendar days) to deliver information to AD on audited file to be consistent with CCR 10107 (a). This time frame will allow a company which does Utilization Review offsite from the Claims Administrator or Employer an appropriate amount of time to collect records which likely are not on site at the UR company so that the file transferred to the AD is complete	Theodore Blatt, MD Medical Director Blue Cross of California Workers' Compensation Services December 11, 2006 Written Comment	We agree.	Subdivision (j) is revised to delete "7 days." Subdivision (k) and (l) are revised to clarify the URO and claims administrator have 14 days.
Section 9792.11(m)	Please define which days are considered "holiday". This wording is ambiguous and cannot be interpreted as it is linked to substantial potential penalties.	Theodore Blatt, MD Medical Director Blue Cross of California Workers' Compensation Services December 11, 2006 Written Comment	We agree. Section 9792.9(b)(5) defines "normal business day" as a business day defined in Labor Code section 4600.4 and Civil Code section 9.	The subdivision will be revised to be consistent with the IUR regulations and define normal business day.
Section 9792.11(p)	If the UR company is not on site at the claims administrator, the UR company should not be required to hold for 5 years <u>copies</u> of documents used to make the UR determination (documents held by the UR company are not originals). The UR company is required to maintain any original documents it has generated for the specified 5-year period.	Theodore Blatt, MD Medical Director Blue Cross of California Workers' Compensation Services December 11, 2006 Written Comment	We agree to revise the section to require the records to be retained for three years since the investigations will occur once every three years. The URO is required to maintain copies if the documents relied upon because the claims administrators will not be investigated simultaneously. Also, it is likely that most of the records the URO has are copies, not originals.	The subdivision will be revised to require the URO to maintain the records for three years instead of five.
Section 9792.12(a)(1)(E)	<u>Please clarify</u> and <u>specifically state</u> what is meant by "prior authorization process in the utilization review plan or process". This wording is ambiguous and cannot be interpreted and is fraught with a substantial penalty.	Theodore Blatt, MD Medical Director Blue Cross of California Workers' Compensation Services December 11, 2006 Written Comment	We agree to delete this subdivision.	This subdivision is deleted.
Section 9792.12(a)(5)	It is least efficient to delay making the determination pending receipt of the <u>written</u>	Theodore Blatt, MD Medical Director	We agree to revise the section to allow the amended written request to	The section will be revised to state:

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	<p><u>amended</u> request if a Provider is withdrawing a portion of the request. It is not realistic to believe that the requesting Provider will immediately transmit an altered written request. This delay of getting this altered written request will likely result in a greater number of Physician Reviews and denials by the UR organization. If the determination is made on the <u>verbal amended</u> request, and the Provider does not feel that this is an accurate representation, the request can be resubmitted by the Provider when he/she receives the verbal and written notification per 9792(b)(4).</p>	<p>Blue Cross of California Workers' Compensation Services December 11, 2006 Written Comment</p>	<p>be sent in after the approval has been given. However, in order to comply with the statute, it is necessary to have the amended request in writing.</p>	<p>Subdivision (a)(5) (now 8) will be revised to state: For failure of a non physician reviewer ... who approves an amended request to possess an amended written request for treatment authorization ...when a physician has voluntarily withdrawn a request in order to submit an amended request: \$25,000.</p>
<p>Section 9792.11(m)</p>	<p>Commenter believes that a "best practice" quality standard is to foster direct communication between a Provider and Reviewer if a requested service cannot be certified per guidelines. The intent of the UR process is clearly to make determinations on evidence based literature, by Reviewers who are acting in the scope of their practice and to allow for variances of the case to be taken into account by the reviewing Physicians in rendering the ultimate decision. This is mandated in Workers' Compensation Utilization Management by URAC, clearly an independent quality standard organization. URAC now mandates dialogue with the Provider at some point during the initial review or the appeal process. The California Workers' Compensation UR process does not necessarily provide for a Physician appeal process, so it is essential that every effort be made to foster this <u>best practice</u> on the <u>initial review</u>. In cases where the request is submitted with all accompanying medical</p>	<p>Theodore Blatt, MD Medical Director Blue Cross of California Workers' Compensation Services December 11, 2006 Written Comment</p>	<p>Disagree. The timeframes are set forth in Labor Code section 4610(g) and the UR regulations section 9792.9. These regulations simply enforce the requirements.</p>	<p>None.</p>

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	<p>information, and does not pass guideline, by mandating the "5 business day" response it is going to be difficult if at all possible to foster communication between the requesting Provider and the Reviewer.</p> <p>Commenter believes that this timeframe will allow at most one attempted contact before the determination is made. If the Provider is not readily available, the determination will be made and likely the request non-certified.</p> <p>Commenter believes that a penalty should not be imposed if the request is addressed within the 14-day period from date of receipt by the Claims Administrator if the case has gone to Physician Review. Commenter believes that in this difficult group of cases in which the service request will likely be denied that best practice would be for the case to have the extension to 14 calendar days as would any case without appropriate medical information to allow adequate assessment by the Physician Reviewer. To mandate that any case which goes to a Physician Reviewer must meet a five business day timeframe will be severely compromising to the intent of these regulations which are to <u>improve the quality of the medical care delivery system to Injured Workers.</u></p>			
Section 9792.11(o)	<p>Commenter opines that the language stating that the Administrative Director <b>may provide</b> a copy of the complaint – <b>or may refuse</b> – offers no accountability of the complainant – similar to facing your accuser in the justice system.</p>	<p>Jay Gerrard Vice President GSG Associates, Inc. December 12, 2006 Written Comment</p> <p>Miriam Lago</p>	<p>We agree to revise this section to clarify that the complaint shall be provided unless providing the information would make the investigation less useful.</p> <p>The complaint form is not part of the</p>	<p>This section will be revised to clarify that the complaint shall be provided unless providing the information would make the investigation less useful.</p>

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	Additionally, the recently published complaint form is vague and is not consistent with the regulations, for example on the issue of “inappropriately” delayed decisions for lack of information, the regulations say a non-physician may delay and request additional information. This type of inconsistency between the complaint and the regulations, combined with the general public’s lack of knowledge of the intricacies of UR can lead to inappropriate complaints and the AD may decide not to reveal the nature of the complaint to the audited company.	Warner Brothers December 12, 2006 Written Comment	regulations as it is not mandatory and therefore the comment goes beyond the scope of the regulations.	
Section 9792.12(a)(3)	Commenter states that there needs to be a better definition of the scope of practice. For example: is it MD to MD, Chiropractor to Chiropractor, etc. If Evidence Based Medicine is the goal of UR, a physician who is NOT debating diagnosis nor modality of injury, but only looking at the appropriateness of treatment for the diagnosis does not necessarily need to be Ortho to Ortho, for example, but could also be an Occupational Medicine to Ortho, General, etc.	Jay Gerrard Vice President GSG Associates, Inc. December 12, 2006 Written Comment  Miriam Lago Warner Brothers December 12, 2006 Written Comment	We agree to define “scope of practice” within the subdivision.	The subdivision is revised to include the words, “within the reviewer scope of practice (as set forth by the reviewer’s licensing board).”
Section 9792.12(a)(4)	Commenter states that this section is not consistent with the regulations. Per the current regulations, a non-physician reviewer may delay for lack of information.	Jay Gerrard Vice President GSG Associates, Inc. December 12, 2006 Written Comment  Miriam Lago Warner Brothers December 12, 2006 Written Comment	We agree to revise this subdivision.	The subdivision will be revised to reference section 9792.9 (b)(2) and (3), which allows a delay for lack of information.
Section 9792.12(a)(5)	Commenter points out that the Division is now referring to negotiation of a new treatment plan as MODIFICATION.	Jay Gerrard Vice President GSG Associates, Inc.	We agree to revise and remove the word “modifies.”	Subdivision (a)(5) (now 8) will be revised to state: For failure of a non

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	<p>Commenter states that when there is a new script from the requesting party, it is negotiated, not modified, but this section now doesn't seem to make a distinction. Commenter opines that his is inconsistent with the regulations.</p>	<p>December 12, 2006 Written Comment</p> <p>Miriam Lago Warner Brothers December 12, 2006 Written Comment</p>		<p>physician reviewer ... who approves an amended request to possess an amended written request for treatment authorization ...when a physician has voluntarily withdrawn a request in order to submit an amended request: \$25,000.</p>
<p>Section 9792.12(a)(10)</p>	<p>Failure to respond to request = \$10,000 penalty. If treatment cannot be reviewed or refused if a company is non-responsive within 5 days, and then (per the regulations) the provider can provide the requested treatment, shouldn't the penalty be if the company refuses to pay for treatment that they did not respond to?</p>	<p>Jay Gerrard Vice President GSG Associates, Inc. December 12, 2006 Written Comment</p> <p>Miriam Lago Warner Brothers December 12, 2006 Written Comment</p>	<p>Disagree. These regulations enforce the UR regulations which require a response to a request for authorization. The physician needs to know if s/he may proceed with the treatment.</p>	<p>The subdivision is revised to reduce the penalty to \$2000 based on other comments.</p>
<p>Section 9792.12(a)(4)</p>	<p>The regulations propose to impose a fine of \$25,000 for any decision to delay or deny treatment authorization by a non-physician reviewer without obtaining the opinion of a reviewer for that case. Commenter request that this provision be stricken from the regulations because it conflicts with other regulatory provisions and would impose undue costs on utilization review organizations.</p> <p>Prior to these regulations being proposed, a "non-physician reviewer" has never been defined under the regulations. To define this term now would conflict with the intent of other provisions of the regulations and would</p>	<p>Kelly M. Weigand, Esq. Managing Attorney First Health December 12, 2006 Written Comment</p>	<p>We agree to revise this subdivision.</p> <p>The word "non-physician reviewer" is deleted from this section and reference to 9792.9(b)(2) and (3) is added.</p>	<p>This subdivision is revised to state: "For failure to comply with the requirement that only a licensed physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve, except as provided for in section 9792.9(b)(2) and (3): \$25,000.</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>have a significant adverse impact on utilization review organizations workflows. To clarify, Section 9792(b)(3) allows a “non-physician reviewer” to request additional information necessary to render a decision. The term “non-physician reviewer” was not defined which allowed utilization review organizations to utilize individuals other than physicians to request additional information related to the treatment request in order to render a decision. In addition, there is nothing in the regulations than prohibits a non-physician reviewer from rendering a denial or a delay when the additional information has not been received. In fact, Section 9792(b)(3) specifically allows such review to be conducted.</p> <p>Additionally, if allowed to pass, this change would have a significant adverse impact on utilization review organizations current workflows. Many utilization review request sare received with little or no information. Commenter’s organization utilizes the services of nurses rather than doctors to secure this information. If, after several attempts, the requested information is not received, a “delay” or “denial” letter is sent to the provider by the nurse. These types of “delay” and “denial” recommendations are not reviewed by a “reviewer” as defined in the regulations since there’s little or no information in which to complete the review. To require a reviewer to make this initial assessment would result in a significant cost increase to utilization review entities.</p>			
General Comment	Commenter’s primary concern with the	Tina Coakley	This comment does not address any	None.

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	current iteration lies with the fact that the proposed process could be used to slow down treatment to the point that our workers could face unfair delays or denials. Commenter strongly recommends that the Division engage the primary stakeholders in this process in a meeting sponsored by the Division to work out a procedure that will expedite the process for the benefit of all concerned; particularly injured employees.	Legislative & Regulatory Analyst The Boeing Company December 12, 2006 Written Comment	specific sections of the regulations. This rulemaking process allows the stakeholders to make suggestions and recommendations.	
Section 9792.11(c)(1) and (2)	The regulations need to further clarify the difference between non-routine audit and non-routine investigation.	Darrell Brown, WCCP, ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	Agree. These sections will be revised and clarified.	Section 9792.11(C) is revised to clarify the routine investigations and target investigations.
Section 9792.11(g)(1)	The requirement for claims administrators or utilization review organization to notify affected employers of the results of an audit and action plan goes beyond the interests of the state. In fact, this requirement could jeopardize the utilization review organization/claims administrator and employer relationship. Ultimately, the results of any utilization review audits will be made available to the public. Regulating how and when the information is communicated to the employer is not a reasonable requirement of the Division.	Darrell Brown, WCCP, ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We disagree. If the employer is aware of the violations caused by the claims administrators or URO it can make market choices to improve the services for its employees.	None.
Section 9792.11(j)	The provision that allows the Administrative Director authority not to give notice to the claims administrator prior to an audit presumes that the administrator is involved in some sort of unethical behavior. It does not set clear parameters for when this audit would be appropriate thus allowing different	Darrell Brown, WCCP, ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We agree to revise this section to clarify that the investigation subject will always receive advanced notice in routine investigations. In special targets or return targets the only time advanced notice will not be provided is when advanced notice will render	The subdivision will be revised to clarify that the investigation subject will always receive advanced notice in routine investigations. In special targets or return targets

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	interpretations. Advance notice of an audit is essential to minimize disruption of the workplace and allows for maximum preparation, coordination and organization. Failure to provide notice will create chaos for the claims administrator and frustration on the part of the auditor. Utilization Review organization must continue to conduct business in the event of audits to ensure timely and quality reviews.		the investigation less useful.	the only time advanced notice will not be provided is when advanced notice will render the investigation less useful.
Section 9792.11(j)(1)	The requirement to track all withdrawals with their source is not reasonable. This requirement should be consistent with URAC and other state requirements. It is unclear how this information would be utilized.	Darrell Brown, WCCP, ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We agree to delete the requirement to track withdrawals.	The requirement to track withdrawals will be deleted.
Section 9792.11(k)	The requirement for the claims administrator to provide the DWC 32 files for possible audit or investigation appears to be arbitrary.	Darrell Brown, WCCP, ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We agree.	Section 9792.11(d) will be added to provide a chart for the number of randomly selected requests for admissions.
Section 9792.11(j)(1)	Relative to the data elements that the utilization review organizations or claims administrators must keep for tracking purposes, the DWC should clearly define the acceptable format.	Darrell Brown, WCCP, ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We agree to revise this section, however, the claims administrators and UROs may maintain their systems in any way, as long as it can be described to allow the AD to draw a sample of requests for authorizations.	This subdivision will be revised to request less information and to request a description of the system used to identify each request for authorization.
Section 9792.11(j)(8)	Clarification is needed as to whether the additional data elements in section 9792.11 (j)(8) are indeed optional.	Darrell Brown, WCCP, ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006	We disagree. The data elements in (8) (now (6)) may be requested. If the AD has the information, it will not be requested. Some of the information may be available depending on the investigation	None.

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		Written Comment	subject, therefore, the word “if available” are included.	
Section 9792.11(j)(8)	The requirement to capture the date the utilization review request was sent by the claims adjuster to the utilization review organization is not information that should be of interest to the DWC as this is what happens behind the scenes. The DWC should be concerned about the timeframes in the regulations and statutes. There is no requirement in either the regulations or the statute that requires the claims adjuster to send a utilization review request to the utilization review organization within a certain period. The DWC is not empowered to define internal relationships and standards for claims administrators or utilization review organizations.	Darrell Brown, WCCP, ARM Workers’ Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We agree to delete this data element.	This data element will be deleted.
Section 9792.11(o)	The provision that permits the Administrative Director to optionally provide a description of the complaint should be made mandatory. In the spirit of full transparency the utilization review or claims administrator has the right to know what the complaint is and be allowed to address it. Failure to provide this information could result in many misunderstandings and also the denial of due process of the claims administrator or utilization review organization.	Darrell Brown, WCCP, ARM Workers’ Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We agree to revise this section to clarify that the complaint shall be provided unless providing the information would make the investigation less useful.	This subdivision will be revised to clarify that the complaint shall be provided unless providing the information would make the investigation less useful.
Section 9792.11(p)	The requirement to maintain files and records for a period of 5 years is unreasonable and inconsistent with requirements of other states. The time period should be 3 years.	Darrell Brown, WCCP, ARM Workers’ Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We agree to change the UROs requirement to maintain records to three years.	The subdivision will be revised to change the UROs requirement to maintain records to three years.
Section 9792.12(a)(2)	The \$50,000 assessment for failure to properly	Darrell Brown, WCCP,	We disagree. It costs approximately	None.

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	employ a medical director is excessive.	ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	\$100,000 – \$200,000 to hire a medical director. Unless the penalty is high, a claims administrator or URO may decide it is cheaper to risk getting caught.	
Section 9792.12(a)(3)	The requirement that decisions to modify or deny treatment requests be made within the scope of the reviewer's practice is vague. The DWC needs to clearly define scope of practice. This area is extremely subjective and open to a myriad of interpretations. Further, the penalty of \$25,000 for violation of this section is excessive.	Darrell Brown, WCCP, ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We agree to clarify "scope of practice." We disagree that the penalty is excessive, otherwise there may be chiropractors denying treatment recommendations by orthopedic surgeons.	"Scope of practice" will be modified with the words "(as set forth by the reviewer's board)"
Section 9792.12(a)(4)	The \$25,000 assessment for a non-reviewer making decision to delay or deny is excessive.	Darrell Brown, WCCP, ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We disagree. Labor Code section 4610(e) specifically requires that only a licensed physician may modify, delay or deny requests for authorization. This is one of the fundamental principles behind utilization review to ensure that injured workers' treatment is not being improperly denied.	None.
Section 9792.12(a)(5)	The \$25,000 assessment for a non-physician reviewer modifying a request for treatment without possessing at the time of approving the modification an amended written request for treatment authorization is excessive.	Darrell Brown, WCCP, ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We agree to clarify the section, but we disagree that the penalty is too high. Unless there is a written amended request, it is impossible to know if the requesting physician agreed to amend the request or if the non physician denied the request. As stated above, only a physician may modify, delay or deny a request for authorization.	The section will be clarified to state: For failure of a non-physician review ... , who approves an amended request for authorization to possess an amended request for treatment authorization ... when a physician has voluntarily withdrawn a request in order to submit an amended request: \$25,000.
Section 9792.12(a)(6)	The \$25,000 assessment for failing to	Darrell Brown, WCCP,	We agree to delete this section.	This section will be

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	authorize treatment pursuant to Labor Code section 5402 (c) is excessive. There could be many reasons why the treatment is not being authorized or reimbursed.	ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment		deleted.
Section 9792.12(a)(7)	The \$15,000 assessment for failing to make and communicate an expedited decision is excessive. Further, the DWC needs to ensure that only requests that are truly expedited fall within the requirements. Many providers submit requests for expedited reviews and label them as such; however, the treatment request should and does not fall under an expedited review provisions. The DWC should further clarify what an expedited review is and the responsibilities of the providers to use care in labeling their requests accordingly.	Darrell Brown, WCCP, ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We disagree that the penalty is too high. Expedited review is defined by section 9792.6(g) as UR when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function. The revised subdivision requires the request to comply with this definition. Clearly, failure to respond to an expedited review has grave consequences for the injured worker and a high penalty is warranted.	The subdivision will be revised to state: "For failure to communicate the decision in response to a request for expedited review, as defined in section 9792.6(g) in a timely fashion, as required by section 9792.9: \$15,000.
Section 9792.12(a)(9)	The \$10,000 assessment for denying authorization or discontinuing medical care in the case of concurrent reviews prior to a discussion with the requesting physician about reasonable options and making good faith efforts to agree on a care plan is excessive. Further, the DWC should define good faith efforts.	Darrell Brown, WCCP, ARM Workers' Compensation Practice – Vice President Sedgwick CMS December 12, 2006 Written Comment	We disagree that the penalty is too high. "Concurrent review" means utilization review conducted during an inpatient stay. When an injured worker is hospitalized, a denial of a request for authorization without even discussing reasonable options with the treating physician could result in grave and costly consequences to the injured worker.	The subdivision is revised to state: For failure to discuss with the requesting physician reasonable options for a care plan as required by Labor Code section 4610(g)(3)(B) prior to denying authorization of or discontinuing medical

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
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			We agree to revise the subdivision for clarity. We will remove the term "good faith."	care, in the case of concurrent review: \$10,000.
General Comment	<p><b>Recommendation</b> Commenter recommends that the proposed enforcement regulations be withdrawn and held in abeyance until all of the relevant regulations implementing the statutory utilization review system have been finalized, the regulations comply with the judicial interpretation of the statute from <u>Sandhagen</u>, and the regulated community has had a fair opportunity to comment on the significant revisions to the utilization review (UR) enforcement plan.</p> <p><b>Discussion</b> <b>The Statutory Scheme for Utilization Review Is Incomplete</b> The medical treatment utilization schedule has not been established and Labor Code section 5307.27 is an integral part of the utilization review process created by SB 899. Once the medical treatment guidelines are in place, providers, UR reviewers, and claims administrators will know what is appropriate under the law and the entire integrated system can begin to function as the law intended. Until then, there is uncertainty and confusion. Implementing an enforcement process before all of the necessary parts of the system are in place and stable will only cause greater confusion and add to the cost of implementation.</p> <p>The effect of the changes made by SB 899 was to establish a reasonable standard of</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	<p>Disagree. We agree to revise 9792.11 (f) to state that the penalties shall only be imposed if the request was subject to the Labor Code section 4610 utilization review process.</p> <p>Disagree. The current medical treatment guideline is ACOEM. As soon as the AD adopts a new medical treatment guidelines, the new standards must be applied. (The regulations are underway and will be submitted to OAL within the next month.)</p>	<p>We agree to revise 9792.11 (f) to state that the penalties shall only be imposed if the request was subject to the Labor Code section 4610 utilization review process.</p> <p>None.</p>

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	<p>medical care within the workers' compensation system. A significant part of that process is the medical treatment utilization schedule. The administrative director (AD) proposed regulations to adopt a treatment schedule in July 2006 but they have not been finalized and implemented as yet. In the AD's Statement of Reasons for the proposed medical treatment utilization schedule regulations, it is clear that the treatment schedule was intended to provide injured employees with the best possible medical treatment and limit ineffective care, to define more clearly the employer's obligation for medical care, and to control the cost and scope of utilization review with unambiguous guidelines.</p> <p>Until that piece of the utilization review program is finalized, medical treatment utilization must be reviewed in accordance with the statute. Imposing an enforcement mechanism on an incomplete system will not bring consistency or clarity. Therefore, the UR enforcement plan should be withheld until all components of the medical treatment review system are finalized.</p> <p><b><u>Sandhagen v. WCAB (Third Appellate District, 048668 and 049286, See: attached opinion of the court)</u></b> Labor Code section 4610 became effective on January 1, 2004 as part of SB 228. The first judicial interpretation of a significant and relevant portion of that statute was not available until November 14, 2006. The <u>Sandhagen</u> decision requires that the AD</p>		<p>Disagree the <i>Sandhagen</i> decision renders the regulations meaningless. Agree to clarify the regulations by adding the sentence that the penalties shall only be imposed if the request was subject to the Labor Code section 4610 utilization review process. Pursuant to Labor Code section 4610, whenever utilization review is done, it must meet the</p>	<p>Agree to clarify subdivision 9792.11(f) by adding the sentence that the penalties shall only be imposed if the request was subject to the Labor Code section 4610 utilization review process.</p>

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	<p>revise the Utilization Review Standards regulations (CCR sections 9792.6 – 9792.10) because the interpretation of Labor Code section 4610 by the AD is in conflict with the judicial interpretation issued by the Court of Appeal.</p> <p>The Court of Appeal in <u>Sandhagen</u> determined the consequences to the defendant of not obtaining a UR report within the time limits stated in section 4610 and the procedural rights of the parties to dispute the recommended treatment. The court also addressed a threshold issue of whether section 4610 requires employers to follow the UR procedures for every medical treatment request. The court held:</p> <p>“Section 4610, subdivision (b) requires the establishment of a UR process; it does not mandate use of that process for each and every medical treatment request.</p> <p>Section 4610, subdivision (g), quoted above, provides the requirements the employer’s UR process must meet if the employer decides to utilize the UR process. Section 4610, subdivision (g) does not state that all medical treatment requests must be subject to these requirements.”</p> <p>The court considered various reasons why the employer might choose the AME/QME process under section 4062 over utilization review, and agreed either process is viable and that the employer need not resort to utilization review in every case. The AD’s utilization</p>		<p>requirements and timeframes of the statute and regulations. Even if the appellate court’s decision is upheld, employers who use utilization review must follow the timeframes and requirements and must establish a UR plan. <i>Sandhagen</i> is currently under review by the California Supreme Court.</p>	

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	<p>review standards regulations state, in essence, that the employer may only deny recommended medical care by resorting to the utilization review process established in section 4610 and the regulations. <u>Sandhagen</u> very clearly states that the employer has a choice, in every case, whether to use the UR process or an AME/QME evaluation under section 4062.</p> <p>This interpretation of the statute undermines the foundation on which the UR standards regulations are based, and since the UR enforcement regulations are intended to implement the UR standards, the <u>Sandhagen</u> opinion will require the reconsideration of the enforcement regulations, as well.</p>			
General Comment	<p><b>The Proposed Regulations Have Been Changed Substantially</b></p> <p>The proposed enforcement regulations have been substantially changed and no longer relate to the original text of the regulations that have previously been the subject of a 45-day public comment period and public hearing. The regulated community has not had sufficient notice of these changes and to allow fair comment, the AD must provide, at least, another 45-day comment period and another public hearing.</p> <p>Since the close of the 45-day hearing on June 29, 2006, the Division has substantially changed the structure and scope of the enforcement plan, creating new penalties, remedial processes, review periods, abatement procedures, and other utilization review system requirements not previously included</p>	<p>Michael McClain General Counsel &amp; Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment</p>	<p>We disagree. The changes made to these sections are sufficiently related the 45 day version of the UR penalty regulations. The proposed changes concern the investigation procedures, the penalty schedule, the penalty adjustment factors, liability for penalty assessments, and the Order to Show Cause, Determination and Order and Review Procedure.</p>	<p>None.</p>

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	in the utilization review regulations or the enforcement regulations. None of these elements has been noticed for hearing previously.			
Section 9792.12(b)(1)	<p>The amendments to this section provide, for the first time, a process by which the Division may waive certain penalties based on the claims administrator’s efforts to remedy the conduct underlying the violations found in the investigation. This represents a structural change to the enforcement process, adding a new and different remedial device. The process, while voluntary on the part of the claims administrator, adds subsection (D), which essentially requires the claims administrator to reimburse the Division for the travel, per diem, and compensation of auditors who will re-review the claims organization to determine whether they are in compliance.</p> <p>These sections introduce the concept of abatement, which has never been a part of the enforcement plan and which the regulated community has never had an opportunity to comment on. While the Institute is not necessarily questioning the use of these new procedures, the merits of the new remedial devices have never been publicly debated. These new proposals are a substantial change from the regulations subject to the administrative hearing in June.</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	We disagree that the addition of an abatement method goes beyond the subject of these regulations. The proposed regulatory changes are “sufficiently related” to the original text because they relate directly to the same subject as the originally noticed regulations.	None.
Section 9792.12(b)(2) (A) through (C)	These subsections require that the subject of the investigation reimburse the Division for “its reasonable costs of investigation,” which include the travel, per diem, and compensation	Michael McClain General Counsel & Vice President – California Workers’ Compensation	We agree to delete subdivisions 9792.12(b)(2)(D) and (b)(6). We disagree that revisions to the subdivisions go beyond the subject of	We agree to delete subdivisions 9792.12(b)(2)(D) and (b)(6).

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	of its investigators (section 9792.12 (b)(6)).	Institute (CWCI) December 12, 2006 Written Comment	these regulations. The proposed regulatory changes are “sufficiently related” to the original text because they relate directly to the same subject as the originally noticed regulations.	
Section 9792.11(j)(1), (6), (7); 9792.11(p); 9792.12(a)(5) and (12)	It is clear from the Division’s Notice of Modification to Text of Proposed Regulations (sections 9792.11 – 9792.15) that these regulations are creating the audit and enforcement plan for the utilization review regulations that are already in place (CCR sections 9792.6 – 9792.10). Yet, several of the proposed enforcement regulations have created additional utilization review standards and have nothing to do with the enforcement plan, including sections 9792.11(j)(1), (6), (7), and (8); 9792.11(p); 9792.12(a)(5); 9792.12(a)(12).	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	<p>Agree to revise (j). The (j) subdivision is requesting information regarding the system to track UR requests and responses. The claims administrator or URO should have this information in some format in order to operate its business, but will only be required to provide the information to the extent that the system identifies the information. By providing the information to the AD, the AD will be able to select the random UR files for investigation.</p> <p>Agree to revise (p). Subdivision (p) will be revised to require the URO records to be maintained for three years and the claims administrator’s records for the amount of time set forth in 8 CCR 10102 to ensure that they will be available for investigation.</p> <p>Agree to revise 9792.12(a)(5). Labor Code section 4610(e) provides that no person other than a licensed physician who is competent to evaluate the specific clinical issues</p>	<p>Section 9792.11(j) will be revised to eliminate some of the data elements and information that will be requested. Additionally, it will only require the investigation subject to produce the information if it has a system to identify requests for authorization and if the data is maintained in its system.</p> <p>Subdivision (p) will be revised to require the URO records to be maintained for three years and the claims administrator’s records for the amount of time set forth in 8 CCR 10102 to ensure that they will be available for investigation.</p> <p>9792.12(a)(5) will be revised to state: For failure of a non-physician reviewer ...who approves an amended request to</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			<p>involved in the medical treatment services, and where these services are within the scope of the physician’s practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve. 8 CCR 9792.6(o) defines a “request for authorization” as a written confirmation of an oral request. In order to comply with these requirements, it is necessary for the non-physician review to obtain a written amended request. Without it, it will appear that the non-physician reviewer has modified the original request for authorization, which would be a UR violation. Nonetheless, the section will be written to allow the written amended request to be sent after the verbal agreement was given.</p> <p>Agree to delete 9792.12(a)(12).</p>	<p>possess an amended written request for treatment authorization as provided under section 9792.7(b)(3) when a physician has voluntarily withdrawn a request in order to submit an amended request: \$25,000.</p> <p>Section 9792.12(a)(12) will be deleted.</p>
Section 9792.11(c)(1)	While the Division refers to the review process as an “investigation,” the schedule contained in this section reveals that it is intended to be a regular audit of the utilization review process – “no less frequently than” once every 3 years or 5 years. The AD’s authority to conduct regular audits is contained exclusively in Labor Code section 129. Previously, investigations were at the discretion of the AD or based on specific complaints. Paragraph (c)(1) changes the	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	We disagree that the UR investigation is a Labor Code section 129 audit. Labor Code section 133 provides authority for the AD to do all things necessary in the exercise of any power conferred upon it in the code. Labor Code section 4610(i) provides authority for the AD to impose penalties for failure to comply with the UR requirements. Initiating regular investigation is a	None.

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	process from a discretionary investigation based on complaints to a mandatory review done on a regular basis.		fair and equal way of determining if the claims administrators and UROs have violated the time frames and requirements of section 4610.	
Section 9792.12(a)(5), (7), (12)	These sections impose new penalties for conduct that has not previously been included in the public hearing and for which the regulated community has had no opportunity to comment.	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	We disagree that revisions to the subdivisions go beyond the subject of these regulations. The proposed regulatory changes are “sufficiently related” to the original text because they relate directly to the same subject as the originally noticed regulations, in this case, UR penalties.  We agree to delete (a)(12).	Subdivision (a)(12) will be deleted.
General Comment	<p><b>The Regulations Impair the Operation of the Statute Recommendation</b></p> <p>The level of proposed penalties for utilization review enforcement is excessive and will impermissibly constrain the operation of the statute, Labor Code section 4610.</p> <p>The proposed penalty scheme narrows the scope of medical utilization review and is, therefore, in conflict with the statute. The revisions since the public hearing in June have increased nearly every proposed penalty – in several areas the increase is five-fold. The new proposed penalties have, therefore, significantly exacerbated the problem. The problem, simply stated, is that the threat of excessive penalties will curtail legitimate utilization review activity that the statute permits.</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	<p>Disagree re: the (a) penalties. The penalties set forth in section 9792.12(a) are for serious violations of the UR requirements, such as failure to have a UR plan, failure to have a medical director, failure to respond to a request for admission.</p> <p>Agree re: the penalties set forth in subdivision (b). These penalties are for lesser violations – violations concerning timeliness and notice requirements. We agree to revise to allow an 85% passing rate and to reduce the increase factor for return investigation.</p>	Section 9792.12(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation,

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	<p>It is the responsibility of the AD to interpret Labor Code Section 4610 to make it specific, and to enforce its dictates. And, at the same time, the AD must permit section 4610 to function at all levels in order to attain its legislative goals. Administrative regulations that alter or amend statute or enlarge or impair its scope are void, and courts not only may, but it is their obligation, to strike down such regulations. <u>Morris v. Williams</u> (1967) 63 CR 689, 67 C2d 733, 433 P.2d 697.</p> <p><b>Discussion</b>  With every penalty regulation adopted, the administrative director is determining not only how to review medical treatment, but also <u>whether</u> medical utilization review will be used at all. It is the AD's stated intent 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." For every penalty established in section 9712, whether it is a stated range or can be altered by mitigating factors, the AD is limiting the tools for medical utilization review that have been provided by statute.</p> <p>The Legislature expected significant system cost reductions from tools like medical utilization review and asked that the impact of these reforms be closely monitored. The Legislative Workers' Compensation Conference Committee Summary of total estimated system savings that was prepared for SB 228 in 2003 noted that the use of</p>			<p>the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p>

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	<p>medical treatment protocols (without reference to the proposed treatment caps) would reduce system costs, on an ongoing basis, \$1 billion to \$1.7 billion each year.</p> <p>The proposed penalty regulations seem to be aimed at bad actors, incompetent medical reviewers, and negligently processed treatment requests. But the byproduct of that deterrence will be that in order to avoid the risk of excessive penalties, the claims administrator must avoid some utilization review. Operating under both sets of utilization review regulations – the UR standards regulations and the enforcement regulations – can only be done cleanly, i.e., correctly without penalties, if the claims administrator limits medical treatment review to high-cost procedures, such as complex surgeries.</p> <p>The newly proposed penalty schedule requires claims administrators to reconsider the level at which utilization review should be conducted. This will essentially eliminate the cost-effective review of physical medicine, including physical therapy and chiropractic care. Medical utilization review tools created by the Legislature will become prohibitive, resulting in an added administrative cost to the system, a lessened ability to control unnecessary and unreasonable medical treatment, and a higher system cost. By making effective utilization review impractical for certain levels of medical care, the AD is allowing poor quality treatment to go unchallenged. The result for injured</p>			

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	<p>workers is that medical care that does no harm, but does no good, will be allowed to reenter the workers' compensation system.</p> <p>The proposed penalty regulations narrow the scope of permissible UR activity under the statute, and are, therefore, invalid. This applies to the individual penalties as well as the cumulative effect of the enforcement plan. The potential penalty for conducting permissible activity under the statute must be clearly stated at reasonable and fair levels, or the regulation is too intrusive into the authority of the statute.</p>			
Section 9792.12	<p><b>Recommendation</b> Calculate multiple incidence penalties based on a ratio between the violations found and the number of requests subjected to physician review, and cap these penalties at \$50,000.</p> <p><b>Discussion</b> The proposed penalties for multiple incidences are based exclusively on the numbers of violations, without regard to the size of the claims organization being reviewed. This factor should be included in the overall penalty determination. Otherwise, the depth of the problem, significant or insignificant, cannot be measured accurately.</p> <p>The penalties proposed in section 9792.12 have been increased five-fold, in some instances, before any review of the UR system has ever occurred. When these proposed fines are compared with other penalties and fines created by the Legislature in the workers' compensation system, the scale of the UR</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	<p>We agree to revise how the penalties in subdivision (b) are calculated.</p> <p>Disagree. . In each of the following cases, the court considers the issue of whether a civil penalty that has been imposed is unconstitutional. In general, penalties are found to be constitutional where various factors are considered including; 1) degree of culpability, 2) prior misconduct, 3) the concern of creating a financial bonanza that would ill serve public policy, and 4) the sophistication and financial strength of the assessed. “Legislature may constitutionally impose reasonable penalties to secure obedience to statutes enacted under the police power so long as those enactments are procedurally fair and reasonably related to a proper legislative goal.” <u>Kinney v. Vaccari</u> (1980) 27 Cal.3d 348, 352.</p>	<p>The number of requests for authorization randomly selected will be based on the table in section 9792.11(d), which will provide a statistically valid sample of random requests.</p> <p>Section 9792(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On</p>

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	<p>penalties is clearly out of proportion and wholly unreasonable.</p> <p>The most significant penalty in the system, which was set by the Legislature in 2004, is Labor Code section 5814.6 -- \$400,000 -- for the knowing violation of section 5814 that indicates a general business practice. The Division's audit authority for claims practices is contained in Labor Code sections 129 and 129.5. The maximum penalty under that scheme, which includes all benefit delivery activity, is the \$100,000 civil fine (section 129.5). Again, these penalties were set by the Legislature.</p> <p>The potential penalties under the proposed UR enforcement regulations can reach hundreds of thousands of dollars for errors that may not have caused any harm to the injured worker or the medical care provider. In determining whether a punitive damage award is "grossly excessive," the courts have, in recent years, scrutinized the award against the actual harm done. The proposed regulations ignore that factor entirely and, in doing so, raise the question of whether the regulatory scheme, on its face, is an abridgment of the Constitution. The AD has determined that the penalty for the failure to establish a utilization review program is \$50,000. Multiple UR penalties should not exceed the penalty for failing to establish a utilization review process.</p>		<p>In <u>Hale v. Morgan</u> (1978) 22 Cal.3d 388, the Supreme Court analyzed former Civil Code §789.3, which authorized a penalty of \$100 per day against a landlord who wilfully deprived a tenant of utility services for the purpose of evicting the tenant. The defendant in <u>Hale</u> was a cable television installer, who owned a small mobile home park and rented spaces to four or five mobile homes. Plaintiff moved a mobile home into the park without defendant's consent and then, after negotiating a small monthly rental, failed to pay rent for several months. When the defendant retaliated by cutting off his water and electrical lines, plaintiff filed an action for statutory penalties under section 789.3. The trial court found that defendant had wilfully cut off utility services for 173 days and imposed penalties in the amount of \$17,300. The monthly rental, however, was only \$65, or \$780 per year. The Supreme Court concluded that under the circumstances in this case, the penalties were excessive and therefore, violated the due process provisions of the Constitution. The amount of the penalty was not discretionary and did not take into account any ameliorating factors (such as degree of culpability, prior misconduct, ability to pay, effect on business and</p>	<p>the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p> <p>Subdivision (a)(1) will be revised to state: "(1) For failure to establish a Labor Code section 4610 utilization review plan: \$50,000;"</p>

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			<p>such other matters as justice may require.) The statute also “permits the occasional experienced and designing tenant to ambush an unknowing landlord converting the single wrongful act of the latter into a veritable financial bonanza.” <u>Id.</u> <b>Additionally, the fixed penalties were imposed upon potential defendants who may vary greatly in sophistication and financial strength.</b> On the factor of financial circumstances, the <u>Hale</u> court faulted the discretionless penalty for former section 789.3 in part because: “A large corporate landlord which callously and by design pursues a policy of ‘shock’ eviction suffers no greater penalty than the elderly widow of modest means who, dependent on the income of a single unit, ignorant of the penalty procedures of the law, exhausted by the machinations of a wily and recalcitrant tenant, and no longer willing or able to bear the expense of utilities for an occupant who refuses to pay rent, finally terminates the tenant’s utility services in order to speed his departure.” <u>Hale</u>, supra, 22 Cal.3d at pp. 399-400.</p> <p>In contrast, the court in <u>Kinney v. Vaccari</u> (1980) 27 Cal.3d 348, found penalties of \$36,000 applied under the same statute as discussed in <u>Hale</u> to be, “both proportioned to the</p>	

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			<p>landlord’s misconduct and necessary to achieve the penalty’s deterrent purposes,” and therefore not constitutionally excessive. The differences in this case from <u>Hale</u> were: (1) the landlord in <u>Kinney</u> had little or no provocation for his conduct; (2) the tenants made an effort to mitigate damages by tendering their rent payments; and (3) the landlord’s conduct in this case was egregious. He turned off the utilities in an extremely harsh winter, depriving the tenants of hot water, heat and cooking facilities. Seven of the plaintiffs were minors and one gave birth during the time period. Finally, (4) the amount of the penalty could not be called confiscatory. It did not exceed the value of the premises.</p> <p>In <u>City and County of San Francisco v. Sainez</u> (2000) 77 Cal. App. 4th 1302, the owners of multi-unit rental property argued that the civil penalties assessed against them for violations of the housing and building codes violated their due process and excessive-fines protections of the state and federal Constitution. The owners due process challenge was based on <u>Hale v. Morgan, supra</u>, 22 Cal.3d 388. The city relied upon <u>Kinney v. Vaccari, supra</u>. Although the owners argued that the \$1000 a day fine was</p>	

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			<p>more draconian than the fine in <u>Hale</u>, the court points out that the \$1000 a day fine is comparable to the \$600 a day (\$100 times the six units) upheld as reasonable in <u>Kinney</u>, two decades ago, for the same number of units. In the <u>Sainez</u> case, the penalties are paid to the City, as opposed to tenants, and therefore there is no concern of penalties creating a “veritable financial bonanza” that ill-serves public policy. Also served is the legitimate police power device of ‘securing obedience’ to the code requirements through penalties. Further, although the trial judge expressed concern that an accumulated penalty might, be too severe in light of a defendant’s overall culpability and financial circumstances, the total here was not impermissibly disproportionate “to the conduct” or to defendants’ “net worth.” In <u>Sainez</u>, the defendants owned 14 rental properties, had a yearly rental income of \$276,000, and could be characterized as sophisticated in their dealings with the City and property management. As stated in <u>Sainez</u>, “while neither <u>Hale</u> nor <u>Kinney</u> considered or had evidence of total net worth, both decisions suggest that net worth can bear on the due process question.” <u>Id.</u></p> <p>Finally, in <u>Ojavan Investors, Inc. v. California Coastal Commission</u></p>	

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			<p>(1997) 54 Cal.App.4<sup>th</sup> 373, real estate investment corporations argued that a fine of almost \$10 million was excessive. The statute in this case gave the trial court some discretion in determining the amount of the fines. The trial court considered five factors: (1) the nature, circumstance, extent, and gravity of the violation; (2) whether the violation was susceptible to restoration or to other remedial measures; (3) the sensitivity of the resource affected by the violation; (4) the cost to the state of bringing the action; and (5) with respect to the violator, any voluntary restoration or remedial measures undertaken, any prior history of violations, the degree of culpability, <b>economic profits, if any resulting from or expected to result as a consequence of the violation</b>, and such other matters as justice may require. Among the factors the trial court found to be egregious were defendants' culpability and the profits made and expected to be made. Distinguishing this statute from the one analyzed in <u>Hale</u>, the court pointed out that the trial court considered five factors listed above and that the consideration of the ameliorating factors distinguished the statute from the one in <u>Hale</u>. The fines were proportionate to the number of violations and to the defendants' flagrant disregard for the</p>	

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			<p>law.</p> <p>The “grossly excessive” line of cases cited by the commenter generally requires that punitive damages should be less than 10 times the amount of compensatory damages in civil damage cases. These penalties do not involve civil damages.</p> <p>We agree to revise (a)(1) for clarity. We dispute the comment that the penalties under (a)(1) and (a)(2) would total \$300,000. Subdivision (a)(1) and (a)(2) are for failure to have a UR plan and failure to designate a medical director, and each is for \$50,000. These two violations are the bases of the entire UR program and a requirement that has been present since 2003. There is simply no reason why a claims administrator should not have a UR plan with a medical director except for an intentional decision not to follow the law for monetary reasons. Therefore, the penalty must be high enough to deter misconduct.</p>	
Section 9792.11(c)	<p><b>UR Process -- Assessment by the Section 129 Audit Recommendation -- Division Workers' Compensation Audit Authority</b></p> <p>Commenter recommends that all auditing performed by the Division of Workers' Compensation (DWC) remain within the confines of the statutory scheme created in Labor Code Sections 129 and 129.5 (AB 749).</p>	<p>Michael McClain General Counsel &amp; Vice President – California Workers' Compensation Institute (CWCI) December 12, 2006 Written Comment</p>	<p>Disagree. While we agree to revise section 9792.11(c)(A) to provide that the routine investigation of the claims administrator will occur once every five years concurrent with the PAR audit. Also, the random sample table from the audit regulations (8 CCR 10107.1) will be incorporated into these regulations as 9792.11(d).</p>	<p>Section 9792.11(c)(A) will be revised to provide that the routine investigation of the claims administrator will occur once every five years concurrent with the PAR audit. Also, the random sample table from</p>

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	<p><b>Discussion</b>  <b>Separate and Independent Audits</b>  The section 9792.11(c) now proposes regular independent auditing of the UR process with separate standards, rules, processes, and penalties. The model for these new audits is not the tiered approach of increasing scrutiny reflected in the profile audit review (PAR) (Labor Code Section 129), but the pre-1998 model – the program that the Legislature scrapped in 2002 because it was ineffective, unfair, wasteful, and ineptly administered.</p> <p>It is unclear what role the Audit Unit will play, if any, in reviewing the efficiency and appropriateness of the UR process. Section 9792.11(c) states that the AD may conduct an audit under section 129, or an independent investigation under the enforcement regulations. The proposed enforcement regulations establish separate and distinct units within the Division to conduct independent audits. That structure is directly contrary to the statutory scheme adopted by the Legislature in AB 749 and implemented in 2003. The social policy decision regarding the Division’s audit authority has been made and the proposed expansion of the audit function is not required or authorized by SB 899. Failing to follow the audit scheme contained in Labor Code section 129 will produce redundant audits, chaotic administration, and wasted resources, as it has in the past.</p> <p><b>DWC Audit Function</b>  An efficient auditing apparatus is essential to the effective operation of the workers’</p>		<p>However, the audit procedures will not work for UR violations. Labor Code sections 129 and 129.5 do not give the AD authority to audit or assess penalties against UROs. Also, Labor Code section 129.5 prohibits the assessment of any penalties if the audit subject passes the PAR and caps penalties that can be assessed at \$5,000. The audit regulations (8 CCR 10107.1 et seq.) provide that the only violations addressed in the PAR audit are failure to pay indemnity payments, late first payments of TD, PD etc., and failure to issue benefit notices. However, Labor Code section 133 provides the AD power and jurisdiction to do all things necessary or convenient in the exercise of any power or jurisdiction conferred upon it under the Labor Code. Therefore, the AD is authorized to conduct investigations pursuant to Labor Code section 4610 of claims administrators and UROs in order to determine if UR violations exist and to assess penalties for the violations.</p>	<p>the audit regulations (8 CCR 10107.1) will be incorporated into these regulations as 9792.11(d).</p> <p>Also, we will revise 9792.12(b) to allow a 85% pass rate, similar to the audit performance standard.</p>

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	<p>compensation system. Commenter has always promoted a professional, proficient, and productive audit function that focused the Division's resources on poor performance. Commenter supports the creation of a strong audit program because it requires a specific performance standard for all claims administrators in the system.</p> <p>Whether the Division's audit function is centralized in the Audit Unit or independently based on clear statutory authority, the essential features of a performance review must reflect the legislative philosophy of Labor Code Sections 129 and 129.5. The level of scrutiny must be just right: too little, and poor performance goes unchecked; too much and the process becomes bureaucratic, unproductive, and costly.</p> <p><b>Core Features of the Audit Function</b> Key Indicators of Performance: The Division must determine the key elements of quality performance for medical utilization review. The statutory requirements and the utilization review standards regulations are the blueprint. Auditors can determine whether the claims organizations meet these standards and can make a judgment about the effectiveness of the UR program. This can be done most efficiently during the PAR audit.</p> <p>Review All Claims Administrators Periodically: The legislative philosophy established in section 129 requires that the Division audit function cover all programs within a reasonable period of time to ensure a</p>		<p>Disagree. During the PAR, medical records are not even reviewed, as the only factors reviewed are indemnity payments and benefit notices.</p>	

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	<p>consistent enforcement. The best way to accomplish that goal is to include the enforcement of the UR standards at the time of the routine PAR audits under section 129.</p> <p>The Initial Review: The initial review should be done within the context of the routine (PAR) audit and should be sufficient to determine compliance. If that initial review demonstrates a more serious pattern of failures, then the AD can conduct a more thorough review, and follow that with additional targeted audits, as necessary, to correct the deficits.</p> <p>The Standard for Compliance: Under the Division’s current regulatory scheme for conducting audits pursuant to section 129, the compliance rate to determine whether to conduct a more comprehensive Full Compliance Audit is set at 80% (Title 8, CCR, section 10107.1(c)(3)(B) &amp; (C)). As the proposed UR enforcement regulations impose severe, unlimited monetary penalties, the Institute recommends the use of the 80% benchmark to demonstrate compliance with the UR statute and standards regulations.</p> <p>Based on the auditor’s findings after a regular section 129 audit, a special investigation under the UR enforcement regulations could be triggered. If the AD finds that the random sample of UR files examined for that investigation demonstrates that 80% of the utilization review activity conducted in those file is in compliance with the statute and the UR standards regulations, then no penalties</p>		<p>We agree to revised 9792.12(b) to allow for a performance standard of 85%. If the investigations subject meets or exceeds 85%, it will not be required to pay the (b) penalties and will not be subject to a return investigation within 18 months.</p> <p>Disagree. Creating a performance rating of 80% would not be the equivalent to the audit performance rating. The audit performance rating is not a straight 80% standard, it is based on a three year historical record of how audited claims administrators ranked. As explained in the annual audit report for 2006, the performance standard is recalculated yearly: “The PAR and FCA performance standards have been updated pursuant to Labor Code section 129(b) and Title 8, California Code of Regulations, section 10107.1(c), (d), and (e). This is accomplished by taking the 2005 audit results and using data for the five major keys subject to the profile audit review program. The results are then combined with the 2004 and 2003 performance rating scores to</p>	

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	<p>under the enforcement regulations should be imposed.</p> <p>While SB 899 gave the administrative director the authority to apply administrative penalties for the failure to establish a complete and effective utilization review process, for all the reasons stated above, the best way to accomplish that goal is through the routine DWC audits that are already in place under section 129, using the independent investigations to supplement the audits as necessary to correct deficient UR programs.</p> <p>Commenter supports the effective enforcement of these new UR standards but the Institute’s members are concerned that the creation of separate and independent audits is not only abandoning a functioning and consistent audit program, but seems to be a rejection of the social policy decision made by the Legislature in 2002. The community wants to avoid a diluted and ineffective program with duplicative procedures, inadequate coordination, and wasted resources by both the regulated community and the DWC.</p>		<p>develop the 2007 PAR/FCA standards. <b>The PAR standard for 2007 is 1.83201 and the FCA standard is 2.21982.</b> Profile audit review audits (PAR audits) commencing after January 1, 2007 use the new standards.”</p> <p>For the UR investigation, there is no history and therefore, it is not possible to do a similar ranking and pass rate. However, we agree to revise section 9792.12(b) to allow an 85% performance rating to allow claims administrators and UROs some margin of error, but still requiring substantial compliance with the UR timeframes and requirement.</p>	
Section 9792.11(c)(1)	<p><b>Recommendation</b></p> <p>(1) <del>A Routine Investigation shall be initiated at each known utilization review organization, or in the case of employer’s performing utilization review on the employer’s business site, no less frequently than once every three (3) years. A Routine Investigation review of an employer’s utilization review processes also may will be initiated conducted at any claims adjusting location concurrently with a routine, target or full profile audit review done</del></p>	<p>Michael McClain General Counsel &amp; Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment</p>	Disagree. See above.	See above.

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	<p>pursuant to Labor Code section 129 or 129.5. A Routine Investigation of the utilization review processes handled at each claims adjusting location shall be <del>done no less frequently than once every five (5) years</del> <u>conducted based on the findings from the audit done pursuant to Labor Code section 129 or 129.5.</u></p> <p><b>Discussion</b> While the Institute has asserted that the evaluation of the UR process should be done in the context of the regular claims practice audits under section 129, at the very least, these reviews should be coordinated. The Division should evaluate the claims organization's utilization review function in the course of every section 129 routine audit. The findings of the routine section 129 audit can be the basis for any further investigation of the UR process under the enforcement regulations.</p> <p>The Standard for Compliance: Even if the AD decides to use special investigations to pursue or correct deficient UR programs found by the auditors, the compliance rate, 80%, articulated for routine audits under sections 129 and 129.5 (Title 8, CCR, section 10107.1(c)(3)(B) &amp; (C)) should be expressly stated in the UR enforcement regulation. Based on the findings of the Audit Unit, the AD may conduct a further investigation under the UR enforcement regulations, and if a random sample of UR files demonstrates that 80% of the utilization review activity is in compliance with the statute and the UR standards</p>		<p>Agree that the routine investigation will be initiated at each claims adjusting location at least once every five years concurrent with the PAR audit.</p> <p>See above re 80% performance standard.</p>	

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	<p>regulations, then no penalties should be imposed. The 80% compliance benchmark is particularly appropriate because the proposed penalties for UR program failures are unlimited and cumulative – only some of which can be waived.</p>			
<p>Section 9792.11(c)(2) through (5)</p>	<p><b>Recommendation -- 9792.11(c)(2) through (5)</b>  (2) A Non-Routine Investigation may be conducted at any time:</p> <p>(A) in the discretion of the Administrative Director or his or her designee, based on <del>factual-verified</del> information or a complaint containing <del>facts-confirmed</del> <u>factual information</u>, indicating the <del>possible</del> <u>probable</u> existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12 of these regulations <u>with a sufficient frequency to justify a further investigation</u>, ...</p> <p>Similar revisions are appropriate in subsection (3) through (5).</p> <p><b>Discussion</b>  See the discussion of the use of complaints to trigger investigations under subsection (o) below.</p>	<p>Michael McClain  General Counsel &amp; Vice President – California Workers’ Compensation Institute (CWCI)  December 12, 2006  Written Comment</p>	<p>We agree to revise this section.</p>	<p>Section 9792.11(c) re: target investigations will be revised to state: “A Special Target investigation may be conducted at any time based on credible information indicating the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.</p>
<p>Section 9792.11(e)</p>	<p>The reference to sections 1822.50 et. seq. of the California Code of Civil Procedure should be deleted.</p> <p><b>Discussion</b>  CCP section 1822.50, et seq. is not an</p>	<p>Michael McClain  General Counsel &amp; Vice President – California Workers’ Compensation Institute (CWCI)  December 12, 2006</p>	<p>We agree.</p>	<p>The reference to CCP 1822.50 will be deleted.</p>

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	<p>appropriate statutory device for this purpose. On its face the statute applies to fire, safety, and other building code violations which require an inspection of a particular location. In the context of a UR program review, the inspection of premises is not within the scope of the AD's authority under the statute. The AD has adequate authority to subpoena records and other materials and has stated that authority in these proposed regulations.</p> <p>There is no discussion in the statement of reasons or elsewhere supporting the need for the power to seek warrants or what authority the AD relies on. Without some additional clarification on the use and intent of this proposed regulation, it is unclear whether the AD intends to reserve this power to the Division, or whether anyone might apply for a warrant on these grounds. Again, the idea of resorting to civil warrants has never been the subject of a public hearing, and the regulated community has never had the opportunity to comment previously.</p>	Written Comment		
Section 9792.11(i)	Reporting the results of a UR investigation to an affected employer should not be required until the entire process has run its course. The Division's "final report of violations" could be reversed in the appeal process, yet, according to the proposed regulations, the preliminary findings must be reported. That report should not be required until the appeal process set forth in section 9792.12(b)(5) has concluded.	Michael McClain General Counsel & Vice President – California Workers' Compensation Institute (CWCI) December 12, 2006 Written Comment	We agree.	We agree to revise this subdivision by addition the following introductory language: Within thirty-one calendar days of the service of the Order to Show cause re Assessment of Administrative Penalties, if no answer has been filed, or within 15 calendar days after any

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				and all appeals have become final.
9792.11(j)	<p><b>Recommendation</b> The data elements required to be produced in an investigation, especially those in subsections (7) and (8), are not captured by most claims administrators, are unnecessary, and would require extensive reprogramming. Commenter recommends that these data elements be deleted and reconsidered.</p> <p><b>Discussion</b> No Authority: The data elements to be provided for an investigation under section 9792.12(j) are not required to be collected by section 4610, the utilization review standards regulations, or even the WCIS data reporting standards. The UR enforcement regulations have been created to enforce the UR standards, and many of the data elements delineated in subsection (j) are, in fact, UR standards that should be included, if at all, in those regulations, but have not been.</p> <p>A prime example is subsection (j)(7), a “list of each and every utilization review case or request received at the investigation site during the time period specified” by the AD. The UR standards regulations do not require the tracking of every request for authorization. The statute does not require it. If the AD wanted to create such a process, then the UR standards regulation (9792.6 – 9792.10) would have to be revised. Then the enforcement regulations could legitimately include the new process.</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	We agree to delete (7) and revise (8). It should be noted that (8) only requires the data element “if available.”	Section 9792.11(j)(7) will be deleted. Section 9792.11(j)(8) is revised by deleting the following data elements: the date the request was sent by the claims administrator to the URO and the name of the requesting physician.

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	<p>No Available Data: The claims organizations track the data necessary to manage the UR process. Not every request for authorization of treatment is given or is required to have assigned “a unique identifying number for each file, case or request,” for example. Many of the data demands in subsection (j) are not currently necessary to manage UR programs and are, therefore, not captured. Burdening the claims administrators with the collection of unnecessary data, only to make the audit process more convenient, would be bureaucratic – the tail wagging the dog – and costly both in terms of resources and the expense of reprogramming.</p> <p>Reprogramming: The data demands contained in 9792.12 are significant and would require considerable restructuring of claims administrators’ data processing systems. By comparison, WCIS has taken nearly a decade to determine the appropriate data requirements for claims administrators across the board. Unless the UR data elements can be put into the UR standards regulations and integrated with WCIS over a reasonable period of time, these data elements should be eliminated.</p> <p>Financial Impact: The financial impact of the data demands, particularly 9792(j)(4), (7), and (8) has never been assessed, as these are newly imposed. The Division’s Statement of Reasons contains no discussion of the financial impact of these new requirements whatsoever. If the AD does not eliminate these new sections, then the regulations should be withdrawn to assess the impact</p>			

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	these rules would make on the regulated community, including the State and municipalities.			
Section 9792.11(k)	<p><b>Recommendation</b> Based on the information provided pursuant to section 9792.11(i) above, the Administrative Director, or his or her designee, shall provide the claims administrator, utilization review organization or other person subject to Labor Code section 4610, with a list of no less than thirty-two (32) specific individual <u>claims or</u> utilization review files, <del>cases or requests</del>, for investigation. Within seven (7) calendar days of receipt from the Administrative Director, or his or her designee, of the list of <u>claims or</u> utilization review files, <del>cases or requests</del> for investigation, the claims administrator, utilization review organization or other person performing utilization review services for the employer shall: ...</p> <p><b>Discussion</b> The phrasing of the subdivision is ambiguous in that there is no definition for “case” or “request”. Since the investigation will be seeking to review utilization review activity only, the single reference to a utilization review file should be sufficient. The claims administrators may or may not have a separate utilization review file. This clarification will allow the claims administrator to provide the appropriate material.</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	<p>We agree to revise this subdivision to refer to randomly selected requests for authorization from a three month calendar period.</p> <p>Subdivision (l) will provide that the investigation subject will have 14 days to deliver the records.</p>	<p>This subdivision will be revised to refer to randomly selected request for authorization from a three month calendar period.</p> <p>Subdivision (l) will provide that the investigation subject will have 14 days to deliver the records.</p>
Section 9792.11(o)	<p><b>Recommendation</b> Upon initiating an investigation pursuant to Title 8 of the California Code of Regulations, section 9792.11(c)(2) into an alleged violation, and solely in the exercise of his or</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI)	We agree to revise this subdivision to clarify that a written description of the complaint or the complaint shall be provided unless providing the information would make the	This subdivision will be revised to clarify that the complaint shall be provided unless providing the information would

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>her discretion, the Administrative Director, or his or her designee, <del>may shall</del> provide to the claims administrator, the utilization review organization or other person subject to Labor Code section 4610 a written description of the factual information or of the complaint containing factual information that triggered the utilization review investigation. <u>The written description shall include all of the following:</u></p> <p>(1) <u>The name of the complainant.</u>  (2) <u>The date the complaint was filed.</u>  (3) <u>A succinct description of the facts of the complaint.</u>  (4) <u>A statement of the Administrative Director's rationale for determining that the complaint was justified that applies the Administrative Director's criteria to the facts of the complaint.</u></p> <p>The Administrative Director, or his or her designee, may refuse to provide such a written description, whenever the Administrative Director or his or her designee determines that providing the information would <del>make the investigation less useful</del> <u>adversely affect the outcome of the investigation. The Administrative Director's rationale for this determination shall be provided to the subject of the investigation.</u> The claims administrator, utilization review organization, or other such person shall have ten (10) business days upon receipt of the written description to provide a written response to the Administrative Director or his or her designee. After reviewing the written response, the</p>	<p>December 12, 2006 Written Comment</p>	<p>investigation less useful.</p> <p>We disagree that a complaint must be verified. There is no required format or method for a complaint. They may be oral or written. Many injured workers are not aware of the legal requirements of UR but have concerns that their treatment requests have been denied. The investigation unit can then determine if it appears that there has been an UR violation before an investigation is initiated.</p>	<p>make the investigation less useful.</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Administrative Director, or his or her designee, shall either close the investigation without the assessment of administrative penalties or conduct further investigation to determine whether a violation exists and whether to impose penalty assessments.</p> <p><b>Authority</b> While Labor Code section 4610(i) allows the Division to conduct investigations based on complaints, it does not and cannot permit regulatory enforcement without a basis in fact.</p> <p><b>Discussion</b> Commenter’s members are concerned that the Division’s proposed regulation allowing complaint investigations is open to abuse because an investigation can be triggered based on any complaint by anyone for anything. Such an open-ended process invites misunderstanding and confusion, at best, and harassment, at worst.</p> <p>Under the proposed regulations, it is still quite likely that if a claims organization refused to provide medical care that is patently deleterious, and the injured worker complains to the Division, an unwarranted investigation can be triggered. If an applicant's attorney, who believes that the utilization review process is grossly unfair, decided to file a complaint on every single utilization review he encountered, the regulation would allow that, and an audit could be initiated for every single complaint. How can a claims administrator defend itself against allegations of wrongdoing if the AD does not disclose the</p>		<p>We agree to add subdivision (e) which will provide that the DWC will review the complaints to determine if they are credible. If they are not, they will not trigger an investigation.</p>	<p>Subdivision (e) will be added to the regulations to state: “(e) Complaints concerning utilization review procedures may be submitted with any supporting documentation to the Division of Workers’ Compensation using the complaint form that is posted on the Division’s website at: <a href="http://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf">http://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf</a> Complaints should be mailed to DWC Medical Unit-UR, PO Box 420603, San Francisco, CA 94142-0603, attention UR Complaints or emailed to <a href="mailto:DWCManagedCare@dir.ca.gov">DWCManagedCare@dir.ca.gov</a>. Complaints received by the Division of Workers’ Compensation will be reviewed and investigated, if necessary,</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>essence of the complaint? How can the claims administrator even provide the necessary data related to the complaint? The reference to “factual” information adds nothing to counter the potential abuse if Division takes no responsibility for verifying the basic allegations.</p> <p>When dealing with complaint-related reviews, it is always a delicate balance between encouraging legitimate objections and preventing harassment by individuals acting in bad faith. The triggering of a UR investigation is a serious and costly matter in terms of data gathering and lost production time for claims administrators, and a significant use of resources for the Division. No one wants to chase specious complaints, but the regulation includes no consequence for filing false or fraudulent objections by physicians, applicant's attorneys, employers, insurers, or injured workers. The regulation should clearly preclude unverified or specious complaints, even if the complaint contains some factual material.</p> <p>A complaint should not be actionable unless the “information” is verified, the “complaints” are in a sufficient number to indicate a problem, and the evidence leads to “the probable existence of” a statutory violation. The regulation must also include some stated consequence for providing false information and for making fabricated complaints or the provision is beyond the authority of the enabling statute.</p>			<p>to determine if the complaints are credible and indicate the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.”</p>
General Comment	<b>Consequence of False or Fraudulent</b>	Michael McClain	We agree to add subdivision (e)	Subdivision (e) will be

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><b>Reporting</b> Complaint Form: The AD posted on the Division’s website a Utilization Review Complaint Form (DWC complaint form 1), which may be used to make a complaint to the Division. The form was issued on November 30. It will not be a part of the regulation and was not, to our knowledge, vetted with any participants in the workers' compensation system.</p> <p>Like the enforcement regulations, the complaint form lacks a crucial element: it fails to advise the complaining party of the consequences of filing a false or fraudulent complaint. Insurance Code section 1871.4 applies to false or fraudulent statements made for the purpose of obtaining or denying benefits or payments. Insurance Code section 1871.4(a)(2). When the Division investigates a UR complaint and finds that it is based on fraudulent information, the Insurance Code requires that this determination be reported to the Fraud Unit of the Department of Insurance.</p> <p>The proposed regulations and the DWC complaint form should, therefore, contain a statement indicating that there are specific consequences for false reporting. The penalty for violating section 1871.4(a) is:</p> <p>(b) Every person who violates subdivision (a) shall be punished by imprisonment in the county jail for one year, or in the state prison, for two, three, or five years, or by a fine not exceeding one hundred fifty thousand dollars</p>	<p>General Counsel &amp; Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment</p>	<p>which will provide that the DWC will review the complaints to determine if they are credible. If they are not, they will not trigger an investigation.</p> <p>Disagree that the complaint form must be part of the regulations. The complaint form is not mandatory. Complainants may forward complaints in any manner, written or oral, with or without using the form. Therefore, it the form does not need to be part of the regulations. The investigating unit will confirm/investigate the allegations in the complaint to determine if it is credible prior to proceeding with a investigation. Also, as set forth in 9792.11(q), upon initiating an investigation based on a complaint, a description of the complaint or the information contained in the complaint will be forwarded to the investigation subject who shall ten days to respond.</p> <p>We disagree that a complaint must be verified. There is no required format or method for a complaint. They may be oral or written. Many injured workers are not aware of the legal; requirements of UR but have concerns that their treatment requests have been denied. The investigation unit can then determine if it appears that there has been an UR violation</p>	<p>added to the regulations to state: “(e) Complaints concerning utilization review procedures may be submitted with any supporting documentation to the Division of Workers’ Compensation using the complaint form that is posted on the Division’s website at: <a href="http://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf">http://www.dir.ca.gov/dwc/FORMS/UtilizationReviewcomplaintform.pdf</a> Complaints should be mailed to DWC Medical Unit-UR, PO Box 420603, San Francisco, CA 94142-0603, attention UR Complaints or emailed to <a href="mailto:DWCManagedCare@dir.ca.gov">DWCManagedCare@dir.ca.gov</a>. Complaints received by the Division of Workers’ Compensation will be reviewed and investigated, if necessary, to determine if the complaints are credible and indicate the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.”</p>

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	<p>(\$150,000) or double the value of the fraud, whichever is greater, or by both that imprisonment and fine. Restitution shall be ordered, including restitution for any medical evaluation or treatment services obtained or provided. The court shall determine the amount of restitution and the person or persons to whom the restitution shall be paid. A person convicted under this section may be charged the costs of investigation at the discretion of the court.</p> <p>The complaint form also states that the information on the form will remain confidential, except to the extent necessary to investigate the complaint. This statement is misleading and should be removed from the form because it will be necessary to disclose almost all the information to the claims administrator or vendor in order to investigate the complaint.</p>		before an investigation is initiated.	
Section 9792.12(b)(1)(2)	<p>The calculation of penalties for a follow-up review on the same issue that includes the Division’s “reasonable costs of investigation” should be eliminated.</p> <p><b>Discussion</b> No Authority: Subsections (b)(2)(A) through (C) all contain the phrase “plus reimbursement to the Division of its reasonable costs of investigation.” Subsection (b)(6) defines “reasonable costs” to include “the actual per diem expenses, travel expenses and compensation paid for the investigation team personnel, including overtime if any, for the time spent on site during the investigation.”</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	We agree.	The phrase “plus reimbursement to the Division of its reasonable costs of investigation” will be deleted.

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	<p>Labor Code section 4610(i) states:</p> <p>If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. ...</p> <p>The statute provides the authority to assess administrative penalties. It does not allow the AD to impose the cost of UR audits against the claims administrator being reviewed, and no other provision of the Labor Code permits the AD to use such a remedial device.</p>			
Section 9792.11(f)	<p><b>Recommendation</b> <i>Sections 9792.11 through 9792.15 of Title 8 of the California Code of Regulations shall apply to any Labor Code section 4610 utilization review investigation conducted on or after the effective date of these regulations and <del>to</del> for conduct which occurred on or after the effective date of these regulations</i></p> <p><b>Discussion</b> This small change clarifies that both the investigation and the conduct must have occurred on or after the effective date.</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	We agree.	The word “to” will be deleted and “for” added.
	<p><b>Recommendation – “Employer”</b> Replace the term “employer” with “claims administrator” or “self-insured employer” wherever possible throughout these regulations, retaining “employer” for the rare</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI)	We agree.	The term claims administrator will be used through out except where it specifically required ‘employer.’”

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	<p>instances that should distinguish the employer from the administrator of the claim.</p> <p><b>Discussion</b> The proposed regulations are confusing because the term “employer” is used in some instance to describe the administrator of the claim and in others to describe an employer.</p>	December 12, 2006 Written Comment		
Section 9792.11(c)(1)	<p><b>Recommendation -- Employer</b> (c) <u>The Administrative Director, or his or her designee, may conduct a utilization review investigation at any location where <del>part or all of an employer’s</del> Labor Code section 4610 utilization review processes occur, as follows:</u></p> <p><b>Discussion</b> This change adds clarity because it eliminates potential disputes over the interpretation of “employer.”</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	We agree. Although this section is revised in general, we will not use the term “employer” when it is possible to use claims administrator.	Although this section is revised in general, we will not use the term “employer” when it is possible to use claims administrator.
Section 9792.11(c)(1)	<p><b>Recommendation -- Frequency of Routine Investigations</b> Confine the routine investigations of claims administrators to utilization review requests not forwarded to a utilization organization for review.</p> <p><b>Discussion</b> Utilization review decisions made by utilization review organizations are subject to double scrutiny: once at the organization’s location, then again at the claims administrator’s location. Claims administrators performing their own reviews are subject to single scrutiny. The regulation should be changed to ensure that all utilization review requests are subject to random selection for a single review.</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	We disagree. If a claims administrator contracts with a URO, it is still responsible for the claims handling. This section is revised.	The section is revised, but it does not limit review of the requests for authorization to those not forwarded to a URO.

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Section 9792.11(c)(1)	<p><b>Recommendation -- Frequency</b></p> <p><u>(1) A Routine Investigation shall be initiated at each known utilization review organization, or in the case of employer's performing utilization review on the employer's business site, no less frequently than once every three (3) years. A Routine Investigation of an employer's utilization review processes also may be initiated at any claims adjusting location concurrently with a routine, target or full audit done pursuant to Labor Code section 129 or 129.5. A Routine Investigation of the utilization review processes handled at each claims adjusting location shall be done no less frequently than once every five (5) years.</u></p> <p><b>Discussion</b></p> <p>As written, the minimum Routine Investigation frequency for an employer (claims administrator) is stated to be once every three years, then once every five years. There should be a single minimum frequency standard for employers (claims administrators) of once every five years.</p>	<p>Michael McClain General Counsel &amp; Vice President – California Workers' Compensation Institute (CWCI) December 12, 2006 Written Comment</p>	<p>We agree to clarify that the URO's will be investigated once every 3 years and the claims administrators will be investigated once every five years.</p>	<p>Subdivision (c) is revised to clarify that the URO's will be investigated once every 3 years and the claims administrators will be investigated once every five years.</p>
Section 9792.12(a)(1)	<p><b>Recommendation -- Failure to Establish a Plan</b></p> <p>(1) A maximum of \$50,000 for failure to establish a utilization review process, <i>and</i> to file <i>with the Administrative Director a written plan that describes the</i> utilization review <i>process, or a letter in lieu of a</i> <u>utilization review plan as specified in CCR section 9792.7(c), <del>plan and</del> or</u></p>	<p>Michael McClain General Counsel &amp; Vice President – California Workers' Compensation Institute (CWCI) December 12, 2006 Written Comment</p>	<p>We agree to revise by separating each of the requirements.</p>	<p>The subdivisions will be revised as follows: (a)(1) For failure to establish a Labor Code section 4610 utilization review plan: \$50,000; (a)(2) For failure to include all of the requirements of section 9792.7(a) in the utilization review plan:</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>for failure</i> to maintain a utilization review process, <del>in compliance with Labor Code section 4610, including the failure to include</del> <i>that complies with</i> all of the following <del>required information</del> <i>requirements of Labor Code section 4610:</i></p> <p><b>Discussion</b> The additional language is necessary because CCR section 9792.7(c) permits a claims administrator to file a letter in lieu of filing a utilization review plan “identifying the external utilization review organization which has been contracted to perform the utilization review functions, provided that the utilization review organization has filed a complete utilization review plan with the Administrative Director.”</p>			<p>\$5,000; (a)(3) For failure to file the utilization review plan or letter in lieu of a utilization review plan with the AD as required by section 9792.7(c): \$10,000...</p>
Section 9792.12(a)(12)	<p><b>Recommendation</b> Delete section 9792.12(a)(12).</p> <p><b>Discussion</b> The purpose of penalty regulations is to enforce only what is required by existing statute and regulation. Neither statute nor regulation requires provision of an authorization number or unique identifying number. No penalty may be assessed for an action that is not required by the statute or the utilization review standards regulations.</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006 Written Comment	Agree.	Subdivision (a)(12) will be deleted.
Section 9792.12(a)(2)	<p><b>Recommendation</b> Delete section 9792.12(c)(2).</p> <p><b>Discussion</b> This paragraph would impose a double penalty. Failing to employ a medical director</p>	Michael McClain General Counsel & Vice President – California Workers’ Compensation Institute (CWCI) December 12, 2006	Agree to revise (a)(1) so the requirement to have a medical director is not listed twice.	Subdivision (a)(1) will be revised to state: “For failure to establish a Labor Code section 4610 utilization review plan: \$50,000;”

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	already results in a \$50,000 fine under section 9792.12(a)(1). If this section were to remain, the failure to employ a medical director would result in a fine of \$100,000.	Written Comment		
General Comment	<p>Commenter strongly supports the increased oversight and penalties proposed to the California Code of Regulations. Commenter feels the penalties should be higher. However with active oversight perhaps the accumulation of penalties will result in more formidable fines.</p> <p>Commenter states that a major concern voiced by her members and many of the physicians that she see is that every single treatment request is sent to utilization review, thereby handicapping treating physicians, delaying treatment unnecessarily, and de facto reduction of treatment, simply by using this process in this way. The intention of the California code was to provide treatment until decisions were made that indicated it was not needed, not to deny treatment categorically until reviewed by utilization review.</p> <p>Commenter states that five-day reviews for suicidal persons is simply too long. Unfortunately injured persons do not know what their options are in terms of requesting second opinions, or filing complaints with the Division. Insurers should be required to clearly inform claimants of all their avenues of appeal. Many people with legitimate claims simply walk away from this confusing bureaucracy. Others become depressed, sometimes suicidal, only to have mental health treatment routinely denied, as Robert</p>	<p>Nancy Mennel President East Bay RSI Support Group December 12, 2006 Written Comment</p>	<p>These comments go beyond the scope of the UR penalty regulations.</p>	<p>None.</p>

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	<p>Picker, M.D., located in Walnut Creek described in his letter to the editor of the Chronicle Business Section. "I've had perhaps 100 cases during this last year in which seriously depressed and suicidal injured workers are told, after several weeks or months of treatment authorized by the insurance company, that continued treatment was being disallowed. Why? Because an outside "qualified medical psychiatric examiner" hired by the insurance firm after a single brief interview with the patient, has determined that the psychiatric injury was "non-industrial." Most adults faced with the loss of employment in today's economic landscape are highly stressed. Mental health care should be routinely provided, rather than routinely denied as it is today. We feel mental health issues need a more in depth assessment by the commission. Numerous clinicians speak of a posttraumatic stress syndrome induced by the workers compensation process itself!</p> <p>While requiring MDs to authorize or deny treatment is a good first start, it does not address the issue of the inappropriate use of evidence. Many of her members have received letters denying treatment quoting research that does not directly relate to their medical condition signed by MDs. How are they supposed to appeal this? The workers comp treating physician has no time to devote hours composing letters for every client justifying what he knows from his clinical practice experience. Clinical practice experience usually precedes and informs</p>			

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	research. If physicians are not allowed to practice medicine with a certain amount of autonomy, new research avenues will diminish, and medicine will remain at a standstill. Injured persons are not physicians with medical training and frequently do not know how to make heads or tails out of this process.			
General Comment	Commenter feels that under Government Code section 11346.8(c)(2) the Division should have another 45 day comment period and public hearing because the proposed changes are not “sufficiently related to the original text that the public was adequately placed on notice that the change could result from the originally proposed action.”	Stewart J. Brooker Associate Counsel CNA December 12, 2006 Written Comment	We disagree that revisions to the subdivisions go beyond the subject of these regulations. The proposed regulatory changes are “sufficiently related” to the original text because they relate directly to the same subject as the originally noticed regulations.	None.
Section 9792.11 (i)	Commenter is concerned about the provisions in this subsection which require reporting the results of an investigation to an employer prior to the completion of any appeal process. A claim organization affected by an investigation could have a negative finding found against them, be forced to notify its customers, have immediate and irreversible customer loss as a result, and be subsequently vindicated on appeal. Any notification requirement should only be applicable after the party under investigation has exhausted the appeal process.	Stewart J. Brooker Associate Counsel CNA December 12, 2006 Written Comment	We agree.	The subdivision will be revised so that the results do not need to be reported until after the report is final.
Section 9792.11(j)	Commenter notes that claims administrators will have to work with their utilization review partners to develop new software systems to comply with the new requirement for information. Developing systems, obviously, is extremely costly. Specifically, commenter is concerned about the tracking requirements under Section 9792.11(j)(4), which will	Stewart J. Brooker Associate Counsel CNA December 12, 2006 Written Comment	We agree.	The subdivision will be revised to only require the information “if available.”

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	<p>require utilization review organizations to provide: the total number of utilization request searchable by time frame, the dispositions of each utilization review request searchable by time frame, and include statistics on three types of claimant treatment request withdrawals searchable by time frame. This type of information request appears to be complicated and voluminous. Databases which are searchable by any time frame add to the complexity and cost of database design. Commenter requests, considering the cost of creating and maintaining searchable databases for in the information requested, the Division investigate if all of this information is necessary to achieve the goals of its investigations and, where possible, minimize the cost to claim administrators.</p> <p>Commenter is also concerned that the information being requested in too short a time frame. Subsection (j) requires that the information request must be supplied in seven calendar days and commenter feels that this is too short a time frame, even if a software system is implemented to gather the required information, to properly gather and supply and summarize in the required format. Commenter requests that the Division reconsider the time allowed to supply the requested information.</p> <p>Commenter is also concerned about the possibility of being notified less than thirty days in advance of an investigation and respectfully requests that subsection (j) be amended to remove the language “Unless the</p>		<p>We agree to change the timeframe from 7 days to 14 days.</p> <p>We agree to provide more time and to clarify the subdivision.</p>	<p>The reference to 7 days in subdivision (j) will be deleted and subdivision (k) will be revised to allow 14 days to provide the information.</p> <p>The investigation subject will be provided at least sixty days notice prior to an investigation. The subdivision will also be</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Administrative Director in his or her discretion determines that advance notice will be less useful. . .” from the first sentence. According to these proposed regulations, commenter will require time to gather and summarize information; therefore, he would not be able to comply without adequate advance notice.			clarified to note that notice will always be given for routine investigations, it is only if it is a Special Target or Return Target where advanced notice may be withheld.
Section 9792.11(o)	Commenter feels he is entitled to be supplied information concerning any allegations triggering a complaint. The proposed subsection provides that “(t)he Administrative Director. . . may refuse (to provide the factual information that triggered an investigation), whenever the Administrative Director. . . determines that providing the information would make the investigation less useful.” Commenter feels that it is in everyone’s interest to make sure that claim administrators have adequate information to properly respond to charges against them.	Stewart J. Brooker Associate Counsel CNA December 12, 2006 Written Comment	We agree to revise this subdivision. Some discretion must be allowed re: disclosing the triggering information because in certain instances, if the investigation subject was aware of the facts, it might alter its records.	The subdivision will be revised to state: Upon initiating a Target Investigation the AD, or his or her designee, shall provide to the claims administrator or the URO a written description of the factual information . . . unless the AD . . . determines that providing the information would make the investigation less useful.”
Section 9792.12	The fifteen-day regulation text changes, under Section 4610(a), many penalties from being discretionary to mandatory. Commenter believes that there should be some discretion available to the decision maker to account for situations that do not rise to the highest level of culpability, represent a genuine mistake, and cause little or no harm to the injured workers or other parties. Commenter requests that any references to these penalties as mandatory be deleted from the rulemaking.	Stewart J. Brooker Associate Counsel CNA December 12, 2006 Written Comment	Disagree. Pursuant to Section 9792.13, the penalties may be mitigated.	None.
Section 9792.12(b)	Commenter notes that the amount of each penalty under this subsection has been at least doubled. These penalties, which do not specifically require harm to an injured worker	Stewart J. Brooker Associate Counsel CNA December 12, 2006	Disagree re: the (a) penalties. The penalties set forth in section 9792.12(a) are for serious violations of the UR requirements, such as	Section 9792(b) will be revised to provide a performance rating based on the number of

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	do not appear to have an absolute cap. Commenter requests the addition of a cap to the amount of total penalty possible for violation under this subsection and suggests that cap to be no higher than \$50,000, the amount set as the penalty for failure to have a Utilization Review process.	Written Comment	failure to have a UR plan, failure to have a medical director, failure to respond to a request for admission.  Agree re: the penalties set forth in subdivision (b). These penalties are for lesser violations – violations concerning timeliness and notice requirements. We agree to revise to allow an 85% passing rate and to reduce the increase factor for return investigation.	violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.
Section 9792.13	<p>Commenter objects to the language contained in section 9792.13(a)(8), which allows adjustment based upon “the impact of the penalties assessed in relation to the business revenue of the entity or person subject to Labor Code section 4610” as being unfair to organizations that have other sources of revenue other than the California workers’ compensation policies. Revenues do not always equal profits. Commenter requests that this subsection either be limited to being a mitigating factor or be changed to reflect only profits arising out of California workers’ compensation policies.</p> <p>Commenter does note and appreciates the inclusion of a mitigation factor to reflect the</p>	Stewart J. Brooker Associate Counsel CNA December 12, 2006 Written Comment	<p>We agree.</p> <p>Disagree. This subdivision has also been deleted. The revision to</p>	<p>This subdivision will be deleted.</p> <p>This subdivision is also deleted.</p>

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	size of the claim organization contained in Section 9792.13.		9792.11(d), which sets forth a sample size based on the number of requests for authorization will allow for a smaller sample for a smaller claims organization.	
General Comment	<p>The Government Code establishes the rule that a state agency must give the public an opportunity to participate in a public hearing on a proposed regulation before the agency moves forward with the adoption of the regulation. The exceptions to this rule are very limited. One exception relates to situations where a regulation is changed after the regulation was the subject of a public notice and hearing. The exception is explained in Government Code Section 11346.8(c) which provides in pertinent part:</p> <p>“(c) No state agency may adopt, amend, or repeal a regulation which has been changed from that which was originally made available to the public pursuant to Section 11346.5, unless the change is (1) non-substantial or solely grammatical in nature, or (2) sufficiently related to the original text that the public was adequately placed on notice that the change could result from the originally proposed regulatory action. ...”</p> <p>Relying on this exception, the division has decided not to convene a public hearing on the November 21, 2006 revisions. The division’s approach violates the Government Code’s rule that the public must be given an opportunity to comment on proposed regulations at a public hearing. The November 21 revisions include changes that (1) are substantial and not solely</p>	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	We disagree. These regulations are subject to public comment for 15 days, which is all that is required because the revisions do not go beyond the subject of these regulations. The proposed regulatory changes are “sufficiently related” to the original text because they relate directly to the same subject as the originally noticed regulations.	None.

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	grammatical in nature and (2) are significantly unrelated to the original version of the proposed regulations that the public could not have anticipated that the changes would have resulted from the original regulations. Specifically, the revision introduces new investigation procedures, new recordkeeping requirements and a wide array of new penalties.			
Section 9792.11	Labor Code Section 4610 is cited as authority for Section 9792.11's utilization review investigations. However, Section 4610 makes no reference to investigations or audits. The administrative director's authority to conduct audits is restricted to Labor Code Sections 129 and 129.5. To the extent the proposed Section 9792.11 seeks to permit utilization review audits contrary with the requirements of Labor Code Section 129 and 129.5, the proposed section is unauthorized and inconsistent with existing law.	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	Disagree. Labor Code section 133 provides authority for the AD to do all things necessary in the exercise of any power conferred upon it in the code. Labor Code section 4610(i) provides authority for the AD to impose penalties for failure to comply with the UR requirements.	None.
Section 9792.11(c)	There is a need to clarify what is meant by a "complaint containing facts." An allegation should not be equated with "fact." There is a need for additional explanation of the intent of this regulation. Because a complaint can trigger an investigation, there ought to be provisions to address those who file a number of unsubstantiated complaints. Otherwise, complaints can be used to harass payers.	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	We agree to revise the term a complaint containing facts. We disagree to limit how many complaints may be filed. The complaints will be reviewed before triggering a complaint and the investigation subject will be provided with a copy of the complaint and allowed to respond pursuant to subdivision (q).	Subdivision (c) is revised to refer to "credible information" and "credible complaints" instead of a complaint containing facts.
Section 9792.11(d)	The latest revision of the proposed regulations seeks to impose penalties that are not authorized by statute. The administrative director's audit and penalty assessment powers are limited by Labor Code Section 129.5. The latest revision ignores those	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	Disagree. Labor Code section 133 provides authority for the AD to do all things necessary in the exercise of any power conferred upon it in the code. Labor Code section 4610(i) provides authority for the AD to	None.

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	limitations. There is no statutory basis for the administrative director to establish penalties for utilization review process violations that are different than the administrative penalties provided by statute for other violations in the course of an audit authorized by Labor Code Section 129.		impose penalties for failure to comply with the UR requirements.	
Section 9792.11(e)	The latest revision seeks to give the administrative director the power to seek a warrant to search the premises pursuant to Section 1822.50 et seq. of the Code of Civil Procedure. The revision's reliance on these statutory sections is inappropriate because the routine investigations called for by the proposed regulations lack the probable cause foundation to support the issuance of a search warrant.	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	We agree to delete reference to these sections.	Reference to CCP section 1822.50 is deleted.
Section 9792.11(i)	This section requires a party providing utilization review services that receives a final report of findings of violations to notify the affected employers of the findings even though the alleged violations may not stand after hearing and appeal. This requirement is unnecessary. There is no proven justification for mandating the reporting of charges that may ultimately be found to be unsubstantiated. Moreover, the requirement is inconsistent with proposed Section 9792.12(b)(5) which limits publication of violations to situations when there has been a final decision, after all appeals.	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	We agree.	The subdivision will be revised to state that the notice is not required until the report is final.
Section 9792.11(j)	The latest revision sets seven calendar days for the delivery of all requested information and records. This not enough time given what the division is requiring to be reported. Moreover, the time requirement should be based on business days, not calendar days.	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	We agree to revise to allow 14 days.	The subdivision is revised to allow 14 calendar days.

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	The division should reconsider whether this amount of detail is needed. For example, if the concern is whether the reviewing entity is appropriately applying the medical treatment utilization schedule, the requested information should focus on that issue.			
Section 9792.11(j)(7)	<p>Section 9792.11(j)(7) mandates providing “a list of each and every utilization review case or request received at the investigation site during the time period specified by the administrative director, or his or her designee.”</p> <p>The practical effect of this mandate is that the list must include every case where authorization was requested. In addition to being unnecessary this mandate would result in significant administrative expense. Section 9792.11(j)(7) should be limited to those utilization review cases referred to a reviewer or an expert reviewer.</p>	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	We agree to delete (j)(7) and only require the information if available.	Subdivision (j)(7) will be deleted. Subdivision (j) will be revised to only require the information if available.
Section 9792.12(a)(1)	Section 9792.12(a)(1) is not consistent with Section 9792.7(c) which sets forth a situation where a claims administrator need not file a utilization review plan if it has contracted with an external review organization that has filed a plan. Also, neither the plan provisions of Sections 9792.7 nor Labor Code Section 4610 require the reporting of the medical director's "current areas of certified specialty" and "express written authority."	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	We agree to revise (a)(1).	Subdivision (a)(1) is revised to state: For failure to establish a Labor Code section 4610 utilization review plan: \$50,000.
Section 9792.12(a)(4)	Section 9792.12(a)(4) would force unnecessary bureaucratic relationships between payers and providers. Non-physician reviewers would be subject to fine for verbally discussing a request with the provider and approving a verbal modification made by the	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	We agree to revise this subdivision.	Subdivision (a)(4) (now 7) is revised to state: For failure to comply with the requirement that only a licensed physician may modify, delay, or deny

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	provider. This could jeopardize the delivery of effective treatment to injured workers.			requests for authorization of medical treatment for reasons of medical necessity to cure and relieve, except as provided for in section 9792.9(b)(2) and (3): \$25,000.
Section 9792.12(a)(8)	Section 9792.12(a)(8) does not provide a mechanism for determining whether in fact the requesting physician has provided "the specific clinical rationale for the requested treatment and has provided or referred to relevant page(s) of other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based." The burden should be on those alleging a violation to show in fact that the requesting physician has met the above requirement.	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	We agree to revise this subdivision.	Subdivision (a)(8) (now 10) is revised to state: For failure to approve the request for authorization solely on the basis that the condition for which treatment was requested is not addressed by the medical treatment schedule adopted pursuant to Labor Code section 5307.27 of the Labor Code: \$5,000.
Section 9792.12(b)(3)(F)(5)	Section 9792(b)(3)(F)(5) does not correctly state the requirements of 9792.9(j). There is no such item required.	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	We agree. The particular language is deleted and the subdivision is revised.	The subdivision is revised to state: (E) For failure to include in the written decision that modifies, delays or denies authorization, all of the items required by section 9792.9(j).
Section 9792.12	The November 21, 2006 revision of the proposed regulations would impose severe penalties for minor, technical mistakes that occur during the utilization review process. Commenter is concerned that the gravity of the proposed penalties would discourage the implementation of effective utilization review programs. That result would harm injured	Tami Cookman Sr. Legislative Assistant Association of California Insurance Companies December 12, 2006 Written Comment	We agree to revise subdivision (b), which deals with the more technical errors to allow a pass rate of 85%.	Subdivision (b) will be revised to allow an 85% pass rate.

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	workers because it would subject them to ineffective and perhaps, even dangerous treatment. The result would also threaten the cost savings that utilization review is now achieving for the workers compensation system.			
General Comment	<p>Commenter states that the proposed regulations are inconsistent with existing regulations regarding utilization review.</p> <p>Current 8 CCR § 9792.8(a)(2) states:</p> <p>“For all conditions or injuries not addressed by the ACOEM Practice Guidelines or by the official utilization schedule after adoption pursuant to Labor Code section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based. Treatment may not be denied on the sole basis that the treatment is not addressed by the ACOEM Practice Guidelines until adoption of the medical treatment utilization schedule pursuant to Labor Code section 5307.27. After the Administrative Director adopts a medical treatment utilization schedule pursuant to Labor Code section 5307.27, treatment may not be denied on the sole basis that the treatment is not addressed by that schedule.” (Emphasis added)</p> <p>The proposed penalty regulations in one section correctly state the law [Proposed 8</p>	<p>Mark Webb Vice President Governmental Relations Employers Direct Ins. Co. December 12, 2006 Written Comment</p>	<p>We agree that (a)(8) – now (10) correctly reflects the legal requirements.</p> <p>We agree to revise the (b) section to clarify each violation.</p>	<p>The violations listed in section 9792.12(b) will be revised for clarity.</p>

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	<p>CCR § 9792.12(a)(8)] - that a request cannot be denied solely on the basis that the condition is not listed within the medical treatment utilization schedule. This, however, applies only to a single instance penalty. The “additional penalties and remediation” regulations, however, state that a penalty may be assessed on a return investigation for one or more violations of the Utilization Review regulations [Proposed 8 CCR § 9792.12(b)(2)]. Additional provisions in the proposed regulations also make general references to violations of the Utilization Review regulations without clarifying what constitutes a violation for penalty purposes. [See: Proposed 8 CCR §§ 9792.11(c)(2); 9792.11(e); 9792.11(i)]</p> <p>As has been stated on numerous occasions, the medical treatment utilization schedule defines the employer’s obligation to provide medical care. [Labor Code § 4600(b)] Labor Code § 4604.5(e), as indicated in the single instance penalties under these proposed regulations, is a correct statement of the law: a payer cannot deny treatment solely on the basis that the medical condition is not addressed in the medical treatment utilization schedule when the treating physician seeks treatment consistent with other evidence-based medicine treatment guidelines. It is an incorrect statement of the law to say that treatment cannot be denied when the requested treatment is not contained within the Medical Treatment Utilization Schedule for a condition that is covered in the schedule.</p>			

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	<p>If the proposed regulations intend to provide multiple instance penalties for violations of 8 CCR § 9792.8, then at a minimum the regulations are unclear. If that is the intent, furthermore, then these regulations lack the same authority as do the Utilization Review regulations and both should be corrected. [Government Code §§ 11349 et seq.]</p>		<p>None of the violations listed in (b) include penalties for a violation of 8 CCR §9792.8 except to the extent the written decision fails to set forth the explanation for the reason for the modification, delay or denial. See (b)((4)(E).</p>	
<p>Section 9792.11(i)</p>	<p>This provision appears to require a claims administrator, utilization review organization or “other person” to notify affected employers of any final report of findings of violations. First, proposed 8 CCR § 9792.11(a) appears to define the audit universe as employers, insurers, and utilization review organizations. It is, consequently, unclear as to what “other person” is subject to this notice requirement and, inferentially, audit. Second, it is unclear what employer is “affected” by the results of the audit. Is it limited to a self-insured employer and insured employers who have a claim that was the basis for finding a violation of the utilization review organization or insurer? [Proposed 8 CCR § 9792.11(i)(2)] Is it all the policyholders of an insurer who contracts with the utilization review organization? Is it all the policyholders of all the insurers who contract with the utilization review organization?</p> <p>Without further definition of what is an “affected” employer, it is unclear who is to receive these notices. It also appears that both the insurer that contracts with the utilization review organization and the utilization review organization itself are required to send these</p>	<p>Mark Webb Vice President Governmental Relations Employers Direct Ins. Co. December 12, 2006 Written Comment</p>	<p>We agree to revise this subdivision (now (v)). We will delete references to “other person...” throughout the regulations. We will also delete reference to “affected employers.”</p> <p>If the employer is aware of the violations caused by the claims administrators or URO it can make market choices to improve the services for its employees.</p>	<p>This subdivision (now (v)) will be revised to state: Within thirty-one calendar days of the service of the Order to Show Cause re: Assessment of Administrative Penalties, if no answer has been filed, or within 15 calendar days after any and all appeals have become final, the claims administrator or utilization review organization shall provide the following to every employer whose utilization review process was assessed with a penalty pursuant to section 9712.12: (1) A notice which shall include a copy of the final investigation report, the measures actually implemented to abate</p>

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	<p>notices [Proposed 8 CCR `s 9792.11(i)]. This is both duplicative and, to a certain extent, confusing. An insured employer has a contract with the insurer, not the utilization review organization. It is the insurer, consequently, who is responsible for the adjustment of the claim and who is substituted for the employer in all proceedings before the Board. (See, e.g., Labor Code § 3755)</p> <p>Regardless of who the claims payer, whether insurer, self-insured employer, or TPA contracts with, they are the responsible party. To assign responsibility to others, whether directly or inferentially obscures the clarity the marketplace needs to make decisions on how to spend precious premium dollars.</p>			<p>such conditions, and the website address for the Division where the final investigation report is posted. If a hearing was conducted under section 9792.15, the notice shall include the Final Determination in lieu of the final investigation report. (2) The notice shall be served by certified mail.</p>
Section 9792.11(g)	<p>This Section makes certain provisions of the regulations governing audits under Labor Code §§ 129 and 129.5 applicable to investigations conducted pursuant to Labor Code § 4610. First, this proposed regulation fails for lack of clarity because it is clearly permissive. Apparently, it is the intent of the Division to apply the regulations under the audit procedure ad hoc and without notice. At a minimum, such a provision in a penalty regulation violates all notions of due process. There is no apparent limit on the Administrative Director's discretion in applying the referenced sections of audit regulations, no notice of whether they are to be applied in a particular audit, and no rationale for why these provisions would be applicable to a utilization review audit anyway. This provision also lacks consistency given the elaborate record</p>	<p>Mark Webb Vice President Governmental Relations Employers Direct Ins. Co. December 12, 2006 Written Comment</p>	<p>We agree to delete (g).</p>	<p>Subdivision (g) will be deleted.</p>

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	keeping requirements of these proposed regulations [See: Proposed 8 CCR § 9792.11(j)]. Exactly what provisions of the current audit regulation are applicable to utilization review audits? The proposed regulations do not make this clear.			
Section 9792.11(j)	<p>This proposed regulation contains elaborate record keeping requirements that are not included in the current Utilization Review regulations, 8 CCR §§ 9792.6 through 9792.12. The proposed regulations are for the implementation of Labor Code § 4610(i), which is limited to violations of Labor Code Section 4610. The Division does not have the authority to specify such record keeping requirements under the authority contained in subdivision (i) of Section 4610, notwithstanding the broad grant of authority in Labor Code § 133. If the Division wants utilization review plans to incorporate such record retention, then it needs to do so under the authority of subdivision (c) of Section 4610, not subdivision (i).</p> <p>The Division may wish to reconsider the concept of developing a parallel audit process. While subdivision (i) clearly states that the enforcement authority granted under Section 4610 is not exclusive, it does not necessarily follow that the exercise of that authority may also be cumulative. At some point, the Division will have sufficient data to develop standards for inclusion of utilization review under the audits authorized by Section 129. This would be consistent with the broad oversight authority provided by that section and clearly consistent with the non-exclusive</p>	Mark Webb Vice President Governmental Relations Employers Direct Ins. Co. December 12, 2006 Written Comment	<p>Agree to revise (j). The (j) subdivision is requesting information regarding the system to track UR requests and responses. The claims administrator or URO should have this information in some format in order to operate its business, but will only be required to provide the information to the extent that the system identifies the information. By providing the information to the AD, the AD will be able to select the random UR files for investigation.</p> <p>While we agree to revise section 9792.11(c)(A) to provide that the routine investigation of the claims administrator will occur once every five years concurrent with the PAR audit. Also, the random sample table from the audit regulations (8 CCR 10107.1) will be incorporated into these regulations as 9792.11(d). However, the audit procedures will not work for UR violations. Labor Code sections 129 and 129.5 do not</p>	<p>Section 9792.11(j) will be revised to eliminate some of the data elements and information that will be requested. Additionally, it will only require the investigation subject to produce the information if it has a system to identify requests for authorization and if the data is maintained in its system.</p> <p>Section 9792.11(c)(A) will be revised to provide that the routine investigation of the claims administrator will occur once every five years concurrent with the PAR audit. Also, the random sample table from the audit regulations (8 CCR 10107.1) will be incorporated into these</p>

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	<p>nature of penalties authorized under subdivision (i) of Section 4610. Conversely, can it be successfully argued that the Legislature intended a separate audit process to progress concurrently under both Sections 129 and 4610 assessing broad based penalties under both schemes for the same act? Clearly, violations of the UR process may result in penalties that are both administrative and judicially enforced (Labor Code § 5814). It is less clear that dual administrative penalties fall within the Legislature’s intent.</p> <p>Commenter is not suggesting that penalties for violation of Section 4610 requirements be de minimis. Commenter is suggesting that until such time as performance standards are developed for inclusion in audits under Section 129 a less elaborate review process be put forth in these regulations. The goal of an enforcement mechanism is to ensure compliance. That goal, however, must be viewed in light of clear expressions by the Legislature of the goals of the workers’ compensation system. Utilization review is intended to be a process whereby quality medicine is promptly delivered. This requires, first and foremost, a common understanding between providers and payers. If the compliance burden frustrates the payer-provider dialogue that is the core of effective utilization review, then the compliance mechanism is too harsh. In other words, medical decisions should not be made in order to avoid to penalties; they should be made to benefit the injured worker.</p>		<p>give the AD authority to audit or assess penalties against UROs. Also, Labor Code section 129.5 prohibits the assessment of any penalties if the audit subject passes the PAR and caps penalties that can be assessed at \$5,000. The audit regulations (8 CCR 10107.1 et seq.) provide that the only violations addressed in the PAR audit are failure to pay indemnity payments, late first payments of TD, PD etc., and failure to issue benefit notices. However, Labor Code section 133 provides the AD power and jurisdiction to do all things necessary or convenient in the exercise of any power or jurisdiction conferred upon it under the Labor Code. Therefore, the AD is authorized to conduct investigations pursuant to Labor Code section 4610 of claims administrators and UROs in order to determine if UR violations exists and to assess penalties for the violations.</p>	<p>regulations as 9792.11(d). Also, we will revise 9792.12(b) to allow a 85% pass rate, similar to the audit performance standard..</p>

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	<p>For example, when one looks at the requirement of proposed 8 CCR § 9792.11(j)(5) requiring a depiction of the “organization’s hierarchy” in some detail, the immediate question is “why”? How does it further the compliance with Section 4610 for the Division to require an org-chart from a utilization review organization? There is no authority for the Division to require a particular structure for utilization review organizations, assuming that the reference to the term “organization” refers only to a utilization review organization. If, instead, it refers to an employer, insurer, or TPA as well then the Division is casting its investigatory net broadly, and is certain to acquire much information that is totally meaningless for purposes of enforcing UR obligations.</p>			
Section 9792.12(a)(12)	<p>For purposes of example, this proposed penalty assessment would seem to elevate form significantly over substance. It would be reasonable to think that when a payer authorizes treatment and communicates that authorization on a timely basis to the treating physician there would be sufficient detail in the authorization that the provider would know what treatment was being authorized and for whom. Apparently, such is not the case in all situations. This would also apparently be inconsistent with existing 8 CCR § 9792.9(i), setting forth only minimal requirements for communicating authorizations to the treating physician. The regulation is also unclear as to what constitutes a “specific claim” for purposes of documentation. It would appear, however, that it is the intent of the regulations that <u>each</u></p>	<p>Mark Webb Vice President Governmental Relations Employers Direct Ins. Co. December 12, 2006 Written Comment</p>	<p>We agree to delete this subdivision.</p>	<p>Subdivision (a)(12) will be deleted.</p>

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	request in <u>each</u> claim be assigned a unique identification number. [See: Proposed 8 CCR § 9792.11(j)(7)(i)]			
General Comment	Commenter states that the Division of Workers' Compensation has no standing or authority to pursue actions under § 17200 of the Business & Professions Code.	Mark Webb Vice President Governmental Relations Employers Direct Ins. Co. December 12, 2006 Written Comment	We agree to delete the reference to section 17200 in section 9792.13(b).	Section 9792.13(b) will be deleted.
General Comment	Commenter states that many of the proposed changes fail to comply with Government Code Section 11346.8(c) and, therefore, fail to comply with the Government Code Section 11349.1 authority standard for the adoption of regulations. The changes are not sufficiently related to the proposed regulations for which notice was first issued, and the DWC lacks the authority to adopt such changes in the absence of the requirements for notice and a full 45 day comment period.	Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment	We disagree. These regulations are subject to public comment for 15 days, which is all that is required because the revisions do not go beyond the subject of these regulations. The proposed regulatory changes are "sufficiently related" to the original text because they relate directly to the same subject as the originally noticed regulations.	None.
Section 9792.11(c)	Addition of periodic investigations, to be conducted every three or five years, depending on the reading of paragraph (I), in lieu of purely discretionary audits in the original proposal, and the addition of follow-up non-routine investigations to determine abatement of violations previously determined to exist. These changes are not sufficiently related to the originally proposed regulatory action.	Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment	We disagree. These regulations are subject to public comment for 15 days, which is all that is required because the revisions do not go beyond the subject of these regulations. The proposed regulatory changes are "sufficiently related" to the original text because they relate directly to the same subject as the originally noticed regulations; specifically: investigation procedures for Labor Code section 4610 UR review violations.	None.

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	<p>Additionally, aside from the costs to claims administrators who conceivably would have to prepare and submit information to the DWC for utilization review investigations and concurrent Labor Code Section 129 audits, the costs of periodic investigations to the DWC or to employers who fund the DWC's operations through assessments were not even contemplated in the initial notice. There, under Fiscal Impacts, DWC stated: "Costs or savings to state agencies or costs/savings in federal funding to the State: None."</p> <p>That statement is no longer applicable. It appears that additional auditors will be required and resources will be shifted from other essential agency functions - and employer assessments may be increased to fund the additional positions.</p>		Disagree. Based on the pilot investigations, the investigations at the claims administrators take two to three days. The medical unit and audit units already hired additional staff in response to the reform legislation.	None.
Section 9792.11(e)	<p>The potential reliance on Code of Civil Procedure Section 1822.50 for a court-ordered investigation of potential violations, which has not previously been used by DWC.</p> <p>Further, necessity for this addition has not been explained in the Initial Statement of Reasons or in the Notice of 15 Day Changes to Proposed Text. Without an explanation and description of the need for this change, persons subject to the regulations do not know of the effect on their operations, or whether DWC or private parties may apply for such orders.</p>	Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment	We agree to delete this reference to CCP section 1822.50.	Reference to CCP section 1822.50 will be deleted.
Section 9792.11(j)	The detailed list of information and records claims investigators will have to produce, includes data and information not required to be created or maintained by statute or current	Steven Suchil Assistant Vice President Western Region American Insurance	Agree to revise (j). The (j) subdivision is requesting information regarding the system to track UR requests and responses. The claims	Section 9792.11(j) will be revised to eliminate some of the data elements and information that will be

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	regulations governing utilization review standards. This subdivision authorizes investigations to commence with no prior notice, something that persons subject to the regulations could not have reasonably anticipated since no other audit process is conducted in that fashion.	Association December 12, 2006 Written Comment	<p>administrator or URO should have this information in some format in order to operate its business, but will only be required to provide the information to the extent that the system identifies the information. . By providing the information to the AD, the AD will be able to select the random UR files for investigation.</p> <p>The only investigation that will go forward without advanced notice is a Special Target or Return Target that would be rendered less useful if advanced notice is given. To the extent the commenter is suggesting this subdivision required 45 day notice, we disagree. The subdivision sufficiently relates to the subject matter: the UR penalty investigation procedure.</p>	requested. Additionally, it will only require the investigation subject to produce the information if it has a system to identify requests for authorization and if the data is maintained in its system.
Section 9792.11(o)	Addition of a provision allowing the Administrative Director to withhold a written description of complaints against the claims administrator on which the director relied as the basis for a non-routine audit. Since absolutely nothing in current statutes or regulations require the Administrative Director to determine the validity of a complaint before proceeding, persons subject to the regulations could not have anticipated that they would be subject to an investigation without having first been given an opportunity to validate the allegations of violations.	Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment	<p>Agree to revise subdivision (o), now (q). We agree to revise this subdivision. Some discretion must be allowed re disclosing the triggering information because in certain instances, if the investigation subject was aware of the facts, it might alter its records.</p> <p>To the extent the commenter is suggesting this subdivision required 45 day notice, we disagree. The subdivision sufficiently relates to the subject matter: the UR penalty investigation procedure.</p>	The subdivision will be revised to state: Upon initiating a Target Investigation the AD, or his or her designee, shall provide to the claims administrator or the URO a written description of the factual information ...unless the AD...determines that providing the information would make the investigation less useful.”
Section 9792.12(a)	While precise penalty amounts were subject to	Steven Suchil	To the extent the commenter is	We agree to revise some

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>revision, the quintupling of penalties in some instances could not have been anticipated and the persons subject to the regulations have not been given an adequate opportunity to assess their impact on a statutorily mandated program.</p>	<p>Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment</p>	<p>suggesting this subdivision required 45 day notice, we disagree. The subdivision sufficiently relates to the subject matter: UR penalties.</p> <p>We agree to revise some of the penalty amounts in .12(a) and clarify how the violations are described. Regarding the penalty amounts, the amount in (a)(1) is the same as originally noticed; we will be adding new penalties as (a)(2) in the amount of \$5000; (a)(3) in the amount of \$10,000; and (a)(4) in the amount of \$5,000; former (a)(2), new (a)(5) is the same amount; former (a)(3), new (a)(6) and former (a)(4), new (a)(7), were increased from \$5000 to \$25,000 and will remain at \$25,000; former (a)(5), new (a)(8) is the same; former (a)(6) is deleted; former (a)(7), new (a)(9) is the same; former (a)(8), new (a)(10) was increased from \$5,000 to \$10,000 and will be revised back to \$5,000; former (a)(9), new (a)(11) was increased from \$5,000 to \$10,000 and will remain at \$10,000; former (a)(10), new (a)(12) was increased from \$5,000 to \$10,000 and will be revised to \$2,000; (a)(13) will be added in the amount of \$1,000; (a)(14) will be added in the amount of \$500; (a)(15) will be added in the amount of \$100. The amounts of the penalties reflect that the (a) violations are serious violations with</p>	<p>of the penalty amounts in .12(a) and clarify how the violations are described. Regarding the penalty amounts, the amount in (a)(1) is the same as originally noticed; we will be adding new penalties as (a)(2) in the amount of \$5000; (a)(3) in the amount of \$10,000; and (a)(4) in the amount of \$5,000; former (a)(2), new (a)(5) is the same amount; former (a)(3), new (a)(6) and former (a)(4), new (a)(7), were increased from \$5000 to \$25,000 and will remain at \$25,000; former (a)(5), new (a)(8) is the same; former (a)(6) is deleted; former (a)(7), new (a)(9) is the same; former (a)(8), new (a)(10) was increased from \$5,000 to \$10,000 and will be revised back to \$5,000; former (a)(9), new (a)(11) was increased from \$5,000 to \$10,000 and will remain at \$10,000; former (a)(10), new (a)(12) was increased from \$5,000 to \$10,000 and will be revised to \$2,000; (a)(13) will be</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			serious consequences to the injured worker and public. The amounts are based on the severity of the violations.	added ion the amount of \$1,000; (a)(14) will be added in the amount of \$500; (a)(15) will be added in the amount of \$100.
Section 9792.12(b)	Penalties which may be waived only on condition that the claims administrator agree to specified conditions, including reimbursement for the cost of any investigation to determine compliance with abatement measures. These provisions could not have been anticipated since no other penalties assessable under the Labor Code include abatement conditions, neither the Labor Code nor any of the Administrative Director's rules has ever provided for or authorized the imposition of the costs of an audit or investigation on the audit subject and no statutory requirements for calculating the costs of an investigation exist.	Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment	We agree to revise this subdivision to remove the requirement to pay for the cost of investigation in the abatement section. We will also revise this subdivision to include a pass rate of 85%.	We will revise this subdivision to remove the requirement to pay for the cost of investigation in the abatement section. We will also revise this subdivision to include a pass rate of 85%.
Section 9792.13(a)(8)	The original proposal listed five factors which would be taken into consideration by the Administrative Director in deciding whether to reduce or mitigate a penalty are familiar to persons subject to the regulations. They are mandatory factors taken into consideration in determining the appropriate penalty for audit subjects. The addition of a factor which considers "the impact of the penalties assessed in relation to the business revenues of the entity. . ." however, could not reasonably have been anticipated by persons subject to the regulations. The concept, lifted from tort law and civil litigation, is both new and unique in regulatory practice and should be given the entire 45 day comment period.	Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment	To the extent the commenter is suggesting this subdivision required 45 day notice, we disagree. The subdivision sufficiently relates to the subject matter of section 9792.13: penalty adjustment factors. However, we agree to delete (a)(8).	Subdivision (a)(8) will be deleted.

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.13(b)	<p>Lab. C. S. 129.5 (e) provides:</p> <p>"(e) In addition to the penalty assessments permitted by subdivisions (a), (b), and (c), the administrative director may assess a civil penalty, not to exceed one hundred thousand dollars (\$100,000), upon finding, after hearing, that an employer, insurer, or third-party administrator for an employer has knowingly committed or performed with sufficient frequency so as to indicate a general business practice any of the following:</p> <p>(1) Induced employees to accept less than compensation due, or made it necessary for employees to resort to proceedings against the employer to secure compensation.</p> <p>(2) Refused to comply with known and legally in disputable compensation obligations.</p> <p>(3) Discharged or administered compensation obligations in a dishonest manner.</p> <p>(4) Discharged or administered compensation obligations in a manner as to cause injury to the public or those dealing with the employer or insurer."</p> <p>In light of this language, persons subject to the regulations might have anticipated a revised rule to reference this section and notify them of the potential for assessment of civil penalties up to \$100,000 for repeat violators of utilization review program requirements. Persons subject to the regulations could not have guessed or anticipated that, with</p>	<p>Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment</p>	<p>We agree to delete section 9792.13 (b).</p>	<p>Section 9792.13(b) will be deleted.</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>authority vested in the Administrative Director by the Labor Code, civil actions under Business and Professions Code Section 17200 would be grafted into regulations pertaining to workers compensation. This expansion should be given the full notice and 45 day comment period.</p> <p>Further, since neither the Initial Statement of Reasons nor the Notice of 15 Day Changes to the Proposed Text provide any information as to the need for imposition of Bus. &amp; Prof. C. Section 17200, this provision fails to comply with the Gov. C. Section 11349.1 necessity standard. The DWC also lacks the statutory authority to impose this unprecedented additional penalty in an administrative or regulatory context.</p>			
Section 9792.13(d)	<p>The amended language in this subdivision shifts the burden of proof to claims administrators to demonstrate that physicians' refusals to cooperate have resulted in non-compliance with a requirement of statute or regulation. Subdivision (g)(5) of Section 4610 of the Labor Code reads, in part:</p> <p>"Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2)."</p> <p>Persons subject to the regulations might reasonably have expected that requesting physicians would be required to show that the requested information had been provided to</p>	Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment	<p>To the extent the commenter is suggesting this subdivision required 45 day notice, we disagree. The subdivision sufficiently relates to the subject matter of section 9792.13(d) as it was originally proposed:</p> <p>Disagree that this section should be revised. This statement only applies in the context stated in the subdivision: when the claims administrator or URO asserts that the injured worker or treating physician refused to cooperate and that the refusal prevented compliance.</p>	None.

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	employers or the employers' insurers, but it could not have anticipated, and such persons have not been given sufficient opportunity to comment on justifications for the shifting of the burden.			
Section 9792.11(j)	<p>Subdivision 9792.11(j) requires a claims administrator, notified that an investigation will be conducted, to provide the Administrative Director with certain information. Paragraph (1)-requires description of the system used to "uniquely identify each utilization review request, <u>which includes but is not limited to each request for authorization</u> for treatment services or pharmaceutical drugs or medical equipment or diagnostic tests or exams, and the method used to track the status of the request." (Emphasis added). The implication, clearly, is that every treatment request must be tracked, not simply those referred for review under the process established in accordance with Labor Code 4610. However, as the WCAB and the 3rd District Court of Appeal held in <u>SCIF v. WCAB (Sandhagen)</u>, (Third Appellate District, 048668 and 940286), nothing in Section 4610 requires a claims administrator to refer every medical treatment request to utilization review.</p> <p>Although the statutory provision gives the Administrative Director authority to enforce its specific requirements, it does not give her authority to track every treatment request submitted to the claims administrator for purposes of enforcing compliance with</p>	Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment	We agree to revise this subdivision to delete the requirement to have a unique identifier. The subdivision will be revised to request a description of the system used to identify each and every request for authorization (if applicable)" and "To the extent the system identifies any of the following..."	This subdivision will be revised to delete the requirement to have a unique identifier. The subdivision will be revised to request a description of the system used to identify each and every request for authorization (if applicable)" and "To the extent the system identifies any of the following..."

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	<p>Section 4610. Title 8 of the California Code of Regulations, Section 9792.9, implicitly recognizes the limitation by establishing the timeframes for the utilization review process.</p> <p>Penalties for failure to timely authorize any treatment request are already specified in Title 8 of the California Code of Regulations, Sections 10100 et. seq. Implicitly, this includes requests that are handled outside the utilization review process where timeliness can be identified from review of the claim files subject to audit.</p> <p>Finally, nothing in the Utilization Review Standards regulation, Title 8, CCR, Section 9792 et. seq. requires claims administrators to assign and maintain "unique" identifiers for each utilization review request, nor does this proposal explain what would constitute an acceptable identifier.</p> <p>Subdivision(1) should be rewritten to read:</p> <p>(1) <u>A description of the way requests for approval of medical treatment. Pharmaceutical drugs, durable medical equipment or diagnostic tests or exams are referred for utilization review and the method used to track the status of those requests.</u></p> <p>Subdivision (6) requires the subject of the investigation to describe how the medical director "is advised of and able to be responsible for all decisions made in the utilization review process..." However,</p>		<p>We agree to delete the words "is advised of and able to be responsible for all decisions made in the utilization review process."</p>	<p>In subdivision (6), the words "is advised of and able to be responsible for all decisions made in the</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Labor Code Section 4610, subdivision (d) makes the medical director responsible for ensuring compliance of the utilization review process with statutory requirements; it does not hold him responsible for each and every decision made by other medical professionals and the Administrative Director is not authorized to impose upon him greater responsibility than required by statute. The subdivision should be withdrawn or narrowed to conform to statute.</p> <p>Subdivision (7), similar to Subdivision (1), requires a list of every utilization review request to be provided to the Administrative director, and further requires "a unique identifying number" for each file, case or request as well as the claim adjuster's claim number. The comments under Subdivision (1) are applicable here. If the Administrative Director wishes to distinguish requirements for investigations at the site of a claims administrator who contracts for utilization review services, and for investigations at the site of a vendor or other entity who conducts utilization review services on behalf of its clients who may track utilization review requests in that fashion, then the problem can probably be addressed. However, a substantial rewrite is necessary to make the distinction.</p>		<p>We agree to delete subdivision (7). Some of the data elements from (7) are moved to (1), however, as stated above, (1) is also revised.</p>	<p>utilization review process" will be deleted.</p> <p>We agree to delete subdivision (7). Some of the data elements from (7) are moved to (1), however, as stated above, (1) is also revised.</p>
Section 9792.12	Subdivision (a)(1) imposes a maximum \$50,000 penalty on claims administrators who fail to establish and maintain a utilization review process and fail to file a plan with the Administrative Director that fails to comply with, in the words of the section, "all of the following requirements of Labor Code Section	Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment	Agree to revise (a)(1).	Subdivision (a)(1) is revised to state: "For failure to establish a Labor Code section 4610 utilization review plan: \$50,000.

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>4610 ..." However, not a single word in that statute requires the medical director to be "employed. ... with the express written authority and responsibility for all utilization review decisions made for the employer..." Had the legislature wished to include such a requirement, it could have chosen to do so. It did not, and the Administrative Director is not permitted to legislate the requirement nor may she dictate the terms of an employment contract through regulation. Subdivision (2) imposes a separate and additional \$50,000 penalty for failure to utilize contractual terms dictated by the Administrative Director but found nowhere in the statute.</p> <p>More broadly, the increased penalty amounts proposed could have a chilling effect on review of medical treatment services as claims administrators calculate the risk of penalties for even simple errors that would far outweigh the costs of simply approving those services. To the extent the proposed penalties operate in this fashion - and failure to scale penalties to the size of a claim operation virtually assures they will - the intent of lawmakers who enacted Labor Code Section 4610 will be frustrated. Just one example will suffice to illustrate the unreasonableness of the penalties proposed.</p> <p>Section 9792.12(b)(2) specifies penalties when violations are found on a return investigation(s). Assume that five violations of the \$100 sort are found on the first return visit. A claims administrator who had a total of 100 utilization review requests would be</p>		<p>We agree to revise the (b) penalty amounts. Section 9792(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p>	<p>Section 9792(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>assessed \$50,000 while a claims administrator who had a total of 1000 utilization review requests would be assessed \$500,000 - even though the percentage of violations is a very small fraction of those found at the smaller claims administrator's location. The amount, by the way, exceeds the most severe penalty assessable under the Labor Code - the \$400,000 maximum the legislature thought appropriate for claims administrators who violate Section 5814 so frequently as to constitute a general business practice.</p>			<p>be multiplied by ten, but will not exceed \$400,000.</p>
Section 9792.12(a)(12)	<p>Under Subdivision (a) (12), a claims administrator or utilization review organization acting on its behalf would be liable for a penalty up to \$1,000 for failure to provide an authorization number or unique identification number linking the authorization to a claim at the time medical treatment is approved. A penalty cannot be imposed for failure to perform an act that is not required by statute or by any implementing regulation that mandates the act to be performed. This is not consistent with the Utilization Review Standards regulation, and for this reason this provision fails to comply with the Gov. C. Section 11349.1 consistency standard.</p>	<p>Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment</p>	<p>We agree to delete (a)(12).</p>	<p>Subdivision (a)(12) will be deleted.</p>
Section 9792.12(b)(4)(E)	<p>Under this subdivision, a claims administrator would be penalized for failure to comply with the specific notice requirements in Section 9792.9(g)(2). However, the options included in the required notice are now in conflict with the appellate court decision in <u>SCIF v. WCAB (Sandhagen)</u>, C048668 and the WCAB en</p>	<p>Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment</p>	<p>Disagree. <u>Sandhagen</u> is currently under review by the Supreme Court and is no longer citable as authority. (Cal. Rule of Court §§ 8.1105(d) (1) and 8.1115) It is not explained how the <u>Willette v. AU Electric and SCIF</u>, 69 Cal.Comp.Cases decision</p>	<p>None.</p>

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	<p>banc decision in <u>Willette v. AU Electric and SCIF</u>, 69 Cal.Comp.Cases. The Third District Court of Appeals in the former case and the WCAB in the latter both held that an expedited hearing is not available to resolve a utilization review dispute until the injured worker has obtained a QME report under Labor Code Section 4062. Until such time as the Administrative Director revises Section 9792.9, no claims administrator can be penalized for a notice which explains that the injured worker must select a QME to resolve the dispute prior to filing an Application for Adjudication and request for expedited hearing. Based on the foregoing, this provision fails to comply with the Gov. C. Section 1 1349.1 consistency standard.</p>		<p>(there are two <u>Willette</u> decisions) conflicts with the proposed rule. Neither <u>Willette</u> case, however, is inconsistent with the proposed regulations because the employer in <u>Willette</u> used the UR process where the notices are required. Therefore there is no inconsistency with any valid appellate authority. How this rule will be interpreted depends on the Supreme Court's decision in <u>Sandhagen</u> concerning whether the UR process is mandatory. Also, the use of an expedited hearing process is appropriate when a claims administrator has advised an injured worker that it has extended the timeframe for a decision because it is awaiting further medical information. No UR decision has been made and as set forth in 8 CCR 10136, there is an expedited hearing procedure available disputes regarding medical treatment. For example, the workers compensation judge could assist in the process by ordering the physician to produce the requested medical information so that a UR decision can issue.</p>	
Section 9792.11(c)(2), (c)(3) and (o)	<p>These subdivisions permit the Administrative Director to initiate an investigation based on "factual information or a complaint containing facts indicating the possible existence of a violation..." Factual information is insufficient to determine whether the complaint is valid. The requested approval of</p>	<p>Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment</p>	<p>Agree. These subdivisions will be revised.</p> <p>Disagree that the complaints should be verified. The investigating unit will confirm/investigate the allegations in the complaint to</p>	<p>Section 9792.11(c) re target investigations will be revised to state: "A Special Target investigation may be conducted at any time based on credible</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>a service or course of treatment may have been denied, but the validity of the denial is what counts and the complaint is just that - a complaint. Investigations are costly, for DWC whose personnel will be assigned to the investigation, and to the subjects of investigations. Truly bad actors should be penalized; therefore, resources should not be wasted on complaints whose validity has not been determined through further inquiry and after opportunity to respond has been given to the claims administrator. Failure to validate the complaint and failure to give the claims administrator an opportunity to respond is an open invitation to harassment of claims administrators by unscrupulous persons who most certainly will use the opportunity to frustrate legitimate utilization review practices. There is also a high probability that injured workers, unfamiliar with medical treatment guidelines and their application to specific injuries and conditions, and the limitations of an employer's responsibilities under the Labor Code, will file complaints when the basis of a denial was perfectly legitimate.</p> <p>Subdivisions (c) (2) and (c) (3) should be rewritten to require that any complaint be verified first, that "factual information" be confirmed (through opportunity to respond) and that the trigger for a non-routine investigation be narrowed to circumstances in which a violation is probable rather than merely possible.</p> <p>New language in Subdivision (o) permits the</p>		<p>determine if it is credible prior to proceeding with a investigation. Also, as set forth in 9792.11(q), upon initiating an investigation based on a complaint, a description of the complaint or the information contained in the complaint will be forwarded to the investigation subject who shall ten days to respond.</p> <p>There is no required format or method for a complaint. They may be oral or written. Many injured workers are not aware of the legal requirements of UR but have concerns that their treatment requests have been denied. The investigation unit can then determine if it appears that there has been an UR violation before an investigation is initiated.</p> <p>Agree to revise subdivision (o), now</p>	<p>information indicating the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.</p> <p>The subdivision will be</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Administrative Director, in her sole discretion, to withhold all complaint information that triggers a Non-Routine Investigation and on the sole basis that the investigation might be "less useful." Nothing could be less useful than commencing an investigation before the complaints verified, the facts are confirmed and the claims administrator has been given an opportunity to respond. The conduct and violations being investigated here are not criminal actions, but the combination of no advance notice in Subdivision 9792.11(j) and the withholding of basic information about the complaint treat claims administrators like suspects in criminal cases. At the very least, a description of the substance of the complaint and the Administrative Director's rationale for determining that the complaint was justified, must be provided, along with sufficient information for the claims administrator to identify and locate the claim file to which the complaint relates.</p>		<p>(q). We agree to revise this subdivision. Some discretion must be allowed re: disclosing the triggering information because in certain instances, if the investigation subject was aware of the facts, it might alter its records.</p>	<p>revised to state: Upon initiating a Target Investigation the AD, or his or her designee, shall provide to the claims administrator or the URO a written description of the factual information ...unless the AD...determines that providing the information would make the investigation less useful.”</p>
<p>Section 9792.11(i)</p>	<p>This section requires claims administrators, upon receipt of a final report, to notify all affected employers of the findings of the investigation and the measures taken to abate whatever violations have been identified. However, claims administrators do have the right to appeal a Final Determination and Order Assessing Penalty. Should an appeal be timely filed, any notification to affected employers would be premature. The first paragraph should be amended to commence as follows:</p> <p>Upon later of the date on which the claims administrator's timely filed appeals from a</p>	<p>Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment</p>	<p>We agree.</p>	<p>This subdivision (now (v)) will be revised to state: Within thirty-one calendar days of the service of the Order to Show Cause re: Assessment of Administrative Penalties, if no answer has been filed, or within 15 calendar days after any and all appeals have become final, the claims administrator or</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Final Determination and Order Assessing Penalty have been exhausted, or the date of receipt of any final report of findings of violations....			utilization review organization shall provide the following to every employer whose utilization review process was assessed with a penalty pursuant to section 9712.12: (1) A notice which shall include a copy of the final investigation report, the measures actually implemented to abate such conditions, and the website address for the Division where the final investigation report is posted. If a hearing was conducted under section 9792.15, the notice shall include the Final Determination in lieu of the final investigation report. (2) The notice shall be served by certified mail.
Section 9792.11(j)	Although claims administrators will generally receive 30 calendar days advance notice of an investigation, at the Administrative Director's discretion, an investigation may be conducted without any notice whatsoever. No other audits are conducted on this basis and no supporting documentation or rationale has been provided to support the need for surprise visits.  Even with advance notice, claims	Steven Suchil Assistant Vice President Western Region American Insurance Association December 12, 2006 Written Comment	We agree to revise this section to clarify that the investigation subject will always receive advanced notice in routine investigations. In special targets or return targets the only time advanced notice will not be provided is when advanced notice will render the investigation less useful.  Subdivision (1) will be revised to allow 14 days to produce the	The subdivision will be revised to clarify that the investigation subject will always receive advanced notice in routine investigations. In special targets or return targets the only time advanced notice will not be provided is when advanced notice will

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>administrators are given a mere seven calendar days to produce an immense quantity of data and information, much of which may relate to claims already closed and much of which may no longer be maintained in readily accessible form at the claims administrator's site. Seven days is half the time claims administrators have to produce a simple claim log under Section 10107.1 -and they have an additional 14 days after notice of the claims files selected for audit to make the files available. Seven days is inadequate and unnecessary. Claims administrators should be provided at least 14 business days with an opportunity to extend the time for production of files.</p>		documents.	<p>render the investigation less useful.</p> <p>Subdivision (l) will be revised to allow 14 days to produce the documents.</p>
Section 9792.11(c)(5)	<p>This subsection proposes that during any non-routine investigation, the Administrative Director (AD) or his/her designee may investigate any complaints received since the time of any prior investigation.</p> <p><b>Recommendation</b> Commenter recommends that this subsection be grouped as subsection 9792.11(c)(4)(C) since it is part of the non-routine investigation to determine abatement.</p>	<p>Jose Ruiz Operations Manager State Compensation Insurance Fund (SCIF) December 12, 2006 Written Comment</p>	<p>We agree to reorganize subdivision (c) to group the types of investigations together.</p>	<p>Subdivision is revised to group the types of investigations together.</p>
Section 9792.11(i)	<p>This section proposes that upon receipt of any final report of violations from the AD, the claims administrator or UR organization shall notify the affected employers with a summary of the findings, measures implemented to abate the conditions, whether an objection or appeal has been filed, and the DWC website where the investigation report is posted.</p> <p><b>Recommendation</b></p>	<p>Jose Ruiz Operations Manager State Compensation Insurance Fund (SCIF) December 12, 2006 Written Comment</p>	<p>We agree. The contents of the final report will be set forth in 9792.15(a).</p>	<p>Section 9792.15(a) will set forth the contents of the final report: the basis for the assessment, a statement of the alleged violations, and the amount of each proposed penalty.</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter recommends that this subsection clearly outline the contents of the final report. It is critical that claimant identifiable and medical information be excluded in order to protect the privacy of injured employees.</p>			
Section 9792.11(j)	<p>This section proposes that unless the AD determines that advance notice will render an investigation less useful, the claims administrator or UR organization will be notified no less than 30 calendar days in advance of an investigation. Upon receipt of the notice of investigation, the claims administrator shall deliver to the AD within seven calendar days, all requested information and records including, but not limited to, the items noted in subsections 9792.11(j)(1) through 9792.11(j)(8).</p> <p><b>Recommendation</b> Commenter recommends that these regulations outline the process to be followed where the AD does <b>not</b> provide advance notice. The timeframes (i.e. 7 calendar days) for the employer to provide all of the required information in this subsection, as well as subsection 9792.11(k), are dependent on the notice from the AD.</p>	<p>Jose Ruiz Operations Manager State Compensation Insurance Fund (SCIF) December 12, 2006 Written Comment</p>	<p>Disagree. The situations where no advance notice is provided will have to be dealt with on a case by case manner depending on the factual situation. The investigating unit may be required to obtain a warrant or subpoena, or the parties may agree on the procedure.</p>	None.
Section 9792.11(k)	<p>This section proposes that the AD shall provide the claims administrator or UR organization with a list of no less than 32 UR files, cases or requests for investigation based on the information provided pursuant to 9792.11(i).</p> <p><b>Recommendation</b> The number of UR files, cases or requests should be adjusted based on the size of the UR</p>	<p>Jose Ruiz Operations Manager State Compensation Insurance Fund (SCIF) December 12, 2006 Written Comment</p>	<p>We agree. The regulations will be revised to provide that a random sample of requests will be requested . The number will be based on the table set forth in section 9792.11(d).</p>	<p>New subdivision 9792.11(d) will set forth the number of requests for authorization that will be randomly selected depending on the population of requests during a three month period.</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	organization or claims administrator being investigated, similar to the audit claims file selection process in CCR §10107. This will provide a true representation of the total population. In addition, it is not clear how the list of files will be generated “pursuant to section 9792.11(i)” as that subsection outlines the notice requirements for the employer.			Subdivision (k) will be revised to refer to the list randomly selected requests for authorization.
Section 9792.11(1)	<p>This section proposes that if the AD determines that additional records or files are needed for review during any onsite investigation, the claims administrator or UR organization shall produce the requested records within one calendar day.</p> <p><b>Recommendation</b> Commenter recommends extending this timeframe to allow up to two or three <u>working</u> days, instead of calendar days. If the AD requests several additional files or several pieces of information, one calendar day is not sufficient. Older files and other additional records (e.g. investigation records, subpoena medical records) are often kept in storage and may take more time to locate even though they are kept on-site.</p>	Jose Ruiz Operations Manager State Compensation Insurance Fund (SCIF) December 12, 2006 Written Comment	Disagree. Audit performed pursuant to 129.5 require additional filed to be produced within 1 day (see 8 CCR 10107.1(i)). There have been no problems with this requirement. Also, the pilot investigations only lasted a few days. Allowing three working days would unnecessarily extend the amount of time the investigators would need to be at the site and delay the completion of the investigation Finally, the subdivision allows the AD to extend time for the production of the requested records upon good cause.	None.
Section 9792.12(a)(4)	<p>This subsection proposes a maximum penalty of \$25,000 if a non-physician reviewer makes a decision to delay or deny a UR request without obtaining the opinion of a reviewer.</p> <p><b>Recommendation</b> Some medical treatment requests do not require a medical review. For example, a medical opinion is not necessary for claims which have been denied or claims that have</p>	Jose Ruiz Operations Manager State Compensation Insurance Fund (SCIF) December 12, 2006 Written Comment	We agree to revise this subdivision.	Subdivision (a)(4) now (7) will be revised to state: For failure to comply with the requirement that only a licensed physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>been settled by a Compromise and Release Agreement. Commenter recommends that this subsection be revised to account for medical treatment requests that do not require a medical opinion as this would only tie up UR resources and add to UR administrative costs.</p>			<p>necessity to cure and relieve except as provided for in section 9792.2(b)(2) and (3): \$25,000.</p>
Section 9792.12(a)(12)	<p>This subsection proposes a maximum penalty of \$1000 for the failure to provide the requesting physician with a UR authorization number.</p> <p><b>Recommendation</b> This subsection introduces a new requirement that is not mandated per LC §4610 or CCR §§9792.6 through 9792.12. Commenter recommends that the UR regulations, CCR §§9792.6 through 9792.12, be re-opened in order to add the requirement of a UR authorization number. As currently written, this penalty does not have any basis since it is not required for performing UR.</p>	<p>Jose Ruiz Operations Manager State Compensation Insurance Fund (SCIF) December 12, 2006 Written Comment</p>	<p>We agree to delete this subdivision.</p>	<p>This subdivision will be deleted.</p>
Section 9792.12(b)(A) through (C)	<p>These subsections provide the penalty calculation methods in the event the AD returns to the same investigation site and finds one or more violations of the same section of LC §4610 or CCR §§9792.6 through 9792.12. The proposed penalty calculation takes the maximum basic penalty amount (i.e. \$100 or \$50) multiplied by a percentage of the total number of UR requests answered in the preceding 30 days. This penalty will be assessed for each instance of the same violation.</p> <p><b>Recommendation</b> Extrapolating penalties appears to be inappropriate when the files that are being</p>	<p>Jose Ruiz Operations Manager State Compensation Insurance Fund (SCIF) December 12, 2006 Written Comment</p>	<p>We agree to revise the (b) penalty amounts. Section 9792(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts</p>	<p>Section 9792(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>audited have not been identified as a random poll. If the 32 files selected were not based on a random poll, but were based on complaints filed, it appears this method would over-penalize employers by extrapolating from the whole and create issues of due process.</p>		<p>will be multiplied by ten, but will not exceed \$400,000. Also, the requests for authorization will be randomly selected per 9792.11(c) and (d).</p>	<p>penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000. Also section 9792.11(c) and (d) will be revised to state that the requests for authorization will be randomly selected.</p>
<p>Section 9792.12(b)(4)(G)</p>	<p>This subsection outlines the information, including the name of the expert reviewer to be consulted, that is required on any written decision to delay or extend the timeframe for making a decision on a request for authorization pursuant to LC §4610(g)(5).</p> <p><b>Recommendation</b> The UR regulations, CCR §9792.9(g)(2), does not require that the notice include the <i>name</i> of the expert reviewer to be consulted because the name of the reviewer is not always known in advance. It only requires the <i>specialty</i> of the expert reviewer to be consulted. Commenter recommends that this subsection be revised to reflect the UR regulations.</p>	<p>Jose Ruiz Operations Manager State Compensation Insurance Fund (SCIF) December 12, 2006 Written Comment</p>	<p>We agree to revise (b)(4)(G) now (B)(5)(g) .</p>	<p>Subdivision (b)(4)(g) now (b)(5)(g) will be revised to state: For failure to explain in writing the reason for delay as required by section 9792.9(g)(2) of Title 8 of the California Code of Regulations when the decision to delay was made under one of the circumstance listed in section 9792.9(g)(1).</p>
<p>Section 9792.14(b)</p>	<p>This subsection indicates that the claims administrator, UR organization, or other entity subject to LC §4610 is liable for all penalty assessments, except where the subject of the investigation or audit is acting as an agent, the agent and the principal are jointly and severally liable for all penalty assessments.</p>	<p>Jose Ruiz Operations Manager State Compensation Insurance Fund (SCIF) December 12, 2006 Written Comment</p>	<p>Disagree. The subdivision states: “except that if the subject of the investigation or audit is acting as an agent, the agent and principal are jointly and severally liable...” Thus, if the insured employer is not acting as an agent, the claims administrator</p>	<p>None.</p>

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	<p>The agent and its principal are not prohibited from allocating the administrative penalty liability between them. However, liability for civil penalties shall not be allocated.</p> <p><b>Recommendation</b> The UR regulation, CCR §9792.6(c), provides a definition of “claims administrator” which includes an insured employer. Page two of The Addendum to Final Statement of Reasons dated September 20, 2005 explains:</p> <p style="padding-left: 40px;">“First, the definition includes the term “an insured employer” because throughout the regulatory process it was determined that some insured employers were conducting some of the utilization review on their own. By including the “insured employer” in the definition of claims administrator it has been assured that if they choose to conduct utilization review on their own, they would be required to comply with the requirements of the regulations, and be subject to penalties for failure to comply with the requirements of the regulations.”</p> <p>Commenter is concerned that where the employer is acting independently from the claims administrator, and by doing so, performs a violation of UR standards, the claims administrator may be jointly and severally liable due to the language in the UR Enforcement Regulations subsection 9792.14(b) despite the fact that the employer is not an authorized agent of the claims administrator. Commenter believes</p>		<p>will not be jointly liable for the insured employer’s penalty assessments. The recommended language is duplicative of the language in the regulation. However, the parties can insert similar language in their URO contracts if desired.</p>	

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>that it may be contrary to public policy for an insurer to pay penalties on behalf of an employer who has stepped out of its role as policyholder, whose claims by contract are to be adjusted by the insurer. Therefore, we propose the following language to address penalties resulting from an insured employer's unlawful and independent actions:</p> <p>(b) The claims administrator, utilization review organization or other entity subject to Labor Code section 4610, respectively, is liable for all penalty assessments made against it, except that if the subject of the investigation or audit is acting as an agent, the agent and the principal are jointly and severally liable for all penalty assessments resulting from a given investigation or audit. This paragraph does not prohibit an agent and its principal from allocating the administrative penalty liability between them. Liability for civil penalties assessed pursuant to Labor Code section 129.5(e) for violations under Labor Code section 4610 or sections 9792.6 through 9792.10 of Title 8 of the California Code of Regulations shall not be allocated.</p> <p><u>When an insured employer acts independently of the insurers responsibility for the Utilization Review program as described in Labor Code §4610, the insurer will not be liable for any penalty assessments for those actions.</u></p>			

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 9792.15(r)	<p>This subsection states, "...Upon timely demand for production of a witness in lieu of admission of an affidavit or declaration, the proponent of that witness shall ensure the witness appears at the scheduled hearing and the proffered declaration or affidavit from that witness shall not be admitted."</p> <p><b>Recommendation</b> Commenter recommends that this subsection be clarified and offers the following language:</p> <p>(r) ...Upon timely demand for production of a witness in lieu of admission of an affidavit or declaration, the proponent of that witness shall ensure the witness appears at the scheduled hearing and the proffered declaration or affidavit from that witness shall not be admitted, <b>unless good cause can be shown as to why the designated witness cannot testify.</b></p>	Jose Ruiz Operations Manager State Compensation Insurance Fund (SCIF) December 12, 2006 Written Comment	Agree to revise this subdivision. The proposed language ignores the parties right to cross-examination.	The following language will be added to this subdivision: If the AD ... determines that good cause exists that prevents the witness from appearing at the hearing, the declaration may be introduced in evidence, but it shall be given only the same effect as other hearsay evidence.
Section 9792.11	Commenter generally supports the proposed investigative procedures but finds the process for filing provider complaints is not clearly addressed. Although the proposed language refers to audit regulations, Commenter believes the UR regulations must include language specific to the reporting of UR violations. Commenter requests that language be included that describes the UR complaint process including at least the following: address for submission, required supporting documentation and any all information necessary to initiate an investigation. In addition, Commenter requests that Division	Frank Navarro Associate Director California Medical Association December 12, 2006 Written Comment	We agree to add subdivision (e) to provide additional information regarding making complaints. We disagree regarding adopting a standard form. An optional form will be available on the website, as stated in the new subdivision. However, complaints may be made in any manner, written or oral. Also, we disagree regarding adding language to the regulations that all complaints will be acknowledged. Although the investigating units will try to do so, there may be times when due to	Subdivision (e) will be added to state: (e) Complaints concerning utilization review procedures may be submitted with any supporting documentation to the Division of Workers' Compensation using the complaint form that is posted on the Division's website at: <a href="http://www.dir.ca.gov/dwc/FORMS/UtilizationRev">http://www.dir.ca.gov/dwc/FORMS/UtilizationRev</a>

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	acknowledge receipt of each complaint. Commenter strongly recommends adoption of a standard form and instructions that are specific to filing a UR complaint		staffing problems it is not possible. Additionally, the complainant may not provide enough information to allow a response.	iewcomplaintform.pdf Complaints should be mailed to DWC Medical Unit-UR, PO Box 420603, San Francisco, CA 94142-0603, attention UR Complaints or emailed to DWCMangedCare@dir.ca.gov. Complaints received by the Division of Workers' Compensation will be reviewed and investigated, if necessary, to determine if the complaints are credible and indicate the possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.12.
Section 9792.12	Commenter appreciates the proposed increased penalties to many of the provisions but states there are areas of serious concern with the newly proposed penalty schedule. Adherence to each of the UR standards including: access hours to telephone and facsimile, all required timeframes, and request and notification requirements are all equally crucial to the timely provision of medically necessary care. While such violations may not cause harm to workers in each case, physicians do not have the resources to continuously follow up with non-compliant UR systems, and such violations will	Frank Navarro Associate Director California Medical Association December 12, 2006 Written Comment	Disagree. The division attempted to include violations for most of the UR requirements. However, if the public is aware of a violation that is not included in the penalty schedule, a complaint may still be made and the investigators will attempt to informally resolve the problem. (Currently that is how all UR complaints are being handled.) There are other remedies available when claims administrators fail to comply with statute or regulations, such as under the Labor Code 129	Section 9792.12(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and

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	<p>inevitably lead to patient harm if not addressed.</p> <p>For these reasons, Commenter opposes the proposed waiver of penalty language for first time offenses under 9792.12(b) and asks that this language be removed.</p> <p>Commenter opposes the low level of proposed basic penalties of \$50.00 to \$100.00. Given the critical importance of decisions being rendered through the UR process, no penalty should be this low. Penalties so paltry are highly unlikely to deter abusive behavior. Commenter recommends they be increased to \$500.00 to \$1000.00 respectively.</p> <p>The proposed formula for calculating penalties for one or more violations upon “return investigation” is unclear. Commenter urges the Division to adopt significant, escalating penalties for multiple violations of the same sections.</p>		<p>and 129.5.</p> <p>Agree to revise the (b) penalties, but not as the commenter has requested. The (b) penalties are a lower amount because they are for lesser violations consisting of timeliness, notice content and service of the notices. Section 9792.12(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000. Also, the requests for authorization will not be randomly selected per 9792.11(c) and (d).</p>	<p>not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p>
Section 9792.12(a)	Proposed §9792.12(a) outlines the structure for applying single instance penalties. All of the penalty amounts in this section were raised considerably from the initial version of the regulations – some by 500%. We believe that the increase in penalty amounts in this second version will serve to discourage the use of utilization review in California.	<p>Jason Schmelzer Legislative Director</p> <p>Scott Lipton Membership Director &amp; Grassroots Coordinator California Coalition on Workers’ Compensation December 12, 2006</p>	We agree to revise (a)(8). The penalty will be reduced to \$5,000 and the subdivision will be clarified.	Subdivision (a)(8) now (10) will be revised to state: For failure to approve the request for authorization solely on the basis that the condition for which treatment was requested in not addressed by the

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	<p>Commenter is especially concerned with proposed §9792.12(a)(8), which provides for a \$10,000 fine for denying treatment because they are not addressed by the treatment guidelines adopted by the Administrative Director pursuant to Labor Code Section 5307.27, when the requesting physician has provided rationale based on “other evidence-based medical treatment guidelines that are generally recognized by the national medical community and are scientifically based.” At the very least we believe that this section should also require that the alternative guidelines are peer reviewed.</p> <p>Proposed §9792.12(a)(8) leaves open the possibility that a request for treatment that is based on some obscure guideline would have to be accepted, even though the guidelines adopted by the Division of Workers’ Compensation, which should be comprehensive, are silent on the requested treatment. This could be true even if the guidelines adopted by the Division of Workers’ Compensation offer other alternatives for the injury in question. A cursory examination of internet resources shows literally hundreds of treatment guidelines that could be used to obtain treatment under this section. We are concerned that this section would significantly weaken the successful application of medical treatment guidelines through utilization review.</p>	Written Comment		medical treatment utilization schedule adopted pursuant to section 5307.27 of the Labor Code: \$5,000.
Section 9792.12(b)	The framework for assessing multiple instance penalties as outlined in proposed §9792.12(b) remains problematic. While the initial penalty	Jason Schmelzer Legislative Director	Agree to revise the (b) penalties. Section 9792.12(b) will be revised to provide a performance rating based	Section 9792.12(b) will be revised to provide a performance rating based

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>structure in proposed §9792.12(b) avoids penalizing a claims administrator or utilization review organization based on size, proposed §9792.12(b)(2) does in fact penalize based on size.</p> <p>Proposed §9792.12(b)(2) outlines how a claims administrator or utilization review organization will be penalized on a follow up non routine investigation, or second investigation at the location. The framework establishes that penalties will be applied by taking the basic penalty amount and then multiplying it by a percentage of the “total number of utilization review requests answered in the 30 days preceding notice of, or onset of...” the investigation. Similar to the first version of the regulations, this means that a claims administrator or utilization review organization with a higher number of utilization review requests answered will face a more significant penalty than a smaller organization with a few number of utilization review requests answered. Although the structure of the penalty framework has been changed from the first version of the regulations, the result is essentially the same in that it will unduly penalize a larger organization simply as a function of size.</p> <p>Commenter objects to a regulatory framework that will unfairly penalize a claims administrator or utilization review organization in a manner that is simply dependant on the size of their business. Requests that the DWC revise the section on multiple instance penalties to treat all</p>	<p>Scott Lipton Membership Director &amp; Grassroots Coordinator California Coalition on Workers’ Compensation December 12, 2006 Written Comment</p>	<p>on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p> <p>Also, the requests for authorization will be randomly selected per 9792.11(c) and (d). The sample will be randomly selected from all requests for authorization during a three month calendar period. The table in (d) provides for a statically valid sample which is adjusted based on the size of the population.</p>	<p>on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p> <p>Also, the requests for authorization will be randomly selected per 9792.11(c) and (d). The sample will be based on the population size.</p>

<b>Utilization Review Standards</b>	<b>RULEMAKING COMMENTS 15 DAY COMMENT PERIOD</b>	<b>NAME OF PERSON/ AFFILIATION</b>	<b>RESPONSE</b>	<b>ACTION</b>
	violations the same independent of the size of the claims administrator or utilization review organization.			
Section 9792.11(i) and 9792(b)(5)	Commenter supports the new provision in the regulations that requires a utilization review organization to notify the employers for whom they administer UR of any violations and remediation. The section also indicates that DWC will post a copy of the final report on the website for the DWC. This reporting and posting provision will provide much needed information to employers who contract with utilization review companies, and will ultimately serve to provide a useful incentive to companies administering utilization review requests.	<p>Jason Schmelzer Legislative Director</p> <p>Scott Lipton Membership Director &amp; Grassroots Coordinator California Coalition on Workers' Compensation December 12, 2006 Written Comment</p>	Agree.	<p>This subdivision (now (v)) will be revised to state: Within thirty-one calendar days of the service of the Order to Show Cause re: Assessment of Administrative Penalties, if no answer has been filed, or within 15 calendar days after any and all appeals have become final, the claims administrator or utilization review organization shall provide the following to every employer whose utilization review process was assessed with a penalty pursuant to section 9712.12: (1) A notice which shall include a copy of the final investigation report, the measures actually implemented to abate such conditions, and the website address for the Division where the final investigation report is posted. If a hearing was conducted under section</p>

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
				9792.15, the notice shall include the Final Determination in lieu of the final investigation report. (2) The notice shall be served by certified mail.
Section 9792.11(j)(7)	Commenter states that clarification is needed as to limitation of time frame. Wants to know if there will be a limit of time frame specified by the Administrative Director?	Mary Ellen Szabo Manager Managed Care Fair Isaac Corp. December 12, 2006 Written Comment	Agree. Subdivision (j)(7) will be deleted and partially merged into (j)(1). A three month calendar time period will be added.	Subdivision (j)(7) will be deleted. Subdivision (j)(1) will provide that the time period is a three month calendar period that will be designated by the AD.
Section 9792.11(k) and (j)	Commenter requests the Division consider changing the number of day required to submit to the AD to 14 calendar days instead of 7 calendar days.	Mary Ellen Szabo Manager Managed Care Fair Isaac Corp. December 12, 2006 Written Comment	Agree.	This change will be made.  Subdivision (j) will be revised to provide at least 60 days notice and (k) will allow 14 days to produce the records.
General Comments	Commenter believes that the monetary penalties proposed are excessive and will serve only to undermine the intent of Labor Code Section 4610. Commenter opines that the breadth and depth of these penalties are a death knell to Utilization Review. Commenter inquires as to why the maximum penalty for UR would become \$400,000 when the maximum penalty under section 129.5 is capped at \$100,000?	Philip M. Vermeulen Governmental Relations AIMS and AMC December 12, 2006 Written Comment	Disagree. Labor Code section 4610 does not impose a cap on the penalties. In contrast to Labor Code section 129.5, Labor Code section 5814.6 allows for penalties up to \$400,000. The (a) penalties are for major violations, such a failure to have a UR plan. The penalties listed in these regulations take into consideration the cost of not complying. For example, hiring a medical director will cost in the range of \$100,000 to 200,000 per year. Therefore, unless the penalty for failure to hire a medical director is high, some entities may decide that	Section 9792.12(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>The audit function should follow the audit rules contained in section 129 of the Labor Code to eliminate redundant audits and to avoid further strains on the Division's resources. Commenter believes that routine audits should be performed every five years as part of the routine PAR audits conducted by the DWC.</p>		<p>it would be cheaper to violate the requirement than to hire a medical director. There, the penalty for failure to hire a medical director is \$50,000.</p> <p>Agree to revise the (b) penalties. Section 9792.12(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p> <p>Agree to conduct the UR investigations at the same time as PAR audits. Section 9792.11(c)(2)(A) will be revised to provide that the routine investigation of the claims administrator will occur once every five years concurrent with the PAR audit. Also, the random sample table from the audit regulations (8 CCR 10107.1) will be incorporated into these regulations as 9792.11(d). However, the audit</p>	<p>penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p> <p>Section 9792.11(c)(2)(A) will be revised to provide that the routine investigation of the claims administrator will occur once every five years concurrent with the PAR audit. Also, the random sample table from the audit regulations (8 CCR 10107.1) will be incorporated into these</p>

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	<p>Under the current regulations the Division is allowed to initiate an audit based upon complaints that contain “factual” information. There is no indication that the Division has the duty to verify the facts before proceeding with an investigation which you are proposing in this latest draft. This has the potential to produce unnecessary audits, draining the resources of both the Division and the regulated community AND with questionable results at best.</p>		<p>procedures will not work for UR violations. Labor Code sections 129 and 129.5 do not give the AD authority to audit or assess penalties against UROs. Also, Labor Code section 129.5 prohibits the assessment of any penalties if the audit subject passes the PAR and caps penalties that can be assessed at \$5,000. The audit regulations (8 CCR 10107.1 et seq.) provide that the only violations addressed in the PAR audit are failure to pay indemnity payments, late first payments of TD, PD etc., and failure to issue benefit notices.</p> <p>Agree to revise 9792.11(c) to require a special target to be based on credible information indicating a possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.10. The complaints that will be included in investigations must be “credible complaints.” Subdivision 9792.11(e) will be added to state that the complaints will be reviewed and investigated, if necessary to determine if the complaints are credible and indicate the possible existence of a UR violation.</p>	<p>regulations as 9792.11(d).</p> <p>Subdivision 9792.11(c) to will be revised to require a special target to be based on credible information indicating a possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.10. The complaints that will be included in investigations must be “credible complaints.” Subdivision 9792.11(e) will be added to state that the complaints will be reviewed and investigated, if necessary to determine if the complaints are credible and indicate the possible</p>

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	<p>The proposed regulations would require both claims organizations and UR organizations to capture data that is totally outside of the requirements presently in-place for these entities. Many organizations do not assign a unique number or identifier for each request for treatment. This presents an undue burden to these organizations.</p> <p>The Division is attempting to adopt these proposed regulations before the Medical Treatment Utilization Schedule has been finalized and implemented. The direct consequence of this action would be that the regulations would be incomplete. Commenter strongly believes that these proposed regulations should not be finalized until the new schedule is in place.</p> <p>These proposed regulations have had substantial revisions made to them since the start of the process. For instance, new language has been added only recently discussing the possible abatement of penalties. Commenter believes that these changes are substantial and thus should require a new 45 day comment period.</p>		<p>Agree to revise (j). The requirement to have a unique identifier will be removed. The (j) subdivision is requesting information regarding the system to track UR requests and responses. The claims administrator or URO should have this information in some format in order to operate its business, but will only be required to provide the information to the extent that the system identifies the information. By providing the information to the AD, the AD will be able to select the random UR files for investigation.</p> <p>Disagree. Pursuant to Labor Code section 4610(c), prior to the AD's adoption of a medical guideline, the procedures and standards must be consistent with ACOEM.</p> <p>Disagree. The changes made to these regulations are sufficiently related to the originally noticed regulations.</p>	<p>existence of a UR violation.</p> <p>Section 9792.11(j) will be revised to eliminate some of the data elements and information that will be requested. The requirement to have a unique identifier will be removed. Additionally, it will only require the investigation subject to produce the information if it has a system to identify requests for authorization and if the data is maintained in its system.</p> <p>None.</p> <p>None.</p>
Section 9792.11(c)(1)	These subsections provide for audit reviews	Kathleen Bissell, CPCU	Agree to conduct the UR	Section 9792.11(c)(2)(A)

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
and (3)	every 3 years or 5 years on a routine or non-routine basis. Commenter understands the need for regulator oversight; however, commenter feels that this proposal would duplicate review already being conducted through the PAR process. Commenter recommends removing these sections.	Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	investigations at the same time as PAR audits. Section 9792.11(c)(2)(A) will be revised to provide that the routine investigation of the claims administrator will occur once every five years concurrent with the PAR audit.	will be revised to provide that the routine investigation of the claims administrator will occur once every five years concurrent with the PAR audit.
Section 9792.11(c)(5)	Commenter opposes this section as it establishes a duplicative oversight process. The practical outcome of this language may prompt a non-routine investigation simply because a provider disagrees with the UR recommendation, thereby creating a potentially substantial burden on the Division to follow-up with a full non-routine investigation.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Agree to revise 9792.11(c) to require a special target to be based on credible information indicating a possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.10. The complaints that will be included in investigations must be “credible complaints.” Subdivision 9792.11(e) will be added to state that the complaints will be reviewed and investigated, if necessary to determine if the complaints are credible and indicate the possible existence of a UR violation.	Subdivision 9792.11(c) will be revised to require a special target to be based on credible information indicating a possible existence of a violation of Labor Code section 4610 or sections 9792.6 through 9792.10. The complaints that will be included in investigations must be “credible complaints.” Subdivision 9792.11(e) will be added to state that the complaints will be reviewed and investigated, if necessary to determine if the complaints are credible and indicate the possible existence of a UR violation.
Section 9792.11(f)	Commenter supports the language where a specific timeframe for implementation is set out simply to allow a reasonable time for those impacted to make the necessary changes to procedures.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Agree.	None.

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Section 9792.11(i)	<p>Commenter believes that the provisions in this subparagraph are unworkable and present an extra-ordinary notification process that could confuse rather than inform the employer. The language provides no guidance as to what specifically needs to be noticed (entire finding or just the finding for the customer's file). Commenter wonders if separate notices would be required. Additionally, there is an inconsistency with the requirements under Section 9792.15(b)(4)(G)(5) where final penalty amounts are defined differently.</p>	<p>Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment</p>	<p>Agree to clarify this subdivision.</p>	<p>This subdivision (now (v)) will be revised to state: Within thirty-one calendar days of the service of the Order to Show Cause re: Assessment of Administrative Penalties, if no answer has been filed, or within 15 calendar days after any and all appeals have become final, the claims administrator or utilization review organization shall provide the following to every employer whose utilization review process was assessed with a penalty pursuant to section 9712.12: (1) A notice which shall include a copy of the final investigation report, the measures actually implemented to abate such conditions, and the website address for the Division where the final investigation report is posted. If a hearing was conducted under section 9792.15, the notice shall include the Final Determination in lieu of</p>

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				the final investigation report. (2) The notice shall be served by certified mail.
Section 9792.11(j)	This section sets out the timeframes for investigation and suggests that notification of review could occur up to 30 days in commencement of the review. Since unspecified file review can cause significant disruption in the claims handling process, commenter strongly recommends that 60 days notice be allowed when 15 or more files will be reviewed. This provision also provides that all requested information be provided to the AD within 7 days. Again, due to the potential for disruption to the normal claims handling and UR process, it is more reasonable to allow 30 days to provide the requested information on up to 15 files and 60 days for 15 or more files.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Agree. Subdivision (j) will be revised to provide at least 60 days notice and (k) will allow 14 days to produce the records.	Subdivision (j) will be revised to provide at least 60 days notice and (k) will allow 14 days to produce the records.
Section 9792.11(j)(1)	This subsection seeks detailed information which may or may not be available and due to the broad definition of “the system used to uniquely identify each UR request which includes <u>but it not limited to...</u> ” and could place an extra ordinary burden on employers and those providing UR services. This expansive level of potential detail could be expensive to produce and costly to implement in terms of system changes.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Agree to revise (j). The requirement to have a unique identifier will be removed. The (j) subdivision is requesting information regarding the system to track UR requests and responses. The claims administrator or URO should have this information in some format in order to operate its business, but will only be required to provide the information to the extent that the system identifies the information. Section 9792.11(j) will be revised to eliminate some of the data elements and information that will be requested. The requirement to have a unique identifier will be removed. Additionally, it will only	Section 9792.11(j) will be revised to eliminate some of the data elements and information that will be requested. The requirement to have a unique identifier will be removed. Additionally, it will only require the investigation subject to produce the information if it has a system to identify requests for authorization and if the data is maintained in its system.

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			require the investigation subject to produce the information if it has a system to identify requests for authorization and if the data is maintained in its system.	
Section 9792.11(j)(4)	This subsection requests a summary of UR request and other information which could be costly and burdensome to produce and yield information that is easily misinterpreted or misguided in promoting fair and reasonable Utilization Review. How will this information be used, from a practical perspective, in determining the appropriate treatment and favorable return to work outcomes?	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Agree to revise this section to remove information concerning withdrawals. The subdivision will also only require the information, "if available." The information will help the AD randomly select the requests for authorization.	This subdivision will be revised to remove information concerning withdrawals. The subdivision will also only require the information, "if available."
Section 9792.11(j)(7)	It is unclear what type of electronic format for providing a list of all UR cases might be acceptable to the AD and commenter strongly recommends that any format used encourage a format, if any exists, which is used by other states to reduce the cost of establishing a separately formatted system for California alone. Also, establishing a 'unique identification number' may not be problematic from the UR perspective, but may not exist within a carrier' database. Establishing such a unique number would be costly and need a lengthy period of time to implement. Time to implement the sorting and resorting suggested in this section would also require extensive, costly system changes.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Agree. Subdivision (j)(7) will be deleted and partially merged into (j)(1). The requirement to have a unique identifier will be removed. An electronic format will not be required.	Subdivision (j)(7) will be deleted and partially merged into (j)(1). The requirement to have a unique identifier will be removed. An electronic format will not be required.
Section 9792.11(k)	This section imposes a 7-day turn around for responding to requests for information on 32 specified files. This short time frame would be difficult, if not impossible to meet.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual	Agree to revise (k) to allow 14 days to provide the information.	Subdivision (k) will be revised to allow 14 days to provide the information.

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	Commenter believes a 30-day time frame is reasonable with the option of allowing additional time if more information on a greater number of files is requested.	December 12, 2006 Written Comment		
Section 9792.11(k)(2)	Under this subsection, complete, original records are required to be produced. For efficiency reasons, most of her company's records are available in electronic format. For this reason, the Division should amend this provision to remove "original" and replace it with "or complete copies."	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Agree.	The subdivision (now (m)) will allow copies to be produced.
Section 9792.11(l)	This section required that record requests, when records are located on the site of the investigation, should be provided within one calendar day. Commenter recommends that 5 calendar days be allowed to provide the information for both on site and off site records.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Disagree. Audits performed pursuant to 129.5 require additional files to be produced within 1 day (see 8 CCR 10107.1(i)). There have been no problems with this requirement. Also, the pilot investigations only lasted a few days. Allowing five calendar days would unnecessarily extend the amount of time the investigators would need to be at the site and delay the completion of the investigation. Finally, the subdivision allows the AD to extend time for the production of the requested records upon good cause.	None.
Section 9792.11(n)(1)	The provisions in the subsection include a confusing set of circumstances to determine when a document is received. Commenter believes the exception language should clearly state that the receipt date, if stamped, should be acceptable.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Disagree. This subdivision is supplementing section 9792(a)(2) which does not address this factual situation.	None.
Section 9792.11(o)	This subparagraph sets out the criteria where the AD will notify the claims administrator or other entity of the need for a written response within 10 business days. Commenter	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual	Disagree. This subdivision provides an opportunity to refute a complaint. If there is a large number of complaints that can not be responded	None.

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	recommends that the AD be allowed to expand the time frame for response to allow a complete, accurate response on a large number of files, as appropriate.	December 12, 2006 Written Comment	to in 10 days, it is probably appropriate for the investigation to go forward. The pilot investigations have lasted only a few days each.	
Section 9792.12(a)(1)	This subparagraph establishes significant penalties for failure to file an acceptable utilization plan. However, the regulations do not, specifically, provide for a process that either guide those who file plans toward an acceptable plan format through a formal or information communication process. Commenter recommends that any regulations that provide severe penalties for non-compliance provide a process for getting feedback prior to the imposition of penalties.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Disagree. The filing process and approval process should be within the UR regulations at 9792.6 - .10. However., the division will have reviewed and commented on all filed UR plans prior to the date these regulations are filed with OAL.	None.
Section 9792.12(a)(4)	Penalties imposed under this subparagraph suggest a \$25,000 penalty could result if a utilization reviewer makes a request for additional information which is not provided or refused by the provider. Exceptions should be made when rational decisions are made to deny UR authorization when the provider inappropriately refuses to cooperate in the UR process.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	This subdivision will be revised. Also, 9792.13(c) provides for the situation where there is a failure to cooperate.	Subdivision (a)(4) now (7) will be revised to state: “(7) For failure to comply with the requirement that only a licensed physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve, except as provided for in section 9782.9(b)(2) and (3): \$25,000;”
Section 9792.12(a)(5)	This subsection exposes utilization reviewers to a \$25,000 penalty where discussions leading to compromise agreements are allowed without having to re-file amended requests, sending confirmation letters, etc. This added administrative burden will only	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	This subdivision will be clarified. However, the statute requires the request for authorization to be in writing and if a non-physician agrees to an amended request, there must be a written amended request.	Subdivision (a)(5) now (8) will be revised to state: (8) For failure of a non-physician reviewer (person other than a

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	lead to delays in securing authorization.			reviewer, expert reviewer or medical director as defined in section 9792.6 of Title 8 of the California Code of Regulations), who approves an amended request, to possess an amended written request for treatment authorization as provided under section 9792.7(b)(3) when a physician has voluntarily withdrawn a request in order to submit an amended request: \$25,000;
Section 9792.12(a)(6)	This subsection establishes a \$25,000 penalty for failure to comply with the immediate medical treatment provisions under LC section 5402(c). Commenter recommends that this section be amended to exempt claims administrators and utilization reviewers when a provider requests treatment that has previously been denied, without any material changes, or a claim or the specific body part has been denied, or the \$10,000 threshold has been reached, no claim form has been received (or an application filed) or the claim administrator has advised the provider that they do not have authorization to provide treatment related to the MPN transfer of care or when other case specific facts indicate an appropriate denial of care has been communicated to the appropriate parties.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	We agree to delete this subdivision.	This subdivision will be deleted.

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Section 9792.12(a)(10)	The subparagraph should reflect that the treating physician's request for review should be in writing and provide all necessary information to allow the utilization reviewer to undertake the appropriate review.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Disagree. By definition (9792.6(o)) the request for authorization must be in writing. The definition sets forth the requirements for a request for authorization.	None.
Section 9792.12(a)(12)	This subparagraph assumes that the UR community currently has in place a formatted database that will allow a unique identifier which links the approved medical treatment authorization number to a specific claim. Such changes could be administratively burdensome or require a number of months to affect systems changes to comply. Any change of this nature needs ample time to affect system/procedural changes.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Agree to delete this subdivision.	This subdivision will be deleted.
Section 9792.12(b)(2)(B) and (C)	Additional penalties imposed under these subparagraphs would appear to have little flexibility for specific situations, practices or potential impact on the injured worker. Commenter suggests that this language reflect the ability of the AD to impose penalties which are reasonable in nature. Commenter also believes that subsection "C" should apply to the "fourth" rather than the "third" follow up investigations.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Agree to revise the (b) penalties. Section 9792.12(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.	Section 9792.12(b) will be revised to provide a performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will

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				be multiplied by ten, but will not exceed \$400,000.
Section 9792.12(b)(3)(D)	This subparagraph imposes a \$100 penalty for failure to make a decision within 5 days, but does not specify a timeframe for the requesting provider. Commenter recommends that the language reflect a 30-day time frame after which a new request for all relevant information must be submitted.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Agree to revise this subdivision. The subdivision tracks the language in the UR regulations. The UR regulations do not provide authority for commenter's suggestion that after 30 days a new request must be submitted.	Subdivision (b)(3)(D) now (b)(4)(C) will be revised to state: (C) For failure to make a decision to approve or modify or deny the request for authorization, within five (5) working days of receipt of the requested information for prospective or concurrent review and to communicate the decision as required by section 9792.9(g)(3);
Section 9792.12(b)(3)(E)	This subparagraph is designed to encourage prompt retrospective reviews and determinations. However, the language appears to ignore the responsibility of the providers to request treatment concurrently or prospectively. In some jurisdictions, treatment is not reimbursed when it is not requested ahead of treatment.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Agree to revise this subdivision. The subdivision tracks the language in the UR regulations.	The subdivision is now (b)(4)(D) and is revised to state: (D) For failure to make and communicate a retrospective decision to approve, modify, or deny the request, within thirty (30) working days of receipt of the information, as required by section 9792.9(g)(4);
Section 9792.12(b)(4) (A) through (G)	These subparagraphs establish several areas where a \$50 penalty may be imposed. Commenter recommends a more reasonable approach would be to allow an aggregate of	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual	Agree to revise the (b) penalties. Section 9792.12(b) will be revised to provide a performance rating based on the number of violations in each	Section 9792.12(b) will be revised to provide a performance rating based on the number of

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	<p>\$250 for incidental non-compliance at the AD's discretion or provide for an "up to a maximum amount" to allow the AD to impose penalties based on the individual circumstances of the situation.</p>	<p>December 12, 2006 Written Comment</p>	<p>of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p>	<p>violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p>
<p>Section 9792.12(b)(6)</p>	<p>This subparagraph places the responsibility for the AD's costs solely on the utilization reviewer or claims administrator but does not provide for any penalties or adjustment when the investigation results in no non-compliance findings or when a provider files a complaint which is ultimately determined to be unreasonable or inappropriate.</p>	<p>Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment</p>	<p>This subdivision will be deleted.</p>	<p>This subdivision will be deleted.</p>
<p>Section 9792.13(b)</p>	<p>This new subparagraph attempts to establish a framework to impose penalties under a pattern and practice approach that gives no consideration to the type of non-compliance, provides no timeframe within which the "3 separate investigations" occur and appears to give no period of time for the location to correct any identified problems.</p>	<p>Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment</p>	<p>This subdivision will be deleted.</p>	<p>This subdivision will be deleted.</p>
<p>Section 9792.13(d)</p>	<p>This subparagraph establishes a burden of</p>	<p>Kathleen Bissell, CPCU</p>	<p>Disagree a revision is needed. This</p>	<p>None.</p>

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	proof standard on the reviewer even when there is no cooperation from the injured worker or provider. Commenter suggests that in those cases where the injured worker is represented that a similar burden of proof be allowed. In addition, the AD may wish to consider establishing a list of providers who consistently refuse to cooperate or file frivolous complaints on the DWC website.	Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	section would apply to both a represented and unrepresented injured worker. The request to list providers who fail to cooperate goes beyond the scope of these regulations.	
Section 9792.14(a)	This subparagraph suggests that duplicate penalties would be imposed when more than one entity is responsible for non-compliance. Commenter suggests that penalties be based on shared violations and should be reasonably share among the parties responsible.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Disagree. The subdivision provides that where over time more than one entity handles the file, the penalty will be imposed on the entity responsible for the violation. It does not state penalties will be imposed on both entities for the same violation.	None.
Section 9792.14(c)	This subparagraph suggests that all non-compliance liabilities will be transferred to an assuming entity. Commenter finds the assumption of liability and exposure to penalty unfair, particularly in a TPA situation or when a self-insured employer contracts for claims administration. The language should recognize these situations.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	Disagree. Successor liability would not apply unless there has been a substantial continuity of business and/or the new business uses the same or substantially same work force.	None.
Section 9792.15(d)	The language in this subparagraph does not consider the circumstances where an appeal is pending and a final determination has not been made. Commenter suggests that the language provide for copies to be sent when the final outcome is determined. The requirements appear to apply during appeals, answers and settlement discussions and it would seem more reasonable and appropriate to require copies be delivered only after all of these elements have finally been resolved.	Kathleen Bissell, CPCU Assistant Vice President Public Affairs Liberty Mutual December 12, 2006 Written Comment	We agree to delete (d). Subdivision 9792.11(v) will require the final report (after all appeals) to be sent to the employer.	Subdivision (d) will be deleted.
General Comment	Commenter believes that the proposed regulations will deter employers from using	The California Chamber of Commerce	Disagree re: the (a) penalties. The penalties set forth in section	Section 9792.12(b) will be revised to provide a

Utilization Review Standards	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>utilization review. Utilization review is a process to resolve conflicts arising in medical treatment decisions internally and expeditiously. While employers are required to have a utilization review program, case law does not dictate that employers submit every contested case to the rigors of utilization review. Employers instead may opt to use the cumbersome dispute resolution process of Labor Code section 4062, which can last weeks or even months. The proposed regulations so severely penalize technical and procedural errors, even those in the absence of harm to the claimant that employers will be far more likely to choose the 4062 procedure to avoid costly penalties resulting from non-substantive errors. The disincentive inherent in the proposed regulation inadvertently conflicts with the goal to provide expedited medical treatment decisions for injured workers. Furthermore, the new two-year cap on temporary disability benefits exacerbates the need for prompt medical decision-making.</p>	<p>December 12, 2006 Written Comment</p>	<p>9792.12(a) are for serious violations of the UR requirements, such as failure to have a UR plan, failure to have a medical director, failure to respond to a request for admission.</p> <p>Agree re: the penalties set forth in subdivision (b). These penalties are for lesser violations – violations concerning timeliness and notice requirements. We agree to revise to allow an 85% passing rate and to reduce the increase factor for return investigation.</p>	<p>performance rating based on the number of violations in each of four categories. If the performance rating is 85% or better, no (b) penalties will be imposed. Subdivision (b) is also revised to provide that on a second investigation, the penalty amounts will be multiplied by two, and not exceed \$100,000. On the third investigation, the penalties will be multiplied by five but will not exceed \$200,000. On the fourth investigation, the penalty amounts will be multiplied by ten, but will not exceed \$400,000.</p>
<p>General Comment</p>	<p>Commenter feels that the medical provider networks could be compromised by the proposed regulations. Medical provider networks were a cornerstone of the recent reforms and were intended to control costs and improve medical care for injured workers with science-based, empirically-proven treatments. The success of the medical provider networks has been aided by the establishment of utilization standards. With utilization review an integral part of medical provider networks, it has not been necessary to overly restrict physician membership with the medical provider networks. The</p>	<p>The California Chamber of Commerce December 12, 2006 Written Comment</p>	<p>Disagree. Providers with MPNs may tell their physicians that they have authority to perform certain types of procedures so that they do not need to request authority each time. Alternatively, the claims administrators could approve requests for authorization when they originate from the MPN providers.</p>	<p>None.</p>

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	excessively punitive nature of the proposed regulations, especially for technical errors in the absence of harm to the claimant, network physician membership roles will likely need to be revisited.			
General Comment	<p>Commenter believes that multiple audits are unnecessarily costly to the system. Effective audits are a vital component of detecting fraudulent activities and are important to workers and law-abiding employers alike. The statutory grant of authority provided in Labor Code section 4610 makes no provision for a separate audit. Despite numerous changes to the labor code in recent years, the only statutory authority for the Administrative Director to conduct audits has remained solely in Labor Code sections 129 and 129.5. The proposed regulations establish authority for a separate audit outside of the statutory confines of the law. Separate audits will increase costs in the system and will not likely improve compliance.</p>	<p>The California Chamber of Commerce December 12, 2006 Written Comment</p>	<p>Disagree. While we agree to revise section 9792.11(c)(A) to provide that the routine investigation of the claims administrator will occur once every five years concurrent with the PAR audit. Also, the random sample table from the audit regulations (8 CCR 10107.1) will be incorporated into these regulations as 9792.11(d). However, the audit procedures will not work for UR violations. Labor Code sections 129 and 129.5 do not give the AD authority to audit or assess penalties against UROs. Also, Labor Code section 129.5 prohibits the assessment of any penalties if the audit subject passes the PAR and caps penalties that can be assessed at \$5,000. The audit regulations (8 CCR 10107.1 et seq.) provide that the only violations addressed in the PAR audit are failure to pay indemnity payments, late first payments of TD, PD etc., and failure to issue benefit notices. However, Labor Code section 133 provides the AD power and jurisdiction to do all things necessary or convenient in the exercise of any power or jurisdiction conferred upon it under the Labor Code. Therefore, the AD is authorized to conduct</p>	<p>Section 9792.11(c)(A) will be revised to provide that the routine investigation of the claims administrator will occur once every five years concurrent with the PAR audit. Also, the random sample table from the audit regulations (8 CCR 10107.1) will be incorporated into these regulations as 9792.11(d).</p> <p>Also, we will revise 9792.12(b) to allow a 85% pass rate, similar to the audit performance standard.</p>

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			investigations pursuant to Labor Code section 4610 of claims administrators and UROs in order to determine if UR violations exists and to assess penalties for the violations.	
General Comment	Commenter opines that the proposed regulations put the cart before the horse. The absence of uniformity in utilization review decisions has in part been a byproduct of the delay in not adopting medical treatment utilization standards as authorized by Labor Code section 5307.27. Those currently pending regulations, along with their higher rebuttal standard requiring actual scientific evidence, should significantly reduce utilization related disputes. The enforcement penalties should not be put into place until after the adoption of applicable medical treatment utilization standards.	The California Chamber of Commerce December 12, 2006 Written Comment	Disagree. Labor Code section 4610 requires claims administrators and UROs to comply with the UR requirements set forth in that section. As stated in section 4610(c), until medical guidelines are adopted by the AD, the policies and procedures shall be consistent with ACOEM.	None.