INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.9.1(c)(2)	Commenter opines that by instituting these regulations into law, the RFA will have no value. Commenter states that the purpose of the RFA was to assist the claims personnel to determine what is being authorized by using a clear and concise document that can be easily reviewed and in return providing a timely response to either authorize or sent to UR. If determined to UR the RFA, the medical director also has a clear understanding of what the primary treating doctor has requested, thereby, assisting the timely process of the UR. Commenter opines that as proposed by these regulations, if ANY request for treatment on any form without an RFA is to be considered as complete within 3 days of receipt and asks - WHAT GOOD IS THE RFA - WHERE IS THE VALUE IN THE RFA? Commenter opines that all that will be accomplished in assisting in the processing to authorize medical treatment will be for not if there is not	Linda Larkins Claims Manager September 27, 2013 Written Comment	To describe the amendment as a means to eviscerate the requirements for the DWC Form RFA is a gross mischaracterization. The option to allow a claims administrator to accept and process a request for authorization that did not utilize the DWC Form RFA was put into place on the request of claims administrators who, professing concern about delivering medical treatment to injured workers on a timely basis, wanted the ability to approve treatment requests without having to mechanically return them for not having a DWC Form RFA. The regulation was clear: if a claims administrator did not want to process a non-compliant request for authorization, i.e., one without a DWC Form RFA attached, it could return the form. The Division believed it would not take a claims administrator 3 business days	9792.9.1 (c)(2)(B) is added to read: "The claims administrator may accept a request for authorization for medical treatment that does not utilize the DWC Form RFA, provided that: (1) "Request for Authorization" is clearly written at the top of the first page of document; (2) all requested medical services, goods, or items are listed on the first page; and (3) the request is accompanied by documentation substantiating the medical necessity for the requested treatment.

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	regulations that will stand behind the RFA form and make it mandatory for all medical personnel. Commenter opines that these new regulations are a way around the RFA. Commenter opines that there should not be away AROUND the RFA and that it should be mandatory, thereby providing some logical meaningful plan of action for medical treatment by the treating doctor that can be relayed to the claims personnel.		to exercise that simple option. Regardless, the Division recognizes that treatment requests submitted in a medical report may be difficult for some claims administrators to locate, therefor the Division has amended the regulation to provide that any non-compliant request must be clearly identified with "Request for Authorization" written at the top of the first page, all requests must be listed on the first page, and the request must be accompanied by sufficient documentation. Claims administrators should be allowed 5 business days to return non-compliant request, the same timeframe in which to request additional information under section 9792.9.1(f)(2).	
9792.12(a)(12-14); 9792.12(b)(4)(c)	Commenter notes that this section creates a new subdivision to establish the administrative penalties for violation of the IMR statutes and	Diane Worley California Applicants' Attorneys	The Administrative Director recognizes the importance of meaningful administrative penalties and the express	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	rules. Commenter support the increase in the daily penalty for some violations as set forth in subdivision (c but opines that the proposed penalties are woefully inadequate in light of the harm to the injured worker from many of the violations identified in this subdivision. As an example, commenter states that, to date, several dozen IMR determinations – all decisions upholding a UR denial – have been issued despite the fact that the claims administrator provided no medical records to the IMRO. Commenter opines that the imposition of the penalties as currently proposed would be a grossly inadequate response to such a flagrant violation of these rules. Commenter supports the proposed rule change that will allow the immediate issuance of an order to show cause for the assessment of administrative penalties but opines that unless the penalty amounts are significantly increased the Division's enforcement efforts will be futile. Commenter opines that it is not appropriate to assess the maximum	Association October 11, 2013 Written Comment	statutory language of section 4610.5(i). That said, the amount of administrative penalties set forth in proposed section 9792.12 is reasonable given the nature and scope of the specific violations and the fact that IMR is a new dispute resolution procedure in workers' compensation. It must be noted that any violation of a claims administrator that can be deemed a "general business practice" can subject a claims administrator to civil penalty under Labor Code section 129.5. It must be noted that under section 9792.10.6(b)(2), if a claims administrator fails to submit the documentation required under section 9792.10.5(a)(1), a medical reviewer may issue a determination as to whether the disputed medical treatment is medically necessary based on both a summary of medical records	

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	penalty in every instance, but that it is equally inappropriate to never assess the maximum penalty. Commenter recommends that this section be rewritten to establish meaningful penalties, including a maximum penalty of $5,000 per day for conduct such as the complete failure to provide medical records to the IMRO.		listed in the utilization review determination issued under section 9792.9.1(e)(5), and documents submitted by the employee or requesting physician under section 9792.10.5(b) or (c). No independent medical review determination shall issue based solely on the information provided by a utilization review determination.	
Expedited UR/IMR	Commenter opines that expedited UR and IMR should be eliminated. Commenter opines that injured workers in need or urgent or emergency care should receive such services immediately. The current and proposed regulations do not adequately address this need; and also create new opportunities for abuse by providers. There is a requirement in LC4610(g)(2) for completion of prospective or concurrent UR within 72 hours when "the employee's condition is such that the employee faces an imminent and serious threat	Robert Ward October 10, 2013 Written Comment	The requirements for expedited review are statutory. See Labor Code section 4610(g)(2). That said, section 9792.9.1(c)(4) has been amended to first require from a physician documentation confirming the need for expedited review, and second to expressly allow claims administrators to convert a request for expedited review into a regular review if the request is not reasonably supported by evidence establishing that the injured	No action necessary.

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	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 employee's life or health or could jeopardize the employee's ability to regain maximum function". This requirement is the basis for the current regulations regarding expedited UR and IMR. However, if the DWC were to mandate that all UR of care requests that fall within the description found in LC4610(g)(2) were to be conducted retrospectively, then the requirement would technically be met. There would never be any prospective or concurrent URs on such care; and therefore every such prospective or concurrent review would have been completed within 72 hours. Commenter recommends that retrospective review be required in all instances when "the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life,		worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under subdivision (c)(3) would be detrimental to the injured worker's condition.	

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	limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function". Current and proposed regulations encourage the claims administrator to inform the provider that such care should be provided immediately, and then reviewed retrospectively. However, this does not go far enough. Retrospective review of such care should be mandated. Rather than conducting expedited UR (and IMR), in each instance where the provider has checked the box for expedited review, the claims administrator should be required to immediately notify the requesting provider that UR may only be conducted retrospectively; and that lack of prior authorization cannot be a basis for denial on that retrospective review. This approach would simplify both the UR and and IMR systems; improve			

	patient safety; and circumvent abuse of the system by providers. In the circumstances described in LC4610(g)(2), 72 hours is too long to insure patient safety; and is often too short for timely review to take place. Additionally, there are a growing number of physicians who are abusing the system by routinely marking the checkbox for expedited review on every Form RFA. This appears to be a deliberate attempt to engineer untimely UR.			
IMRO Fines	Commenter recommends that in the event that IMR is completed outside the established time frames for completion, that the DWC should impose administrative fines on the IMRO. Similar to the fines established for failure of the claims administrator to support the IMR process in a timely manner, these should be structured such that the fine compounds daily to some maximum. The daily increase provides continued incentive to complete the IMR continues even after it initially becomes untimely. The maximum should be sufficiently high that it poses a real cost above and	Robert Ward October 10, 2013 Written Comment	Labor Code section 4610.6 does not extend remedies for an untimely IMR determination to the parties. Any penalties for an untimely determination would be a matter of contract between the Administrative Director and the IMRO.	No action necessary.

	beyond the payment to be received for the IMR.			
General Comment	Commenter states that his intent was to go point-by-point through the Regulations; but a review shows that the Legislative Intent has not yet been achieved. Commenter opines that these regulations are going require major reconstructive surgery; not a band aid. Commenter though it commendable when Rosa Moran and Christine Baker turned to the industry for recommendations and solutions. Commenter states that it is time to involve the players [employers, carriers, employees and physicians] to write a new set of Regulations of both Utilization Review and the IMR process. Commenter recommends that representatives of the Legislature be part of this process so that where clean up legislation is needed to fix these problems before it brings the process to a screeching halt such legislation can be introduced.	Dennis Knotts December 7, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. .	No action necessary.
Article 5 – Title	Commenter recommends the following change for the title of Article 5: Article 5 ~~Predesignation of Personal Physician; Request for Change of~~	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013	Agree in part.	The title of Article 5.5.1 has been amended to read: "Utilization Review Standards; Independent Medical

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	~~Physician;~~ Reporting Duties of the Primary Treating Physician; Petition for ~~-~~Change of Primary Treating Physician, <u>Utilization Review and Independent Medical Review</u>.	Written Comment		<u>Review."</u>
2992.01	Commenter opines that a conflict created in the early days of Utilization Review is that the authors and implementers of the system did not understand the hierarchy of who makes the decisions on a claim file. Regulation 2592.01 (b) notes: "…"Claims adjuster" does not include the medical director or physicians utilized by an insurer for the utilization review process pursuant to Labor Code section 4610." Why is this so significant? Because it is the claims adjuster, acting as the trier of facts under contract [i.e. the workers' compensation insurance policy] who makes the determination of compensability – the liability of the employer. Even the defense attorney is not permitted to act as the trier of facts and make determinations on the case regarding the liability of the employer to provide benefits. This role is also specifically denied to the reviewing physician. The reviewing physician	Dennis Knotts December 7, 2013 Written Comment	The Division does not believe that the regulations of the Department of Insurance conflict with the proposed regulation. It must be noted that: (1) Labor Code section 4610 does not distinguish between a claims administrator and any separate utilization review organization hired on the claims administrator's behalf; and (2) Labor Code section 4610(e) allows claims adjusters to approve requests for medical treatment. Only a physician may delay, deny, or modify a request.	No action necessary.

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	cannot be the trier of fact. The treating physician cannot be classified as a claims adjuster. It is forbidden by Regulation 2592.01 (b) of the Insurance Code.			
9792.9.1(c)(2)	Commenter opines that the reduction of time from five to three days for the return of an incomplete DWC Form RFA is untenable. The DWC Form RFA is meant to expedite the process so that requesting physicians are clear in their requested treatments. Commenter opines that the incomplete use of that form will be the rule rather than exception if Claims Administrators are not given the ability to reject the form with the specified reasons for its return.	Stephen L. Kline General Counsel EK Health Services October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.
9792.12(a)(12), (13) and (14)	Commenter requests that the modified language added "or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted" be deleted from these 3 sections. Commenter opines that only a valid DWC Form RFA should be subject to UR standards, timeframes, procedures, notices and penalties per our comments under 9792.9.1.	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.
9792.12(a)(12), (13) and (14)	Commenter recommends the following revised language:	Brenda Ramirez Claims and Medical	See response to September 27, 2013 comment by Linda	No action necessary.

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	(a)(12) For failure to respond to a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted~~ by the injured employee's requesting treating physician, in the case of a non-expedited concurrent review: $ 2,000; (a)(13) For failure to respond to a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted~~ by the injured employee's requesting treating physician, in the case of a non-expedited prospective review: $ 1,000; (a)(14) For failure to respond to a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted~~ by the injured employee's requesting treating physician, in the case of a retrospective review: $ 500; Commenter requests that the DWC delete the modified language referencing the alternative request for	Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Larkins regarding section 9792.9.1(c)(2).	

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	authorization under section 9792.9.1(c)(2). There should only be one uniform and identifiable request for authorization form. Commenter opines that only a valid DWC Form RFA should be subject to UR standards, timeframes, procedures and penalties.			
9792.12(a)(12), (a)(13) and (a)(14)	Commenter recommends the following revised language: (a)(12) For failure to respond to a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted~~ by the injured employee's requesting treating physician, in the case of a non-expedited concurrent review: $ 2,000; (a)(13) For failure to respond to a complete DWC Form ~~RFA or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted~~ by the injured employee's requesting treating physician, in the case of a non-expedited prospective review: $ 1,000; (a)(14) For failure to respond to a complete DWC Form RFA ~~or other~~	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	~~request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted~~ by the injured employee's requesting treating physician, in the case of a retrospective review: $ 500; Commenter recommends that the DWC delete the modified language referencing the alternative request for authorization under section 9792.9.1(c)(2). Commenter opines that there should only be one uniform and identifiable request for authorization form and that only a valid DWC Form RFA should be subject to UR standards, timeframes, procedures and penalties.			
9792.12(a)(11), (12) and (13)	Commenter notes that these subsections will impose a fine for failure to respond to a request for authorization accepted by the claims administrator under 9792.9.1(c)(2). As noted in her comments on 9792.9.1(c), the carrier must either accept the submission and process the request or send a letter rejecting the submission within 3 business days and explain why the submission is being rejected. If the carrier misses a submission, the carrier appears to have been deemed	Anne Searcy, MD Sr. Vice President & Medical Director The Zenith October 10, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

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	to have accepted it by failure to send a communication rejecting it within 3 business days. Commenter states that there is no guidance provided on what the AD will consider a valid treatment request for audit purposes or imposition of the fines. Commenter requests that either the fine be removed for submissions that are not on a RFA or that the DWC clarify what will be considered a valid treatment request.			
9785(b)(3)	Commenter recommends the following revised language: Except for determinations pursuant to Labor Code section 4610, ~~I~~if the employee disputes a medical determination made by the primary treating physician, including a determination that the employee should be released from care, the dispute shall be resolved under the applicable procedures set forth in Labor Code sections 4060, 4061, 4062, 4600.5, 4616.3, or 4616.4. Commenter opine that the recommended addition clarifies that all PTP determinations except for	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	The language of the regulations is sufficiently clear to show that treatment disputes under Labor Code section 4610 are resolved through the procedures of section 4610.5.	No action necessary.

	those subject to Labor Code section 4610 are resolved under the procedures in the section listed in the first sentence.			
9785(b)(3)	Commenter opines that the DWC is attempting to reconcile the two-track IMR process created in SB 863 by differentiating between disputes with the primary treatment physician and disputes over a UR determination when medical care is being provided through an MPN. In so doing, commenter opines that the Division appears to have unintentionally expanded the role of the WCAB in the determination of medical necessity issues. The proposed regulation states that if the employee objects, "to a *decision made* pursuant to Labor Code section 4610" then the dispute shall be resolved by IMR. While this language is consistent with Labor Code § 4062(c), this is not the only part of Section 4062 that explains the rights of an injured worker. Labor Code § 4062(a) begins with, "If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues not	Mark E. Webb Vice President and General Counsel PacificComp October 11, 2013 Written Comment	The Division finds that the proposed UR and IMR regulations accurately implement the mandates of SB 863. The question of whether the regulations have affected the scope of the WCAB's jurisdiction over disputes involving medical treatment disputes is a matter that must be resolved by the WCAB, as the Division has no authority to dictate that agency's jurisdiction.	No action necessary.

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	covered by Section 4060 or 4061 and *not subject to Section 4610…*" Commenter states that it is important to distinguish between a dispute over a UR decision [Section 4062(c)] and the issue of whether the WCAB has jurisdiction over the dispute. [Section 4062(a) -- the fact that UR was not attempted, or was in some other way defective, does not mean that the medical issue was not *subject* to Section 4610. Commenter states that it is clear that the DWC has the authority to penalize claims administrators for their failure to meet the timeframes required of UR. [Labor Code § 4610(i)] Commenter states that the proposed regulations demonstrates that the Division clearly understands its authority in this regard and with the myriad other requirements by which UR may be found to be defective. Commenter states that it is also clear that prior to SB 863 a claims administrator could only dispute medical necessity through the mechanism of UR. [State Compensation Insurance Fund v. WCAB (Sandhagen) (2006), 44 Cal.			

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	4th 230, 186 P.3d 535, 79 Cal. Rptr. 3d 171] Commenter states that changes in SB 863 place Sandhagen in a different light – essentially raising the question of whether its bar against claims administrators utilizing the WCAB to adjudicate medical necessity issues now applies to claimants as well. If it does, then the challenge to the Division is to address the Sandhagen fact pattern and provide an expedited path to IMR for an injured worker when the claims administrator has not complied with the requirements of UR. Commenter states that the language in Section 4062 supports such a conclusion, as do the amendments to Labor Code §§ 4061 and 4064. In addition, the limited jurisdiction of the WCAB to review IMR decisions found in Labor Code § 4610.6(h) further underscores that the WCAB is expected to no longer be a forum where the issue of medical necessity is adjudicated. The commitment to having medical professionals make medical necessity determinations is			

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	also reinforced by the procedure that occurs if a determination of the administrative director following an IMR review is reversed: "the dispute shall be remanded to the administrative director to submit the dispute to independent medical review by a different independent review organization." [Labor Code § 4610.6(i)]. Among its extensive findings made part of SB 863, the Legislature declared, "That having medical professionals ultimately determine the necessity of requested treatment furthers the social policy of this state in reference to using evidence-based medicine to provide injured workers with the highest quality of medical care and that the provision of the act establishing independent medical review are necessary to implement that policy." Commenter opines that any process by which this finding can be frustrated, whether by claims administrators or injured workers, must be looked at very carefully. Even if one argues that the Appeals Board has the ability to			

	adjudicate whether UR was not properly done [for example Labor Code § 5300(f)], that does not confer jurisdiction upon the Appeals Board to make the ultimate determination of whether the requested treatment was medically necessary. It would be preferable if the Division would establish a process whereby a defective UR results in a referral to IMR from the Division based on the requesting physician's properly documented request and the independent review organization (IRO) makes the determination of medical necessity. Commenter opines that there are issues that will arise from such a process, and a procedure cannot be developed in such a way as to lessen the impact of the failure to observe UR statutory and regulatory requirements. On the other hand, consider the costs, delays, and uncertainty brought about by using such violations or oversights as a way to avoid the structure so clearly intended in SB 863. Commenter opines that allowing such a judicially created *status quo ante* is a			

	considerably worse outcome.			
9785(a)(1)	Commenter recommends the following revised language: The "primary treating physician" is the treating physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. Commenter states that the addition of "treating" provides a more complete definition.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	No action necessary.
9792.12(c)(8)	Commenter notes that this subsection provides for imposition of a $250 fine for failure to pay a bill submitted under9 792.10.8(c). Commenter states that 9791.10.8(c) already provides that if the bill is not paid timely, then an additional amount of 10% will be due plus interest at the legal rate. Commenter opines that the state should not be able to impose two penalties for non-payment of a single bill. Commenter states that either the fine should be removed or the 10% additional amount plus interest provision should be removed. Both	Anne Searcy, MD Sr. Vice President & Medical Director The Zenith October 10, 2013 Written Comment	The purpose of the administrative penalty assessed under subdivision (c)(8), now renumbered as (c)(9), is to remedy the harm to the overall IMR program caused by claims administrators who fail to pay for the services under the statutory mandate of Labor Code section 4610.6(*l*). The interest added in subdivision 9792.10.8(c) is to remedy the harm caused to the IBRO for the late payment.	No action necessary.

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	should not be imposed. Commenter states that there is nothing in 9792.10.8 that allows the recipient of the bill to contest charges. Commenter opines that some form of reconciliation process should be permitted if the billing includes full charges when the IMR was withdrawn and the payor should not be required to submit payment for contested charges until a review process has been completed. Commenter opines that the wording concerning the payment due date is confusing. Commenter recommends the following revised language: 9792.10.8 (c) The aggregate total **uncontested** fee owed by the claims administrator for the prior calendar month shall be paid to the independent medical review organization within thirty (30) days of **receipt of** the billing. If the aggregate **uncontested** total fee is not paid within ten (10) days after it becomes due forty (40) days of **receipt of** the billing, there shall be added an additional amount equal to 10 percent, plus interest at the legal rate, which shall be paid at the		Regarding section 9792.10.8(c), the comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. That said, the Administrative Director finds that the best way to resolve any dispute between a claims administrator and the IBRO over charges for IMR reviews should be left to the parties with minimal regulatory constraints.	

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	same time but in addition to the total aggregate **uncontested** fee. **If the claims administrator is disputing any portion of a billing, the claims administrator must submit a letter to the billing entity identifying the specific charges being disputed and the reason why the charges are being disputed within 30 days of the date the billing was received by the claims administrator. The billing entity must provide the claims administrator the opportunity to communicate directly with the appropriate billing office to resolve any billing discrepancies. Billing disputes must be resolved with 45 business days after the billing entity receives notice of the dispute. If the dispute cannot be resolved with 45 business days, the dispute shall be submitted to the Administrative Director for a final review and determination. If any additional amounts are found to be due after the reconciliation process, the claims administrator will submit payment of the amounts due within 30 days of the final determination. Applicable time frames will be extended by 5 days for mailing**			

	when communications are sent by mail.			
9792.12(b)(4)(C) and (b)(4)(D)	Commenter recommends the following revised language: (b)(4)(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 a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2)~~ submitted by the injured employee's requesting treating physician, or receipt of the requested information for prospective or concurrent review, and to communicate the decision as required by section 9792.9(h)(3) and section 9792.9.1(f) (4); (b)(4)(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 a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2)~~ submitted by the injured employee's requesting treating	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

	physician, or receipt of the requested information, as required by section 9792.9(g h)(4) and section 9792.9.1(e)(4), and (f)(6); Commenter recommends that the DWC delete the modified language referencing the alternative request for authorization under section 9792.9.1(c)(2) and opines that there should only be one uniform and identifiable request for authorization form.			
9785(g)	Commenter opposes the deletion of the following sentence from this subsection: <u>A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment *if it is not clearly referred to in the Medical Treatment Utilization Schedule.*</u> Commenter has added the language in italics intended to reduce needless justification by a physician.	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	A request for authorization should include all facts and substantial medical evidence substantiating the need for the recommended medical treatment. A simple reference to the MTUS guidelines may be insufficient; there is no assurance that the UR physician reviewer is in possession of the employee's relevant medical records to make a sound decision regarding medical necessity.	No action necessary.
9785(g)	Commenter recommends retaining the	Rob Shatsnider	Agree.	9785(g) has been

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	last sentence of this subsection as follows: "The DWC for RFA must include as an attachment documentation substantiating the need for the requested treatment." Commenter opines that there will be an increase in the amount of delays and UR requests for additional information if providers are not required to submit supporting documentation with their RFA. This would not be beneficial to injured workers because it creates additional delays and non-certifications.	Vice President, Claims CompWest October 9, 2013 Written Comment		amended to reinsert: "A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment."
9785(g)	Commenter recommends the addition of the following sentence: <u>A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include or attach information to substantiate the need for the requested treatment.</u> Commenter recommends restoring this language as it is important to identify when the submission confirms an	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Agree.	See above.

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	earlier oral request, and information substantiating the need for treatment remains necessary.			
9792.9.1(c)(4)(B) and (c)(4)(C)	Commenter recommends that these subsections be reinstated. Commenter states that when physicians submit plainly incomplete RFA forms, a non-physician reviewer should be able to seek the necessary information without having to send a formal UR determination notice within the 14-day calendar period.	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	The former requirements of this section have been moved to subdivision (f). A non-physician reviewer is able to seek the necessary information as previously allowed.	No action necessary.
9785(g)	Commenter recommends retaining the following deleted sentence: <u>A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment.</u> Commenter states that the modified proposed regulations remove the ability for providers to make verbal treatment requests. Commenter opines that in some circumstances oral requests made directly to a claims administrator are the most efficient and timely method to make a request.	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	Agreed.	9785(g) has been amended to reinsert: "A written confirmation of an oral request shall be clearly marked at the top that it is written confirmation of an oral request. The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment."

	Commenter opines that the UR regulations should accommodate these circumstances by permitting oral requests and providing an area on the RFA form to denote that an oral request was made. Commenter provided a modified PR-2 Form. [Available upon request.]			
9792.12(c)(7)	Commenter recommends the following revised language: For the failure to reimburse the reasonable amount of service in accordance with applicable fee schedules for services already rendered that has been found to be medically necessary by the independent medical review organization in the final determination issued under section 9792.10.6 within twenty (20) days after receipt of the final determination, or within twenty (20) days from the date the determination is final if an appeal of the determination has been filed under Labor Code section 4610.6(h), subject to resolution of any remaining issue of the amount of payment pursuant to Labor Code sections 4603.2 to 4603.6, inclusive: $500.00 for each day up to a maximum of $5,000.00.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Disagree. The violation is expressly set forth in statute; see Labor Code section 4610.6(j) and (k). As provided in the regulation, any dispute over the amount should be resolved though Labor Code section 4603.2 et seq.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter states that IMR decisions determine whether a treatment is medically necessary, not the appropriateness of the amount billed for the treatment. Commenter states that this section needs clarification to accommodate situations where the amount billed for treatment is in dispute. As this section is currently drafted, a claims administrator has 20 days to reimburse the provider for services rendered that have been found medically necessary by the independent medical review organization. A dispute over the amount of payment for the service may arise and continue beyond these 20 days. Commenter opines that in a situation where the claims administrator reimbursed the provider the reasonable amount of the service pursuant to a fee schedule - even if it is not the billed amount – the claims administrator should not face penalties.			
9792.12(c)(7)	Commenter recommends that the DWC clarify that the claims administrator is only required to pay the **undisputed amount** for services already rendered within the 20-day	Peggy Thill Claims Operations Manager Yvonne Hauscarriague	See above response to above comment by CWCI regarding this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	timeframe outlined in this section. Commenter recommends the following revised language: For the failure to reimburse the undisputed amount for services already rendered that ~~has~~ have been found to be medically necessary by the independent medical review organization in the final determination issued under section 9792.10.6 within twenty (20) days after the final determination…	Assistant Chief Counsel State Compensation Insurance Fund October 11, 2013 Written Comment		
9792.12(c)(7)	Commenter recommends the following revised language: For the failure to reimburse the reasonable amount of service (in accordance with applicable fee schedules) for services already rendered that has been found to be medically necessary by the independent medical review organization in the final determination issued under section 9792.10.6 within twenty (20) days after receipt of the final determination, or within twenty (20) days from the date the determination is final if an appeal of the determination has been filed under	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See above response to above comment by CWCI regarding this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Labor Code section 4610.6(h), subject to resolution of any remaining issue of the amount of payment pursuant to Labor Code sections 4603.2 to 4603.6, inclusive: $500.00 for each day up to a maximum of $5,000.00. Commenter notes that IMR decisions determine whether a treatment is medically necessary, not the appropriateness of the amount billed for the treatment. Commenter states that this section needs clarification to accommodate situations where the amount billed for treatment is in dispute. As this section is currently drafted, a claims administrator has 20 days to reimburse the provider for services rendered that have been found medically necessary by the independent medical review organization. A dispute over the amount of payment for the service may arise and continue beyond these 20 days. Commenter opines that in a situation where the claims administrator reimbursed the provider the reasonable amount of the service pursuant to a fee schedule - even if it is not the billed amount – the claims administrator should not face			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	penalties.			
9792.10.3(a)(3) and (a)(4)	Commenter recommends the following revised language: (a)(3) Any assertion by the claims administrator that a factual, medical or legal basis exists that precludes liability on the part of the claims administrator for an occupational injury or a claimed injury to any part or parts of the body. (a)(4) Any assertion by the claims administrator that a factual, medical or legal basis exists that precludes liability on the part of the claims administrator for a specific course of treatment requested by the treating physician. Commenter states that there are three distinct ways to dispute liability: factual, legal and medical and that all three should be included in the regulations. Commenter opines that by omitting the term "medical," these regulations fail to acknowledge that medical causation is a basis for disputing liability.	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	Agree.	The subsections have been amended to allow a claims administrator to assert a medical basis.
9785.5	Commenter recommends that the DWC mandate that the RFA have the	John Don October 6, 2013	A request for authorization should include all facts and	No action necessary.

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	MTUS, ACOEM or ODG guideline section supporting the treatment requests attached to the RFA. Commenter opines that if the treatment is not covered then the DWC should mandate that the primary treating physician indicate why the treatment is supported using the evidence based hierarchy in the code.	Written Comment	substantial medical evidence substantiating the need for the recommended medical treatment. A simple reference to the MTUS guidelines may be insufficient; there is no assurance that the UR physician reviewer is in possession of the employee's relevant medical records to make a sound decision regarding medical necessity.	
9785.5 DWC Form RFA	Commenter requests that the regulations should be amended to clarify that both the Workers' Compensation claims administrator or their utilization review agent and the Independent Medical Review process should specify that the reviewer performing the utilization review, be required to address <u>all</u> services requested in order to have fulfilled the utilization review process within the stated timelines. If the entity believes the service is not necessary, they should deny the service or request additional information, not just ignore the request leaving the surgeon to wonder whether they will be able to ultimately get approval for the service.	Diane Przepiorski Executive Director October 10, 2013 Written Comment	Labor Code section 4610 requires that all treatment request go through the UR process. To duplicate this requirement in regulation is unnecessary.	No action necessary.

	Commenter opines that the practice of requesting services for the entire episode of care may be a new process for some payors and that they may be more accustomed to receiving individual requests for each service; however, she opines that this is a very inefficient utilization review system and has the potential to delay care. The Request for Authorization Form allows for multiple services to be requested, and she believes that it was the intent of the Division to allow providers to request multiple services.			
9785.5 DWC Form RFA	Commenter notes that Page 2 of the instructions for the RAF refers to a "comment" section on the form. Commenter could not find the comment field on the form. Commenter opines that it may have been deleted in the revisions to the form.	Diane Przepiorski Executive Director October 10, 2013 Written Comment	The comment section will be at the bottom of the one-page form.	No action necessary.
9785.5 DWC Form RFA	Commenter notes that the amended rules propose that the instructions for the Request for Authorization Form be amended to state that a request for an expedited, urgent, or rush review not made in good faith may result in civil or criminal penalties and removal from a Medical Provider Network. Commenter opines that the provision	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	Agreed. The Division does not have statutory authority to penalize, or threaten penalties, against providers for a violation of the expedited review process.	Amend the DWC Form RFA to delete "A request for an expedited, urgent, or rush review not made in good faith may result in civil or criminal penalties and removal from a

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	for civil and criminal penalties is not supported by the statute, nor does the Administrative Director have any jurisdictional authority to order criminal penalties against a treating physician or to remove a physician from an MPN. Additionally, such penalties cannot even be considered without affording the treating physician their due process rights which includes providing notice with sufficient detail to fully inform the doctor of the basis for the penalties being assessed against them, the right to a hearing to present evidence to rebut the allegations against them, and the right to appeal if not satisfied with the outcome of the hearing. Commenter states that this language is not authorized by statute, does not provide any due process protections for physicians, and ultimately would only create more opportunities for disputes, delays, and added system costs. Commenter states that section 9792.6, subdivision (h), and section 9792.6.1, subdivision (j), currently provide a definition of "expedited review". The rules further provide that when			Medical Provider Network."

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	determining eligibility, if the request does not meet this definition the Administrative Director will process it as a regular request. Commenter opines that there is no need for further regulation of this issue. Commenter recommends that this language be deleted from the RFA form.			
9785.5 DWC Form RFA	Commenter states that treating physicians do not want to have to complete two forms – the Primary Treating Physician's Progress Report (PR-2) and the Request for Authorization (DWC Form RFA). Commenter objects to the Division allowing requests for authorization that do not utilize the DWC Form RFA because without this form, commenter is concerned that the claims administrator may not be able to identify a request or not be able to identify it in a timely manner, generating unnecessary treatment delays, disputes and penalties. Commenter recommends replacing these two forms with a single standard form that integrates aspects of both to request authorizations for treatment	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. The Division is reviewing the Form PR-2 and intends to revise the form in future rulemaking to include a request for authorization.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	and as a progress report. Commenter as submitted two proposed forms [available upon request]. Descriptions of each are as follows: The first sample DWC RFA Form is modeled on the current PR-2 Form. A request for authorization is easily indicated by checking a field at the top of the form. The form can be used as an optional FAX-back method for authorizing requested goods and services. The main advantage of this form is that physicians, who must use the form, are used to this basic format and will therefore be able to easily transition to it. Programming changes may also be minimized. The second sample DWC RFA Form is an amalgam of the proposed DWC RFA Form and the PR-2 Form. It contains all the information on each form without duplication. It, too, easily identifies a request for authorization and it, too, can be used as an optional FAX-back method to authorize requested goods and services. Although the form is less familiar to physicians, it includes some additional information, has a bit			

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	more capacity for requests, and includes instructions for requesting authorization and for responding to requests. Commenter supports the adoption of either of their proposed forms.			
9785.5 – DWC Form RFA	Commenter recommends eliminating the DWC Form RFA (§ 9785.5) and replacing it with a modified DWC Form PR-2. This modified PR-2 would contain a clear check box at the top to denote that the physician is requesting treatment authorization. Experience over the past few months has demonstrated that providers currently struggle with adapting to the new RFA form. Commenter opines that modifying the PR-2 allows providers to continue working with a familiar form, which will streamline the process and ease provider concerns. Commenter submitted a modified PR-2 form. [Copy available upon request.]	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. The Division is reviewing the Form PR-2 and intends to revise the form in future rulemaking to include a request for authorization.	No action necessary.
9785.5 DWC Form RFA	Commenter recommends, instead of only being contained in the instructions on this form, that the text of the regulations include, that in order to be considered complete, the RFA	Jerrold Garrard GSG Associates October 11, 2013 Written Comment	Agreed.	Amend sections 9785(g) and 9792.9.1 (c)(2)(A) and (B) to require that a DWC Form RFA or

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	must be accompanied by reasonably necessary information that substantiates the need for the requested treatment. Commenter states that that the definition of a complete request does not even require that the RFA include a medical report. Commenter states that one of the problems faced when attempting to determine if treatment is necessary, is getting appropriate, objective medical information. When examining over 1 million treatment requests, over 10% of the requests are incomplete, with little or no reasonably necessary information included. Even after going through the Denial for Lack of Information process, only about 10% of those Denied come back for Reconsideration. That means about 9 to 10% of all requests that are submitted NEVER include reasonably necessary information to make a determination. Commenter notes that this revision of 9785(g) strikes the requirement to include "documentation substantiating the need for the requested treatment."			accepted request must include as an attachment documentation substantiating the need for the requested treatment

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	Commenter opines that under 9792.6.1(t), the definition of "Complete" is more nebulous than before, and does not require any documentation substantiating the need for treatment.			
9785.5 DWC Form RFA	Commenter is concerned that the treating physician is required to provide an original signature on the RFA. Commenter opines that claims administrators always manipulate regulations to be as troublesome as possible and that if a claims administrator decides that the signature on the RFA is not the treating physician's original signature – the signature is not original, the signature is not by the treating physician, the signature is a forgery, etc. - and for that reason only, returns the RFA to the treating physician, challenging the treating physician to prove it is the treating physician's original signature, who decides what exactly is the treating physician's original signature?	H. Hollie Rutkowski October 10, 2013 Written Comment	Electronic signatures may be used upon agreement by the parties.	No action necessary.
9785.5 DWC Form RFA	Commenter requests that the Division allow for flexibility with respect to CPT/HCPCS that may be required as part of the authorization request. In	Gregory M. Gilbert SVP Reimbursement and Governmental Relations	The Division appreciates the comment	No action necessary.

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	some instances this can be determined at the time of authorization but in many other cases it cannot because the Provider who is asking for Request for Authorization may not know the exact CPT or HCPCS that may be needed until the patient has been assessed. (e.g. physical therapy referral).	Concentra October 11, 2013 Written Comment		
9785.5 DWC Form RFA	Commenter opines that if you don't reimburse doctors for completing the RFA Form that many providers will stop treating workers' compensation patients.	Ross Lauger October 1, 2013 Written Comment	The overriding purpose of the DWC Form RFA, as set forth in section 9785.5, is to reduce disputes between the requesting physician and the claims administrator over the nature of treatment requests such that number of requests for IMR may be reduces. The form, which only asks for CPT/HCPCS Codes if they are known, only requires basic identifying information and a plain statement of the treatment request. As such, the Administrative Director has determined that additional reimbursement for the form is not warranted. However, the Division, upon analysis of evidence and data, will revisit this determination in the future.	No action necessary.

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9785.5 DWC Form RFA	Commenter opines that the DWC Form RFA should be combined with the PR-2 Form so that all of the medical information is in one document. Commenter provided an example of this form [available upon request].	Anita Weir, RN CRRN Director, Medical & Disability Management Safeway, Inc. October 8, 2013	See above comment by CWCI regarding the form. The Division is considering this suggestion in conjunction with a revision of DWC Form PR-2.	No action necessary.
9792.6.1(r)(1) through (6)	Commenter notes that the definitions for "medically necessary" and "medical necessity" have been deleted. Commenter recommends keeping these definitions intact. Commenter states that the definition of "medically necessary" and "medical necessity" is contained in LC Section 4610.5(c)(2) as a component of the review of utilization review decisions and the commenter opines that it should be a component of the utilization review standards as well.	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	The definition of "medically necessary" and "medical necessity" is taken from Labor Code section 4610.5(c)(2) and sets for the standard that must be applied by an IMR reviewer when determining whether a requested medical treatment is medically necessary. The subdivision does not expressly provide that this standard must be applied to claims administrators when conducting UR. As such, it should be removed from this section.	No action necessary.
9792.6.1(r)(1) through (6)	Commenter recommends the previous language be retained. Commenter states that the standards for utilization review must remain consistent with Labor Code sections 4600, 4610(f) and 5307.27.	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles	See above response to comment by Republic Indemnity Company regarding this subsection.	No action necessary.

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	Commenter opines that these recommended modifications are necessary to harmonize these sections and the standards for Independent Medical Review in Labor Code section 4610.5(c). The recommended modifications are consistent with Labor Code section 5307.27 standards, which are required to be evidence-based, peer-reviewed, and nationally recognized.	CAJPA October 11, 2013 Written Comment		
9791.9.1(e)(6)(B)	Commenter recommends the following language: "Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve." This recommended language is found in LC4610 (g)(3)(B).	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	Agreed. The regulation should be aligned with the language of the statute.	Amend section 9792.9.1(e)(6)(B) to indicate that treatment should be that medically necessary.
9792.10.3(6)	Commenter congratulates the Division for the addition of this section that he opines will prompt the requesting physician to be more compliant with requests for additional information necessary to render a UR determination, and should help prevent unresponsive physicians from abusing the system by intentionally	Philip Vermeulen Governmental Relations Advocate for AIMS/AMC October 11, 2013 Written Comment	The Division appreciates the comment.	No action necessary.

	not responding to the UR but instead waiting for the IMR process.			
9792.10.3(a)(6)	Commenter is in full support of this new subsection. Commenter opine that until the physician provides the requested information necessary for a UR determination, an application should not be eligible for IMR, thereby preventing Independent Review when necessary information is not submitted, preventing end runs around UR when requested information is sent directly to IMR instead of to UR, and eliminating unnecessary IMR costs.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	The Division appreciates the comment.	No action necessary.
9792.9.1(e)(6)(B)	Commenter notes that this section states that medical care provided during a concurrent review shall be medical treatment that is reasonably required to cure or relieve from the effects of the industrial injury. This is only a partial statement of Labor Code 4610(g)(3)(B). Commenter recommends that if this is being included the section be expanded to include additional elements of 4610(g)(3)(B) to avoid confusion as follows: 9792.9.1(e)(6)(B) Medical care provided during a concurrent review	Anne Searcy, MD Sr. Vice President & Medical Director The Zenith October 10, 2013 Written Comment	See above response to comment by Republic Indemnity Company regarding this subdivision.	No action necessary.

	shall be care that is medically necessary to cure and relieve and an insure or self –insured employer shall only be liable for those services determined medically necessary to cure and relieve.			
9792.9.1(e)(6)(B)	Commenter recommends the following revised language: Medical care provided during a concurrent review shall be medical treatment that is reasonably required to cure or relieve from the effects of the industrial injury pursuant to Labor Code section 4610(g)(3)(B). Commenter recommends adding this Labor Code reference that includes specific additional requirements.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	See above response to comment by Republic Indemnity Company regarding this subdivision.	No action necessary.
9792.9.1(e)(6)(B)	Commenter recommends the following revised language: Medical care provided during a concurrent review shall be medical treatment that is ~~reasonably required~~ medically necessary to cure or relieve from the effects of the industrial injury. Commenter states that the "medically	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See above response to comment by Republic Indemnity Company regarding this subdivision.	No action necessary.

	necessary" standard provided in the modified regulations differs from the statutory standard in Labor Code section 4610(g)(3)(B). Commenter opines that altering the standard in these regulations falls outside of statutory authority and may spur disputes over whether proper care was provided. The recommended modification cures this issue by harmonizing this section with the Labor Code.			
9792.1(e)(5)	To align the regulations with the statute, commenter recommends that the DWC modify §9792.1(e)(5) to allow only physician reviewers to sign UR determinations to modify, delay, or deny a request for authorization of medical treatment. In addition, if the reviewer's signature is made mandatory, commenter recommends that the DWC accept electronic signatures. Commenter opines that permitting the claims administrator to sign the decision appears contrary to Labor Code §4610(e), which requires all decisions to modify, delay or deny a request for medical treatment to be evaluated by a licensed physician. A	Peggy Thill Claims Operations Manager Yvonne Hauscarriague Assistant Chief Counsel State Compensation Insurance Fund October 11, 2013 Written Comment	While it is correct that only a physician reviewer may make a decision to delay, deny, or modify a treatment request, see Labor Code section 4610(e), there is no corresponding requirement that the physician reviewer sign the written communication informing the injured worker and their physician of the adverse UR determination.	No action necessary.

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	written decision signed by the claims administrator may result in disputes over who rendered the decision, potentially delaying necessary medical treatment and increasing claims costs.			
9792.12(c)(2) and (c)(3)	Commenter states that subdivisions (c)(2) and (c)(3) are redundant and should be struck. Essentially, there are now three sets of penalties for the same act – failing to provide a complete statement to an injured worker along with a decision to modify, delay or deny treatment. Section 9792.12(c)(1) penalizes claims administrators for failure to provide this statement, while sections 9792.12(c)(2)-(3) provide penalties for deficient statements. Commenter opines that there is little operative distinction between the different violations, and this will likely lead to a piling-on of penalties on claims administrators for essentially one violation. Commenter recommends that the DWC strike these sections and address these penalties through the penalty scheme recommended in section 9792.12(c)(1).	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Disagree. The penalty sections address specific elements that must be contained in an adverse UR letter. See section 9792.9.1(e)(5). Subdivision (c)(3) (formerly (c)(2)), addresses the statement that treatment disputes must be resolved through IMR. Subdivision (c)(4) (formerly (c)(3)) address the necessity for claims administrators to describe their internal appeal process (if there is one).	No action necessary.
9792.12(c)(2) and	Commenter recommends the	Jeremy Merz	See above response to	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
(c)(3)	following revised language: Commenter opines that these penalty sections are redundant and should be struck. Commenter states that there are now three sets of penalties for the same act – failing to provide a complete statement to an injured worker along with a decision to modify, delay or deny treatment. Section 9792.12(c)(1) penalizes claims administrators for failure to provide this statement, while sections 9792.12(c)(2)-(3) provide penalties for deficient statements. There is little operative distinction between the different violations, and this will likely lead to a piling-on of penalties on claims administrators for essentially one violation. Commenter recommends that the DWC strike these sections and address these penalties through the penalty scheme commenter recommended for section 9792.12(c)(1).	CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	comment by CWCI regarding these subdivisions.	
9792.10.4(b)(5)	Commenter states that the proposed regulations provide for significant penalties for claims administrators who fail to make timely contributions to the IMR process. Unfortunately, in	Robert Ward October 10, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	No action necessary.

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	some instances, the start and/or end points of the mandated procedure are not subject to control nor within the awareness of the claims administrator, and are therefore unreasonable. Section 9792.10.4(b)(5), where the time frame for the claims administrator to provide documents starts on "the date designated on the notification" and ends when "the independent review organization . . . receive[s] the documents". Commenter opines this effectively makes the claims administrator responsible for the performance of delivery services on both sides of this process; something that is not within their ability to control. Commenter states that the appropriate time frames for any party to complete a required action should start when the party becomes aware of the need to act (e.g., date of receipt of notice; not date of notice) and should end when the party completes their required action (e.g., sends the documentation; not when the recipient receives the documentation).			
9792.9.1(e)(5)(G)	Commenter recommends the	Judy Donofrio, RN,	Given that claims	No action necessary.

	following sentence to this subsection: There are fax transmission problems with the IMR Form. In order to avoid those problems and delays, it would be helpful if the DWC allowed Claims Administrators/UR Organizations to replicate the IMR form in a different format.	CCM, CPC Rising Medical Solutions October 7, 2013 Written Comment	administrators must complete the information on the form and then provide it to the injured worker for signature and submission, it is necessary that the form is standardized so as insure the data is complete and not subject to alternation.	
9792.9.1(c)(2) and (3)	Commenter states that it appears that this section allows anything that can be construed as a request for treatment such as an unidentified narrative report with a request buried on the 15th page to be identified and processed timely in UR or sent back to the provider within 3 days. Commenter opines that the DWC should maintain the requirement that a request for treatment must clearly be identified as such with the words "Request for Authorization" at the top of the first page of any such report in order for an obligation to process the request or return it to the provider to be triggered. Commenter states that it will be more difficult for UR to be processed with an adherence to the strict UR timeframes when the treatment requested is not specified.	Rob Shatsnider Vice President, Claims CompWest October 9, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

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	Commenter opines that there is an assumption that there would be enough other information on a partially completed RFA for an administrator to process it in the absence of an employee name or requesting provider. If the employee name and claim number are both omitted from the form, how will the administrator identify the claim with which the request is associated? If the provider is omitted, how will the administrator know who to contact regarding additional information or the determination. How will the administrator know where to return the request if the provider is not listed? Commenter opines that this entire section has the potential to create an enormous administrative burden and should be reconsidered. Commenter states that the requirement that a defective RFA be returned to the provider within 3 days rather than 5 makes the process more difficult and costly to administer. Commenter opines that the originally proposed requirement of 5 days should remain if there is to be such a requirement and an associated timeframe.			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter suggests two proposed revisions to the current language as follows: **<u>First Option</u>** (2) If the treating physician requests a course of treatment in a manner that does not utilize the DWC form RFA but is otherwise complete and the request is clearly marked at the top of the first page with the words "Request for Authorization" a non-physician reviewer as allowed by section 9792.7 or reviewer must regard the request as a complete DWC form RFA and comply with the timeframes for decision set forth in this section. Any medical report that is not accompanied by the DWC form RFA or does not contain the phrase "Request for Authorization" across the top of the first page does not require UR or any other action on the part of the claims administrator. (3) If the DWC form RFA or a Request for Authorization as allowed in section 9792.9.1 (c)(2) does not identify the employee or provider, does not identify a recommended			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	treatment or is not signed by the requesting physician, the claims administrator is not obligated to process UR within the applicable timeframes. The claims administrator may proceed with UR on the request if there is sufficient information to proceed with review. **<u>Second Option</u>** (3) If the DWC form RFA or a Request for Authorization as allowed in section 9792.9.1 (c)(2) does not identify the employee or provider, does not identify a recommended treatment or is not signed by the requesting physician, a non-physician reviewer as allowed by section 9792.7 or reviewer must return it to the requesting physician marked "not complete", specifying the reasons for the return of the request no later than 5 days from receipt. The timeframe for a decision on that returned request for authorization shall begin anew upon receipt of a completed DWC form RFA. If there is sufficient information on the request to process UR within the applicable timeframes, the claims administrator may proceed with UR			

	on the request instead of returning the request to the provider.			
9792.9.1.(e)(5)(G)	Commenter notes that this section states that the claims administrator is to complete all sections of the DWC Form IMR except for the signature of the employee. Commenter states that the latest version of the DWC Form IMR includes a section titled Disputed Medical Treatment. The section will include a listing of all treatment requests that were denied or modified. This means that the IMR will automatically include all services that were denied or modified. Commenter would like to know what happens if the injured worker was satisfied with the modification and does not wish to dispute it. How will that be determined to avoid unnecessary submission of records and reviews by MAXIMUS?	Anne Searcy, MD Sr. Vice President & Medical Director The Zenith October 10, 2013 Written Comment	If the injured worker was satisfied with the treatment modification and does not wish to dispute it, they could decline to file the form is that is sole disputed treatment. If the accepted modified treatment is among other disputed treatments, absent the employee striking out the modified treatment on the form, the submission of records by the parties under section 9792.10.5 should resolve for the IMRO what treatments should be reviewed. Of course, meaningful communication between the parties should minimize problems of this kind.	No action necessary.
9791.9.1(c)(4)(B) and (C)	Commenter recommends that the language in these two sections that was deleted be reinstated. LC Section 4610(g)(1) outlines the UR process for prospective or concurrent decisions that allows a non-physician reviewer to seek necessary information from the requesting physician within five	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	The former requirements of this section have been moved to subdivision (f). A non-physician reviewer is able to seek the necessary information as previously allowed.	No action necessary.

	working days, but in no event more than 14 days. Commenter does not understand why these two sections were deleted.			
9791.9.1(e)(4)	For retrospective review, commenter recommends that the deleted language "information that is reasonably necessary to make this determination" be added back in and that the language that was added "the request for authorization" be deleted. The language that was deleted is contained in 4610(g)(1). Retrospective reviews occur in many instances when the claims administrator does not have a DWC Form RFA and has only received an invoice for medical services already rendered with no request for treatment in advance of the services being performed. The claims administrator must then request information necessary in order to make a retrospective UR decision.	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	Agree.	Amend section 9791.9.1(e)(4) to reinstate previously deleted language.
9792.9.1(e)(5)	Commenter opines that the language "either the claims administrator or" should be deleted from this paragraph because a decision modifying, delaying or denying medical treatment must come from the physician reviewer and therefore can only be signed by the physician. Commenter	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	See response to comment by State Compensation Insurance Fund regarding this subdivision. While it is correct that only a physician reviewer may make a decision to delay, deny, or modify a treatment request, see Labor	No action necessary.

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	recommends that the rule also require that the specialty of the physician be provided on the decision.		Code section 4610(e), there is no corresponding requirement that the physician reviewer sign the written communication informing the injured worker and their physician of the adverse UR determination.	
9792.9.1(e)(5)	Commenter recommends the following revised language: The written decision modifying, delaying or denying treatment authorization shall be provided to the requesting physician, the injured worker, ~~the injured worker's representative,~~ and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall be signed by either the claims administrator or the reviewer, and shall only contain the following information specific to the request: Commenter states that this section conflicts with Labor Code section 4610.5(j) which prohibits the injured worker from designating a representative before the receipt of the decision. The recommended deletion will eliminate the conflict.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	No action necessary.

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9792.9.1(e)(5)(G)	Commenter approves of the change to this subsection making the regulation consistent with the statute so that the pre-addressed envelope need only be sent to the injured worker.	Stephen L. Kline General Counsel EK Health Services October 11, 2013 Written Comment	The Division appreciates the comment.	No action necessary.
9792.9.1(c)(5)	Commenter recommends the following revised language: Retrospective decisions to approve modify, delay, or deny a request for authorization shall be made within 30 days of receipt of the complete request for authorization. Commenter opines that requests for authorization should not trigger the 30-day time limit. An analysis of whether to approve, modify, delay or deny a request cannot be undertaken until a complete request is received.	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	The subdivision has been amended to require medical information that is reasonably necessary to make a determination. This requirement is equivalent to "complete" and is sufficient to start the timeframe.	No action necessary.
9792.9.1(e)(5)	Commenter recommends the following revised language: The written decision shall be signed by ~~either the claims administrator or~~ the reviewer, and shall only contain the following information specific to the request: Commenter states that only a physician (reviewer) can issue a	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See response to comment by State Compensation Insurance Fund regarding this subdivision. While it is correct that only a physician reviewer may make a decision to delay, deny, or modify a treatment request, see Labor Code section 4610(e), there is no corresponding requirement that the physician reviewer	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	decision modifying, delaying or denying treatment. Commenter opines that permitting a claims administrator to sign the written utilization review decision creates confusion over who made the decision. To eliminate this confusion, the regulations should only permit the physician (reviewer) to sign the decision.		sign the written communication informing the injured worker and their physician of the adverse UR determination.	
9792.12(b)(4)(C) and (D)	Commenter requests that the modified language added "or other request for authorization accepted by a claims administrator under 9792.9.1(c) (2)" be deleted. Commenter opines that only a valid DWC Form RFA should be subject to UR standards, timeframes, procedures, notices and penalties per our comments under 97972.9.1.	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.
9792.12(b)(4)(C)	Commenter recommends the following revised language: For failure to make a decision to approve or modify or deny the request for authorization, within five (5) working days of receipt of a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2)~~ submitted by the injured employee's requesting treating	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	physician, or receipt of the requested information for prospective or concurrent review, and to communicate the decision as required by section 9792.9(h)(3) and section 9792.9.1(f) (4); Commenter requests that the DWC delete the modified language referencing the alternative request for authorization under section 9792.9.1(c)(2). There should only be one uniform and identifiable request for authorization form. Commenter opines that only a valid DWC Form RFA should be subject to UR standards, timeframes, procedures and penalties.			
9792.12(b)(4)(D)	Commenter recommends the following revised language: For failure to make and communicate a retrospective decision to approve, modify, or deny the request, within thirty (30) working days of receipt of a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2)~~ submitted by the injured employee's requesting treating physician, or receipt of the requested	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	information, as required by section 9792.9(h)(4) and section 9792.9.1(e)(4), and (f)(6); Commenter requests that the DWC delete the modified language referencing the alternative request for authorization under section 9792.9.1(c)(2). There should only be one uniform and identifiable request for authorization form. Commenter opines that only a valid DWC Form RFA should be subject to UR standards, timeframes, procedures and penalties.			
9792.12(c)(4)	Commenter recommends the following revised language: For the failure to timely provide information requested by the Administrative Director under section 9792.10.3(b): $500.00 for ~~each day the response is~~ an untimely response under section 9792.10.3(c)~~, up to a maximum of $5,000.00~~. Commenter states that there is no statutory authority for assessing penalties against a claims administrator for failing to timely provide the Administrative Director	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Labor Code section 4610.5(i) provides that a claims administrator "should not engage in any conduct that has the effect of delaying the [IMR] process." For such conduct, the statute allows the Administrative Director to assess an administrative penalty of up to $5,000 per day. The penalty is reasonable if a claims administrator fails to respond to a request by the Administrative Director for additional information to	No action necessary.

	with requested information and there is little need for this penalty. Commenter opines that if a claims administrator fails to provide the requested information, the Administrative Director may move forward with independent medical review and base the decision solely on the information already provided. This risk already serves as a deterrent to delaying the submission of requested information. Commenter suggests a non-cumulative penalty of no more than $500.00.		determine whether a request for IMR is eligible for a medical necessity determination, when a claims administrator can easily provide the information and expedite the IMR review.	
9792.12(c)(4)	Commenter recommends the following revised language: For the failure to timely provide information requested by the Administrative Director under section 9792.10.3(b): $500.00 for ~~each day the response is~~ an untimely response under section 9792.10.3(c)~~, up to a maximum of $5,000.00.~~ Commenter opines that no statutory authority exists for assessing penalties against a claims administrator for failing to timely provide the Administrative Director with requested information and there is	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See above response to comment by CWCI regarding this subdivision.	No action necessary.

	little need for this penalty. Commenter states that if a claims administrator fails to provide the requested information, the Administrative Director may move forward with independent medical review and base the decision solely on the information already provided. This risk already serves as a deterrent to delaying the submission of requested information. Commenter suggests a non-cumulative penalty of $500.00.			
9792.10.3(a)(4)	Commenter recommends the following revised language: Any assertion by the claims administrator that a factual, medical or legal basis exists that precludes liability on the part of the claims administrator for a specific course of treatment requested by the treating physician. Commenter states that liability can be denied based on a medical determination.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Agreed.	Amend section 9792.10.3(a)(4) to add "medical" as a basis for assertion.
9792.9.1(e)(4)	Commenter recommends the following highlighted language be placed back into this subsection as	Steven Suchil Assistant Vice President/Counsel American Insurance	Agreed.	9792.9.1(e)(4) has been amended to provide: "For retrospective review,

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	follows: For retrospective review, a written decision to deny part or all of the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the complete information that is reasonably necessary to make this determination. ~~the request for authorization.~~ Commenter states that this change is needed because it is inappropriate to require a decision without requiring submission of the information required to make a decision.	Association October 8, 2013 Written Comment		a written decision to deny part or all of the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination."
9791.9.1(c)(3)	Commenter recommends that the language that was deleted "but in no event more than 14 calendar days from initial receipt of the complete DWC Form RFA" be reinstated. This language is contained in LC Section 4610(g)(1).	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	Disagree. Extension of time based on the need for additional information is found in subdivision (f).	No action necessary.
9792.9.1(c)(4)	Commenter notes that this section stipulates that "The requesting physician must certify the need for an	David A. Ingrum, MD October 11, 2013	Agreed. The subdivision should require documentation from the provider	9792.9.1(c)(4) has been amended to provide: "Prospective

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	expedited review…" Commenter opines that this section should be expanded to stipulate precisely how the requesting physician should do this. Commenter states that the statute should further contain admonition discouraging the submission of expedited requests without clear medical basis for urgent review. See comment regarding 9792.6.1 (j).	Written Comment	substantiating the employee's condition. If such documentation is absent, the claims administrator should be able to covert the request to an expedited review.	or concurrent decisions to approve, modify, delay, or deny a request for authorization related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A request for expedited review that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious

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				threat to his or her health, or that the timeframe for utilization review under subdivision (c)(3) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in subdivision (c)(3)."
9792.9.1(e)(4)	Commenter recommends the following revised language: Unless (d)(3) is applicable, for ~~For~~ retrospective review, a written decision to deny part or all of the requested medical treatment shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable, within 30 days of receipt of the request for authorization. Commenter states that this conflicts	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	The provisions of subdivision (d)(3) address the manner in which a retrospective approval is communicated. It does not affect the 30-day timeframe in which a decision must be made.	No action necessary.

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	with Section 9792.9.1(d)(3) which deems any timely payment of a medical bill for services requested retroactively on the DWC Form RFA to be a retrospective approval. If (d)(3)(B) applies, a response under (e)(4) will not be necessary. Commenter states that the recommended modification will clarify that (e)(4) will not apply if an explanation is supplied under (d)(3)(B).			
9792.10.1(b)(3)	Commenter notes that this paragraph mandates that a request for an expedited IMR include a "certification" that the employee faces an imminent and serious threat to his or her health, and that it is unclear what "certification" means in this instance. Commenter opines that the failure to clearly define what is required by this paragraph will inevitably lead to disputes, delay, and unnecessary costs.	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	To "certify" is to say officially that something is true, correct, or genuine. See http://www.merriam-webster.com/dictionary/certifying?show=0&t=1386962565 . A physician should understand this word with sufficient clarity to comply. That said, documentation confirming the employee's serious condition should be provided to corroborate a written statement.	Amend section 9792.10.1(b)(3) to require a written certification from the employee's treating physician with documentation confirming that the employee faces an imminent and serious threat to his or her health.
9792.10.3(a)(3)	Commenter recommends the following revised language:	Brenda Ramirez Claims and Medical	Agreed.	Amend section 9792.10.3(a)(3) to

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	Any assertion by the claims administrator that a factual, medical or legal basis exists that precludes liability on the part of the claims administrator for an occupational injury or a claimed injury to any part or parts of the body. Commenter states that liability can be denied based on a medical determination.	Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment		add "medical" as a basis for assertion.
9792.6.1(t)(3)	Commenter recommends the following revised language: The ~~form~~ request for authorization must be signed by the treating physician and may be mailed, or faxed or e-mailed to dedicated lines. By agreement of the parties, the treating~~ment~~ physician may submit the request for authorization with an electronic signature. Commenter opines that the transmission of personal medical information and time sensitive documents must only be to dedicated FAX and e-mail lines in order to protect an employee's privacy and to ensure immediate attention.	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	The Division has yet to determine that a uniform method for transmitting health records via e-mail, with necessary technical safeguards, exists such that their inclusion in the regulations would be appropriate. That said, the Division fully intends to further explore issues regarding the secure electronic transmission of health records and may propose changes to this definition in future rulemaking.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.6.1(t)(3)	Commenter recommends the following revised language: The request for authorization must be signed by the treating physician and ~~may be~~ mailed, faxed or e-mailed to the designated mailing address, fax number, or email address. By agreement of the parties, the ~~treatment~~ treating physician may submit the request for authorization with an electronic signature. Commenter states that the first recommended modification will ensure the request for authorization is submitted to the proper recipient. If it is not, the short timeframes may not be met, causing the injured employee's treatment to be delayed, and the triggering of penalties.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Agree.	9792.6.1(t)(3) is amended to, "The request for authorization must be signed by the treating physician and may be mailed, faxed or e-mailed to, if designated, the address, fax number, or e-mail address designated by the claims administrator for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature."
9792.6.1(t)(3)	Commenter supports the change to this subsection that allows for the use of electronic signatures when mutually agreed to by the parties. Commenter opines that e-signature by mutual agreement is problematic because it is costly to track and monitor which claims administrator will accept an e-signature and which will not. Commenter states that all in other	Ron Crowell, MD President California Occupational Medicine Physicians October 11, 2013 Written Comment	The overriding purpose of the DWC Form RFA, as set forth in section 9785.5, is to reduce disputes between the requesting physician and the claims administrator over the nature of treatment requests such that number of requests for IMR may be reduces. The form, which only asks for	No action necessary.

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	states that accept e-signatures, it is for all if the providers so chooses to use it. Commenter recommends that the Division implement a $15 completion fee in order to mitigate the cost issues inherent in form completion and management.		CPT/HCPCS Codes if they are known, only requires basic identifying information and a plain statement of the treatment request. As such, the Administrative Director has determined that additional reimbursement for the form is not warranted. However, the Division, upon analysis of evidence and data, will revisit this determination in the future. Regarding electronic signatures, they may be used upon agreement of the parties.	
9792.6.1(t)(3)	Commenter recommends the following revised language: The request for authorization must be signed by the treating physician and may be mailed, faxed or e-mailed to the designated address, fax number or email address. By agreement of the parties, the ~~treatment~~ treating physician may submit the request for authorization with an electronic signature. Commenter states that the recommended modification is necessary to ensure that the request for	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See response to comment by CWCI regarding this subdivision. The Division acknowledges using "treating."	No action necessary.

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	authorization is sent to the proper recipient. Commenter states that the correct term is “treating physician.”			
9792.9.1(d)(3)(B)	Commenter recommends the following revised language to correct a citation error: Payment, or partial payment consistent with the provisions of California Code of Regulations, title 8, section 9792.5, of a medical bill for services requested on the DWC Form RFA, within the 30-day timeframe set forth in subdivision (c) ~~(~~4 5), shall be deemed a retrospective approval, even if a portion of the medical bill for the requested services is contested, denied, or considered incomplete.	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	Agree.	9792.9.1(d)(3)(B) has been amended to replace the erroneous citation to subdivision (c)(4) with the correction citation, subdivision (c)(5).
9792.9.1(f)(3)(A)	Commenter states that this subsection lacks a citation: If the information reasonably necessary to make a determination under subdivision (f)(1)(A) that is requested by the reviewer or non-reviewer physician under subdivision ___ is not received within fourteen (14) days from receipt of the completed request for authorization	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	Agreed.	Amend subdivision 9792.9.1(f)(3)(A) to delete the word “Subdivision.”

	for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.			
9791.9.1(c)(2)	Commenter recommends that the modifications to this section be deleted and that the language remain as it is currently written in the emergency regulations. The modifications would require the claim administrator to regard any request for treatment, even if the required DWC Form RFA is not utilized, to either comply with the UR timeframes for decision or return the document to the requesting physician marked "not complete", specifying the reasons for the return of the request, no later than three (3) business days from receipt. Commenter opines that this modification would place an undue hardship on the claims administrator to review and respond to each and every piece of correspondence from a treating physician if it appears they are requesting a course of treatment. Commenter states that this modification undermines the	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

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	requirement & defeats the purpose of the treating physician having to submit the DWC Form RFA when requesting a course of treatment and may encourage some treating physicians not to comply with the reporting requirements in 9785(g). Under the text of the modified regulations, the response time has been decreased from five (5) business days down to three (3) business days. This is an impractical timeframe to achieve in light of the high volume of reports claim administrators receive from physicians. Commenter urges that the requirements under 9792.9.1(a) that a request for authorization for a course of treatment must be in a written form set forth on the "Request for Authorization for Medical Treatment (DWC Form RFA)" be enforced. Commenter states that per 9792.6.1(y) that the utilization review process does not begin until the completed DWC Form RFA has been submitted and is received by the claims administrator. If the DWC Form RFA is not complete and does not include a PR2, DFROI or narrative that substantiates the need for the requested treatment; then the claims administrator should			

	be allowed five (5) business days to return it to the requesting physician marked "not complete". Commenter states that the claims administrator should not be required to return correspondence to treating physicians as "not complete" within any timeframe if the requesting physician did not submit their request utilizing the DWC Form RFA.			
9791.9.1(f)(2)(A)	Commenter recommends that the modified language "or other accepted request for authorization" be deleted for the reasons outlined above in (c)(2). Commenter opines that only a completed DWC Form RFA should trigger the UR standards, timeframe, procedures and notice requirements.	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.
9791.9.1(f)(2)(B)	Commenter recommends that the modified language "or accepted request for authorization" be deleted for the reasons outlined above in (c)(2). Commenter opines that only a completed DWC Form RFA should trigger the UR standards, timeframe, procedures and notice requirements.	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.
9792.9.1(a)(3)	Commenter notes that this section indicates that the process for CA to receive authorization requests after business hours shall be satisfied by CA maintaining a "voice mail system	David A. Ingrum, MD October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	No action necessary.

	or facsimile number…" This section does not prohibit an automated system, nor require that the system be staffed after business hours. Commenter states that this seciton does not provide for short timeframe requests, specifically expedited requests, where the entire 72 hour timeframe could begin and end outside of business hours, for example over a holiday weekend			
9792.9.1(d)(1) and (2)	Commenter states that these sections repeatedly use the term "decision." This term is not defined in 9792.6.1, and is subject to interpretation regarding at what point in the UR workflow that the "decision" on the requested treatment is actually made. Other statutes regarding the IMR process reckon timeframes from the date of the UR "determination." This term is also not defined, but some references mention the date of the "determination letter." The date of the determination letter is a documented date that must fall within statutory timeframes for the type of review conducted. Commenter recommends that UR "determination" be formally defined in this manner, and that the term UR "decision," when used to	David A. Ingrum, MD October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. The said, the regulations sufficiently distinguish between "decisions" made on treatment requests, and written decisions or determinations that must follow a decision within a specific period. The Division does acknowledge the possible confusion between the terms and may address this in future rulemaking.	No action necessary.

	reckon timeframes, either be replaced with UR "determination" or be stipulated as synonymous.			
9792.9.1(e)(3)	This section indicates that specified UR decisions shall be communicated to the requesting physician "within 24 hours of the decision…" Commenter notes that term "decision" is not defined, and as such is ambiguous as a marker to reckon timeframes. Commenter states that there is no recognition of the practical impossibility of accomplishing this stipulation within 24 hours if the "decision" occurs on, during or immediately before a weekend or holiday. Commenter requests that the Division change the wording from "decision" to "determination," which should be defined in 9792.6.1 to mean the date on the "determination letter." Commenter opines that this section should be changed to delete the 24 hour limit, and rather to stipulate that the communication to the requesting physician shall be *on the next business day* following the "determination."	David A. Ingrum, MD October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period	No action necessary.
9792.9.1(e)(3)	Commenter opines that the requirement for written notice should also replace "decision" with "determination," and should further	David A. Ingrum, MD October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-	No action necessary.

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	stipulate that expedited determination should be communicated *on the next business day* if the 72 hour limit falls on a weekend or holiday.		day comment period	
9792.9.1(f)(3)(A)	Commenter states that this section uses the term "non-reviewer physician." Commenter opines that this section should read "non-physician reviewer."	David A. Ingrum, MD October 11, 2013 Written Comment	Agreed.	9792.9.1(f)(3)(A) has been amended to "non-physician reviewer."
9792.9.1(f)(3)(B)	Commenter recommends that the time limit for receipt of the additional examination or test required under subparagraph (f)(1)(B), or the specialized consultation under subparagraph (f)(1)(C), be changed from thirty days to fourteen days in order to be consistent with Labor Code section 4610(g)(1) and (5) and with subparagraph (f)(1)(A) of this section. Whether or not that change is made, commenter recommends that a provision be added mandating that where the UR reviewing physician recommends an additional test or consultation and the UR determination is delayed pending receipt of that examination or test, the claims administrator must within one business day provide written	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	Disagree. The 30-day extension for additional tests or a specialized consultation is reasonable. Unlike information within a provider's possession, it is not reasonable to believe that a test or consultation can be scheduled, performed and reported on in the 14-day timeframe. If an additional test or consultation is requested by the claims administrator, it would appear to follow that the test or service would be approved. The Division does not believe that additional regulation in this area is necessary, although data indicating an abuse could	No action necessary.

	authorization for the requested examination or test. Commenter opines that this will help reduce delays because in practice most physicians will not proceed with the additional examination or testing until written authorization is received.		result future rulemaking to address the matter.	
9792.9.1(d)(3)(B)	Commenter state that the reference to (c)(4) should be changed to (c)(5).	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Agreed.	This has been corrected.
9792.9.1(f)(3)(A)	Commenter recommends the following revised language: If the information reasonably necessary to make a determination under subdivision (f)(1)(A) that is requested by the reviewer or non-~~reviewer~~ physician reviewer under subdivision (f)(2)(A) is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for authorization for retrospective review, the reviewer shall deny the request	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	See response to comment by David A. Ingrum, MD regarding this subdivision. The rest of the subdivision requires no further clarification.	9792.9.1(f)(3)(A) has been amended to replace "non-reviewer physician under subdivision" with "non-physician reviewer."

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	with the stated condition that the request will be reconsidered upon receipt of the information. The first recommended modification is merely to correct a typographical error. "(f)(2)(A)" appears to have been unintentionally omitted. The last recommended modification is for clarity and consistency.			
9792.9.1(c)(3)	Commenter recommends the following revised language: Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed DWC Form RFA, but in no event more than 14 calendar days from initial receipt of the complete DWC Form RFA. Commenter opines that it is unclear why the 14-day timeframe was removed from this section as it is	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	The former requirements of this section have been moved to subdivision (f). A non-physician reviewer is able to seek the necessary information as previously allowed.	No action necessary.

	consistent with both Labor Code section 4610 and section 9792.9.			
9792.9.1(f)(3)(A)	Commenter recommends the following revised language: If the information reasonably necessary to make a determination under subdivision (f)(1)(A) that is requested by the reviewer ~~or non-reviewer physician~~ non-physician reviewer *under subd*ivision (f)(2)(A) is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information. Commenter recommends the revision to correct a typographical error and the correct the omission of the referenced subdivision.	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See response to comment by David A. Ingrum, MD regarding this subdivision. The rest of the subdivision requires no further clarification.	9792.9.1(f)(3)(A) has been amended to replace "non-reviewer physician under subdivision" with "non-physician reviewer."
9792.9.1(f)(3)(A)	Commenter states that this section contains two typographical errors that should be corrected. First, the text of the proposed rules makes reference to "…the reviewer or **non-reviewer**	Lisa Anne Forsythe Senior Compliance Consultant Coventry October 11, 2013	See response to comment by David A. Ingrum, MD regarding this subdivision. The rest of the subdivision requires no further	9792.9.1(f)(3)(A) has been amended to replace "non-reviewer physician under subdivision"

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	physician…. This language should be corrected to refer to the "non-physician reviewer". Secondly, the proposed rule as written references a subdivision, but the accompanying section number is missing. Again, in pertinent part, the proposed rule states, "…if all the information reasonably necessary to make a determination under subdivision (f)(1)(A) that is requested…**under subdivision** [sic]is not received within fourteen (14) days…" This should be corrected to insert the appropriate cross-reference.	Written Comment	clarification.	with "non-physician reviewer."
9792.9.1.(c)(2)	Commenter recommends the following revised language: A non-conforming request for authorization (i.e., an incomplete Form RFA including an RFA not accompanied by supporting documentation such as the DLSR 4021 or the PR-2, or request that does not use the form) must be returned to the requesting physician within three business days or else be considered as complete and subject to all applicable timeframes and requirements.	Judy Donofrio, RN, CCM, CPC Rising Medical Solutions October 7, 2013 Written Comment	Agreed.	Amend section 9792.9.1.(c)(2) to ensure that the necessary medical documentation is included with the request.
9792.10.1(c)(2)	Commenter recommends the following revised language:	Diane Przepiorski Executive Director October 10, 2013	Disagree. This is repetitive as it already provides for a written decision "with all	No action necessary.

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	…..(1) shall not begin to run until the claims administrator provides the written decision <u>addressing all requested services</u> with all required elements, to the employee.	Written Comment	required elements…"	
9792.10.1(d) and (d)(2)	Commenter opines that changing the date for the submission of a voluntary appeal to being requested within 10 days is a good idea; however, there is no completion date for the voluntary appeal decision. This is complicated by the requirement of §9792.10.1(d)(2) that a modification must contain a DWC Form IMR. Commenter questions whether this triggers a whole new time-line for IMR or would this be a second IMR with a new time-line. Commenter is unclear what would happen if the voluntary appeal was to authorize the requested treatment and an IMR application had already been filed. Is that automatically withdrawn? Is the fee for the IMR waived because the issues have been resolved?	Stephen L. Kline General Counsel EK Health Services October 11, 2013 Written Comment	Agreed.	9792.10. 1(d)(2) has been amended to now read: "A request for an internal utilization review appeal must be completed, and a determination issued, by the claims administrator within thirty (30) days after receipt of the request under subdivision (d)(1). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6 (c) that determines the medical necessity of the disputed medical treatment." The existing subdivision

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				(c)(2) is now renumbered as (c)(3).
9792.10.1(b)(2)	Commenter opines that the intent in SB 863 is ignored in these Regulations. SB 863 allowed the employee to designate a third party to assist in appealing the Utilization Review decision. Commenter states that it was the intent of the lawmakers in allowing this assignee status to reduce the automatic and unnecessary appeals to the IMR process. Commenter opines that so many times the resources of the DWC are eaten up with unnecessary appeals and appeals that when the employee was finally given the right to undergo surgeries or procedures; they changed their minds and would not submit to the treatment or procedure. Commenter states that by making the assignee process only performed after the Utilization Review decision was handed down ensured that the employee really wanted to appeal the decision; rather than a physician or attorney moving forward without authorization to do so. Commenter has heard of doctor offices and attorney offices who have	Dennis Knotts December 7, 2013 Written Comment	The regulation complies with the statutory mandate of Labor Code section 4610.5(j). It must be noted that an injured worker has the right to be represented by an attorney in the workers' compensation claim and appeal process. See, for example, Labor Code section 5700. Many injured workers have legal representation while they are receiving medical treatment for their occupational injuries; to require an additional designation by the employee for their attorney after a utilization review decision issued would be superfluous. It is telling that the statutory provision requiring the designation, Labor Code section 4610.5(j), does not mention attorneys as a party that an employee would designate to act on their behalf during the IMR process. This striking	No action necessary.

	employees sign a blank and undated assignee form during their first meeting, thereby violating the legal requirement to make the assignee after receipt of the Utilization Review decision is received by the employee. Commenter states that there is an escalating number of IMRs in the last few months and he opines that physicians and attorneys are seeking intentionally or by accident to overwhelm the resources of the DWC, bog down the process, delay decision – thereby delaying treatment; and forcing employers to make business decisions to approve medical treatment not appropriate per the MTUS. Commenter states that the Division has removed the medical decision from the hands of the medical provider and runs the risk of authorizing treatment that may be harmful for an injured employee. Commenter opines that this is opening the system up to unnecessary treatment; and therefore fraud and abuse.		absence may reflect a Legislative intent that represented employees and their attorneys are subject to the subdivision's mandate. That said, proposed section 9792.10.1(b)(2)(A) does require that a notice of representation or other written designation confirmation representation accompany the IMR application.	
9792.10.5 (a)(2)	Commenter opines that the addition of the requirement to filter out the mental health records will create much greater	Rob Shatsnider Vice President, Claims	The requirement to serve a list of documents provided to the IMRO, and a copy of any	9792.10.5 (a)(2) has been amended to exclude mental health

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	administrative problems and costs to comply with the regulations. Commenter suggests that rather than requiring service of all medical records on the other parties, require that an itemization of the medical records be served on the employee and their representative. Allow any employee or their representative to request and be served with any report on the list if they advise the claims administrator that they do not have a copy of it in their possession. Mental health records would be excluded from the requirement of service on the employee but a response outlining the reason that the reports can't be served on the employee would be required in the event than an employee requested those records. Commenter recommends the following revised language: (2) The claims administrator shall, concurrent with the provision of documents under subdivision (a), forward to the employee or the employee's representative a notification that lists all of the documents submitted to the	CompWest October 9, 2013 Written Comment	document not previously provided to the employee is statutory. See Labor Code section 4610.5(o). The regulation reasonably addresses the withholding of mental health records.	records withheld from the employee pursuant to Health and Safety Code section 123115(b).

	independent review organization under subdivision (a). If any of the documents have not been previously served on the employee or the employee's representative and the employee or the employee's representative requests a copy of a report on the list, the claims administrator shall forward a copy of the requested report to the employee or the employee's representative. If mental health records are withheld from the employee pursuant to Health and Safety Code section 123115(b) the claims administrator shall advise the employee in writing upon receipt of a request from the employee for a copy of a record being withheld pursuant to Health and Safety Code section 123115(b).			
9792.10.5(b)(2)	Commenter notes that this paragraph requires that the employee "serve" on the claims administrator any documents provided to the IMRO. However, under proposed section 9792.10.5(a)(2), the claims administrator must only "forward" documents to the employee. Commenter opines that the parties should have the same obligation.	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	Agreed.	9792.10.5(b)(2) has been amended to specifically include the employee's attorney as a party who may forward documents or a document list on the claims administrator. Amend to substitute "forward" for

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	Commenter states that Labor Code section 4610.5(l) mandates that the employer "concurrently provide a copy of the documents required by this paragraph to the employee and the requesting physician...." However, section 4610.5(f)(3), which establishes the employee's right to provide information or documentation, has no similar requirement that the employee must provide a copy of this information or documentation to the claims administrator or employer. Commenter agrees that the adoption of a rule requiring the employee to provide copies to the claims administrator is appropriate; however, she believes there is no justification to require "service" by the employee and not by the claims administrator. In order to establish an equal obligation by both parties, commenter recommends that this paragraph be amended to require that the employee "forward" documents to the claim administrator			"serve."
9792.10.5(a)(2)	Commenter recommends the following revised language: The claims administrator shall, concurrent with the provision of	Brenda Ramirez Claims and Medical Director California Workers' Compensation	See response to comment by CompWest regarding this subdivision.	No action necessary.

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	documents under subdivision (a), forward to the employee or the employee's representative a notification that lists all of the documents submitted to the independent review organization under subdivision (a). ~~The claims administrator shall provide with the notification a copy of all documents that were not previously provided to the employee or the employee's representative, excluding mental health records withheld from the employee pursuant to Health and Safety Code section 123115(b).~~ If any of the documents have not been previously served on the employee or the employee's representative and the employee or the employee's representative requests a copy of a report on the list, the claims administrator shall forward a copy of the requested report to the employee or the employee's representative. If mental health records are withheld from the employee pursuant to Health and Safety Code section 123115(b) the claims administrator shall advise the employee in writing upon receipt of a request from the employee for a copy of a record being withheld pursuant to	Institute (CWCI) October 11, 2013 Written Comment		

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	Health and Safety Code section 123115(b). Commenter opines that filtering out mental health records will create administrative problems and costs. Commenter recommends requiring instead that an itemization of the medical records be served on the employee and their representative with a notice that the employee or the employee's representative may request to be served with any report on the list if they advise the claims administrator that they do not have a copy of it in their possession. Mental health records would be excluded from the requirement of service on the employee, but a response outlining the reason that the reports can't be served on the employee would be required in the event that an employee requested those records.			
9792.10.5(a)(2)	Commenter supports the exclusion of mental health records withheld from the employee pursuant to Health and Safety Code section 123115(b).	Lisa Anne Forsythe Senior Compliance Consultant Coventry October 11, 2013 Written Comment	The Division appreciates the comment.	No action necessary.
9792.10.5(a)(2)	Commenter requests that the Division amend this subsection to clarify	Lisa Anne Forsythe Senior Compliance	The provisions of the Health and Safety Code should be	No action necessary.

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	whether the claims administrator is obligated to send mental health records to an *employee representative* in a situation where the records had not previously been disclosed to the injured worker pursuant to Health and Safety Code Section 123115(b), as well as clarify the definition of "employee representative" within the context of this section to indicate whether a claimant's attorney is considered an "employee representative".	Consultant Coventry October 11, 2013 Written Comment	reviewed as to the parties entitled to review the documents. "Employee's representative," does not need a separate definition for this subdivision.	
9792.6.1(t)(2)	Commenter recommends the following revised language: (2) "Completed," for the purpose of this section and for purposes of investigations and penalties, means that information specific to the request has been provided by the requesting treating physician for all fields indicated on the DWC Form RFA, ~~the form request for authorization must identify both the employee and the provider~~, and identify with specificity a recommended treatment or treatments. Commenter strongly objects to the proposed definition of "completed."	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	Agree in part. Identifying information, in combination with the supporting documentation, will produce wholly adequate information to proceed with a treatment review.	Section 9792.6.1(t)(2) has been amended to require documentation substantiating the need for the requested treatment with the request for authorization.

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	Commenter opines that provision of wholly inadequate information will lead to treatment delays, disputes, and penalties while the necessary information is obtained. Commenter believes that no change should occur to the original definition.			
9792.6.1(t)(2)	Commenter notes that RFA must identify requested treatment "with specificity." Commenter opines that this will probably help reduce ambiguities, and is appreciated	David A. Ingrum, MD October 11, 2013 Written Comment	Agreed.	Section 9792.6.1(t)(2) has been amended to required treatment be identified with specificity.
9792.7(b)(2)	Commenter notes that this refers to "reviewer's scope of practice," and opines that it should include the language "as defined by the applicable licensure board." See comment regarding 9792.6.1 (w).	David A. Ingrum, MD October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. The reviewer's scope of practice has not been changed by IMR .	No action necessary.
9792.6.1(t)(2)	Commenter recommends the following revised language: "Completed," for the purpose of this section and for purposes of investigations and penalties, means that information specific to the request has been provided by the requesting treating physician for all fields indicated on the DWC Form RFA, ~~the~~	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	See above response to comment by American Insurance Association regarding this subdivision.	No action necessary. .

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	~~request for authorization must~~ including information identifying both the employee and the provider, ~~and~~ identifying with specificity a recommended treatment or treatments, and substantiating the need for the requested treatment. Commenter states that in order to respond to requests and validate the need for treatment within the required timeframe, it is vital that the treating physician complete all applicable fields on the form so that the administrator can quickly confirm that it is a request for authorization of treatment; identify the claim as well as the specific treatment that is being requested; and contact the treater with a response or if clarification or additional information is needed.			
9792.6.1(t)(2)	Commenter supports the expanded language of "completed" to require that an RFA must identify both the employee and the provider, and identify with specificity a recommended treatment or treatments. Commenter opines that inclusion of this language will make great strides toward improving the quality of RFA's received.	Lisa Anne Forsythe Senior Compliance Consultant Coventry October 11, 2013 Written Comment	Agreed.	Section 9792.6.1(t)(2) has been amended to required treatment be identified with specificity.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.9.1(c)(2)	Commenter states that the provision which requires claim administrators to return an incomplete RFA to the requesting physician within 3 business days will place an unreasonable burden on claims examiners. Commenter opines that the burden to provide a correct RFA should be the responsibility of the treating physician and if that responsibility is breached the RFA should not be deemed authorized or subject a claims administrator to penalties and/or sanctions. Commenter states that it is difficult to see how a claim department could meet this burden and he believes there will be physicians who will take advantage of this rule by having nothing to lose by providing an incomplete and/or unsigned RFA. Commenter opines that the DWC should provide training to the physicians and not place that burden on the claims administrators.	Antoine Smith Sr. Examiner Ameron International Corporation October 1, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.
9792.9.1(c)(2)	Commenter opines that changing the time frame from five (5) to three (3) days is too restrictive. Commenter opines that the revised language means that now it's not incumbent on the requesting	Alan E. Randle, M.D. Medical Director Allied Managed Care October 4, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

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	physician to use the DWC RFA form as mandated by SB863. Commenter states that the requesting physician could submit potentially any type of request for authorization without the DWC RFA form, and if the reviewer did not send it back within 3 days indicating that it was "not complete" – they would be stuck with processing it within the usual 5 days. Commenter opines that this is completely contrary to the intent of SB863 and undermines the requirement to use the properly completed RFA form to start the UR clock - and transfers the burden from the requesting physician to provide a proper request for authorization to the reviewer to identify it as not complete even if the DWC form is not used. Commenter opines that some physicians will intentionally not use the RFA form in the hope that the time frame for "not complete" will be missed and the reviewer will be forced to proceed with whatever type of request for authorization they sent to be processed.			
9792.9.1(f)(2)(A)	Commenter opines that the	Steven Suchil	See response to September	No action necessary.

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and (B)	highlighted language should be retained: (2) (A) If information reasonably necessary to make a determination is not provided with DWC Form RFA ~~or other accepted request for authorization~~ , a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request. (B) If any of the circumstances set forth in subdivisions (f)(1)(A), (B) or (C) ~~above~~ are deemed to apply following the receipt of a DWC Form RFA ~~or accepted request for authorization,~~ the reviewer shall immediately notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and ~~specify~~ request, as applicable, the information ~~requested but not received~~ reasonably necessary to make a determination, the additional examinations or tests required, or the specialty of the expert	Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	

	reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered. Commenter opposes the alternative to the RFA.			
9792.9.1(c)(2)	Commenter interprets the revised language to mean that it's **NOT** incumbent on the requesting physician to use the DWC RFA form as mandated by SB863. Thus the requesting physician could potentially submit any type of request for authorization without the use of the DWC RFA form, and if the claims administrator did not send a "not complete" back to the physician within 3 days they would be mandated to process the request within the existing 5 day processing period. Commenter is concerned by these two proposed changes since they appear contrary to the intent of SB 863 and he opines that they represent an unrealistic time demand which totally undermines the requirement to use the	Philip Vermeulen Governmental Relations Advocate for AIMS/AMC October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

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	properly completed RF A form to start the UR clock. Commenter states that it transfers the burden from the requesting physician to provide a proper request for authorization to the Claims Administrator to identify the request as not complete even if the DWC form is not used. Commenter state that should this change be approved, a Claims Administrator would have only 3 days instead of the existing 5 days to either accept this form "as is" or reject it as "not complete. Commenter strongly urges the DWC to withdraw both of these proposed changes. Commenter opines that it is unreasonable (and highly unwise) to reduce the timeframe from 5 days to 3 days from the date of receipt. Commenter states that this time period is used to scan the document and provide the initial review by the claims examiner who may or may not be able to determine if the request is "complete" and if necessary receive input from a nurse reviewer.			
9791.9.1(d)(1)	Commenter recommends that the deleted language “set forth in a DWC Form RFA” be put back in this section	Cheryl Richardson, ARM, Vice President Republic Indemnity	See response to September 27, 2013 comment by Linda Larkins regarding section	No action necessary.

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	for the reasons she outlined regarding section 9791.9.1(c)(2).	Company October 11, 2013 Written Comment	9792.9.1(c)(2). Parameters for requests for authorization have been clarified. They must be clearly identified with "Request for Authorization" written at the top of the first page, all requests must be listed on the first page, and the request must be accompanied by documentation.	
9792.9.1(c)(2)	Commenter notes the change in the time frame for CA to respond to incomplete RFA from 5 business days to 3 business days. Commenter opines that this is an onerous requirement upon the CA that appears purely arbitrary, with no clear evidence that the 5 day timeframe has resulted in unnecessary delay in treatment. Commenter requests that this change be rescinded and that the 5 business day timeframe be retained.	David A. Ingrum, MD October 11, 2013 Written Comment	Agreed.	9792.9.1(c)(2) is now identified as subdivision (c)(2)(A) and is amended to specify the reasons for the return of the request, no later than five (5) business days from receipt. The timeframe for a decision on a returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.9.1(f)(2)(B)	Commenter notes that that this section states "the reviewer shall notify the requesting physician" if the circumstances of (f) (1) (A) apply, namely that CA or reviewer is not in receipt of necessary information. Commenter opines that this section should state "the reviewer *or non-physician reviewer* shall immediately notify…"	David A. Ingrum, MD October 11, 2013 Written Comment	A non-physician reviewer can only request information under subdivision (f)(1)(A). References to this subdivision should be deleted from subdivision (f)(2)(B).	Section 9792.9.1(f)(2)(B) has been amended to delete references to subdivision (f)(1)(A).
9792.9.1(b)(2)	Commenter supports the proposed amendment to this section which now clearly defines when Utilization Review must start if UR is deferred because the claims administrator disputes liability for the claim or the treatment. Commenter opines that one way to assure that the claims administrator complies with the statutory time requirements is by the creation of a new form to be completed by the claims administrator that documents the dates when the RFA was received, when the notice of deferral was sent to the employee, and when the liability determination became final. This form could be required to be provided to the employee within one working day of the date the determination of liability becomes final. Commenter states that	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	No action necessary.

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	this will help reduce litigation by placing all parties on notice of the pertinent dates in the statutory UR timeline, and will also provide documentary evidence for the Division's audit unit of the claim adjuster's compliance with these timelines.			
9792.9.1(c)(2)	Commenter supports the proposed amendments to this paragraph. As amended, this paragraph sets out the claim adjuster's responsibility where the request for authorization does not use the DWC Form RFA. Commenter opines that although the rules state that physicians must utilize the DWC Form RFA, it is imperative that these rules provide guidance to the parties as to their responsibilities under all probable scenarios. Commenter states that the addition of this proposed language is an extremely important change that will help prevent unnecessary delays and added costs. Commenter opines that the amendment to this subdivision requiring the reviewer to specify the reasons for the return of the request for authorization no later than three	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	business days from receipt is an improvement from the earlier version as it facilitates communication between the reviewer and the treating physician and provides the claims administrator with a reasonable time frame so further delay is avoided.			
9792.9.1(c)(2)	Commenter recommends the following revised language: Unless the treating physician fails to utilize the DWC Form RFA, or ~~If the treating physician requests a course of treatment in a manner that does not utilize the DWC Form RFA, or if~~ the DWC Form RFA does not identify the employee or provider, does not identify a recommended treatment, or is not signed by the ~~requesting~~ treating physician, a non-physician reviewer as allowed by section 9792.7 or reviewer must either respond to ~~regard~~ the request as though it were a complete DWC Form RFA and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete**,**" specifying the reasons for the return of the request**,** no later than five (5) ~~three (3)~~ business days from receipt. The timeframe for a decision	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	on that returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA. Commenter states that it is the responsibility of the treating physician to submit a complete request for authorization to ensure the provision of timely medical treatment to his or her patient. At a minimum, the physician must submit the request on the required form, identify the employee, provider and recommended treatment, and sign the form. Commenter opines that it will not be enough to supply the name of the employee because that will not be sufficient to identify the claim, -- especially when the employee has a common name. Commenter states that if requests for authorization are not confined to a standard form they may not be identified within three or five working days, or at all because requests for authorization may be hidden in voluminous medical reports and other information. Commenter opines that only if the physician meets these minimum requirements should any response be required within any			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	mandated timeframe. Commenter states that responding to requests for authorization within five working days is a Herculean task. Commenter opines that reducing that time to three working days to respond in writing to vague, incomplete and deficient requests with specific reasons for returning them is draconian, unrealistic and will be expensive. Albeit unintended, these requirements will result in non-compliant physicians further increasing the cost of utilization review and discouraging utilization review. Commenter does not believe that the Administrative Director has statutory authority to apply or enforce a three-day response to deficient requests for authorization.			
9792.9.1(f)(2)(A)	Commenter recommends the following revised language: If information reasonably necessary to make a determination is not provided with DWC Form RFA ~~or other accepted request for authorization~~, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5)	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Disagree. Parameters for requests for authorization have been clarified. They must be clearly identified with "Request for Authorization" written at the top of the first page, all requests must be listed on the first page, and the request must be accompanied by	Section 9792.9.1(f)(2)(A) has been amended to conform with changes made to the request for authorization.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	business days from the date of receipt of the request.		documentation.	
9792.9.1(f)(2)(B)	Commenter recommends the following revised language: If any of the circumstances set forth in subdivisions (f)(1)(A), (B) or (C) are deemed to apply following the receipt of a DWC Form RFA ~~or accepted request for authorization~~, the reviewer shall immediately notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the reviewer cannot make a decision within the required timeframe, and request, as applicable, the information reasonably necessary to make a determination, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	See response to the above comment.	No action necessary.
9792.9.1(c)(2)	Commenter recommends that the DWC continue to mandate use of a standardized form for submission of all treatment requests. Commenter opines that all language allowing treating physicians to submit requests in alternative formats should be stricken from the revised regulations.	Peggy Thill Claims Operations Manager Yvonne Hauscarriague Assistant Chief Counsel	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter urges maintaining the **5-day timeframe** for responding to requests for authorization. Commenter states that by standardizing how physicians request authorization for medical treatment with the introduction of the DWC Form RFA, the Division of Workers' Compensation (DWC) clearly recognized the challenge claims administrators have historically faced in identifying and prioritizing large volumes of treatment requests received in various formats. A standard request form allows claims administrators to easily identify and process treatment requests within statutory timeframes, including those that need to be reviewed on an expedited basis. As modified, commenter opines that the draft regulations undermine efforts to streamline and simplify the utilization review (UR) process, as they provide no incentive for requesting physicians to use the DWC Form RFA. Commenter states that they again place the burden of identifying, reviewing, and responding to *all*	State Compensation Insurance Fund October 11, 2013 Written Comment		

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	requests received on the claims administrator. Commenter opines that the modified regulations create the very issues that adoption of the DWC Form RFA was intended to resolve: they will only cause disputes over what constitutes a complete request for authorization and ultimately lead to medical treatment delays. Commenter states that the 5-day UR timeframes already posed an operational challenge to claims administrators to respond timely given the volume of treatment requests received and that reducing the timeframe will only exacerbate the issue, as claims administrators will be required to review a request, determine its adequacy, and request additional information, if necessary, within 3 days.			
9792.9.1(f)(2)(B)	Commenter notes that this subsection uses the word immediately as the time limit for the reviewer to notify the parties that a decision cannot be made within the 5 days because of missing information reasonably necessary to make a determination. Commenter opines that this change from sending out the Request for more Information	Stephen L. Kline General Counsel EK Health Services October 11, 2013 Written Comment	Agreed.	The word "immediately" has been replaced with "within five (5) business days from the date of receipt of the request for authorization,"

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	letter within 5 business days and extending the timeframe to 14 calendar days is ambiguous. Immediate is defined by 8 CCR §9792.6.1(m) as within one business day. The calculations for timeframes are more complicated. Commenter questions when the decision is made for the need for more information. Commenter recommends that the division continues to require the Request for Information letter within the 5 calendar days.			
9792.9.1(c)(2)	Commenter recommends the following revised language: If the ~~treating physician requests a course of treatment in a manner that does not utilize the DWC Form RFA, or if~~ the DWC Form RFA does not identify the employee or provider, does not identify a recommended treatment, or is not signed by the requesting physician, a non-physician reviewer as allowed by section 9792.7 or reviewer ~~must~~ may either regard the ~~request~~ form as ~~a~~ complete ~~DWC Form RFA~~ and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	complete," specifying the reasons for the return of the request, no later than ~~three (3)~~ five (5) business days from receipt. The timeframe for a decision on that returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA. Commenter opines that the §9792.9.1 modified regulations have shifted the timeframes for the utilization review process in an unworkable direction. Currently, claims administrators have five business days from date of receipt of the completed DWC Form RFA to evaluate the adequacy of the request and, in instances where requests are incomplete, return the request to the provider identifying the needed information. Under the modified regulations, this response timeframe has been condensed to three business days - an impractical timeframe given the high volume of documents claims administrators receive and the time needed to analyze and respond to a request. Commenter opines that there is absolutely no statutory authority			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	directing the DWC to reduce this timeframe. Commenter states that if the claims administrator does not object to a request within this short window, then the request is deemed complete – even if material information is missing. Commenter opines that this effectively eliminates the incentive for providers to submit full and complete requests for authorization by placing the onus almost entirely on the claims administrator to review and quickly reject incomplete responses. Commenter notes that the modified regulations have also made it more difficult for claims administrators to quickly identify requests. This difficulty has arisen because these regulations widen the universe of documents that may serve as a request for authorization. Claims administrators receive volumes of documents from various sources and must quickly prioritize the most urgent and time-sensitive requests. Commenter states that the proposed revision will allow nearly any document from a requesting physician to constitute a request for			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	authorization, thereby eliminating the ability to quickly identify requests for medical treatment – which is an advantage of a singular, defined, and unique form. Commenter opines that the UR standards, timeframes, procedures, notice and penalties should only apply to treatment requests properly submitted on the DWC Form RFA per 9792.6(1) and 9792.9.1(a). Commenter recommends that the DWC adopt a singular, defined, and unique form for requests for authorization in order to streamline the request process, expedite the claims administrators' review and ensure that requests are promptly processed (or returned to the physician should additional information be required). Commenter states that claims administrators already receive a multitude of documents, and utilizing a singular form will eliminate the potential for ambiguity in the request for authorization process and lower the opportunities for delayed treatment.			
9792.9.1(f)(2)(A)	Commenter recommends the following revised language:	Jeremy Merz CalChamber	Disagree. Parameters for requests for authorization	Section 9792.9.1(f)(2)(A) has

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	If information reasonably necessary to make a determination is not provided with DWC Form RFA ~~or other accepted request for authorization~~, a reviewer or non-physician reviewer shall request the information from the treating physician within five (5) business days from the date of receipt of the request. Commenter recommends that the DWC delete the modified language referencing the alternative request for authorization. Commenter opines that there should only be one uniform and identifiable request for authorization form.	Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	have been clarified. They must be clearly identified with "Request for Authorization" written at the top of the first page, all requests must be listed on the first page, and the request must be accompanied by documentation.	been amended to conform with changes made to requests for authorization.
9792.9.1(f)(2)(B)	Commenter recommends the following revised language: If any of the circumstances set forth in subdivisions (f)(1)(A), (B) or (C) are deemed to apply following the receipt of a DWC Form RFA ~~or accepted request for authorization~~, the reviewer shall immediately notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney in writing, that the	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	Disagree. Parameters for requests for authorization have been clarified. They must be clearly identified with "Request for Authorization" written at the top of the first page, all requests must be listed on the first page, and the request must be accompanied by documentation.	Section 9792.9.1(f)(2)(A) has been amended to conform with changes made to requests for authorization.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	reviewer cannot make a decision within the required timeframe, and request, as applicable, the information reasonably necessary to make a determination, the additional examinations or tests required, or the specialty of the expert reviewer to be consulted. The reviewer shall also notify the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney of the anticipated date on which a decision will be rendered. Commenter recommends that the DWC delete the modified language referencing the alternative request for authorization. Commenter opines that there should only be one uniform and identifiable request for authorization form.			
9792.9.1(f)(2)(B)	Commenter requests that the Division correct the language in this subsection to replace the term "immediately" with the 5-day turnaround time specified in §9792.9.1(F)(2)(A).	Lisa Anne Forsythe Senior Compliance Consultant Coventry October 11, 2013 Written Comment	Agreed.	The word "immediately" has been replaced with "within five (5) business days from the date of receipt of the request for authorization,"
9792.9.1(c)(2) and	Commenter recommends the	Jerrold Garrard	See response to September	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.9.1(f)(1) through (f)(3)	following revised language: (2) If the treating physician requests a course of treatment in a manner that does not utilize the DWC Form RFA, or if the DWC Form RFA does not identify the employee or provider, does not identify a recommended treatment, **does not include necessary documentation (First Report, PR-2, or Narrative) which substantiates the need for the requested treatment.** or is not signed by the requesting physician, a non-physician reviewer as allowed by section 9792.7 or reviewer y must either regard the request as a complete DWC Form RFA and comply with the timeframes for decision set forth in this section or return it to the requesting physician marked "not complete," specifying the reasons for the return of the request, no later than three (3) business days from receipt. The timeframe for a decision on that returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA. Commenter would like to see the definition of a complete request include "documentation substantiating the need for treatment." Commenter would prefer verbiage about "Objective Findings," "Diagnostic Reports," and "Specific to the	GSG Associates October 11, 2013 Written Comment	27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Injured Worker."			
9792.9.1(c)(2)	Commenter opines that the language in this section contradicts the REQUIREMENT to submit an RFA, and absolves the requesting physician of any requirement to adhere to the RFA process. Commenter states that allowing that the requesting physician might not use the RFA form, and using the words "the reviewer MUST either regard the **request** as complete…" means that a "request" may come in any form as Pre-SB863, and the onus is on the Administrator when the requesting physician is not compliant.	Jerrold Garrard GSG Associates October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.
9792.12(c)(1)	Commenter recommends the following revised language: For the failure to provide the Application for Independent Medical Review, DWC Form IMR, set forth at section 9792.10.2, with all applicable fields completed by the claims administrator, with a written decision modifying, delaying, or denying a treatment authorization under sections 9792.9(l) or 9792.9.1: ~~$2,000~~. Commenter opines that the proposed penalty is overly punitive for what can	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Agree in part. The penalty regulations should distinguish between: (1) failing to include the form; (2) failing to provide essential information on the form: and (3) failing to provide other information.	9792.12(c)(1) has been amended to delete "with all applicable fields completed by the claims administrator." (c)(2) A subdivision is added to allow for the assessment of administrative penalties for the failure of the claims administrator to

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	amount to a nonmaterial administrative error that will have little if any effect on the IMR process. Under this section, a claims administrator would face a $2,000 fine for failing to fill out any one of the fields on the IMR application. Commenter opines that this type of administrative error does not rise to the same level as failing to provide an injured worker with an IMR application and, as such, should not impose the same level of punishment. Commenter recommends that the DWC create a three-tiered penalty scheme for IMR applications: 1. **Nonmaterial failure to complete IMR application form fields**: A penalty of no more than $100 should be assessed against the claims administrator for a non-material administrative error that does not have a significant effect on the IMR application process. 2. **Material failure to complete IMR application form fields**:			complete all applicable fields of the Application for Independent Medical Review, DWC Form IMR, found at section 9792.10.2, that is provided with a written utilization review determination that delays, denies, or modifies a treatment recommendation. The proposed penalties are as follows: $500 for a failure to provide the Employee Name, Address, Phone Number, and Date of Injury; $500 for a failure to provide the Requesting Physician Name, Address, Specialty, and Phone Number;

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	A penalty of no more than $500 should be assessed for material errors that have a significant effect on the IMR application process. 3. **Failure to provide IMR application with the complete written decision modifying, delaying or denying treatment**: A penalty of no more than $2,000 should be assessed for failure to provide the IMR application to the injured worker with the complete written decision. Commenter states that the total amount of the penalty should be at the discretion of the Administrative Director and should be based on an analysis of the severity of the violation, the effect on the IMR process and efforts undertaken to remedy the error.			$500 for a failure to provide the Claims Administrator Name, Adjustor/Contact Name, Address, and Phone Number; $500 for a failure to complete any field under the section heading "Disputed Medical Treatment." $100 for a failure to provide any field not identified above.
9792.12(c)(1)	Commenter recommends that the DWC adopt a penalty scheme where the penalty and/or penalty amount is commensurate with the severity of the violation. Commenter states that nonmaterial violations (e.g. those that	Peggy Thill Claims Operations Manager Yvonne Hauscarriague	See above response to comment by CWCI regarding this subdivision.	No action necessary.

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	do not result in a delay in the injured worker's medical care) should result in a minor penalty, if any. Material failures that significantly impact the injured worker's IMR rights and/or his/her access to medical care (e.g. failure to provide the IMR application to the injured worker at the time an adverse UR decision is issued) should result in higher penalties. Commenter notes that this subsection of the revised regulations propose the assessment of a $2,000 penalty where the claims administrator provides the required IMR application to the injured worker but fails to complete all applicable fields on the form. Commenter acknowledges that it is the claims administrator's obligation to complete the IMR application under 9792.9.1(e)(5)(G); however, it is possible that information will be omitted simply due to a clerical error that would have no impact on the injured worker's medical care. For non-material errors, commenter states that the proposed penalty is excessive.	Assistant Chief Counsel State Compensation Insurance Fund October 11, 2013 Written Comment		
9792.12(c)(1)	Commenter opines that the proposed penalty is overly punitive for what can amount to a nonmaterial	Jeremy Merz CalChamber	See above response to comment by CWCI regarding this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	administrative error that will have little (if any) affect on the IMR process. Under this section, a claims administrator would face a $2000 fine for failing to fill out any of the fields on the IMR application. Commenter states that this type of administrative error does not rise to the same level as failing to provide an injured worker with an IMR application and, as such, should not impose bring the same level of punishment. Commenter recommend that the DWC create a three-tiered penalty scheme for IMR applications, as follows: 1. **Nonmaterial Failure to Complete IMR Application Form Fields**: A $100 penalty should be assessed against the claims administrator for any non-material administrative errors that do not have a significant effect on the IMR application process. 2. **Material Failure to Complete IMR Application Form Fields Material**: A $500 penalty should be assessed for material errors that have a significant effect on the IMR	Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment		

	application process. 3. **Failure to Provide IMR Application or Complete Written Decision Modifying, Delaying or Denying Treatment**: A penalty of up to $2000 should be assessed for failure to provide the IMR application to the injured worker or failure to provide a complete written decision. The total amount of the penalty should be at the discretion of the Administrative Director and should be based on an analysis of the severity of the violation, the effect on the IMR process and efforts undertaken to remedy the error.			
9792.10.1(c)(1)	Commenter state that the reference to subdivision (b)(2) in the paragraph is incorrect and should read (b)(1) instead.	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	Agreed.	The correction has been made.
9792.10.1(d)(1)	Commenter notes that this paragraph has been amended to delete the requirement that the internal UR review process be completed within 15 days. Commenter acknowledges that it could be difficult to comply	Diane Worley California Applicants' Attorneys Association October 11, 2013	Agreed. The regulations should contain a deadline for when an internal appeal must be completed.	Add section 9792.10.1(d)(2) to require that an internal review be completed within a 30 day period.

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	with that requirement, but states that it is unavoidable that the internal UR process must be compressed in order to protect the worker's right to file for IMR within the statutory time limit of 30 days. Commenter recommends that this paragraph include a deadline for completion of the internal UR process that gives the worker sufficient time to file for IMR. If this paragraph is adopted as proposed, commenter opines that it is likely that some workers will end up losing their right to file for IMR, while others will file for an IMR that is unnecessary. Commenter states that neither of these outcomes is desirable, but both would be prevented by adoption of a reasonable deadline for completion of the internal UR process.	Written Comment		
9792.10.1(b)(1)	Commenter recommends the following revised language: A request for independent medical review must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 30 days of service of the utilization review decision. The request must be made on	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	The language of the regulation is reasonable to imply that the DWC Form IMR-1 to be submitted is that provided by the claims administrator under section 9792.9.1(e)(5)(G).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	the Application for Independent Medical Review, DWC Form IMR completed by the claims administrator, and must be submitted with a copy of the written decision delaying, denying, or modifying the request for authorization of medical treatment. Commenter states that the recommended modification clarifies that the eligible party must submit the form completed by the claims administrator.			
9792.10.1(d)(1)	Commenter recommends the following revised language: Any request by the injured worker or treating physician for an internal utilization review appeal process conducted under this subdivision must be submitted to the claims administrator within fifteen (15) ~~ten (10)~~ days after the receipt of the utilization review decision. Commenter states that the injured employee has thirty days from the receipt of the UR decision to request an IMR, therefore fifteen days is doable within the timeframe. Commenter notes that those using an	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	The 10-day period in which to request an internal appeal is reasonable and provides the claims administrator with additional time in which to resolve – either informally or through a formal internal appeal – medical treatment disputes. Note that a new subdivision, (d)(2), has been added to require that treatment disputes be completed within 30 days of a request.	Add section 9792.10.1(d)(2) to require that an internal review be completed within a 30 day period.

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	internal UR process report seeing up to 50% of the determinations overturned during the internal process, primarily because the initial denial was based on lack of documentation necessary to make a decision when the requesting physician failed to respond to a request for information necessary to make a determination, and the information came in during the 15-day timeframe. Commenter opines that if the number of days is reduced from fifteen to ten, the number of IMR requests will increase unnecessarily.			
9792.10.1(b)(1)	Commenter supports the addition of the requirement to provide a copy of the IMR application to the claims administrator.	Lisa Anne Forsythe Senior Compliance Consultant Coventry October 11, 2013 Written Comment	The Division appreciates the comment.	No action necessary.
9792.10.1(d)(1)	Commenter recommends adding the following sentence at the end of this subsection: "Any request by the injured worker or treating physician for an internal utilization review appeal process conducted under this subdivision must be submitted to the claims administrator within ten (10) days after the receipt of the utilization	Lisa Anne Forsythe Senior Compliance Consultant Coventry October 11, 2013 Written Comment	See above response to comment by CWCI regarding this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	review decision **and completed by the UR agent within fifteen (15) days of the original UR decision."** Commenter opines that this section should include the companion language that requires that a decision on the internal appeals process must be made within 15 days of the original UR decision.			
9792.10.1(b)(1)	Commenter is concerned that the employee is required to provide a copy of the signed DWC Form IMR, without a copy of the adverse utilization review decision, to the claims administrator. Commenter states that many of her clients do not have any way of making copies except for going to a Staples, Kinko's, Office Depot or other vendor. Commenter states that it should be the mission of the Division to make life easier for the injured worker. Commenter would like to know if there is a penalty for the injured worker for not providing this form to the claims administrator.	H. Hollie Rutkowski October 10, 2013 Written Comment	The purpose of this subdivision is to put the claims administrator on notice, at the earliest point in time possible, that the employee intends to submit a request for IBR. This may allow an earlier resolution of the treatment dispute, either through a formal internal appeal or informal review, can facilitate communication between the claims administrator and provider, and allow the claims administrator to collect all pertinent records that may need to be provided to the IMR reviewer. Currently, there are no express penalties for a failure to provide the	No action necessary.

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			form, but this may be reconsidered in future rulemaking.	
9792.10.3(a)(1)	Commenter recommends the following revised language: Following receipt of the Application for Independent Medical Review, DWC Form IMR, pursuant to section 9792.10.1(b), the Administrative Director shall determine, within 15 days following receipt of the application and all appropriate information to make a determination, whether the disputed medical treatment identified in the application is eligible for independent medical review. If the Administrative Director assigns a designee to review the eligibility for independent medical review pursuant to Labor Code section 4610.5(k), the designee shall have no financial interest in the independent medical review. In making this determination, the Administrative Director shall consider: Commenter recommends that the DWC assign an entity separate and distinct from the independent medical review organization (IMRO) to make	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	No action necessary.

	IMR eligibility determinations because the IMRO has a financial interest in maximizing the number of IMRs conducted. Commenter opines that having a separate entity make eligibility determinations will eliminate the appearance of impropriety or conflict of interest. Assigning a separate entity will also have the added benefit of reducing the IMRO's workload and curtailing the current backlog of applications.			
9792.10.5(a)(1)(B)	Commenter opines that this subsection should be deleted. Commenter states that the need for the claims administrator to include the determination is unclear as it is required to be submitted with the Application. Commenter opines that subsection (a) (1) (B) seems to be inconsistent with subsection (a)(1)(C).	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	Agreed.	9792.10.5(a)(1)(B) has been amended to provide that the claims administrator must only include a copy of the Application for Independent Medical Review, DWC Form IMR, that was included with the written UR determination.
9792.10.5(a)(1)(A)	Commenter opines that arbitrarily limiting the submission of medical records by the claims administrator to the most recent year is inconsistent	Diane Worley California Applicants' Attorneys	The Division finds it reasonable to interpret Labor Code section 4610.5(*l*)(1)(A)'s mandate as	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	with the authorizing statute. Commenter notes that the current proposal reduces the arbitrary time period to just 6 months. Commenter states that this rule does not comply with the authorizing statute and must be amended. Labor Code section 4610.5(l) provides that the claim administrator must provide to the IMRO: "(1) A copy of all of the employee's medical records in the possession of the employer or under the control of the employer relevant to each of the following: (A) The employee's current medical condition. (B) The medical treatment being provided by the employer. (C) The disputed medical treatment requested by the employee." Commenter state that the statutory language clearly mandates submission of all "relevant" medical records;	Association October 11, 2013 Written Comment	meaning six months of medical records relevant to the employee's current medical condition. Six months of records provides an IMR reviewer in essentially every claim with sufficient medical evidence to make a medical necessity determination on a requested treatment. To require all records, regardless of the date, may tax the resources of claims administrators, and may result in the IMR process becoming unwieldy, costly, and time consuming. It must be noted that if additional records are required for an IMR reviewer to reach a determination, they have the ability to request those records from the parties. See section 9792.10.5(c). .	

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	however, this amended rule would require submission of only those reports of the requesting physician produced within the most recent six months. The proposed rule also requires submission of only those reports from other physicians where that physician has provided treatment for less than six months. Commenter opines that in cases where medical treatment has been on-going for more than six months, there is a significant probability that medical records that are essential to reach the correct determination of medical necessity will not be provided. The end result will be either a large number of disputes over the completeness of the medical evidence, or the issuance of a large number of incorrect determinations, which in turn will lead to appeals that should not have been necessary. Commenter states that unrepresented injured workers may lack the sophistication, knowledge or language proficiency to know or understand what is relevant for the IMRO to review to make a considered analysis.			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	They would be unable to identify what additional medical records would need to be sent to the IMRO to support the need for the recommended medical treatment beyond those provided by the carrier for this limited six month period. Commenter states that this is why the statute places the duty on the carrier and not the injured worker to provide all relevant medical records, and hence no arbitrary time limit was provided. Commenter opines that adoption of this proposed rule is a recipe for disaster. The only possible outcome would be an IMR process that is as unwieldy, costly, and time consuming as the current UR process. Commenter recommends that this rule be amended to conform to the authorizing statute and require submission to the IMRO of "all relevant records in the possession of or under the control of the claims administrator."			
9792.10.5(a)(1)(B)	Commenter recommends the following revised language: A copy of ~~the written determination~~	Brenda Ramirez Claims and Medical Director California Workers'	Agree in part.	9792.10.5(a)(1)(B) has been amended to provide that the claims administrator

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	~~by the claims administrator issued under section 9792.9.1(e)(5) that notified the employee and the requesting physician that the disputed medical treatment was denied, delayed or modified. The copy should not include~~ the application for independent medical review included with the determination pursuant to sections 9792.10.1(b) and 9792.10.2 . The application's instructions may be excluded. Commenter states that an application for IMR is ineligible if it is not submitted with the written determination issued by the claims administrator or reviewer pursuant to 9792.9.1(e)(5). If IMR is found eligible and is assigned for independent medical review, the IMRO is already in receipt of the determination and another copy is not necessary. Commenter states that even though the IMR application form instructions prohibit any changes to the application, many applications have been, and continue to be altered. Commenter recommends including the	Compensation Institute (CWCI) October 11, 2013 Written Comment		must include a copy of the Application for Independent Medical Review, DWC Form IMR, that was included with the written determination, issued under section 9792.9.1(e)(5), that notified the employee that the disputed medical treatment was denied, delayed or modified. Neither the written determination nor the application's instructions should be included.

	original application in the package of documents that go to the IMRO so that the reviewer has the required information. Commenter opines that this requirement may also discourage the practice of altering the application.			
9792.10.5(a)(1)(A)	Commenter supports the amendment in timeframes from one year, as previously outlined, to the new, more succinct 6-month timeframe. Commenter opines that providing six months of medicals is more than adequate to provide a comprehensive picture of the claimant's medical status for the purposes of determining an appropriate treatment regimen, and avoids overburdening the IMRO with "older" medical reports that may not even accurately reflect the claimant's current medical condition.	Lisa Anne Forsythe Senior Compliance Consultant Coventry October 11, 2013 Written Comment	The Division appreciates the comment.	No action necessary.
9792.10.5(a)(1)(B)	Commenter requests that this subsection be modified to remove the language requiring the claims examiner to manually separate the Adverse Determination from the accompanying IMR application and instructions, to help facilitate production of the needed information to the IMRO in the most expedient and cost-efficient fashion possible, while maintaining the integrity of the	Lisa Anne Forsythe Senior Compliance Consultant Coventry October 11, 2013 Written Comment	The subdivision has been amended to only require a copy of the IMR application. The claims administrator will not be sanctioned if it chooses to provide the UR determination also.	9792.10.5(a)(1)(B) has been amended to provide that the claims administrator must include a copy of the Application for Independent Medical Review, DWC Form IMR, that was included with the written

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	original documents.			determination, issued under section 9792.9.1(e)(5), that notified the employee that the disputed medical treatment was denied, delayed or modified. Neither the written determination nor the application's instructions should be included.
9792.6.1(t)(1)	Commenter recommends that the language added "Unless accepted by a claims administrator under section 9792.9.1(c)(2)" be removed. Keep the definition to mean that a request for authorization must be set forth on a "Request for Authorization for Medical Treatment (DWC Form RFA)," completed by a treating physician. Commenter states that the rules & regulations for the Reporting Duties of the Primary Treating Physician under 9785(g) require the DWC RFA Form for a written treatment request which must include as an attachment documentation substantiating the need for the	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	requested treatment. Commenter opines that it is important to facilitate communication between the treating physicians and the claims administrators when a course of treatment is being requested, that the treating physicians utilize the DWC Form RFA so that valid requests for treatment can be easily identified by the claims administrator to start the utilization review process. Utilization review standards, timeframes, procedures, notices & penalties should only apply to treatment requests properly submitted on a DWC Form RFA. Commenter states that the modified language conflicts with 9792.6.1(y) and 9792.9.1(a).			
9792.6.1(t)(1)	Commenter recommends the following revised language: ~~Unless accepted by a claims administrator under section 9792.9.1(c)(2),~~ A request for authorization must be set forth on a "Request for Authorization for Medical Treatment (DWC Form RFA)," completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5. ~~Prior to March 1, 2014, any~~	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

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	~~version of the DWC Form RFA adopted by the Administrative Director under section 9785.5 may be used by the treating physician to request medical treatment.~~ Commenter recommends requiring the use of the form adopted in this rulemaking on a going-forward basis for all requests for review submitted after the permanent regulations are implemented, or starting on a date certain, to avoid confusion and dispute over the instructions and rules that should apply.			
9792.6.1(t)(1)	Commenter recommends the following revised language: ~~Unless accepted by a claims administrator under section 9792.9.1(c)(2),~~ A request for authorization must be set forth on a "Request for Authorization for Medical Treatment (DWC Form RFA)," completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5. Prior to March 1, 2014, any version of the DWC Form RFA adopted by the Administrative	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Director under section 9785.5 may be used by the treating physician to request medical treatment. Commenter recommends that the DWC delete the modified language referencing the alternative request for authorization under section 9792.9.1(c)(2).			
9792.9.1(d)(1)	Commenter recommends the following revised language: All decisions to approve a request for authorization set forth in a DWC Form RFA shall specify the date the complete request for authorization was received**,** the specific medical treatment service requested, the specific medical treatment service approved, and the date of the decision. Commenter opines that the highlighted language should be re-instated. Commenter states that it is important that the date provided be when the information necessary for decision making was complete.	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	Agreed.	9792.9.1(d)(1) has been amended to specify that a decision to approve a request for information shall specify the date the complete request for authorization was received.
9792.9.1(f)(1)	Commenter recommends that the highlighted language be retained:	Steven Suchil Assistant Vice President/Counsel	The requirement is statutory. See Labor Code section 4610(g)(5). If the absence of	No action necessary.

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	The timeframe for decisions specified in subdivision (c) may only be extended with a written notice of delay by the reviewer under one or more of the following circumstances:	American Insurance Association October 8, 2013 Written Comment	this express provision results in confusion, the Division may reinsert it in future rulemaking.	
9792.12(a) and (b)	Commenter recommends the following revisions: (a)(12) For failure to respond to a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted~~ by the injured employee's requesting treating physician, in the case of a non-expedited concurrent review: $ 2,000; (a)(13) For failure to respond to a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2)~~ submitted by the injured employee's requesting treating physician, in the case of a non-expedited prospective review: $ 1,000; (a)(14) For failure to respond to a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2) submitted~~ by the	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2). Parameters for requests for authorization have been clarified. They must be clearly identified with "Request for Authorization" written at the top of the first page, all requests must be listed on the first page, and the request must be accompanied by documentation.	Section 9792.12(b) has been amended to conform with changes made to requests for authorization.

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	injured employee's requesting treating physician, in the case of a retrospective review: $ 500; (b) (4) (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 a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2)~~ submitted by the injured employee's requesting treating physician, or receipt of the requested information for prospective or concurrent review, and to communicate the decision as required by section 9792.9(~~g~~ h)(3) and section 9792.9.1(f) (4); (b) (4) (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 a complete DWC Form RFA ~~or other request for authorization accepted by a claims administrator under section 9792.9.1(c)(2)~~ submitted by the injured employee's requesting treating physician, or receipt of the requested			

	information, as required by section 9792.9(h)(4) and section 9792.9.1(e)(4), and (f) (6); Commenter opposes this alternative to the Request for Authorization mentioned in each of the preceding subdivisions.			
9792.12	Commenter requests that the Division adopt penalties for failure to address all services requested.	Diane Przepiorski Executive Director October 10, 2013 Written Comment	The requirement is statutory. See Labor Code 4610. Under section 9792.12(a)(12), a claims administrator is subject to a $2,000 penalty for the failure to respond to a complete DWC Form RFA.	No action necessary.
9792.10.2 9792.10.5(a)	Commenter states that MAXIMUS is receiving too many records for each review. Commenter recommends for represented cases that the DWC allow the party seeking IMR to submit any pertinent records with the initial IMR request with service on the opposing party. Then the opposing party can send any rebuttal records that they desire. Commenter recommends that for cases where the worker is not represented that the carrier continue to send all the records that they are now required to send in.	John Don October 6, 2013 Written Comment	The list of documents required to be submitted by the claims administrator is expressly set forth in statute. Labor Code section 4610.5(l). .	No action necessary.
9792.10.2 DWC	Commenter recommends removing	Cheryl Richardson,	The comment does not	No action necessary.

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Form IMR	the WCIS Jurisdictional Number and the EAMS Case Number. It is not clear why the 22 digit WCIS Jurisdictional claim number and the EAMS Case Number are required.	ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	address the substantive changes made to the proposed regulations during the 1st 15-day comment period. That said, claims administrators should have easy access to these identifying numbers, especially the WCIS numbers since practically all claims in California must be reported to the WCIS. See 8 C.C.R. section 9702. The numbers will assist the Division in linking databases and conducting research regarding medical treatment in the workers' compensation system.	
9792.10.2 DWC Form IMR	Commenter states that there is a typographical error in the heading of the first box on the form. Independent is misspelled in the heading "TO REQUEST INDEPENDENT MEDICAL REVIEW". Commenter recommends that the instructions on the form be amended to provide that "An application for IMR must be filed within thirty-five (35) days from the mailing date of the utilization review decision letter	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	Agree. Agree.	This misspelling has been corrected on the form. The "Instructions for Completing the Application for Independent Medical Review Form" is restructured and

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	informing you that the medical services or treatment requested by your treating physician was denied or modified." This would be consistent with CCP section 1013(a) allowing for an additional five days to respond to a notice served by mail. Commenter states that this would also conform to the proposed language in Section 9792.10.5 (a)(1) that a non-expedited review requires the claims administrator to send medical records to the IMRO (Maximus) "within fifteen(days) following receipt of the mailed notification…." Commenter notes that Labor Code section 4610.5(l) gives the employer only 10 days to provide the requested documentation. Commenter opines that the 5 day extension in section 9792.10.5(a)(1) is not authorized by statute, if the employer is given an additional 5 days to provide requested documentation, providing an additional 5 days for the injured worker would be consistent with both that provision and CCP section 1013(a).		The 15 day deadline for the simultaneous submission of documents (24-hours for expedited review) by the parties is necessary to ensure that IMR is completed in an expeditious manner while affording all parties the right to submit those documents that are relevant to the case. The timeframe takes into consideration two statutory mandates: The 10-day period of Labor Code section 4610.5 (*l*) and Code of Civil	simplified for clarity. The fifth bullet point provides that the IMR application must be received by Maximus Federal Services, Inc. within thirty-five (35) days from the mailing date of the written utilization review determination letter. "Determining Your Eligibility for IMR" has been deleted and replaced with contact information for the Division's Information and Assistance Officers.

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			Procedure sections 1010.6 and 1013(a), which extend certain deadlines to act or respond to documents that are served by mail (5 additional days). The Division feels this extension is reasonable and necessary to obviate any prejudice resulting from a delay in the receipt of a request for additional documents.	
9792.10.2 DWC Form IMR	Commenter submitted a revised version of this form [available upon request]. The reasons for the recommended changes are summarized as follows: • There is a typographical error in the spelling of "independent" in the box near the top of the form. • It is not clear why the EAMS case number and the 22-digit WCIS Jurisdictional claim number (JCN) are required. They are not necessary in the application process for independent review, nor are they useful for performing independent review. It has been suggested that they are necessary	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Agree in part. The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. That said, claims administrators should have easy access to these identifying numbers, especially the WCIS numbers since practically all claims in	Amend DWC Form IMR to correct misspelling and clarify terms.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	as replacements for the Social Security number here, however the Social Security number is also unnecessary. The claim number, or the employee name, and date of injury, which are included on the form, provide the identification that is necessary, are less burdensome, and can and are used by the Division to crosswalk to the EAMS and JCN numbers in the event they are necessary. The date of birth can be added for additional identification. If the Administrative Director retains these requirements, the additional time and expense needed to provide that information must be considered and disclosed in the regulatory process. • Recommended changes are necessary to clarify that the disputed treatment is to be entered as described by the physician on the request for authorization. • It is necessary to identify		California must be reported to the WCIS. See 8 C.C.R. section 9702. The numbers will assist the Division in linking databases and conducting research regarding medical treatment in the workers' compensation system. The disputed medical treatment is that which has been denied or modified by the claims administrator. The liability dispute checkbox should alert the IMRO of any	

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	services or goods: o For which the medical necessity is disputed during utilization review but that are also disputed for reasons other than medical necessity because this will alert the Administrative Director that IMR must be delayed until the non-medical necessity dispute is resolved. o That are delayed or disputed because the physician did not submit the reasonably requested medical information that is necessary to review the request for authorization, because the IMR application should be ineligible until the necessary information is timely submitted for a request for authorization and the claims administrator completes the utilization review.		dispute that involves other than medical necessity. A IMR application is required to accompany every adverse UR decision. Labor Code section 4610.5(f). Regarding eligibility under section 9792.10.3, the UR decision accompanying the application will notify the Administrative Director of the nature of the dispute.	

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	• Requiring the injured employee's original signature on the IMR form completed by the claims administrator when requesting the review will ensure that the employee is aware of, and wishes this independent review. • Typographical error which can be corrected by replacing "singed" with "signed." Commenter states that the deletion of Maximus as the destination of the application for initial review is recommended as there is an evident financial conflict of interest as noted also in the introduction to these comments. Commenter believes the application must instead instruct the injured employee to submit the application either directly to the Division of Workers' Compensation or to a designated entity that has no such conflict of interest. Doing so will also help reduce the large backlog of independent medical reviews.		The injured worker may have a representative act on their behalf in the IMR process. Labor Code section 4610.5(j). Corrected. The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. That said, the Administrative Director can designate the IMRO as the location for filing and conducting an initial review of the application. Labor Code section 4610.5(k). The Administrative Director retains the right to make eligibility determinations. Section 9792.10.3.	

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9792.10.2 – DWC Form IMR	Commenter makes the following recommendations for changes to the current draft of this form [revised copy available upon request.]: **1) Remove the WCIS Jurisdictional Number and the EAMS Case Number:** It is not clear why the EAMS case number and the 22-digit WCIS Jurisdictional claim number (JCN) are required. They are not necessary in the application process for independent review, nor are they useful for performing independent review. It has been suggested that they are necessary as replacements for the social security number here; however, the social security number is also unnecessary. The claim number, or the employee name, date of birth and date of injury, which are included on the form, provide the identification that is necessary, are less burdensome, and can and are used by the Division to crosswalk to the EAMS and JCN numbers in the event they are	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	1) The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. That said, claims administrators should have easy access to these identifying numbers, especially the WCIS numbers since practically all claims in California must be reported to the WCIS. See 8 C.C.R. section 9702. The numbers will assist the Division in linking databases and conducting research regarding medical treatment in the workers' compensation system. 2) The term has been corrected. 3) Addition pages can be used to describe the disputed medical treatment, including goods and services. The liability dispute checkbox	Amend DWC Form IMR to correct misspelling and clarify terms.

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	necessary. If the Administrative Director retains these requirements, the additional time and expense needed to provide that information must be considered and disclosed in the regulatory process. **2) Change the Term "Treating Physician" to "Requesting Physician":** The term "requesting physician" will eliminate any confusion that may arise when a treatment request is made by a physician who is not the primary treating physician. **3) Modify the Disputed Medical Treatment Section of the Application:** Recommended changes are necessary to clarify that the disputed treatment is to be entered into the application as described by the physician on the request for authorization. Additional space is also needed to identify services or goods whose medical necessity is disputed during utilization review but that are also disputed for reasons other than medical necessity.		should alert the IMRO of any dispute that involves other than medical necessity. 4) The injured worker may have a representative act on their behalf in the IMR process. Labor Code section 4610.5(j).	

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	This will alert the Administrative Director that IMR must be delayed until the non-medical necessity dispute is resolved. **4) Require Original Employee Signature:** This will ensure that the employee is aware of, and wishes to proceed with, the independent medical review.			
9792.10.2 DWC Form IMR	Commenter states that there is no longer any place for the Claims Administrator to clearly indicate to the IMR that there is a dispute as to the eligibility for IMR: If LC 9792.10.3 directs the IMR to consider factors for eligibility, the IMR form should have check-boxes to allow the Claims Administrator to draw the attention of the IMR to the dispute.	Jerrold Garrard GSG Associates October 11, 2013 Written Comment	Agreed. The DWC Form IMR as proposed does not contain a field where a claims administrator can indicate that a liability dispute exists. The form should contain this essential information.	Revise the DWC Form IMR, section 9792.10.2, to include a field where a claims administrator can indicate as to whether a liability dispute exists.
9792.10.3	Commenter recommends that this subsection specify that the request be made with five (5) "business" days. Commenter opines that the original 15 day response period is preferable; however, he recommends that the response time be business days in order to avoid the lost days due to weekends and holidays.	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	Agreed.	9792.10.3 (c) has been amended to allow parties five (5) business days to respond to any reasonable request by the Administrative Director under subdivision (b) following receipt of

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				the request.
9792.10.3(c)	Commenter notes the reduced the time frame for parties to respond to requests from the Administrative Director from 15 to 5 days. Commenter opines that more time should be given to respond. As written, if a request is received on Friday, the response would be due on Wednesday leaving only two days to research the request, compile the response and mail it out on Wednesday. Commenter suggests the response time be changed to either 5 business days or 10 calendar days.	Anne Searcy, MD Sr. Vice President & Medical Director The Zenith October 10, 2013 Written Comment	See above response to comment by the American Insurance Association regarding this subdivision.	No action necessary.
9792.10.3(c)	Commenter opines that the change from fifteen (15) days to five (5) days to respond to any reasonable request from the Administrative Director following receipt of the request is unrealistic. Commenter requests that the fifteen (15) days to respond be reinstated.	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	See above response to comment by the American Insurance Association regarding this subdivision.	No action necessary.
9792.10.3(c)	Commenter recommends that the time period for responding to any reasonable request pursuant to subdivision (b) be amended to five (5) business days.	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	See above response to comment by the American Insurance Association regarding this subdivision.	No action necessary.

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9792.10.3(a)	Commenter recommends the following revised language: Following receipt of the Application for Independent Medical Review, DWC Form IMR, pursuant to section 9792.10.1(b), the Administrative Director shall determine, within 15 days following receipt of the application and all appropriate information to make a determination, whether the disputed medical treatment identified in the application is eligible for independent medical review. If the Administrative Director assigns a designee to review the eligibility for independent review pursuant to Labor Code section 4610.5(k), the designee shall have no financial interest in the independent medical review. In making this determination, the Administrative Director shall consider: Commenter opines that the IMR application form must be reviewed for eligibility by the Administrative Director or her impartial, disinterested designee before being assigned to the IMR contractor, which has a clear financial interest in the review. Doing	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. That said, the Administrative Director can designate the IMRO as the location for filing and conducting an initial review of the application. Labor Code section 4610.5(k). The Administrative Director retains the right to make eligibility determinations. Section 9792.10.3.	No action necessary.

	so will also reduce the current IMR contractor's workload which may help reduce the large backlog of pending independent medical reviews.			
9792.10.3(c)	Commenter notes that the timeframe to respond to the request has been reduced to five days from fifteen. Commenter opines that five days is an unreasonably short time in which to identify the request, locate and obtain the requested information and to transmit the information to the Administrative Director, particularly if information must be obtained from third parties or disparate locations. If the Administrative Director must make a determination within fifteen days of receipt of the IMR application "and all appropriate information to make a determination," as now proposed in sub-section (a), the commenter recommends restoring the fifteen-day timeframe in which parties must respond. If however the Administrative Director must make a determination within fifteen days of receipt of the IMR application (regardless of the date "all appropriate information to make a determination" is received), commenter recommends instead allowing ten days for parties to	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	See above response to comment by the American Insurance Association regarding this subdivision.	No action necessary.

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	respond.			
9792.10.3(e)	Commenter recommends the following revised language: The parties may appeal an eligibility determination by the Administrative Director ~~that a disputed medical treatment is not eligible for independent medical review~~ by filing a petition with the Workers' Compensation Appeals Board. Commenter states that parties must be able to appeal a determination that a disputed medical treatment is either not eligible or is eligible.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Disagree. Under Labor Code section 4610.5(k), if the Administrative Director approves a request for IMR, the request is assigned to resolve the medical treatment dispute. Claims administrators are only allowed to defer IMR if there is a dispute regarding liability for the injury or the treatment (on grounds other than medical necessity). To allow an appeal of an eligibility determination would undermine the Legislature's intent that IMR provide an expedient resolution to medical treatment disputes. If a claims administrator believes that the Administrative Director did not have jurisdiction to proceed with IMR, they can appeal the IMR determination to the WCAB under Labor Code section 4610.6(h)(1).	No action necessary.
9792.10.3(c)	Commenter opines that compliance with the modified proposed timeframe of five days is impracticable. Commenter	Jeremy Merz CalChamber	See above response to comment by the American Insurance Association	No action necessary.

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	recommends that upon receipt of the request, parties should have ten days to find, collect and submit the requested information to the Administrative Director.	Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	regarding this subdivision.	
9792.10.3(a)	Commenter recommends that the Division implement a new process to the proposed rules that allows a UR reviewer to "suspend" a UR review while waiting for documentation after expiration of the statutory 14-day time period. The UR reviewer would issue a Lack of Information Letter to the provider outlining the documentation sought and informing the provider of the 14-day timeframe for response. No pre-populated IMR application would be provided in conjunction with the Lack of Information letter, and no Formal Denial would issue during that timeframe. By definition, the claimant would then be prohibited from being able to file a formal IMR application, as jurisdiction for an IMR would not attach in the absence of a Formal Denial. If, after the 14-day time period, the requested information is then provided to the UR reviewer, the timeframes would start afresh, and the	Lisa Anne Forsythe Senior Compliance Consultant Coventry October 11, 2013 Written Comment	The proposed process, while a reasonable suggestion, is not authorized by Labor Code sections 4610 and 4610.5.	No action necessary.

	request would process as usual in accordance with the standard UR guidelines. Commenter states that precedent for such a "suspense" process is well established in the URAC (Utilization Review Accreditation Commission) Work Comp Utilization Management Policy (WCUP), Document Number 29, upon which many states' UR rules are based.			
9792.10.3(c)	Commenter requests that modification of the subsection to specify that the parties shall respond to any reasonable request made pursuant to subdivision (b) within five (5) business days following the receipt of the request.	Lisa Anne Forsythe Senior Compliance Consultant Coventry October 11, 2013 Written Comment	See above response to comment by the American Insurance Association regarding this subdivision.	No action necessary.
9792.10.4(a)	Commenter recommends the following revised language: The independent review organization delegated the responsibility by the Administrative Director to conduct independent medical review pursuant to Labor Code section 139.5 (IMRO) may consolidate two or more eligible applications for independent medical review by a single employee for resolution in a single determination if the applications involve the ~~the~~ same	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Agreed.	Revise section 9792.10.4 to delete the duplicate word. .

	requesting physician and the same date of injury. Commenter supports the consolidation of requests by the same physician for treatment of the same injured employee for the same date of injury. Individual requests for treatment that are -- or should be -- part of the same treatment plan should be considered together. The medical necessity of an individual service or good is dependent on the other services and goods that are also requested.			
9792.10.4(c)	Commenter states that section 9792.10.6.1(j) should be section 9792.6.1(j). Since there is no Section 9792.10.6.1(j) commenter opines that this is likely a typographical error.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Agreed.	Amend section 9792.10.4(c) to correct the citation to section 9792.6.1(j).
9792.10.4(a)	Commenter recommends that the Division expand the language of this section by adding the following provisions: (1) creation of a standardized Consolidation Notification letter sent jointly to the Claims Examiner and the Utilization Reviewer to be sent within fifteen (15) days of an IMRO decision to	Lisa Anne Forsythe Senior Compliance Consultant Coventry October 11, 2013 Written Comment	At this time, the Division does not find that further regulation is necessary. If the procedure described in this section cannot be effectively implemented in the absence of further guidelines, the Division will consider future rulemaking to impose	No action necessary.

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	consolidate, that includes details of the specific treatment regimens that are being addressed by the consolidated request, and providing the anticipated decision date, and (2) a reasonable, specified timeframe (such as 60 days) after which no further treatment regimens for a given claimant and physician can continue to be aggregated into a single consolidation, as measured from date of receipt by the AD of the first IMR request in the series. Commenter notes a typo as the word "the" is repeated.		additional guidelines. This has been corrected.	
9792.6	Commenter states that sections 9792.6, 9792.6.1, 9792.9 and 9792.9.1 all provide language concerning which process governs based on particular events; however, the triggering events in the various sections do not align and create conflicting requirements.	Anne Searcy, MD Sr. Vice President & Medical Director The Zenith October 10, 2013 Written Comment	Agreed.	Section 9792.6 has been amended to reinstate language of emergency regulations effective January 1, 2013: "The following

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	Commenter notes that Labor Code 4610.5(2) states that 4610.5 applies to "any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury." Therefore, the code is basing application of the processes on the date the decision is communicated. Commenter recommends the following revised language: ~~As used in this Article:~~ The following definitions apply to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for an occupational injury or illness occurring prior to January 1, 2013 if the **decision on the request is communicated to the requesting physician** ~~request for authorization of medical treatment is made~~ prior to July 1, 2013.			definitions apply to any request for authorization of medical treatment, made under Article 5.5.1 of this Subchapter, for an occupational injury or illness occurring prior to January 1, 2013 if the decision on the request is communicated to the requesting physician prior to July 1, 2013."
9792.6(f)	Commenter recommends the following revised language: "Dispute liability" means an assertion by the claims administrator that a factual, medical or legal basis exists	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI)	Agreed.	Section 9792.6(f) has been amended. The definition of "Disputed liability" is amended to include a medical basis as a

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	that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment. Commenter states that liability decisions are sometimes based on medical determinations.	October 11, 2013 Written Comment		reason that would preclude compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.
9792.6(f)	Commenter recommends the following revised language: "Dispute liability" means an assertion by the claims administrator that a factual, medical or legal basis exists that precludes compensability on the part of the claims administrator for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment. Commenter states that there are three distinct ways to dispute liability: factual, legal and medical and that all three should be included in the regulations. Commenter opines that by omitting the term "medical," these regulations fail to acknowledge that medical causation is a basis for	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See above response to comment by CWCI regarding this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	disputing liability.			
9792.6.1(a)	Commenter recommends the following revised language: (a)"Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on ~~either~~ a completed "Request for Authorization for Medical Treatment," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, ~~or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2),~~ that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Authorization for Medical Treatment," DWC Form RFA	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

	if that form was initially submitted by the treating physician. Commenter opposes the proposed alternative to the RFA.			
9792.6.1(f)	Commenter recommends the following revised language: "Denial" means a decision by a physician reviewer that the requested treatment or service ~~cannot be~~ <u>has not been</u> authorized.	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	Agreed.	Section 9792.6.1(f) has been amended. The definition of "Denial" is amended to replace "cannot be" with "is not."
9792.6.1(k)	Commenter notes that the new last sentence of this subsection states that the expert reviewer shall not be an employee of the claims administrator or the utilization review organization under contract to provide or conduct the claims administrator's utilize review responsibilities. Commenter is concerned that the limited time frame for an expert reviewer to be assigned and respond will be impossible to comply with if companies are not allowed to contract in advance with these individuals. Commenter recommends adding language stating that this would be permissible.	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	Agreed.	The definition of "Expert Reviewer" in section 9792.6.1(k) is amended to delete the requirement that the expert reviewer not be an employee of the claims administrator or the utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.
9792.6.1(t)	Commenter recommends the	Steven Suchil	See response to September	No action necessary.

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	following revised language: (t) "Request for authorization" means a written request for a specific course of proposed medical treatment. (1) ~~Unless accepted by a claims administrator under section 9792.9.1(c) (2),~~ A request for authorization must be set forth on a "Request for Authorization for Medical Treatment (DWC Form RFA)," completed by a treating physician, as contained in California Code of Regulations, title 8, section 9785.5. Prior to March 1, 2014, any version of the DWC Form RFA adopted by the Administrative Director under section 9785.5 may be used by the treating physician to request medical treatment. Commenter opposes the alternative to the RFA.	Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	
9792.6.1(m)	Commenter notes that this subsection defines the term "immediately" and references subdivisions (c) and (f)(1) of 9792.9.1; however, the term "immediately" is used only in (f)(2)(B) of 9792.9.1. Commenter recommends the	Anne Searcy, MD Sr. Vice President & Medical Director The Zenith October 10, 2013 Written Comment	Agreed.	9792.6.1(m) has been amended to define "immediately" to be within one business day.

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	following revised language: (m) "Immediately" means within ~~24 hours~~ **one business day** after learning the circumstances that would require an extension of the timeframe for decisions specified, in subdivision ~~(c) and (f)(1)~~ (f)(2)(B) of section 9792.9.1 Commenter notes that the term "immediately" is also used in 9792.10.3(c); 9792.10.4(c); 9792.10.5(a)(3) and (b)(3); and 9792.12(b)(4)(A). Is it the intent that the term "immediately" as used in these sections be given the same definition as the term as defined in 9792.6.1(m)? If so, commenter notes that the definition would need to be expanded to include those subsections within the definition.			
9792.6.1(k)	Commenter notes that the modified the definition of "expert reviewer" states that "the expert reviewer shall not be an employee of the claims administrator or the utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities." Commenter disagrees with the imposition of this limitation. Many	Anne Searcy, MD Sr. Vice President & Medical Director The Zenith October 10, 2013 Written Comment	See above response to comment by American Insurance Association regarding this subdivision.	No action necessary.

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	companies and utilization review entities employ multiple physicians with varying degrees of expertise. Commenter opines that if the utilization review entity has a contract with multiple physicians, then the reviewing physician should not be precluded from consulting another provider. Similarly, the administrator may have more than one medical director with differing areas of expertise. Commenter states that a medical director with an occupational medicine specialty should not be precluded from consulting with a medical director who has a specialty in surgery or another field of medicine. Both the name of the reviewer rendering the decision and the name of the expert reviewer with credentials listed could be included in the decision letter for disclosure purposes. Commenter opines that forcing the use of a third party will simply increase the costs to the process and increase time necessary to obtain the review because a third party physician with appropriate credentials who is willing to conduct the review will have to be			

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	located, terms for payment will have to be agreed to, and a contract or letter of agreement will have to be entered into for the specific review to be conducted to provide for payment and non-disclosure. All of that would have to occur before the third party could receive the confidential medical records needed for review. Commenter states that the agreements between the administrator and the utilization review entity and between the entity and reviewers already have the appropriate confidentiality issues addressed and generally require that any additional reviewer be one that has not previously been involved in the review or decision making process with respect to the treatment request being addressed. Commenter recommends the added sentence be removed from the definition of "expert reviewer".			
9792.6.1(a)	Commenter recommends retaining the original version of the definition of "Authorization" and deleting the proposed modifications. Commenter states that pursuant to 9792.9.1(a) the request for authorization must be in written form set forth on the "Request	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

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	for Authorization for Medical Treatment (DWC Form RFA)."			
9792.6.1(m)	Commenter supports the modification of the definition of "immediately" from 24 hours to one business day.	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	Agreed.	The definition in 9792.6.1(m) has been changed to one business day.
9792.10.6(i)	Commenter requests that the language in this section be deleted in its entirety. There is already a process in place under 9792.11(c)(2)(A) for the UR Routine Investigation to include a review of any credible complaints received by the Administrative Director and under 9792.11(c)(2)(B) for a Special Target Investigation that may include any credible complaints received by the Administrative Director. Any person with a complaint may file an Audit Referral Form. Claims Administrators are subject to audit every 5 years.	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	The overriding purpose of IMR is to resolve medical treatment disputes by having medical experts make considered medical necessity determinations in an expeditious manner. Realizing the importance of avoid delay in the system, the Legislature enacted Labor Code section 4610.5(i) to authorize the Administrative Director to assess administrative penalties for a claims administrator's failure to promptly comply with any IMR obligation. Rather than the random UR investigation and audit process of section 9792.11, in which years could go by before a file is audited for violations, the Division found that violations could be more	No action necessary.

			efficiently remedied, and future conduct more quickly deterred, by an 'Order to Show Cause" procedure that would bring more immediacy in correcting the underlying conduct. The faster assessment of penalties will provide an added incentive for claims administrator to comply with the IMR rules.	
9792.10.6(b)	Commenter recommends adding "on all services disputed" to clarify that the Independent Medical Review must address all issues in dispute.	Diane Przepiorski Executive Director October 10, 2013 Written Comment	The regulation is sufficiently clear. The definition of "disputed medical treatment " in section 9792.6.1(h) encompasses all disputed services.	No action necessary.
9792.6.1(k)	Commenter believes that the reviewer should not be "affiliated' with the claims administrator or the utilization review organization. Commenter understands that some "affiliated" arrangements have formed with claims administrators and individual that they employ in the management of the claim. Commenter recommends the following amendment: "The expert reviewer shall not be an employee of <u>or affiliated with</u> the claims administrator or the utilization	Diane Przepiorski Executive Director October 10, 2013 Written Comment	IMR reviewers are covered by the conflict-of-interest rules set forth in Labor Code section 139.5(d)(5). Further regulation in this area is unnecessary.	No action necessary.

	review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.			
9792.6.1(a)	Commenter requests that the terms "approved" and "approval" be retained. Commenter states that the words "approved" and "approval" are actually useful, and are found repeatedly throughout the UR regulations, as applying to UR decisions, as distinct from authorizations by the Claims Administrator ("CA"). Commenter cites 9792.7(b)(3) and 9792.9.1(f)(4), (5) and (6) as examples.	David A. Ingrum, MD October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. That said, the plain meaning of the word as used in the regulations is sufficient.	No action necessary.
9792.6.1(e)	Commenter opines that this section appears to indicate that a "Delay" determination may be made by a physician or non-physician reviewer, per 9792.9.1 (f). Previously a "Delay" could only be made by a physician reviewer. Commenter states that this implies that a written request for additional information issued by a non-physician reviewer would now also be referred to as a "Delay." It is not clear whether this is intentional or inadvertent.	David A. Ingrum, MD October 11, 2013 Written Comment	The regulations do not currently provide for a "delay" decision. Under section 9792.9.1(f) a provider may be put on notice of a delay in applying the timeframes in section 9792.9.1(c) based on the lack of information, but there is no formal "delay" decision.	No action necessary.
9792.6.1(m)	Commenter notes the change of definition of "Immediately" from 24	David A. Ingrum, MD	The Division appreciates the comment.	No action necessary.

	hours to 1 business day. Commenter opines that this appropriately recognizes that business offices are typically closed on weekends and holidays, and that there is no practical mechanism to process information during these times.	October 11, 2013 Written Comment		
9792.6.1(w)	Commenter notes that this section indicates that treatment services must be "within the scope of the reviewer's practice." Commenter requests that the language be clarifed as follows: "…scope of the reviewer's practice *as defined by the applicable licensure board*."	David A. Ingrum, MD October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	No action necessary.
9792.6.1(z)	Commenter notes that this section prohibits transmission of employee's health records via electronic mail. Commenter states there are no HIPAA or other statutory prohibitions of this practice, and this is a new law that will necessitate changes in workflow for some CAs and UROs. Commenter states that this is puzzling in view of the encouragement of communication of UR determinations and other documents by electronic mail. Commenter requests that this subsection be rescinded. If preserved, then commenter requests a transition	David A. Ingrum, MD October 11, 2013 Written Comment	The Division has yet to determine that a uniform method for transmitting health records via e-mail, with necessary technical safeguards, exists such that their inclusion in the regulations would be appropriate. That said, the Division fully intends to further explore issues regarding the secure electronic transmission of health records and may propose changes to this	No action necessary.

	period is requested, with the statute formally taking effect at some future date.		definition in future rulemaking.	
9792.6.1(y)	Commenter states that the last sentence in this subdivision could cause confusion as to when the UR process starts in light of the proposed changes in section 9792.9.1(c)(2). Commenter recommends that this sentence be revised as follows: "The utilization review process begins when the completed DWC Form RFA or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2) is first received…"	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	Agreed.	Amend section 9792.6.1(y) to account for requests for authorization accepted under section 9792.9.1(c)(2).
9792.6.1(a)	Commenter recommends the following revised language: "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on ~~either~~ a completed "Request for Authorization for Medical	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2). Requests for authorization cannot be provided on any form, they must be clearly identified with "Request for Authorization" written at the top of the first page, all requests must be listed on the first page, and the request must be accompanied by	No action necessary.

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	Treatment," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, ~~or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2),~~ that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Authorization for Medical Treatment," DWC Form RFA if that form was initially submitted by the treating physician. Commenter strongly objects to the modifications to the proposed revisions that would permit requests for authorization to be made in any form and to be presumed to be agreed to if not objected to within three business days.		documentation. .	
9792.6.1(c)	Commenter recommends the inclusion of a new subsection "c." (c) "Complete request for	Brenda Ramirez Claims and Medical Director California Workers'	The definition of "request for authorization" under subdivision (t) accounts for all required elements. Further	No action necessary.

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	authorization" is one that is submitted on the DWC Form RFA with all applicable fields completed, the need for the requested treatment substantiated, the form signed by the treating physician, and reasonably requested additional information has been supplied. Commenter opines that a definition is needed so that it is clear what constitutes a complete request for authorization. If this additional subsection is accepted, it will be necessary to alphabetically reorder the definitions.	Compensation Institute (CWCI) October 11, 2013 Written Comment	regulation would be redundant and unnecessary.	
9792.6.1(f)	Commenter recommends the following revised language: "Denial" means a decision by a physician reviewer that the requested treatment or service is not ~~cannot be~~ authorized. Commenter opines that some might argue over whether or not a physician reviewer is capable of authorizing. "Is not" is the accurate term to use in this definition.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Agreed.	Amend section 9792.6.1(f) to delete "cannot be."
9792.6.1(k)	Commenter recommends the removal of the last sentence of this subsection.	Brenda Ramirez Claims and Medical	See above response to comment by American	No action necessary.

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	Commenter opines that the DWC's modification implies there is something improper about a claims administrator or URO having a specialist on staff. Commenter states that this is not improper and is in fact, appropriate for an expert reviewer to be an employee of the claims administrator or its utilization review organization. It can also be a practical necessity to meet the abbreviated workers' compensation utilization review timelines in California.	Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	Insurance Association regarding this subdivision.	
9792.6.1(r)	Commenter recommends restoring the eliminated language for "medically necessary" and "medical necessity" with the following modifications noted in bold: (4) Expert opinion **that is based on evidence that is peer-reviewed and nationally recognized**. (5) Generally accepted standards of medical practice **that are nationally recognized, evidence-based, and published in peer-reviewed national journals**.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	The definition of "medically necessary" and "medical necessity" were taken from Labor Code section 4610.5(c)(2) and sets forth the standard that must be applied by an IMR reviewer when determining whether a requested medical treatment is medically necessary. The subdivision does not expressly provide that this standard must be applied to claims administrators when conducting UR. As such, it was properly removed from this section.	No action necessary.

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	(6) Treatments that are likely to provide a benefit to a patient, **according to articles published in evidence-based, peer-reviewed and nationally recognized journals,** for conditions for which other treatments are not clinically efficacious. Commenter states that it is important that all participants know the standards that must be followed for treatment plans, utilization review and independent medical review. Commenter states that the standards for utilization review must remain consistent with Labor Code sections 4600, 4610(f) and 5307.27. Commenter opines that the recommended modifications are necessary to harmonize these sections and the standards for Independent Medical Review in Labor Code section 4610.5(c). The recommended modifications are consistent with Labor Code section 5307.27 standards which are required to be evidence-based, peer reviewed, and nationally recognized.			
9792.6.1(w)	Commenter recommends the	Brenda Ramirez	Disagree. The wording of the	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	following revised language: "Utilization review decision" means a decision pursuant to Labor Code section 4610 to approve, modify, delay, or deny a treatment recommendation or recommendations pursuant to a request for authorization submitted by a physician prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code sections 4600 or 5402(c). Commenter states that clarification is needed that a utilization review decision follows a request for authorization.	Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	statute is sufficiently clear to show that UR decisions are based on treatment requests.	
9792.10.6(d)	Commenter recommends the following revised language: The determination issued by the medical reviewer shall state whether the disputed medical treatment is medically necessary. The determination shall include the employee's medical condition, a list of the documents reviewed, a statement of the disputed medical treatment, references to the Medical Treatment Utilization Schedule and specific	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	The standards for medical necessity are expressly set forth in Labor Code section 4610.5(c)(2). The statute is referenced in section 9792.10.6(b)(1) as the standard for an IMR reviewer to determine medical necessity. No further reference is necessary.	No action necessary.

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	medical and scientific evidence utilized pursuant to section 9792.6.1(r), and the clinical reasons regarding medical necessity. Commenter states that Labor Code section 4610.5(c)(2) requires the MTUS to be applied and relied on unless it is inapplicable to the employee's medical condition. The determination must reference the Medical Treatment Utilization Schedule (MTUS) because it is the highest ranked standard, and if the MTUS is inapplicable to the employee's medical condition, the report should reference the reason it is inapplicable. If the commenter's recommendation to restore a modified definition for "medically necessary" and "medical necessity" is accepted, commenter recommends restoring the reference to section 9792.6.1(r) regarding the standards that the independent medical reviewer must use. Commenter opines that the standards must be supported by medical evidence that is peer-reviewed and nationally recognized.			

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.10.6(i)	Commenter recommends the following revised language: Upon receipt of credible information that the claims administrator has failed to comply with its obligations under the independent medical review requirements set forth in Labor Code sections 4610.5 or in sections 9792.6 through 9792.10.8 of this Article, the Administrative Director shall~~,~~ ~~concurrent or subsequent to the issuance of the final determination issued by the independent review organization, issue an order to show cause under section 9792.15 for the assessment of administrative penalties against the claims administrator under section 9792.12(c)~~ send complete documentation to the audit unit for review and assessment of appropriate administrative penalties when the claims administrator undergoes its next regularly scheduled "PAR" or "non-random" audit. Commenter opines that it is unnecessary, duplicative and overly punitive to conduct a separate summary proceeding for a claims administrator's alleged failure to	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	See response to comment by Republic Indemnity Company regarding this subdivision.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	comply with the IMR requirements because audit and penalty schedules already exist to deter noncompliance. Adding this separate summary proceeding will amount to a piling-on of penalties for the same act. Commenter opines that in instances where a credible complaint is made against a claims administrator, the complaint should be logged in the claims administrator's file and investigated during the subsequent PAR or targeted audit per 9792.11(c)(2)(A)(B).			
9792.6.1(a)	Commenter recommends the following revised language: "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on either a completed "Request for Authorization for Medical Treatment," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, ~~or a request for authorization of medical~~	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	~~treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2),~~ that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Authorization for Medical Treatment," DWC Form RFA if that form was initially submitted by the treating physician. Commenter requests that the Division delete the modified language referencing the alternative request for authorization under section 9792.9.1(c)(2).			
9792.6.1(e)	Commenter recommends the following revised language: "Delay" means a *decision by a reviewer that no determination based on medical necessity may be made within the 14-day time limit for the reasons listed in 9792.9.1(f).* ~~determination, based on the need for additional evidence as set forth in~~	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See response to comment by David A. Ingrum, MD regarding this subdivision.	No action necessary.

	~~section 9792.9.1(f), that the timeframe requirements for the utilization review process provided in section 9792.9.1(c) cannot be met.~~ Commenter recommends that the DWC delete the modified language and reinstate the previously proposed language allowing for a 14-day time limit.			
9792.6.1(h)	Commenter recommends the following revised language: "Disputed medical treatment" means medical treatment that has been modified, ***delayed***, or denied by a utilization review decision. Commenter opines that this definition should be harmonized with Labor Code section 4610, which sets out the statutory scheme for the utilization review process and permits a utilization review to modify, delay or deny medical treatment. Commenter states that the regulatory definition for "disputed medical treatment" should be consistent with this Labor Code section and also incorporate all of these terms.	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See response to comment by David A. Ingrum, MD regarding this subdivision. It is noted that while Labor Code section 4610 references decisions to "delay," there is no provision in the regulations to issue a delay decision. If the Division adopts a delay decision in future rulemaking, the definition will be amended.	No action necessary.
9792.10.6(i)	Commenter recommends the	Jeremy Merz	See response to comment by	No action necessary.

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	following revised language: Upon receipt of credible information that the claims administrator has failed to comply with its obligations under the independent medical review requirements set forth in Labor Code sections 4610.5 or in sections 9792.6 through 9792.10.8 of this Article, the Administrative Director shall~~,~~ ~~concurrent or subsequent to the issuance of the final determination issued by the independent review organization, issue an order to show cause under section 9792.15 for the assessment of administrative penalties against the claims administrator under section 9792.12(c) shall~~ send complete documentation to the audit unit for review and assessment of appropriate administrative penalties when the claims administrator undergoes its next regularly scheduled "PAR" or "non-random" audit. Commenter opines that it is unnecessary, duplicative and overly punitive to conduct a separate summary proceeding for a claims administrator's alleged failure to comply with the IMR requirements	CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	Republic Indemnity Company regarding this subdivision.	

	because audit and penalty schedules already exist to deter noncompliance. Commenter states that adding this separate summary proceeding will amount to a piling-on of penalties for the same act. Commenter recommends that, in instances where a credible complaint is made against a claims administrator, the complaint should be logged in the claims administrator's file and investigated during the subsequent PAR or targeted audit per 9792.11(c)(2)(A)(B).			
9792.6.1(t)	Commenter opines that under 9792.6.1(t), the definition of "Complete" is more nebulous than before, and does not require any documentation substantiating the need for treatment. Commenter recommends that the language be revised to include: "and be accompanied by documentation (First Report, PR-2, Narrative) which substantiates the need for the requested treatment."	Jerrold Garrard GSG Associates October 11, 2013 Written Comment	Agreed.	Section 9792.6.1(t) has been amended. "Completed," for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization must identify both the employee and the provider, identify with specificity a recommended treatment or

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
				treatments and be accompanied by documentation substantiating the need for the requested treatment."
9792.6.1(k)	Commenter opines that is not clear why the following language was added to this subsection: "The expert reviewer shall not be an employee of the claims administrator or the utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities." Commenter would like to know if this includes expert reviewers. Commenter questions how a URO would maintain a physician panel so that UR determinations are not delayed.	Jerrold Garrard GSG Associates October 11, 2013 Written Comment	See above response to comment by American Insurance Association regarding this subdivision.	No action necessary.
9792.6.1(t)	Commenter is concerned about the amendment, allowing, by agreement of the parties, an electronic signature. Commenter opines that written agreements between claims administrators and the injured worker would be unmanageable. Commenter does not understand why the division	H. Hollie Rutkowski October 10, 2013 Written Comment	The use of electronic signatures is now common in many commercial settings, provided that the parties have sufficient means to verify signatures. The use of an electronic signature on the DWC Form RFA should be	No action necessary.

	feels compelled to regulate electronic signatures.		allowed provided the parties agree.	
9792.6.1(t)	Commenter thanks the Division for including making e-signature acceptable; however, commenter would like for DWC to state that an e-signature be acceptable for an RFA form and that it does not have to be by mutual agreement. Commenter opines that if an e-signature by mutual agreement is made part of the permanent rules it would be problematic and costly to track and monitor which claim administrators will accept an e-signature and which will not. In all other states that accept e-signatures, it is for all if the provider so chooses to use. Commenter states that in order to mitigate the cost issues inherent in form completion and management, many other States have assigned a fee for completion of required state forms. Commenter requests that the same consideration be contemplated for this new form and he suggests a $15 fee.	Gregory M. Gilbert SVP Reimbursement and Governmental Relations Concentra October 11, 2013 Written Comment	See above response to comment by H. Hollie Rutkowski regarding this subdivision.	No action necessary.
9792.10.7(d)	Commenter notes that if the Appeals Board reverses the final determination that the dispute to IMR will be submitted again for review by another	Anne Searcy, MD Sr. Vice President & Medical Director The Zenith	The avenues for resolution following a decision by the WCAB to reverse an IMR decision are limited by	No action necessary.

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	independent review organization or to the same organization but to a different reviewer. Commenter seeks clarification as to at what point the process will end if the second reviewer reaches the same decision that was sent to the Appeals Board. Commenter recommends that the DWC institute a process to determine when the appeal process concludes and the decision is final.	October 10, 2013 Written Comment	statute. Under Labor Code section 4610.6(i), the decision must either submit the dispute to another IMRO (if another exists), or to another IMR reviewer if there is only one IMRO. Note that: (1) the WCAB cannot make a determination of medical necessity contrary to that of the IMRO; (2) it is difficult to draft regulations under the shadow of hypotheticals.	
9792.10.7(b)	Commenter requests that the language in this section be deleted in its entirety for the same reason she provided for section 9792.10.6(i).	Cheryl Richardson, ARM, Vice President Republic Indemnity Company October 11, 2013 Written Comment	See response to comment by Republic Indemnity Company regarding this subdivision. The same response applies.	No action necessary.
9792.6.2(f) and (r)	Commenter states that revision strikes "not medically necessary," and indicates that a "Denial" by a physician reviewer "cannot be authorized," presumably by the Claims Administrator. Commenter opines that this is in conflict with 9792.6.1 (r), which stipulates that a "Modification" indicates a request is "not medically necessary," and which does not prohibit the CA from overruling the UR denial and	David A. Ingrum, MD October 11, 2013 Written Comment	The Division does not find a conflict. It is noted that a "denial" is a decision by a physician reviewer that the requested treatment is not authorized. It is the physician reviewer who makes the decision.	No action necessary.

	authorizing the request.			
9792.6.2.(j)	Commenter notes that this section indicates Expedited Review is appropriate for serious medical conditions, i.e. "imminent and serious threat…" etc. However, there is no statutory mechanism for the CA or URO to challenge this assertion by the requesting physician. Commenter is starting to see RFAs that have form-checked the "Expedited Review" box, where the medical condition and the requested treatment very clearly do not meet any of the criteria specified, such as a request for a topical balm with a diagnosis of back sprain. See comment regarding 9792.9.1 (c) (4). Commenter states that it is not clear that Expedited Review in fact needs to exist as an option. Note is made that 9792.9.1 (e) (2) stipulates that emergency services may be subjected to retrospective review. The treater has the option of providing the treatment and submitting the request for retrospective review, and expedited timeframe is actually unnecessary. Commenter opines that if Expedited	David A. Ingrum, MD October 11, 2013 Written Comment	The requirements for expedited review are statutory. See Labor Code section 4610(g)(2). That said, section 9792.9.1(c)(4) has been amended to first require from a physician documentation confirming the need for expedited review, and second to expressly allow claims administrators to convert a request for expedited review into a regular review if the request is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under subdivision (c)(3) would be detrimental to the injured worker's condition.	No action necessary.

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	Review is preserved, then the requesting physician should be admonished regarding abuse of this option (again, see 9792.9.1 (c) (4), below), and further stipulation should be made that if the 72 hour time frame starts, falls, or concludes within a weekend or holiday, then the timeframe is extended to the next business day.			
9792.10.7(a)	Commenter states that under Labor Code section 4610.6(j), the employer is obligated to promptly implement an IMR decision "unless the employer has also disputed liability for any reason besides medical necessity." Commenter states that this proposed rule provides no guidance on what action is required if the claims administrator is disputing liability for any reason besides medical necessity. Commenter opines that if this rule is not revised to provide guidance to the parties in this situation, disputes, delays, and added costs will be the inevitable result. Commenter recommends that this subdivision be revised to mandate that the claims administrator notify the employee within five (5) working days	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	Labor Code section 4610.6(j) provides that a claims administrator "shall promptly implement the [IMR] decision…unless the employer has also disputed liability for any reason beyond medical necessity." The regulation merely repeats the statutory exclusion of liability disputes from IMR timelines. Guidelines or mandates as to how parties must implement an IMR decision in relation to liability disputes at this stage of the process may impinge on the rules or procedures of other venues, such as the WCAB, as to how liability disputes are resolved.	No action necessary.

	of receipt of the determination that there is a dispute over liability and that the treatment will be deferred until a determination is made regarding that dispute. Consistent with other rules, this rule should further provide that if the requested treatment is deferred and it is finally determined that the claims administrator is liable for treatment of the condition for which treatment is recommended, either by decision of the Workers' Compensation Appeals Board or by agreement between the parties, the treatment shall be authorized within five (5) working days of the date the determination of the claims administrator's liability becomes final.			
9792.10.7(b)	Commenter recommends the following revised language: Upon receipt of credible information that the claims administrator has failed to implement the final determination as required in subdivision (a), the Administrative Director shall ~~issue an order to show cause under section 9792.15 for the assessment of administrative penalties against the claims administrator under section 9792.12(c)~~ send complete	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	See response to comment by Republic Indemnity Company regarding this subdivision. The same response applies.	No action necessary.

	documentation to the audit unit for review and assessment of appropriate administrative penalties when the claims administrator undergoes its next regularly scheduled "PAR" or "non-random" audit. Commenter states that it is unnecessary, duplicative and overly punitive to conduct a separate summary proceeding for a claims administrator's alleged failure to comply with the IMR requirements because audit and penalty schedules already exist to deter noncompliance. Adding this proceeding will amount to a piling-on of penalties for the same act. Commenter opines that in instances where a credible complaint is made against a claims administrator, the complaint should be logged in the claims administrator's file and investigated during the subsequent PAR or targeted audit per 9792.11(c)(2)(A)(B).			
9792.10.7	Commenter notes that under the proposed regulations, in the event that a IMR is found to be without standing, and is remanded back to the DWC by the WCAB per 9792.10.7, the employer/insurer is required to pay for	Robert Ward October 10, 2013 Written Comment	Agreed. A fee for a second IMR following an appeal should not be assessed. Section 9792.10.8 only allows a fee for each "application," not for each separate review	No action necessary.

	the additional IMR. Commenter opines that the employer/insurer should not bear the cost of the second IMR, as this is both unjust and provides the IMRO with an incentive to provide sub-standard work. Rather, the IMRO that failed to provide proper service should bear that expense.		performed on an application.	
9792.10.7	Commenter understands that the decision of the IMR process is not appealable – except for questions of procedure; however, he opines that it does not mean that the IMR process and its participants should not be held accountable. Commenter states that authority without accountability invites fraud and corruption – something SB 863 was designed to prevent. Commenter is not suggesting bringing the WCAB back into the decision process. He believes that there should be a Board of Quality Control to ensure accountability on the part of the IMR physicians and the IMR services. Commenter states that it was never intended to turn decisions over and to accept them blindly; only to speed up the appeals process and make it both more effective, and more cost effective.	Dennis Knotts December 7, 2013 Written Comment	The comment appears to be aimed at the mandates of Labor Code sections 4610.5 and 4610.6, rather than the regulations that reasonably implement those statutes. The Division cannot respond for the Legislature.	No action necessary.

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	Commenter states that there have been cases where letters from Maximus were either back-dated or held several days before being mailed and this resulted in untimely responses; and a potential of $50,000 per day penalties. With this kind of money involved, the playing fields need to be leveled. The employer needs the same protection as the employee. Maximus – or any IMR service – must be subject to audit and accountability. If employees can file complaints to the audit Unit against carriers; carriers and employers should be allowed to file complaints against the IMR services and have the Audit Unit investigate. Commenter states that regulations that make clocks begin to run on the date something is sent is a complete denial of due process. Commenter opines that you cannot make a party responsible for something until it has received the document and been aware of their obligations. The clock should not begin to run until the documents are received by the party responsible to make the decisions.			
9792.9	Commenter states that sections 9792.6, 9792.6.1, 9792.9 and 9792.9.1	Anne Searcy, MD Sr. Vice President &	The sections should conform to the triggering dates found	Section 9792.9 has been amended to,

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	all provide language concerning which process governs based on particular events; however, the triggering events in the various sections do not align and create conflicting requirements. Commenter notes that Labor Code 4610.5(2) states that 4610.5 applies to "any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury." Therefore, the code is basing application of the processes on the date the decision is communicated. Commenter recommends the following revised language: This section applies to any request for authorization of medical treatment, **made submitted** under Article 5.5.1 of this Subchapter, for an occupational injury or illness occurring prior to January 1, 2013 **if the decision on the request is communicated to the requesting physician prior to July 1, 2013.** ~~where the request for authorization is~~ **made received** ~~prior to July 1, 2013.~~	Medical Director The Zenith October 10, 2013 Written Comment	in the authorizing statutes.	"This section applies to any request for authorization of medical treatment, submitted under Article 5.5.1 of this Subchapter, for an occupational injury or illness occurring prior to January 1, 2013 where the request for authorization is received prior to July 1, 2013."
9792.9	Commenter states that it is unclear	Diane Przepiorski	The consequences of an	No action necessary.

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	what happens if the claims administrator or their utilization review agent fails to act within the required time frames. Commenter requests that the regulations be clarified to say that if the claims administrator or their utilization review agent fails to act in a timely manner, the service(s) requested is deemed approved.	Executive Director October 10, 2013 Written Comment	untimely UR decision by a claims administrator has been addressed by the California Supreme Court in State Compensation Insurance Fund v. WCAB (Sandhagen) (2008) 44 Cal.4th 230. Since Labor Code section 4610 is silent as to the effect of an untimely decision, the Division believes that determinations regarding this issue are best left to the Legislature or the judicial process.	
9792.10.8(c)	Commenter recommends the following revised language: The aggregate total fee owed by the claims administrator for the prior calendar month shall be paid to the independent medical review organization within ~~thirty (30)~~ forty-five (45) days of the billing. If the aggregate total fee is not paid within ten (10) days after it becomes due, there shall be added an additional amount equal to 10 percent, plus interest at the legal rate, which shall be paid at the same time but in addition to the total aggregate fee.	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) October 11, 2013 Written Comment	The 30-day timeframe to pay an IMRO invoice is reasonable. There is no compelling reason to align the timeframe with that for the payment of medical bill under Labor Code section 4603.2.	No action necessary.

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	Commenter states that the timeframe for payments to the independent medical review organization should be consistent with payments to providers under Labor Code section 4603.2. Commenter suggests extending the timeframe in this section to forty-five days.			
9792.10.8(c)	Commenter recommends the following revised language: Commenter states that the timeframe for payments to the independent medical review organization should be consistent with payments to providers under Labor Code section 4603.2. Commenter recommends extending the timeframe in this section to forty-five days.	Jeremy Merz CalChamber Jason Schmelzer CCWC Julianne Broyles CAJPA October 11, 2013 Written Comment	See above response to comment by CWCI regarding this subdivision.	No action necessary.
9792.10.8(a)	Commenter opines that cost is where the IMR system has failed. First of all, the employer can send a Request for Authorization through the Utilization Review process in a timely manner The Utilization Review system can make the correct decision, and make it timely. Yet for all the timeliness and correctness of the Utilization Review process, the employer still has to pay – and pay as much as if it did not follow the Utilization Review process	Dennis Knotts December 7, 2013 Written Comment	The cost of IMR was negotiated between the Administrative Director and the current IMRO, Maximus Federal Services, under Labor Code section 139.5(a)(2). The cost was based on an estimated number of IMR reviews, the administrative cost of selecting a sufficient number of IMR reviewers, and the cost of building a	No action necessary.

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	correctly. Cost in IMR appeals is just as major a factor as costs for Utilization Review decisions in driving up the cost of the workers' compensation claim; and the employer's premium – thereby undermining the intent of SB 899 in 2004 when it gave the MTUS the Presumption of Correctness to upgrade the authority of the Utilization Review decisions. Commenter states that the arguments he is now hearing from applicant attorneys is, why are you spending more money to defend a Utilization Review decision than it would cost to provide the treatment? It is a valid question; and one that is now undermining the intent of the Utilization Review statutes. Commentators on SB 863 stated that the IMR process was to ensure medical decisions were kept in the medical arena and that no one could achieve what the commentator called a "Gottcha" Moment. This is when a slip of a legal procedure barred an appropriate medical procedure; or forced an inappropriate medical		reliable infrastructure to conduct IMR for the California workers' compensation system. The Division notes section 9792.10.4(a), which allows the IMRO to consolidate several IMR requests if the application involves the same requesting physician and the same date of injury for the employee.	

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	procedure upon an employee. Commenter opines that charging an employer when the employer has done everything correctly and already invested funds to use an effective Utilization Review service which rendered the correct decision in the first place creates a kind of double jeopardy for the employer; and literally doubles the cost of ensuring the correct medical decision. Commenter doubts this was the intent of the lawmakers in creating the IMR process. Commenter opines that if the employer must be charged [he does not believe the Labor Code mandates in all cases] it should be at a much-reduced rate when the IMR supports the Utilization Review decision. This way there is an off-set to the employer for doing their work correctly – similar to the experience modification system used in underwriting.			
9792.9.1(c)	Commenter recommends the following revised language: (c) Unless an extension is requested under subdivision (f), the utilization	Steven Suchil Assistant Vice President/Counsel American Insurance Association	See response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2).	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	review process shall meet the following timeframe requirements: (2~~) If the treating physician requests a course of treatment in a manner that does not utilize the DWC Form RFA, or~~ If the DWC Form RFA is not completed as defined in section 9792.6.1(t) (The unchanged version) ~~does not identify the employee or provider, does not identify a recommended treatment, or is not signed by the requesting physician, a non-physician reviewer as allowed by section 9792.7 or reviewer may must either treat regard the form the request as a complete DWC Form RFA and comply with the timeframes for decision set forth in this section or~~ it must be returned~~return it~~ to the requesting physician marked "not complete," specifying the reasons for the return of the request, no later than five (5) ~~three (3)~~ business days from receipt. The timeframe for a decision on that returned request for authorization shall begin anew upon receipt of a completed DWC Form RFA. Commenter opposes the alternative to the RFA. Commenter opines that if	October 8, 2013 Written Comment		

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	this alternative RFA method is rescinded, and the readily identifiable RFA is maintained as the only eligible RFA, then the 3 business day turnaround, while very limited, might be feasible. Commenter states that if the RFA can be submitted to a claims administrator in any format, it must first be identified as containing an RFA, then matched to a file. If the injured employee's name is common this could take an inordinate amount of time. The three business days could easily expire before a decision on the request could even be considered.			
9792.9.1	Commenter states that sections 9792.6, 9792.6.1, 9792.9 and 9792.9.1 all provide language concerning which process governs based on particular events; however, the triggering events in the various sections do not align and create conflicting requirements. Commenter notes that Labor Code 4610.5(2) states that 4610.5 applies to "any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury." Therefore, the code is basing	Anne Searcy, MD Sr. Vice President & Medical Director The Zenith October 10, 2013 Written Comment	See above response to comment by The Zenith regarding section 9792.9.	No action necessary.

INDEPENDENT MEDICAL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	application of the processes on the date the decision is communicated. Commenter recommends the following revised language: This section applies to any request for authorization of medical treatment, **~~made~~ submitted** under Article 5.5.1 of this Subchapter, for either: (1) an occupational injury or illness occurring on or after January 1, 2013; or (2) where the ~~request for~~ authorization is **~~made~~ received** decision on the request is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.			
9792.9(k)	Commenter states that this subsection defines the term "immediately" and reference subdivisions (b)(1), (b)(2) or (c) and (g)(1) of section 9792.9; however, 9792.9 no longer includes the term "immediately". Commenter notes that the term is used in 9792.9(h)2 Commenter recommends the following revised language: ~~(j)~~ (k) "Immediately" means within 24	Anne Searcy, MD Sr. Vice President & Medical Director The Zenith October 10, 2013 Written Comment	The regulation takes into consideration, for injuries occurring prior to January 1, 2013, utilization review decisions that are communicated both prior to July 1, 2013 and those after that date, when the request for authorization is received prior to July 1. Amended in the emergency regulations to accommodate the timeframes for the implementation of the	

	hours after learning the circumstances that would require an extension of the timeframe for decisions specified in subdivisions ~~(b)(1), (b)(2) or (c) and (g)(1)~~ **(h)(2)** of section 9792.9.		IMR program (see Labor Code section 4610.5(a)), the regulation is no longer in use and thus further amendment is unnecessary	
9792.9.1(c)	Commenter notes that this section mentions a request for an extension under subdivision (f). Commenter opines that it is not actually the extension that is being requested, rather the additional medical information. Commenter suggests the following revised language: "Unless additional medical information is requested, necessitating an extension under subdivision (f)…"	David A. Ingrum, MD October 11, 2013 Written Comment	Agreed.	Section 9792.9.1(c) has been amended. The first sentence of the subdivision is amended to read: "Unless additional information is requested necessitating an extension under subdivision (f)…."
9792.9.1(h)	Commenter notes that this section states that specified UR decisions shall remain effective for 12 months from the date of the decision "without further action by the claims administrator…" Commenter opines that this implies that the CA is permitted to simply ignore duplicative requests. If so, commenter states that clarification would be helpful, such as, "no notification of the parties is required in this circumstance," or similar language. Commenter states that the undefined term "decision" is	David A. Ingrum, MD October 11, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. That said, the language "without further action" is statutory, see Labor Code section 4610(g)(6), and cannot be reasonably interpreted any other way.	No action necessary.

	used to reckon time, and should be replaced with date of the "determination letter."			
9792.9.1	Because of the changes in section 9792.9.1(c)(2) as to when the UR process starts, commenter recommends that subdivision (a) referring to the DWC Form RFA be amended to include the language "or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2)." Commenter opines that where ever there is a reference to "DWC Form RFA" the following language should be added: "or accepted request for authorization under section 9792.9.1(c)(2)," including subdivisions (a)(1); (a)(2)(A), (B) & (C); (b)(1)(A); (b)(2); (c)(1)(3); and (d)(1)(B).	Diane Worley California Applicants' Attorneys Association October 11, 2013 Written Comment	The UR process starts with the receipt of the DWC Form RFA. The form is mandatory, although a claims administrator may accept a non-complaint request under limited circumstances. Section 9792.9.1(c)(2). Under that section, timeframes are based on the date of receipt. If data indicates there is confusion regarding the receipt date of a request for authorization, the Division will attempt to clarify the issue in future rulemaking.	No action necessary.
9792.9.1(c)(2)(a); 9792.9.1(c)(5)	Commenter opines that these deleted subsections and language should be reinstated as it was before. Commenter opines that it is inappropriate to require a decision without requiring submission of the information required to make the	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 8, 2013 Written Comment	Agreed.	Subdivision 9792.9.1(c)(2)(A) and (5) should be amended to require information necessary to make a determination.

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	decision.			
9792.10.6(j) and 9792.12(c)(4)	Commenter recommends prohibiting Maximus from making a determination regarding IMR whenever the carrier has either willfully or negligently failed to provide the required medical records. Commenter finds these revised sections inadequate to address this issue. Commenter opines that instead, the rule could provide that an IMR determination where the records were not submitted is null and void and must be redone. Or a rule could say that if the carrier breaches its obligation to submit information, the applicant prevails on the issue by default. Alternatively, commenter opines that the Division that could have required a grace period for applicants and their attorneys. If Maximus received no records whatsoever or if Maximus noted that key records were missing, notice of that should be forwarded to the worker to provide an opportunity to cure the problem.	Julius Young October 11, 2013 Written Comment	Agreed. An IMR determination should not issue in the absence of documents. However, there is no statutory authority for the Division to essentially authorize medical treatment – without a review for medical necessity – based on a procedural violation by the claims administrator.	Section 9792.10.6(b)(2). has been amended to provide that if a claims administrator fails to submit the documentation required under section 9792.10.5(a)(1), a medical reviewer may issue a determination as to whether the disputed medical treatment is medically necessary based on both a summary of medical records listed in the utilization review determination issued under section 9792.9.1(e)(5), and documents submitted by the employee or requesting physician under section 9792.10.5(b) or (c). No independent medical review

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	Commenter opines that stiffening penalties is a weak solution. Most unrepresented workers are unlikely to be sufficiently well informed as to complain in order to trigger penalties. How these penalties will be handled, and in what format complaints can be rendered is not made clear.			determination shall issue based solely on the information provided by a utilization review determination.
9792.6.1(t) and 9792.9.1(c)(2)	Commenter notes that subsection 9792.6.1(t) sets the definition for a "request for authorization." Commenter opines that the modifications made to subsection 9792.9.1(c)(2) conflict with other portions of 9792.9.1(a) and create an unreasonable burden on the claims administrator. Commenter states that 9792.9.1(a) states that the request for authorization "must be in written form set forth on the Request for Authorization for Medical Treatment (DWC Form RFA), as contained in California code of Regulations, title 8, section 9785.5." Commenter states that under 9792.9.1(c) this requirement is contradicted by stating that if the treating physician requests a	Anne Searcy, MD Sr. Vice President & Medical Director The Zenith October 10, 2013 Written Comment	As for the use of an alternative to the DWC Form RFA, see response to September 27, 2013 comment by Linda Larkins regarding section 9792.9.1(c)(2). See also response to above comment by California Applicants' Attorneys Association regarding section 9792.9.1 and the determination of a "receipt date." See above response to comment by CWCI regarding the DWC Form RFA. The Division is considering this suggestion in conjunction with a revision of DWC Form PR-2.	No action necessary.

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	course of treatment in a manner that does not utilize the DWC Form RFA, the claims administrator or reviewer will have to respond to the request, even though it is not on the RFA, and either accept the submission as a complete treatment request or send a letter stating why they are returning the request. If the claims administrator is going to reject the submission, it must do so within 3 business days and send a letter explaining why the submission is rejected. Subsection (c)(2) as written does not require the provider to include any language in the submission stating the submission is a treatment request. Commenter notes that the subsection also does not address what happens if a treating physician makes a submission they believe contains a request for treatment but the claims administrator simply misses the language the provider believes is conveying the request because it was buried in the report. As written, 9792.9.1(c)(2) requests the claims administrator to review all submissions for anything that might be a treatment request and allows the provider to simply ignore			

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	9792.9.1(a) which requires the request to be submitted on the RFA. Commenter opines that this defeats the purpose of the RFA which is to assist with more easily identifying treatment requests and to trigger the processes that would lead up to IMR. Commenter notes that the wording in 9792.9.1(c)(2) requires the claim administrator to accept or reject the request within 3 business days. If the administrator fails to recognize the request and therefore neither accepts or rejects it, the treatment will be considered approved by default. Commenter states that this does not align with the definition of "Request for Authorization" contained in 9792.6.1(t) which implies that unless a claims administrator accepts a submission, the request for treatment must be set forth on the RFA. Commenter states that the definition of "Utilization Review process" under 9792.6.1(y) provides that the process "begins when the completed DWC Form RFA is first received…" Commenter opines that this definition would have to be aligned with the			

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	non-RFA language if non-RFA submissions are permitted. Commenter states that under 9792.12(b)(4)(C) and (D) the administrator may be subject to fines and penalties for failure to make a decision within the specified time frame. Commenter opines that in an audit situation, the auditor could find the claims administrator should have recognized the request and impose findings and penalties for failure to comply with requirements. Commenter requests that the division employ one of the following approaches: • The requirement to use the RFA be reinstated and enforced unless the claims administrator choose to accept an incomplete RFA; or • The RFA be discarded and the PR2 be modified to include a notation that a treatment request is included on the report and the provider be required to specify what treatment is being requested on			

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	the report; or • The provision be modified to state that the claims administrator and provider can agree that a treatment request can be submitted in a form that is mutually agreeable to both parties but otherwise the request must be submitted on a RFA form. Anything submitted that is not either on the RFA or the agreed format is automatically not considered a treatment request with no additional action taken by the claims administrator. Commenter opines that if no modifications are made, that the conflicting sections of 9792.9.1 be modified to eliminate conflicts.			
9792.10.6(i) and 9792.10.7(b)	Commenter recommends deleting the provision allowing the AD to issue an order to show cause for the assessment of penalties under §9792.10.6(i) and §9792.10.7(b). Commenter opines that credible complaints regarding a claims administrator's compliance with IMR requirements should be documented in the claims administrator's file for investigation during the next regularly	Peggy Thill Claims Operations Manager Yvonne Hauscarriague Assistant Chief Counsel State Compensation Insurance Fund	See response to comments by Republic Indemnity Company regarding these subdivisions. .	No action necessary.

	scheduled PAR/UR Investigation.	October 11, 2013 Written Comment		
9792.6; 9792.9 and 9792.10	Commenter states that these sections effectively became legacy regulations on 7/1/2013. By the time that permanent regulations go into effect on 1/1/2014, the only purpose that these sections will serve is to inform triers of fact as to the regulatory requirements that were in effect from 1/1/2013 to 6/30/2013. For this reason, commenter recommends that the permanent regulations for sections 9792.6, 9792.9 and 9792.10 should consist of the emergency regulations currently in effect for these sections; without any amendments of any kind. Commenter opines that to do otherwise provides no perceivable benefit; and risks incorrect findings at the WCAB arising from application of incorrect standards to UR conducted between 1/1/2013 and 6/30.213; and/or conflict resolution arising from such review.	Robert Ward October 10, 2013 Written Comment	The regulations take into consideration, for injuries occurring prior to January 1, 2013, utilization review decisions that are communicated both prior to July 1, 2013 and those after that date, when the request for authorization is received prior to July 1. Amended in the emergency regulations to accommodate the timeframes for the implementation of the IMR program (see Labor Code section 4610.5(a)), the regulations are no longer in use, but remain to provide a distinction between the two-track IMR process created by section 4610.5. The Division anticipates their deletion in future rulemaking.	No action necessary.
General Comment	Commenter opines that the IMR requirement is distressing to those who serve workers injured by burns.	Susan A. Callihan Medical/Legal Coordinator	The comment appears to be aimed at the mandates of Labor Code sections 4610,	No action necessary.

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	Commenter opines that most clinicians who review requests for authorization are unfamiliar with treatment of burns and rely solely on "guidelines", which often do not address treatment of burns or burn reconstruction. Commenter states that these reviewers deny requests for time-sensitive items such as compression garments for scar management. Garment therapy, when needed, has to be initiated immediately, when requested, not months down the road. The longer garment therapy is delayed, the more likely it is the patient will require expensive reconstructive surgery, which then delays the injured worker's ability to return to work. Commenter states that physical and occupational therapy is another area where there are a lot of denials (or modifications, as if the reviewer knows the patient's needs better than the treating physician). Commenter opines that an IW with burned hands and/or arms may very well need months of therapy for optimal	Grossman Medical Group September 30, 2013 Written Comment	4610.5 and 4610.6, rather than the requirements of the regulations that implement those statutes. The Division cannot respond for the Legislature.	

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	restoration of function, again with the goal of returning him/her as close to his/her pre-injury state as possible. Commenter opines that the lengthy IMR process serves only to delay needed therapies for those unfortunate IWs who sustained severe or catastrophic burns, costing the insurers more in the long run than the therapy being denied. Commenter states that many injured workers get the IMR form and haven't a clue what to do with it. Commenter opines that it is this type of rule that drives injured workers to get legal representation, and legal representation ALWAYS results in a higher award than the patient would otherwise have gotten, thus being more costly to the insurers. Commenter states that so many IMR requests are coming in, now the			

	system is unable to handle the load. Commenter opines that this is the unintended consequence of poor legislation that causes harm to the IWs the system is supposed to help.			
Physician Return-to-Work and Voucher Report	It is the commenter's understanding that this new report is to be attached to the PR-3 or PR-4 report. Since this is a new burden on physicians and the report provides valuable information for the carrier in determining functional limitations, commenter opines that it is reasonable that the physician be reimbursed for this report. Commenter requests that the Division clarify that the Physician Return-to-Work and Voucher Report be considered an additional page in the PR-3 or PR-4 report, allowing providers to bill for the additional page of the report.	Diane Przepiorski Executive Director October 10, 2013 Written Comment	The Physician's Return-to-Work & Voucher Report is part of the Supplemental Job Displacement Benefit regulations which are not a part of this rulemaking. The report is to be attached to a comprehensive medical-legal evaluation from either a treating physician or a QME which have differing fee schedules.	No action necessary.
General Comment	Commenter states that there is a perception that one of the intentions of SB863 was to remove from WCAB judges the ability to make decisions on medical necessity. Applicant attorneys and WCAB judges are currently	Robert Ward October 10, 2013 Written Comment	The comment appears to be aimed at the mandates of Labor Code section 4610, rather than the requirements of the regulations that implement those statutes.	No action necessary.

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	actively seeking overturn of UR on technical grounds, precisely to place medical necessity determinations back into the hands of the WCAB judges. The CAAA has recommended to its members that they seek an expedited hearing to contest the validity of each and every adverse determination issued through UR. Applicant attorneys have heard this message, and the frequency of such expedited hearings has recently increased dramatically. Such hearings will continue to be a common and expensive feature in the work comp landscape, unless the DWC places limits. Currently, the experience at the WCAB is that if there are any technical errors of any kind in the conduct of UR, the UR is deemed inadmissible and the care is immediately ordered as authorized; even if there is significant potential for harm to the patient and no meaningful probability of benefit. The approach to this issue that was placed in 9792.10.7(d) for IMR serves as a model for a possible approach to this problem for UR. Under the		Since Labor Code section 4610 is silent as to the remedy for a "defective" UR decision, the Division believes that determinations regarding this issue are best left to the Legislature or the judicial process. .	

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	proposed regulations for IMR, if an IMR determination is found by the WCAB not to have standing, rather than control of medical determinations reverting to the WCAB, the case is instead remanded to the DWC and the DWC obtains a new IMR. Similarly, the DWC could prepare regulatory language that limits the actions of the WCAB judge upon finding of technical errors in the conduct of UR (e.g., untimely completion, notice, etc.) to either; (a) accepting the UR determination into evidence in spite of the noted errors, or (b) remanding the disputed UR back to the claims administrator for a new UR, to be completed within the time frames indicated in 9792.9.1; with the date of the WCAB judge's demand for a new UR to substitute for the date of receipt of request for authorization. This approach would eliminate the incentive for AAs to seek frequent expedited hearings; would serve to reduce or remove medical decision			

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	making from judges; and would prevent harm to injured workers arising from inappropriate care. This approach should also be compliant with the newly adopted regulation 10451.2(c)(1)(C): "a dispute over whether UR was timely undertaken or was otherwise procedurally deficient; however, if the employee prevails in this assertion, the employee or provider still has the burden of showing entitlement to the recommended treatment." Since entitlement under LC4600(a) rests on medical necessity, it follows that absent meaningful evidence of medical necessity, care should not be authorized.			